September 11, 2017

Seema Verma,
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Administrator Verma:

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit comments regarding the Centers for Medicare & Medicaid Services' (CMS) proposed rule, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program," published July 13, 2017.

CHIME is an executive organization serving more than 2,400 chief information officers (CIOs) and other senior health information technology leaders at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business technology systems that are facilitating healthcare transformation.

Appropriate Use

New requirements stemming from the Protecting Access to Medicare Act (PAMA) signed into law in April 2014, call for clinicians to employ "appropriate use" criteria (AUC) when ordering advanced imaging studies. The AUC program has far-reaching implications and applies to every physician or other practitioner who orders or furnishes advanced diagnostic imaging services (i.e., magnetic resonance imaging (MRI), computer tomography (CT) or positron emission tomography (PET)). CMS notes that the current list of priority clinical areas for which this policy applies represents about 40 percent of all advanced diagnostic imaging services reimbursed by Medicare.

CHIME agree with CMS that AUC needs to be integrated as seamlessly as possible into a clinician's workflow. We also agree that clinical decision support mechanisms (CDSMs) are likely to be more effective when they are integrated into existing EHRs as opposed to be stand-alone systems. The

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law is very prescriptive with the way the AUC program will function and outlines four major components beginning with the establishment of the program by November 1, 2015; identifying the mechanisms that clinicians must consult (CDSMs) by April 1, 2016; requiring clinicians to consult these mechanisms when ordering certain images combined with the rendering clinician reporting that the AUC was indeed consulted by the ordering clinician by January 1, 2017; and finally an annual identification of clinicians considered to be "outliers" also by January 1, 2017. Those clinicians identified as outliers will be required to seek prior authorizations for patient imaging beginning January 1, 2020.

Since CMS did not meet the April 1, 2016 deadline to name approved mechanisms, the agency was unable to meet the other succeeding deadlines. As such, CMS has proposed delaying the date by which clinicians must consult CDSMs from January 1, 2018 (already delayed one year beyond the statutory deadline) to January 1, 2019. **CHIME strongly supports this extension and appreciates that CMS has taken into consideration feedback offered previously by CHIME requesting the deadline be extended.** As we have described to CMS in the past, providers need ample time to secure requisite technology and install it, including time for educating clinicians and adapting workflow. Given the list of approved CDSMs was only made available with less than six months to the earlier established deadline of January 1, 2018, this would not have provided sufficient time to accommodate this process.

The law also says that CMS may exempt a clinician from the AUC policy if meeting it would represent a significant hardship. Previously CMS had proposed that the AUC hardship policy follow the Meaningful Use exception policy. The Meaningful Use exception policy included exceptions available for insufficient internet connectivity, clinicians who have been practicing for less than two years, extreme and uncontrollable circumstances, lack of control over the availability of certified electronic heath record technology (CEHRT) and lack of face-to-face patient interaction. However, in this new proposed rule CMS has called for largely aligning the AUC hardship policy with the Advancing Care Information (ACI) performance category of the Merit-based Incentive Payment System (MIPS) since this new program supplants the Meaningful Use program for Medicare clinicians. They call for doing this by granting hardships for all but one of the aforementioned categories for clinicians who have had their ACI category re-weighted to zero.

Specifically, CMS calls for adopting the same types of hardships previously adopted under Meaningful Use, except for clinicians practicing for less than two years since those clinicians are already exempted from having to meet MIPS. Further, CMS calls for automatically exempting clinicians who have had their ACI category reweighted to zero for one of the other remaining criteria (insufficient internet connectivity, extreme and uncontrollable circumstances, lack of control over availability of CEHRT, and lack of face-to-face interaction). **CHIME supports this proposal and appreciates CMS' efforts to align the AUC criteria with the MIPS program.** CMS also states that they will establish a separate process that mimics these criteria for those clinicians who may need a hardship but have not had their ACI category re-weighed to zero, though they say it may be granted for less than 12 months. To maintain consistency, we recommend CMS grant these hardships for a 12-month period as well.

We do seek clarification, however, on one point. CMS notes that the hardship would only apply to the ordering clinician. Since the claims would be submitted by the clinician rendering the image, how does CMS plan to ensure their claims are not denied if the ordering clinician has been exempted?

Medicare Telehealth Services

Under CMS' policies, several conditions must be met before Medicare will reimburse for telehealth services. Namely, the service must be on the list of Medicare telehealth services and meet all of the following additional requirements: 1) The service must be furnished via an interactive telecommunications system; 2) The service must be furnished by a physician or other authorized practitioner; 3) The service must be furnished to an eligible telehealth individual; and 4) The individual receiving the service must be located in a telehealth originating site. Also, with some limited exceptions, the services must be delivered through an interactive telecommunications system that includes two-way, real-time interactive communication between the patient and provider.

In the proposed rule, CMS calls for adding additional telehealth services to those already reimbursed by Medicare. These services include:

- Counseling visit to discuss the need for lung cancer screening using low dose CT scan;

- Psychotherapy for crisis with the explicit condition of payment that the distant site practitioner be able to mobilize resources at the originating site to defuse the crisis and restore safety.

CMS has also proposed reimbursing for the following services which are considered "add-on codes," meaning, they refer to additional conditions that would be reimbursable when reported with existing codes. These include:

- Interactive complexity services (factors that complicate the delivery of a primary care psychiatric procedure);
- Administration of a patient-focused health risk assessment instrument (i.e. health hazard appraisal); and
- A comprehensive assessment of and care planning for patients requiring chronic care management services.

CHIME supports CMS' proposal to increase the types of services reimbursable using telehealth technology. However, we continue to hear from members that the pace by which CMS is increasing Medicare telehealth reimbursement is too slow and is hampering reimbursement among other payers. We recommend CMS continue to speed the pace and number of services for which patients may seek care via telehealth and for which clinicians and providers are reimbursed.

CMS reiterates that Medicare reimbursement for telehealth services is restricted by statute and limits the use of telehealth by defining both eligible originating sites (the location of the beneficiary) and the distant site practitioners who may furnish and bill for telehealth services. Originating sites are limited both by geography and provider setting. CMS says they have the authority to add to the list of eligible services but they are precluded from changing policies associated with geography, patient setting, or type of furnishing practitioner because these requirements are set in statute.

CMS specifically seeks comments on how they can further expand access to telehealth services within the current statutory authority. **Because 1834(m) of the Social Security Act requires that telehealth utilize an "interactive telecommunications system," we urge CMS to update their old definition established in 2001 of an "interactive telecommunications system" to reflect the wide range of connected health technology available today.** CMS should also exercise its established authority to waive arduous restrictions imposed by 1834(m) on "telehealth. The term "interactive telecommunications system" is not defined in Section 1834(m) or any other relevant statute text. CMS' legacy definition of the statutory term "interactive telecommunications system" to require the use of "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication" is now unmistakably out-of-date, given the diverse and innovative developments in connected health technology since 2001. We further note that Section 190 in Chapter 12 of the Medicare Claims Processing Manual notes that "[a]n interactive telecommunications system is required as a condition of payment; however, [the law] does allow the use of asynchronous 'store and forward' technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii."

Conclusion

CHIME appreciates the opportunity to offer our perspective on these policy issues. Should you have any questions concerning our comments please contact Mari Savickis, Vice President, Federal Affairs at msavickis@chimecentral.org.

Sincerely,

Russell P. Branzell, CHCIO, LCHIME
President and CEO
CHIME

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