

April 22, 2013

Ms. Marilyn Tavenner - Centers for Medicare and Medicaid Services
Farzad Mostashari, M.D. - Office of the National Coordinator
The Department of Health and Human Services
Attention: Interoperability RFI
Hubert H. Humphrey Building, Suite 729D
200 Independence Ave, S.W.
Washington, DC 20201

**Subject: CMS-0038-NC: *Advancing Interoperability and Health Information Exchange*,
Request for Comments**

Dear Ms. Tavenner and Dr. Mostashari:

The Private Practice Section of the American Physical Therapy Association (PPS) is pleased to submit these comments and suggestions in response to your request for information published in the *Federal Register* on March 7, 2013, for the “*Advancing Interoperability and Health Information Exchange*.”

The over 4200 members of PPS own and operate physical therapy businesses that provide convenient, cost-effective rehabilitative therapy to patients across the spectrum of impairments and functional limitations secondary to neurologic and/or musculoskeletal conditions. The PPS endeavors to foster the growth, economic viability, and business success, of physical therapist-owned physical therapy services provided for the benefit of the public.

As you proceed with your efforts to accelerate health information interoperability, PPS urges you to be continuously mindful of non-physician providers, including the constituency we represent, the independent physical therapists who are an integral element of our nation's delivery system. PPS members provide a valuable service to communities across the country and they do so in a convenient cost-effective manner.

This letter contains PPS's responses to selected questions as well as some additional observations with respect to the CMS/ONC request for information, *Advancing Interoperability and Health Information Exchange*.

1. *What changes in payment policy would have the most impact on the electronic exchange of health information, particularly among those organizations that are market competitors?*

PPS Comment:

- a. As you know, nonphysician health professionals, such as private practice physical therapists, were not included in the EHR stimulus programs that encourage and reward the adoption of health information technology by physicians and hospitals. Yet, physical therapists provide an important and valuable service that should be included in coordinated care and in electronic communication. These providers and their patients

are disadvantaged when the field is not level and the market is distorted. Thus, these professionals are not able to offset costs of EHR implementation through meaningful use incentives. Because of this fact, it is imperative that nonphysician professionals be afforded access to the same incentives, and a comparable overall timeframe before penalty, to implement EHR systems. This fundamental flaw should be promptly corrected.

- b. Future federal policies should consider requiring all health care providers across all settings to record and share the patient's functional status as part of an electronic file whenever a patient is being transferred or referred.
- c. In order to ensure interoperability, HHS must set the standards for information transmission similar to the guidance used by the FCC and the FAA. An "information superhighway" that does not carry all traffic is not helpful.

2. Which of the following programs are having the greatest impact on encouraging electronic health information exchange: Hospital readmission payment adjustments, value-based purchasing, bundled payments, ACOs, Medicare Advantage, Medicare and Medicaid EHR Incentive Programs (Meaningful Use), or medical/health homes? Are there any aspects of the design or implementation of these programs that are limiting their potential impact on encouraging care coordination and quality improvement across settings of care and among organizations that are market competitors?

PPS comment: From the models in the above list, PPS believes the ACO program (and to a lesser degree the medical homes) will most encourage electronic health information exchange. Accountable care organizations rely on the use of real time data on quality in order to operate efficiently. However, ACOs and medical homes may have a limited influence on HIE due to the low number of participants. And it remains to be seen to what extent hospitals develop partnerships with independent nonphysician professionals in their communities. Our members' experiences indicate very little of this activity to date.

Moreover, because ACOs rely on health information technology, it is imperative that the field be leveled as independent therapists do not have access to the capital (government stimulus funds) available to physicians and hospitals. And those organizations often view independent PTs as competitors, meaning the therapists are highly unlikely to be offered financial assistance despite the presence of the EHR exception to the federal Physician Self-Referral law and EHR safe harbor to the federal Anti-Kickback Statute which protect the donation of certain software and related training and services when various requirements are met. In other words, the very policy intended to foster collaboration between and among providers, is the same that could be used to collude against market competitors.

PPS believes programs and policies should not pursue EHR use as the ultimate, but rather as a byproduct that develops because the incentives result from the benefits of delivering high-quality services efficiently. Done in this way, providers will expand use of EHR and demand interoperability from the marketplace.

Nevertheless, it is recognized that the Medicare and Medicaid EHR Meaningful Use Incentive Programs have had the greatest impact on encouraging health information exchange. Without these monetary incentives many hospitals and eligible providers could not have afforded to

obtain or update their HIT systems. Because of this fact, it is imperative that nonphysician professionals such as independent physical therapists be afforded access to the same incentives, and a comparable overall timeframe, to implement EHR systems.

3. To what extent do current CMS payment policies encourage or impede electronic information exchange across health care provider organizations, particularly those that may be market competitors? Furthermore, what CMS and ONC programs and policies would specifically address the cultural and economic disincentives for HIE that result in "data lock-in" or restricting consumer and provider choice in services and providers? Are there specific ways in which providers and vendors could be encouraged to send, receive, and integrate health information from other treating providers outside of their practice or system?

PPS comment: Transitions of care, be they transfers, referrals, or discharges, represent an opportunity for gaps in care, continuity disruption, redundant tests and measures, patient confusion, risk of noncompliance and many other incidents that can contribute to low quality care and perhaps a less than optimal outcome. These experiences are more costly for the payer and less satisfying for the patient. PPS believes federal policies should require all health care providers across all settings to record and share the patient's functional status (using valid, reliable and responsive measures) as part of an electronic file whenever a patient is being transferred or referred.

4. What CMS and ONC policies and programs would most impact post-acute, long term care providers (institutional and HCBS) and behavioral health providers' (for CMS-0038-NC 17 example, mental health and substance use disorders) exchange of health information, including electronic HIE, with other treating providers? How should these programs and policies be developed and/or implemented to maximize the impact on care coordination and quality improvement?

PPS comment: See response to Question 3

5. How could CMS and states use existing authorities to better support electronic and interoperable HIE among Medicare and Medicaid providers, including post-acute, long-term care, and behavioral health providers?

PPS comment: See response to Question 3

6. How can CMS leverage regulatory requirements for acceptable quality in the operation of health care entities, such as conditions of participation for hospitals or requirements for SNFs, NFs, and home health to support and accelerate electronic, interoperable health information exchange? How could requirements for acceptable quality that involve health information exchange be phased in overtime? How might compliance with any such regulatory requirements be best assessed and enforced, especially since specialized HIT knowledge may be required to make such assessments?

PPS comment: HHS and Congress should apply robust resources to the development of regional health information organizations (RHIOs) across the country. Standards should be set by HHS including and especially those for interoperability. Then with modest incentives providers will move quickly to create their own interface with the RHIO in order to communicate

with their professional colleagues about their patients. Consistency of standards between regions will foster continuity of care through nationwide interoperability.

7. How can CMS leverage regulatory requirements for acceptable quality in the operation of health care entities, such as conditions of participation for hospitals or requirements for SNFs, NFs, and home health to support and accelerate electronic, interoperable health information exchange? How could requirements for acceptable quality that involve health information exchange be phased in overtime? How might compliance with any such regulatory requirements be best assessed and enforced, especially since specialized HIT knowledge may be required to make such assessments?

PPS comment: See response to Question 6

8. How could the EHR Incentives Program advance provider directories that would support exchange of health information between Eligible Professionals participating in the program. For example, could the attestation process capture provider identifiers that could be accessed to enable exchange among participating EPs?

PPS comment: Provided the previous recommendations for nonphysician provider incentives, stimulus and comparable time are met, the agencies could then publish and maintain an up-to-date online directory of RHIOs and their qualified participating providers.

9. What CMS and ONC policies and programs would most impact patient access and use of their electronic health information in the management of their care and health? How should CMS and ONC develop, refine and/or implement policies and program to maximize beneficiary access to their health information and engagement in their care?

PPS comment: HHS could require providers to include in the patient record, an item that indicates the degree to which, if any, the patient felt involved in the clinical decision-making process. This information would be reportable at any transition of care, be that a transfer, a referral or a discharge. Building on a program such as this would increase shared decision-making and patient involvement in their health care.

General Comments

- a. Advancing Interoperability and HIE--** In formulating policies relating to health information exchange among stakeholders, PPS emphasizes that not only is it important to encourage the implementation of secure health information exchange, but to ensure that the data exchanged is the most useful for the patient's care and for the providers at the particular setting to which the patient is being transitioned. But need for information exchange goes beyond the instance when a patient is being transitioned. Beneficiaries being treated in ambulatory outpatient offices are frequently seen by numerous practitioners for various conditions, some related, some not. Consequently, all of the patient's providers should have access to the documentation of all other professionals in order for the care to be most coordinated, comprehensive and timely.
- b. Disability Status and Meaningful Use Requirements**
PPS supports the statement submitted by the American Physical Therapy Association with respect to the use of the term "disability status" in the Meaningful Use Stage 2

proposed rule. HHS requested input regarding whether EHR technology certified to the 2014 Edition EHR certification criteria should be capable of recording the functional, behavioral, cognitive, and/or disability status of patients (collectively referred to as "disability status."). Specifically, the department asked whether there is an existing standard appropriate for recording disability status and referenced the ICF and the Continuity Assessment Record and Evaluation (CARE) tool as potential tools for recording and reporting disability status.

Physical therapists provide health services to individuals with impairments, limitations and disabilities and, therefore, would be involved in the collection of data and determination of disability status. Physical therapy services encompass the diagnosis of, interventions for, and prevention of impairments, activity limitations, and participation restrictions related to movement, function and health. (Guide to physical therapist practice, second edition. *Phys Ther.* 4 2001;81(1):9-746.) They are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations.

Rather than including "disability status" as information that is exchanged among providers, PPS recommends including a patient's "functional status" as exchanged information, with the proviso that the functional status be determined using measures that are valid, reliable and responsive.

The use of the term "functional status" in place of "disability status" is supported by the 2007 Institute of Medicine's (IOM) report, which includes a framework and vocabulary standard that embraces the International Classification of Functioning, Health and Disability (ICF). Organizing content around the ICF domain categories would be highly logical, consistent with the IOM recommendations and advantageous in retrospective analyses of data.

c. Continuity Assessment Record and Evaluation (CARE) Tool

PPS joins APTA in its description of the shortcomings of the Continuity Assessment Record and Evaluation (CARE) tool as the preferred method of assessing a patient's status across settings. The CARE tool is not widely accepted in the clinical community for many reasons including administrative burdens, lack of sensitivity and questionable psychometrics. Therefore, PPS does not support the use of the CARE tool as the preferred method of assessing a patient's status across settings.

Conclusion

As was pointed out in the RFI itself, incentives to date are not enough to bring about the widespread interoperability and electronic exchange of information necessary for delivery reform where information will routinely follow the patient regardless of where they receive care.

In addition to our above recommendations, PPS urges the agencies and Congress to extend to non-physician providers the same incentives previously directed to physicians and hospitals to establish electronic health records and a comparable overall timeframe before penalty. Non-physician providers such as independent physical therapists provide an important and valuable service that should be coordinated and communicated electronically.

The sooner Congress and the administration can set the standards for interoperable electronic health records that include independent physical therapists, the sooner waste and redundancy can be wrung out of the system and high-value care ensured.

Thank you for the opportunity to respond to your RFI. The Private Practice Section of the American Physical Therapy Association is eager to work with the agencies to advance interoperability and health information exchange.

Sincerely,

A handwritten signature in cursive script that reads "Tom DiAngelis".

Tom DiAngelis, PT, DPT
President
Private Practice Section/APTA