

September 7, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
PO Box 8011
Baltimore, Maryland 21244-1850

RE: Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements [CMS-1751-P]

Dear Administrator Brooks-LaSure:

On behalf of the American Health Information Management Association (AHIMA), thank you for the opportunity to provide comments on the proposed changes to the Payment Policies Under the Physician Fee Schedule for Calendar Year (CY) 2022, as published in the July 13, 2021 Federal Register (CMS-1751-P).

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. AHIMA's mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and providers. Our leaders work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide.

Our comments and recommendations on selected sections of the Physician Fee Schedule proposed rule are below.

D. Telehealth and Other Services Involving Communications Technology, and Interim Final Rule with Comment Period for Coding and Payment of Virtual Check-in Services-- Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

AHIMA supports the use of public policy and other tools to expand access to care, reduce costs, and improve convenience for patients by using telehealth. HI professionals have considerable knowledge and relevant experience to contribute to the development of public policy that seeks to expand telehealth while ensuring the continuity of accurate, timely, and trusted health information. AHIMA appreciates CMS' attention to the need to safely expand access to these services both during and after the Covid-19 Public Health Emergency (PHE).

Revised Timeframe for Consideration of Services Added to the Telehealth List on a Temporary Basis

In response to the COVID-19 PHE, CMS created a category of criteria for adding services to the Medicare telehealth services list on a temporary basis. This category included the services that were added during the PHE to ensure patient access to care is maintained despite the ongoing pandemic. The agency believed that there is likely to be clinical benefit when furnished via telehealth but acknowledged that sufficient evidence was not yet available to consider including the services as permanent additions to the Medicare Telehealth list under Category 1 or Category 2 criteria. CMS noted that the agency “recognized that the services we added on a temporary basis under Category 3 would ultimately need to meet the criteria under Categories 1 or 2 in order to be permanently added to the Medicare telehealth services list, and that there was a potential for evidence development that could continue through the Category 3 temporary addition period.”¹ To allow for evidence development, CMS stated “that any service added on a temporary basis under Category 3 would remain on the Medicare telehealth services list through the end of the calendar year in which the PHE for COVID–19 ends.”²

When it was proposed, AHIMA supported this policy, noting that it would be disruptive to both clinical practice and beneficiary access to abruptly eliminate Medicare payment for telehealth services as soon as the PHE ends without first providing an opportunity to use information developed during the PHE to support requests for permanent changes to the Medicare telehealth services list. In response to calls for further clarification, CMS is now proposing “to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023.”³ This proposal would clarify the timeline for evidence generation, rather than directly connecting it to the termination of the PHE. AHIMA supports this proposed change and believes that a sufficiently long and clearly defined timeline for evidence generation and consideration will support patient access to care while ensuring that Medicare program integrity is protected. AHIMA encourages the agency to continue to consider data over the next year for potential inclusion of Category 3 telehealth services in Categories 1 or 2 in forthcoming rulemaking. Additionally, AHIMA believes that CMS should consider extending the timeframe for evidence generation beyond CY 2023, if the PHE is extended beyond 2023. This would ensure that Medicare beneficiaries do not lose access to telehealth services during the PHE.

Implementation of Provisions of the Consolidated Appropriations Act, 2021 (CAA)

AHIMA believes that policy must ensure that patients and providers are not arbitrarily limited by geography or modality when receiving or offering telehealth services. Policy must also ensure that patients have access to telehealth services anywhere, including at home. As such, AHIMA strongly supports implementation of provisions of the Consolidated Appropriations Act (CAA) that “broaden the scope of services for which the geographic restrictions under section 1834(m)(4)(C)(i) of the Act do not apply and for which the patient’s home is a permissible originating site to include telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished on or after the end of the PHE for COVID-19.”⁴

¹ 86 Fed. Reg. at 39136

² Id.

³ 86 Fed. Reg. at 39137

⁴ 86 Fed. Reg. at 39145

CMS is soliciting comments on whether a claims-based mechanism could be used to distinguish between visits newly authorized under the CAA, and those that had already been authorized prior to passage of the CAA. To distinguish between a newly authorized mental health telehealth visit and a previously authorized telehealth visit to treat substance use disorder, AHIMA notes that the combination of the use of a mental health or behavioral health diagnosis codes on the claim for which no substance use disorder code is reported, place of service is home, and for which modifier 95 is used would identify a mental health telehealth visit that is newly covered under the CAA.

The CAA also prohibits payment for a telehealth service furnished in the patient's home "unless the physician or practitioner furnishes an item or service in-person, without the use of telehealth, within 6 months prior to the first time the physician or practitioner furnishes a telehealth service to the beneficiary, and thereafter, at such times as the Secretary determines appropriate."⁵ The agency is seeking comment on "whether the required in-person, non-telehealth service could also be furnished by another physician or practitioner of the same specialty and same subspecialty within the same group as the physician or practitioner who furnishes the telehealth service."⁶ The agency notes there are several circumstances "under which we have historically treated the billing practitioner and other practitioners of the same specialty or subspecialty in the same group as if they were the same individual."⁷ AHIMA believes the agency should ensure parity between telehealth services and in-person services and that policy must treat remote services no differently than services provided to patients in-person in terms of the scope of services that can be provided. Therefore, AHIMA supports alternative policy to also "allow the prerequisite in-person, non-telehealth service for certain mental health telehealth services to be furnished by a practitioner in the same specialty/subspecialty in the same group when the physician or practitioner who furnishes the telehealth service is unavailable or the two professionals are practicing as a team."⁸

Payment for Medicare Telehealth Services Furnished Using Audio-Only Communication Technology

The agency is proposing to amend the definition of "interactive telecommunications system to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients when the originating site is the patient's home."⁹ AHIMA believes that policy must encourage all technologies and/or modes of telehealth, provided the technology is safe, effective, appropriate, secure, interoperable, and can be integrated into a provider's clinical workflow. AHIMA concurs with the agency that this proposal would promote access to care. AHIMA notes that broadband access is a significant barrier to health equity and concurs with the agency that this policy change would be especially beneficial for patients with poor broadband access. AHIMA concurs with limiting permissible originating sites to the patient's home and agrees that other originating sites are likely to have stronger broadband and that there are likely to be supports in place to ensure

⁵ Id.

⁶ 86 Fed. Reg. at 39146

⁷ Id.

⁸ Id.

⁹ 86 Fed. Reg. at 39148

that patients are comfortable using an audio-video platform. AHIMA also supports CMS' proposal to create a service level modifier to identify mental health telehealth visits "furnished to a beneficiary in their home using audio-only communications technology."¹⁰

The agency is soliciting comments regarding whether it would be appropriate to establish a different interval for subsequent in-person, non-telehealth visits when telehealth services for mental health condition to a patient at home is provided through audio-only technology. As stated above, AHIMA believes that policy must encourage all technologies and/or modes of telehealth, provided the technology is safe, effective, appropriate, secure, interoperable, and can be integrated into a provider's clinical workflow. As such, absent a clearly demonstrated safety, efficacy, appropriateness, or security issue necessitating a different interval, AHIMA believes that a different interval would be inappropriate and unduly burdensome on patients and providers.

Interim Final Provisions in the CY 2021 PFS Final Rule

In the 2021 PFS final rule, the agency finalized the establishment of HCPCS code G2252 on an interim basis. This code covers a brief virtual check-in service that may be provided via synchronous technology, including audio-only technology. CMS is now proposing to "permanently adopt coding and payment for CY 2022, HCPCS code G2252 as described in the CY 2021 PFS final rule."¹¹ AHIMA believes there will continue to be a need for audio-only interactions to determine the necessity of an in-person visit. As such, AHIMA supports this proposal to permanently adopt coding and payment for HCPCS code G2252.

F. Evaluation and Management (E/M) Visits

Critical Care by a Single Physician or NPP

CMS notes that the CPT prefatory language does not indicate how practitioners should report critical care services when a service lasts beyond midnight and is seeking comment regarding reporting of CPT codes 99291 and 99292 when a service extends beyond midnight to the following calendar day. AHIMA urges the agency to work with the AMA to have guidance added within the CPT prefatory language, so that consistent guidance exists across payers, rather than CMS addressing this issue on its own. AHIMA believes that this approach will lessen provider burden and confusion.

N. Medicare Provider and Supplier Enrollment

Expansion of Authority To Deny or Revoke Based on Office of Inspector General (OIG) Exclusion

The agency is proposing to expand the categories of parties within the purview of the denial and revocation provisions to include excluded administrative or management services personnel who furnish services payable by a federal health care program, such as a billing specialist, accountant,

¹⁰ 86 Fed. Reg. at 39150

¹¹ Id.

or human resources specialist. While AHIMA concurs that protecting Medicare program integrity is of the utmost importance, AHIMA notes that the Office of the Inspector General OIG List of Excluded Individuals and Entities (OIG LEIE) does not contain standardized name formats, which can cause inadvertent compliance issues.

Providers and facilities with large numbers of employees searching the OIG LEIE for exact matches with the intention of following OIG compliance guidance in conducting OIG LEIE searches on hire and periodically afterwards may inadvertently miss a match due to a lack of standardization in the entries within the OIG LEIE. For example, it is possible that a potential hire with a common name and several common nicknames may apply for a job under a name that is not an exact match with the name listed for that individual on the OIG LEIE. AHIMA recommends that CMS consider an exception if the provider can demonstrate a good faith effort to identify potentially excluded individuals by running searches of employees or other personnel against the OIG LEIE, for which such searches did not reveal an actual or potential match, despite a good faith effort to conduct a screening search.

Closing the Health Equity Gap in CMS Clinician Quality Programs—Request for Information (RFI)

In recognition of persistent health disparities and the importance of closing the health equity gap, CMS is requesting information on improving demographic data collection. AHIMA appreciates CMS' attention to this critical issue and supports efforts to close the health equity gap, both in the face of the ongoing pandemic and in healthcare more generally.

AHIMA supports the standardized collection of accurate and complete patient demographic and social determinants of health data and notes this data must be collected in ways that are culturally appropriate and community competent with an understanding of the community being served and related needs. AHIMA also recommends the agency prioritize addressing workforce development needs to ensure that the healthcare workforce is more equipped to consistently and accurately collect patients' demographic information in ways that are culturally sensitive. A culturally competent healthcare workforce will be a critical element in overcoming historical mistrust in healthcare institutions within certain communities. We also note that data on sexual orientation and gender identity is frequently not collected at the time of admission. AHIMA recommends working to ensure there is a standardized methodology in place to capture these demographic elements, as a patient's gender identity or sexual orientation may change over time.

AHIMA also recognizes the role of technology in closing the health equity gap. We recommend leveraging technology to analyze quality-of-care and outcomes using both patient demographics and clinical data to identify and address disparities. This should include promoting the development of machine-learning and artificial intelligence techniques that identify and address biases in the data and avoid exacerbating existing health disparities and inequities.

Updates to the Quality Payment Program

Promoting Interoperability Performance Category

Proposed Changes to the Query of Prescription Drug Monitoring Program Measure under the Electronic Prescribing Objective

The agency is proposing for the 2022 performance year (PY 2022) to maintain the Electronic Prescribing Objective's Query of PDMP measure as optional with 10 associated bonus points. AHIMA appreciates that this proposal is in alignment with a similar proposal contained in the 2022 Inpatient Prospective Payment System proposed rule, as AHIMA believes that alignment across PI reporting programs will reduce compliance burden. AHIMA agrees that this measure should remain optional until exchange can be more uniformly supported across health care system stakeholders. In previous comments, AHIMA has stated operational concerns with fully integrating Health IT systems with PDMPs and agrees this measure should remain optional until these issues can be addressed.

Proposed Changes to the Provide Patients Electronic Access to Their Health Information Measure Under the Provider to Patient Exchange Objective

CMS is proposing to modify the Provide Patients Electronic Access to Their Health Information measure to require MIPS-eligible clinicians to ensure that patient health information remains available to the patient (or patient-authorized representative) to access indefinitely and using any application of their choice that is configured to meet the technical specifications of the API in the MIPS-eligible clinician's CEHRT. The new proposed requirement would apply beginning with the 2022 performance period and would include all patient health information from encounters on or after January 1, 2016. AHIMA has significant concerns with this proposal and urges the agency to rescind this new proposed requirement within the existing measure.

We note that, citing the significant operational concerns and lack of clarity surrounding this requirement, CMS has decided not to move forward with a similar proposal in the final Inpatient Prospective Payment System (IPPS) rule. AHIMA believes a similar approach is appropriate to ensure alignment across programs and to minimize compliance burden. Additionally, given that this proposal was withdrawn from the final IPPS rule, AHIMA believes that an indefinite requirement would be infeasible for providers that rely on facilities subject to the IPPS to be the custodians of their records, as those facilities would not be required to retain records indefinitely.

When considering the operational implications of this proposal, AHIMA is specifically concerned with the administrative burdens, costs, and security risks associated with a requirement to make information available indefinitely. AHIMA believes that this proposed requirement does not align with existing policies and standards at most healthcare facilities. We note that historically regulations regarding record retention have not contained indefinite requirements.¹²¹³ As such, the need to maintain records from old systems in perpetuity is likely to place substantial administrative burdens on MIPS-eligible clinicians and HIM professionals. Going forward into the future, AHIMA is concerned with how this requirement will age and believes there are likely to be substantial costs associated with maintaining records in numerous legacy systems, dating back to 2016. AHIMA also believes there are likely to be elevated risks in

¹² Pritts, Joy, et al. Office of the National Coordinator for Health IT, Aug. 2009. Privacy and Security Solutions for Interoperable Health Information Exchange.

¹³ Condition of participation: Medical record services, 42 CFR §482.24

the future associated with ensuring the security of decades-old records that were created on decades-old systems. AHIMA also requests clarification on the auditing process for this measure. Specifically, how long will MIPS-eligible clinicians need to keep documentation after this measure is completed and submitted?

AHIMA members have also expressed concerns related to retrieval of records using archival systems and we note many archival systems lack public facing capabilities. Absent this capability, it may be difficult and burdensome to make an archived record available to patients on demand in electronic format. AHIMA members believe most archival systems were not chosen with public facing capabilities in mind. This requirement effectively would require additional functionality from archival systems, which is not presently available, and which may impose additional costs on MIPS-eligible clinicians. Additionally, there are likely to be issues associated with data conversion as our members report that the data sets that are converted are usually smaller than what may be required under this proposal.

Continuing, AHIMA requests clarification on the term “patient health information.” It is unclear to AHIMA whether this term would refer to the designated record set, the elements included in the USCDI, or potentially a broader set of information. AHIMA believes there is an opportunity for harmonization with requirements contained in other recently finalized rules, including the ONC Cures Act final rule, and urges the agency to clarify this term. Absent this clarification, this requirement is likely to lead to undue burden and confusion for HIM professionals and MIPS-eligible clinicians.

AHIMA has for decades been generally concerned with the lack of specific guidance from both federal and state regulators about record retention, regardless of their format. States can have multiple, conflicting retention laws if they have any at all. Currently, there is a patchwork of state and federal retention requirements that are confusing to our members. While AHIMA welcomes standardized, retention timeline guidance, we are deeply concerned about having an ‘indefinite’ requirement.

Finally, AHIMA is concerned with the retrospective nature of this proposal. As this proposal would apply to encounters dating back to January 1, 2016, this proposal would effectively punish MIPS-eligible clinicians for failure to prepare for a requirement that they could not have possibly been aware of at the time. AHIMA notes that, absent a statutory requirement, retroactive requirements are only allowed in cases in which “failure to apply the change retroactively would be contrary to the public interest.”¹⁴ AHIMA believes, given the above stated operational challenges, that this new requirement may fail to meet this threshold.

Modifications to the Public Health and Clinical Data Exchange Objective

CMS is proposing to require reporting for two of the measures associated with the Public Health and Clinical Data Exchange Objective, beginning with the performance period in CY 2022: Immunization Registry Reporting and Electronic Case Reporting. Previously, MIPS-eligible clinicians were required to submit a yes/no response for two different public health agencies or clinical data registries for any of the five measures associated with the Public Health and Clinical

¹⁴ 42 U.S.C. § 1395hh(e)(1)(A)

Data Exchange objective. CMS' stated rationale for this requirement is that "these two measures would put PHAs on better footing for future health threats and a long-term COVID-19 pandemic recovery by strengthening two important public health functions: (1) vaccine uptake; and (2) case surveillance."¹⁵ AHIMA concurs that the proposed modifications to the objective could better prepare the healthcare system for future health threats and long-term pandemic recovery by strengthening critical public health functions. AHIMA supports the proposed modifications of this objective, noting that significant strides have been made in both immunization reporting and in electronic case reporting throughout the PHE, that have enabled those that previously lacked the resources to successfully report on these measures to now do so. AHIMA also supports the proposal to retain the Public Health Registry Reporting, Clinical Data Registry Reporting, and Syndromic Surveillance Reporting measures, and to make them optional and available for bonus points beginning with the performance period in CY 2022.

SAFER Guides

CMS is proposing to add a new SAFER Guides measure to the Protect Patient Health Information objective beginning with the 2022 performance period. For this measure, MIPS-eligible clinicians must attest to having conducted an annual self-assessment using the High Priority Practices Guide at any point during the calendar year in which the performance period occurs. The agency also proposes that this measure would be required, but it would not be scored, and that reporting "yes" or "no" will not affect the total score for the PI category. AHIMA agrees with the agency that this measure will encourage program participants to regularly assess their progress on practices to optimize the safety and safe use of EHRs. AHIMA concurs that it is appropriate to require using the High Priority Practices guide, and that this requirement balances the need to promote data privacy and security, without overly burdening MIPS-eligible clinician. AHIMA supports CMS' proposals to make this measure unscored and that attesting to either a "yes" or "no" will not impact the participant's total PI score.

Thank you for the opportunity to provide comments in response to the 2022 Medicare Physician Fee Schedule Proposed Rule. Should you or your staff have any additional questions or comments, please contact Lauren Riplinger, AHIMA's Vice President, Policy & Government Affairs, at lauren.riplinger@ahima.org and (202) 839-1218 or Matt Kerschner, AHIMA's Director of Regulatory Affairs at matthew.kerschner@ahima.org and (312)-233-1122.

Sincerely,



Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer

¹⁵ 86 Fed. Reg. at 39412