AAAHC

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

September 13, 2021

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

Via Electronic Submission at *http://www.regulations.gov*

RE: CMS-1751-P
RIN 0938-AU42

Dear Administrator Brooks-LaSure,

The Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) greatly appreciates the opportunity to submit comment to the Centers for Medicare & Medicaid Services (CMS) regarding the recently proposed 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.

The AAAHC is a private and independent 501(c)(3) non-profit accreditation organization formed in 1979. Since its inception, AAAHC has promoted a voluntary, peer-based, and educational survey process to advance patient care. These values hold true today, as embodied in our mission statement: *Improving health care quality through accreditation*. With more than 6,000 accredited organizations in a variety of ambulatory health care settings, AAAHC is a leader in developing Standards to advance and promote patient safety, quality care, and value for ambulatory health care through its accreditation programs, education, research, and other resources. Currently, more than 1,000 ASCs are committed to excellence through AAAHC accreditation under the deemed status program, making AAAHC the leading Medicare-approved, non-hospital accreditation organization in the country. AAAHC also provides accreditation services to the United States Coast Guard ambulatory health centers, Federally Qualified Health Centers that receive funds from United States Health Resource and Services Administration (HRSA), Indian Health Services funded health centers, and Correctional Healthcare units under the United States Federal Bureau of Prisons (BOP).Other AAAHC accredited organizations include Community Health Centers, Indian Health Centers, Student Health Centers, Medical Group Practices, and Office-based Surgery Procedure Centers.

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Telehealth Services for Mental Health

Request: Should certain telehealth services approved for use during the COVID-19 pandemic receive approval for use through 12/31/2023 to allow for continued evaluation?

Request: Should CMS cover audio-only telehealth for established patient diagnosis, evaluation, and treatment of mental health disorders from the patient's home where the beneficiary is not capable of (or does not consent to) audio-video technology BUT limit this coverage to providers capable of audio-visual communications?

Response: AAAHC believes that telehealth services, are necessary for ongoing access to care not only in the current pandemic environment but on an ongoing basis for those with resource limitations and medical conditions that affect their ability to access care; and, therefore, AAAHC supports CMS continuation of the telehealth approval for continued evaluation. AAAHC recommends that the evaluation include identification and application of quality standards necessary to ensure that any telehealth services paid for by Medicare are delivered in accordance with nationally recognized standards that demonstrate an organization's commitment to quality improvement and patient safety.

AAAHC recommends that CMS consider AAAHC Standards that require patient participation and empowerment, effective communication and sufficient time, address patient concerns and mental health status, among others, to potentially establish a telehealth medical home for those providers who increasingly bill Medicare for primary care telehealth services. AAAHC Standards that apply to the provision of telehealth services include requirements for covering appropriate and timely client triage, policies regarding crisis intervention and emergency services, plans for the use of technology and privacy protection, client-centered treatment plans, and evidence of sufficient and appropriate resources to deliver quality care. Requirements similar to the above, when combined with current Medicare requirements, such as information security, confidentiality, standards of care, appropriate training, and continuity of care, can ensure mental health services are properly planned for and provided to patients in a safe and quality manner, regardless of the modality used. AAAHC is available to collaborate with CMS in achieving this, or similar, efforts.

The resources available to various providers must also be given fair consideration. AAAHC believes that as long as nationally recognized quality standards are followed, providers lacking audio-visual communications are as capable of providing quality care to their patients as those who do have audio-visual communications access. Quality standards should be followed by all practitioners to ensure an ongoing commitment to quality care for beneficiaries during every interaction and each appropriateness of care determination. Reimbursing only those providers who can offer audio-visual telehealth services has the potential to further limit access to care, and AAAHC does not support this proposal. AAAHC recommends that CMS establish standards for all providers of telehealth services to ensure quality care is provided to all beneficiaries.

Request: Should additional documentation be required in the patient medical record to support the clinical appropriateness of audio-only telehealth, and should audio-only telehealth be precluded for high-level services (i.e., level 4 or 5 E/M visits or psychotherapy with crisis)?

Request: What guardrails should CMS consider to maximize program integrity and patient safety with telehealth, including intervals, appropriate services for audio-only interaction, and addressing care from an alternative provider where the beneficiary's regular practitioner is unavailable?

Response: AAAHC believes that documentation of clinical appropriateness for the delivery of any service is key to quality care and patient safety. Patient information should be reviewed and incorporated into the record as required by organizational policies, patients should be advised of necessity, appropriateness and risks of any proposed care provided through any modality, alternative models of care should be discussed, and continuity of care with patient follow-ups should occur. AAAHC supports requirements for appropriate documentation related to the appropriateness of care provided to patients.

Evaluation and Management (E/M) Visits

Request: Should CMS require medical record documentation identifying the two individuals who performed the visit with the individual providing the substantive portion signing and dating the medical record for E&M visit billing?

Response: Under current AAAHC Standards, Medical Records should always be maintained according to an organization's documented policies, including which information is required for inclusion. AAAHC Standards already require that the Clinical Records include the health care professional's signature at each visit.

Medical Nutrition Therapy

Request: Should CMS remove the requirement that the medical nutrition therapy referral be made by the "treating physician"?

Response: Under current AAAHC standards, referrals for care must come from an appropriate source. AAAHC Standards indicate that referrals should be appropriate and timely and clearly outlined to the patient. AAAHC does not support removing the requirement that the medical nutrition therapy referral be made by the treating physician.

Vaccinations

Request: Information regarding costs involved in furnishing preventive vaccines to inform the development of more accurate rates for these services, on different types of health care providers who furnish vaccines and how have those providers changed since the start of the pandemic, and on costs of furnishing flu, pneumococcal, and hepatitis B vaccines compare to the costs of furnishing COVID-19 vaccines and how costs may vary for different types of health care providers.

Response: As a greater variety of health care practitioners are furnishing vaccines across facilities due to the COVID-19 pandemic, AAAHC encourages CMS to ensure that appropriate quality standards apply to all vaccine providers. Documented policies for vaccine administration, including storage, safe injection practices, inventory monitoring, recall procedure, and patient prescreening and recording, should be present to help ensure the quality of care being delivered and the safety of vaccination patients irrespective of provider type or facility location.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Request: Should CMS bolster the ability for RHCs and FQHCs to furnish care through audio-only counseling and therapy sessions where audio/video technology is not available to (or consented to by) the beneficiary if all other requirements for services are met. If so, should a service-level modifier be required, and should the medical record be documented with the rationale for audio-only services?

Response: AAAHC believes that telehealth services are vital for access to care, most notably for persons with limited resources and with pre-existing difficulty accessing care. AAAHC believes that medical records should include documentation of rationale for furnishing audio-only services where an option exists, just as appropriateness of care should always be included within the clinical record under AAAHC Standards. Where a provider does not have audio-visual communication capabilities, the provider must still evaluate the appropriateness of audio-only communication. Similarly, where the patient requests or does not consent to visual communication, the provider must still evaluate whether audio-only services are an appropriate method for care delivery for the individual and the symptoms presented. In both instances, AAAHC would expect the provider to document the reason for, and appropriateness of, audio-only care.

Tribal FQHC Payments

Request: Should CMS make all IHS- and tribally-operated outpatient facilities/clinics eligible for payment at the Medicare outpatient per visit/AIR regardless of owned, operated, or leased by IHS?

Response: In accordance with Indian Health Services (IHS) Circular No. 97-01, available at https://www.ihs.gov/ihm/circulars/1997/accreditation-certification-of-hospitals-and-health-centers/, all IHS facilities are required to meet the requirements of a nationally recognized accrediting or certifying body, and tribally operated programs are encouraged to do so. Where IHS- and tribally-operated outpatient facilities and clinics meet the criteria and measures for Patient Centered Medical Home (PCMH) status, they receive increased reimbursements through additional quality points. This additional quality reimbursement could be made applicable to all tribal and FQHC locations.

Electronic Prescribing of Controlled Substances

Request: Should there be EPCS exceptions for when (i) prescriber and dispensing pharmacy are same entity, (ii) prescribers issuing fewer than 100 Part D controlled substance drugs per calendar year, and/or (iii) prescribers in the area of a natural disaster or granted a waiver based on extraordinary circumstances?

Response: According to Stephen Abresch's article, "ASCs Face Challenges in Electronic Prescribing Requirements", published in *The ASCA Journal* in May 2021, thirty-one (31) states will have requirements for electronic prescribing in place by end of year. Of those, eight have a waiver process incorporated, allowing a practitioner to apply for a temporary waiver from the State electronic prescription requirement if economic hardship can be demonstrated. AAAHC commends CMS for proactively seeking to address the opioid crisis through a centralized data management system. However, ASCs have been disadvantaged by their continuous exclusion as hospitals and Critical Access Hospitals (CAHs) were involved in the development and implementation of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs since 2011. Additionally, surgery centers have not been incorporated into incentives for use of Health Information Technology (HIT).

According to the Abresch article, an estimated twenty percent (21%) of surgery centers nationwide have EHR systems in place, compared to 95% penetration at hospitals and physician offices. As electronic prescribing relies on the use of EHR technology, ASCs do not have the ability to easily implement e-prescribing for ASC physicians if an electronic system is not already in place at the facility. Additionally, while electronic prescribing is a MIPS measure, clinicians performing 75% or more of covered services in ASCs are exempt from EHR-related measures.

AAAHC encourages CMS to provide ample consideration to the factors above and consider the burden additional IT requirements may have on providers when requiring EPCS and finalizing rules for waivers and exceptions.

For any questions regarding this comment, please contact Ann Carrera, Senior Counsel, Corporate Affairs at 847-853-6060 or acarrera@aaahc.org.

Sincerely,

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