AAAHC

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

September 6, 2022

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

RE: CMS-1770-P
RIN 0938-AU81

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 and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts.

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 6,600 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 Payment, Medicare, page 45886-45902

In General

AAAHC believes that telehealth services are necessary for patients with resource limitations and behavioral health, as well as medical conditions that affect access to care, not only in the current pandemic environment but on an enduring basis. Telehealth services increase access to care and accountability, with studies showing a resulting decrease in no-show appointments[1,2]. Therefore, AAAHC supports the extension of telehealth approval for continued evaluation. AAAHC recommends that the evaluation of telehealth services include identification and application of quality standards necessary to ensure that any telehealth services reimbursed by Medicare are delivered in accordance with nationally recognized standards that demonstrate an organization's ongoing commitment to quality improvement and patient safety.

AAAHC recommends that CMS consider AAAHC Standards to establish a telehealth medical home for those providers who increasingly bill Medicare for primary care telehealth services. Standards should address patient participation and empowerment, effective communication with providers, sufficient time allotted for the patient/provider relationship, continuity of care, and a focus on comprehensiveness of care inclusive of both physical and mental health parameters. Other AAAHC Standards that apply to the provision of telehealth services include requirements for appropriate and timely client triage, policies regarding crisis intervention and emergency services, plans for the use of technology and privacy protection, development of client-centered treatment plans, and evidence of sufficient and appropriate resources to deliver quality care. Requirements similar to the above, if combined with current Medicare requirements such as information security, confidentiality, standards of care, appropriate training, and continuity of care, can ensure health services are provided to patients in a safe and quality manner, regardless of the modality used for delivery. AAAHC is available to collaborate with CMS in achieving this, or similar, efforts.

AAAHC further believes that, where nationally recognized quality standards are followed, providers lacking access to audio-visual communications can provide quality care to patients. AAAHC believes that appropriateness of care should be documented in the clinical record and therefore documentation of the rationale for furnishing audio-only services should also be included. 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.

Reimbursing only those providers able to offer audio-visual telehealth services limits access to care for the populations with greatest need, and AAAHC does not support this proposal. AAAHC recommends that CMS establish standards for all providers offering telehealth services to ensure quality care is provided to all beneficiaries.

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[1] Adepoju OE, Chae M, Liaw W, Angelocci T, Millard P, Matuk-Villazon O. Transition to telemedicine and its impact on missed appointments in community-based clinics. Ann Med. 2022 Dec;54(1):98-107. doi: 10.1080/07853890.2021.2019826. PMID: 34969330; PMCID: PMC8725902.

[2] Drerup B, Espenschied J, Wiedemer J, Hamilton L. Reduced No-Show Rates and Sustained Patient Satisfaction of Telehealth During the COVID-19 Pandemic. Telemed J E Health. 2021 Dec;27(12):1409-1415. doi: 10.1089/tmj.2021.0002. Epub 2021 Mar 4. PMID: 33661708.

AAAHC supports the extension of Category 3 telehealth services both for 151 days after the public health emergency (PHE) expires and beyond. The increase in beneficiary access to telehealth services has improved both access and equity in health care throughout the nation. Allowing for the provision of care from the patient's home, regardless of provider location and the ability for providers to bill for both video and audio-only consultations, can increase previously existing barriers. According to the Federal Communications Commission (FCC) *2020 Broadband Deployment Report*[3], more than 21 million Americans lack access to internet service, whether due to lack of infrastructure or lack of affordability. Recreating the barriers to access and equity that CMS has relieved through the PHE telehealth provisions would be detrimental to the most vulnerable populations served by CMS programs, such as the 65% of rural residents[4] and 40% of low-income Americans[5] who lack access to broadband services. Audio-only telehealth has served as a successful tool for overcoming barriers to care such as lack of transportation, limited mobility, and shortages in local providers and behavioral health care services. The ability to obtain affordable, efficient, and safe health care services regardless of location and other factors has proven both successful and significant for reducing inequities in access to care.

Therefore, AAAHC encourages CMS to permanently implement the telehealth benefits put into place during the PHE to continue improving health care access and equity. Safe, accessible care for beneficiaries can be provided with telehealth, and removal of this accessibility should not be made lightly. AAAHC supports the permanent integration of PHE-era telehealth policies into both CMS programs and health care in general.

Revision of Direct Supervision Requirements

Request: CMS is considering revision of the definition of "direct supervision" and of provider types allowed to bill for services, and is seeking comment: (1) on whether the flexibility to meet immediate availability requirement for direct supervision through real-time audio/video technology should be made permanent; (2) the possibility of permanently allowing immediate availability for direct supervision through virtual presence using real-time audio/video technology for only a subset of services as it may be inappropriate to allow direct supervision without physical presence for some services due to potential concerns over patient safety; and (3) more information as CMS considers whether to make permanent a temporary exception to the direct supervision policy.

Response: AAAHC Standards require that all personnel assisting in the provision of health care services are appropriately qualified and supervised. Supervision requirements are also predicated on state laws and vary based on practitioner type, scope of practice, and level of access. AAAHC suggests that as long as a provider is practicing in compliance with state law requirements, that provider should be allowed to bill for the services provided.

[3] Broadband Deployment Report. Federal Communications Commission, April 24, 2020, at https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2020-broadband-deployment-report
[4] Vogels, E., 2021. Some digital divides persist between rural, urban and suburban America, Pew Research Center, at https://www.pewresearch.org/fact-tank/2021/08/19/some-digital-divides-persist-between-rural-urban-and-suburban-america/
[5] Vogels, E, 2021. Digital divide persists even as Americans with lower incomes make gains in tech adoption, Pew Research Center, at https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/

Code Valuations, page 45902-45986

Medicare Potentially Underutilized Services RFI

Request: Services such as those promoting health and wellbeing may decrease the need for more expensive care (i.e., Diabetes Self-Management Training, Annual Wellness Visit). CMS is seeking comment on ways to identify specific services and recognize possible barriers to improved access to high value, potentially underutilized services by Medicare beneficiaries PLUS ways to identify and improve access.

Response: AAAHC proposes that CMS can identify underutilized services through the analysis of data already available to the agency, such as patient diagnosis codes and payments made on behalf of Medicaid and Medicare beneficiaries. Such analysis would allow CMS to identify the specific populations, regions, and/or providers with the highest underutilization rates, enabling CMS to develop and implement meaningful marketing and education materials based on that information or to provide incentives for provider initiatives related to the identified underutilized services.

Potential methods for CMS to facilitate, encourage, and improve accessibility and utilization include allowing (or continuing to allow) these high value services to be provided via telehealth without unnecessary restrictions such as requiring audio-visual capabilities; ensuring that providers have both the resources and the motivation to provide high value services through fair payment for services; and encouraging service utilization by beneficiaries through education, awareness, and/or promotions. AAAHC also suggests that patient utilization of high value and preventative services would naturally improve through increased patient engagement from both issuers and providers. By ensuring timely access to an accessible provider with whom the patient is comfortable (i.e., gender, language, etc.), increasing beneficiary knowledge of covered benefits and language services availability, encouraging providers to recommend services and screenings, providing written materials as follow-up to in-person discussions, and promoting processes that ensure test results are consistently provided even when patients prove difficult to contact.

Promoting Medical Home accreditation and certification programs may also play a role in provider identification of underutilized services. The Medical Home model emphasizes a team-based approach to patient care, where the Medical Home team provides comprehensive, coordinated care across multiple specialties and community resources. Recognized Medical Home practices foster engagement and partnership with patients resulting in healthier outcomes, decreased costs, and increased patient satisfaction – the triple aim for health care.

A medical home provides services that are patient-centered, physician, nurse practitioner, or physician assistant-directed (as permitted by state law/regulation), comprehensive, accessible, continuous, and delivered to meet the needs of the individual patients served. AAAHC Accreditation with Medical Home provides an in-depth onsite assessment from both the organizational structure/systems perspective and from the perspective of the patient.

AAAHC also requires Medical Home accredited organizations to perform quality improvement (QI) studies. Although these organizations identify their own QI topics based on self-identification of prominent issues for study, the overutilization or underutilization of services is a suggested study topic within the AAAHC Medical Home Standards.

Caregiver Consultations in Psychotherapy

Request: CMS proposes to change the Psychotherapy policy from "Medicare coverage is limited to items and services that are for the diagnosis and treatment of the individual beneficiary and Medicare does not pay for services that are furnished to parties other than the beneficiary and which Medicare does not cover, for example, communication with caregivers" to "Consultations with a beneficiary's family and associates are covered only where the primary purpose is the treatment of the patient's condition".

Response: AAAHC supports the decision to cover consultations with a beneficiary's family or associates when the primary purpose of the communication is treatment of the patient's condition. Behavioral health services are vital to whole-person care, as mental illnesses are among the most common health conditions in the U.S., with more than 50% of the population receiving a mental health diagnosis during their lifetime and 20% of Americans experiencing a mental illness each year.[6] This change furthers patient-centered, whole-person care by ensuring that caregivers and family members are included in the care plan and knowledgeable of the beneficiary's needs. In support of this change, AAAHC would also support furtherance of this policy beyond psychotherapy services.

AAAHC Standards require that written operating policies for the provision of behavioral health care address the provision of consultation services as needed to appropriate entities, staff, and caregivers. Providers must communicate effectively with their patients and coordinate with caregivers to provide comprehensive services, including assessing and addressing the needs of a patient's personal caregiver specifically as it impacts the care of the patient.

In 2015, CMS introduced a billing code allowing specified practitioners to receive payment for twenty minutes of care coordination services for beneficiaries with multiple chronic conditions each month. This code includes mandatory service components and allows for the inclusion of time spent communicating with caregivers. Patient-centered care requires the inclusion of caregivers when necessary, allowing providers to obtain reimbursement for time spent supporting caregivers is critical for the success of caregiver efforts.

Although CMS has a variety of policies and services that support and recognize family caregivers though the home health program, the ability for non-home health providers to bill for caregiver assessment and education remains limited to patients with multiple chronic conditions. Caregiving plays a significant role in a patient's quality of life, providing assistance with social and health needs such as daily living (e.g., bathing, dressing, transportation, and shopping), emotional support, and disease/disability management.[7] Beyond mental health and multiple chronic conditions, family caregivers are also heavily involved in the care of beneficiaries with conditions such as Alzheimer's and dementia, cancer, orthopaedic issues, and others. AAAHC encourages CMS to review possible remedies for this limitation.

[6] National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. June 28, 2021. About mental health, at https://www.cdc.gov/mentalhealth/learn/index.htm
[7] National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. July 30, 2019. Caregiving for Family and Friends – a public health issue, at https://www.cdc.gov/aging/caregiving/caregiver-brief.html

Payment for Behavioral Health Services

Request: CMS is soliciting comment on how to best ensure beneficiary access to behavioral health services, including any potential adjustments to the PFS rate-setting methodology, for example, any adjustments to systematically address the impact on behavioral health services paid under the PFS.

Response: AAAHC's Patient-Centered Medical Home programs ensure the provision of whole-person care, which include physical and behavioral health. In addition to the commitment of supporting Medical Home within CMS programs, timely interventions and referrals are important in removing barriers to care and improving care coordination. AAAHC Standards require the direct provision or coordination of crisis intervention and emergency services for patients presenting with high acuity, imminent danger, and/or high-risk behaviors. This includes adequate monitoring with appropriate treatment planning and service provision and providing appropriate referral services to resources within the organization and/or community. Providers are to include the patient and caregiver(s) in the plan of care and referral options based on the patient's presenting needs, functioning level, and acuity of symptoms.

Audiology Testing without Physician Order, page 46029-46033

Recognition of Audiologist Services Without a Referral

Request: CMS has received ongoing feedback from stakeholders requesting the recognition of audiologist services without requiring a physician's order. Medicare Part B does not recognize audiologists for the treatment or management of patients and the scope of Medicare B includes only diagnostic hearing and balance assessment services. CMS finds that patients suffering an acute condition or disequilibrium could face delayed care if they visit an audiologist first, and audiologists may balance bill beneficiaries thereby increasing beneficiary costs unnecessarily and potentially encouraging the overutilization of services. In compromise, CMS proposes to allow only non-acute hearing assessments without an order/referral.

Response: Under current AAAHC Standards, referrals for care must come from an appropriate source. AAAHC Standards indicate that referrals should be (i) appropriate and timely and (ii) clearly outlined to the patient. However, as beneficiaries may be unable to schedule timely appointments with their primary care physician for non-acute hearing issues, AAAHC supports improving patient access to these services and commends CMS for considering ways in which access may be improved.

Dental Services, Medicare A/B, page 46033-46041

Medicare Coverage of Dental Service Based on Substantial Relationship to Covered Services

Request: Medicare Part B currently pays for dental services under the PFS when a dentist furnishes a service(s) that is integral to the covered primary procedure or service rendered when treating the primary medical illness. This is set forth in a manual, but CMS will codify in regulation and clarify that Medicare payment would be made for these dental services regardless of whether the services are furnished in an inpatient or outpatient setting. CMS proposes that payment can also be made for services that are ancillary to these dental services, such as x-rays, administration of anesthesia, use of an operating room, and other facility services. No payment is made for dental services when an excluded service is the primary procedure involved. CMS invites public comment on whether there are other clinical scenarios involving acute or chronic conditions that would have an improved patient outcome if dental services were furnished, and if so, whether we should consider these services as inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services.

Response: AAAHC supports the coverage of dental services under Medicare to the extent currently suggested by CMS and beyond. It is widely accepted that dental health directly correlates to overall health, making preventative dental care coverage a vital benefit that has been overlooked for too long. The bacterial infection Streptococcus mutans, commonly found in the mouth and significantly increasing tooth decay, has been found to infect nearly every person by adulthood[8]. Streptococcus mutans is the most prevalent bacteria found in extirpated heart valve tissues and atheromatous plaques[9] and has also been associated with infective endocarditis[10]. It is estimated that 42% of U.S. adults suffer from periodontal disease, a chronic inflammatory condition resulting in bone loss, loose teeth, and painful, swollen gums[11]. And, both within the U.S. and throughout the world, occurrence rates of mouth and throat cancer are increasing[12].

Income inequality is associated with lower oral health and a reduced oral health-related quality of life. Lack of oral health care has been shown to impact the way others treat low-income persons and results in a lessened ability to obtain employment[13]. Furthermore, as publicly insured or uninsured patients[14] help drive emergency department visits for the treatment of acute tooth pain to more than 2.4 million annually, it can hardly be denied that increased costs and a general lack of access to dental care are negatively impacting both beneficiaries and the healthcare system as a whole. Dental services are inextricably linked to whole-person care, are integral to reaching our national health equity goals, and should not be limited to oral care with a "substantial relation" to other covered medical services.

AAAHC encourages CMS to add quality standards for facilities providing dental care and sedation under CMS programs. AAAHC includes a Dental Health chapter within its ambulatory accreditation program, where applicable. The AAAHC Accreditation with Dental Home program recognizes dental facilities who excel at communication and coordination with the primary physician, along with providing high-level education services to their patients.

[8] Marcenes W, Kassebaum NJ, Bernabé E, et al. Global Burden of Oral Conditions in 1990-2010: A Systematic Analysis. Journal of Dental Research. 2013;92(7):592-597. doi:10.1177/0022034513490168.
[9] Nakano K, Inaba H, Nomura R, et al. Detection of cariogenic Streptococcus mutans in extirpated heart valve and atheromatous plaque specimens. J Clin Microbiol. 2006 Sep;44(9):3313-7. doi: 10.1128/JCM.00377-06. PMID: 16954266; PMCID: PMC1594668.
[10] Toda M, Yamaguchi M, Katsuno T, et al. Streptococcus mutans-induced infective endocarditis associated with hypocomplementemia and positive anti-double-stranded DNA antibody. J Clin Rheumatol. 2021 Jan 1;27(1):e15-e16. doi: 10.1097/RHU.0000000000001205. PMID: 31743271.
[11] Eke PI, Thornton-Evans GO, Wei L, et al. Periodontitis in US adults: national health and nutrition examination survey 2009-2014. J Am Dent Assoc. 2018 Jul;149(7):576-588.e6. doi: 10.1016/j.adaj.2018.04.023. PMID: 29957185; PMCID: PMC8094373.
[12] Rodríguez-Gómez IM, Gómez-Laguna J, Ruedas-Torres I, et al. Global, regional, and national prevalence, incidence, and disability-adjusted life years for oral conditions for 195 countries, 1990–2015: a systematic analysis for the global burden of diseases, injuries, and risk factors. Veterinary Pathology. 2017;96(4):574-577. doi:10.1177/0300985821991565.
[13] Moeller J, Starkel R, Quiñonez C, Vujicic M. Income inequality in the United States and its potential effect on oral health. J Am Dent Assoc. 2017 Jun;148(6):361-368. doi: 10.1016/j.adaj.2017.02.052. Epub 2017 Apr 18. PMID: 28427720.
[14] Allareddy V, Rampa S, Lee MK, et al. Hospital-based emergency department visits involving dental conditions: profile and predictors of poor outcomes and resource utilization. J Am Dent Assoc. 2014 Apr;145(4):331-7. doi: 10.14219/jada.2014.7. PMID: 24686965.

Dental Health Integration

Request: CMS seeks comment on additional ways to integrate the payment for dental and oral health care services within existing and future payment models using the Innovation Center's waiver authority in existing or future service delivery models, including models focused on equity, care coordination, total cost of care and specific disease conditions.

Response: In addition to our Medical Home program, AAAHC offers Dental Home recognition through accreditation of dental practices that function as a Dental Home and are integral to the primary care medical home. This program focuses on the Dental Home as the primary point of care for the patient and their family and ensures care coordination across providers. Furthermore, AAAHC accredits Federally Qualified Health Centers (FQHCs), Indian Health Service, United States Coast Guard and Federal Bureau of Prisons facilities, all of which include the provision of dental services. AAAHC recognizes the need for integration of oral health in primary care and encourages CMS to expand coverage for dental procedures

To move oral health and primary care integration forward, dental coverage must be considered an integral component of health insurance – not an optional benefit. State Medicaid programs are now required to include dental coverage for adults and children and are expected to include oral health in value-based payment arrangements. However, Medicare, a federal-level program, has not been expanded to include these oral health and dental services. This care must become a priority if older adults and seniors, a population facing high rates of unmet oral healthcare needs, are going to receive equal access to care.

Medicare Shared Savings Program, page 46093-46218

Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health Measures and Future Measure Development RFI

Request: CMS proposes the addition of two APPs: 1) Screening for Social Drivers of Health assesses the rate at which providers screen beneficiaries 18 years and older for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety and 2) Screen Positive Rate for Social Drivers of Health, which assesses the percentage of patients who screened positive for health-related social needs.

Response: As a non-profit accreditation organization, AAAHC prides itself on assisting health care organizations that serve underserved populations, such as the Indian Health Service, HRSA, and Medicare populations, to achieve a higher quality of care. Through our Standards, AAAHC requires that facilities address disparities across a variety of socioeconomic factors. AAAHC Standards already require that facilities and providers offer translation services, ensure discharge (i.e., someone to drive the patient home), maintain policies on patient and staff education, conduct ongoing review of data to identify trends or occurrences in physician care that affect patient outcomes, and establish internal benchmarks. AAAHC supports strengthened focus on Social Drivers of Health.

In comparison to other medical settings, the physician's office generally offers a closer and more patient-centered focus on care, resulting not only in higher quality patient evaluation but also increased knowledge of the patient as an individual. AAAHC finds that Medical Home principles, and many of the Standards required of a Medical Home practice, naturally reduce disparities in health care. Example areas in which Medical Home practices are likely already engaged in practices that support social drivers of health outcomes, as reflected in AAAHC Standards, include requiring patient education materials to be provided in appropriate languages and literacy levels for the population served, providing evidence the facility has knowledge of community resources that support the needs of patients and families, and facility recognition of the community's service limitations.

AAAHC believes that SDOH screening will be easiest and most effective for providers if a template screening tool is provided and encourages CMS to consider the time and resources required for providers to implement any new requirements. After implementation, CMS can use Screen Positive Rate data to impact and improve care for underserved populations through data analysis to identify locations with highest positivity rates, reviewing community resources being offered in that area, and supporting additional program developments based on the information supporting community need.

Most importantly, AAAHC requests that CMS ensure all measures and data are actionable and able to be impacted by intervention. Measures and data should be prioritized, within the control of the entity or provider, and constructed to minimize burden, keeping in mind that the greatest level of burden will likely fall onto those communities with the fewest resources.

Addition of New Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) Survey Questions RFI

Request: CMS proposes to implement new CAHPS survey questions pertaining to health disparities and price transparency, which would support implementation of the No Surprises Act; specifically (1) the potential future inclusion of health disparities and price transparency questions and whether there are other questions that should also be considered for potential future inclusion in the CAHPS for MIPS Survey; and (2) whether they have any input on creating a shortened version of the CAHPS for MIPS Survey measure such that it is more applicable to specialty group.

Response: AAAHC supports equity and transparency in health care. Proposed CAHPS survey question Number 1 reads "In the last 6 months, did anyone from a clinic, emergency room, or doctor's office where you got care treat you in an unfair or insensitive way because of any of the following things about you?" The potential responses include health condition, disability, age, culture, sex (including sexual orientation and gender identity) and income. AAAHC would like to see additional information regarding what actions CMS intends to take to improve and/or what follow-up will occur in response to results from this newly proposed survey question.

Proposed CAHPS survey question Number 2 asks "whether the patient talked with anyone on their health care team about the cost of health care services and equipment," AAAHC would like to see clarification within the wording of this proposed survey question that addresses patients who would respond no because there was no patient cost to be discussed.

Based on the limited information available within this proposal, AAAHC encourages CMS to consider a method to better filter response results or to modify the question to inquire if the patient is in receipt of an unexpected bill for which cost was not discussed by the health care team.

Electronic Prescribing Requirements for Medicare D and MA-PD, page 46238-46241

Updates to Quality Payment Program, 46256-46340

Addition of New Enabling Exchange Under Trusted Exchange Framework and Common Agreement (TEFCA) Measure in the Promoting Interoperability Performance Category

Request: CMS proposes a measure to provide eligible clinicians with the opportunity to earn credit for the Health Information Exchange objective if they: are a signatory to a "Framework Agreement" as that term is defined in the Common Agreement; enable secure, bi-directional exchange of information to occur for all unique patients of eligible clinicians, and all unique patient records stored or maintained in the EHR; and use the functions of CEHRT to support bidirectional exchange.

Response: AAAHC supports the TEFCA measure in the Promoting Interoperability performance category to promote EHR adoption and believes it is important for CMS to incentivize adoption across all programs, providers, clinicians, facilities, issuers, and services. The ability to have cohesive and comprehensive records that enable a holistic view of patient health, ease care coordination and tracking between providers, expand collaboration on patient outcomes, offer on demand and immediate access to patient charts, reduce paperwork, enhance workflows, advance data analytics (e.g., Google and VA AI analysis for suicidal thoughts) and the resulting notifications, track community health trends, reduce errors caused by illegible notes or misplaced documents, and improve chart flagging of contraindications and interactions.

However, meaningful and lasting change will require assistance to the providers and patients who lack technology access, whether due to economic causes or lack of technological access in the region. Providers who lack access, or who serve populations that lack access, should not be penalized and should receive support to improve their ability to purchase or enroll in these technologies. Additionally, CMS and providers cannot assume that patients have the ability to access an EHR, as doing so will result in increased inequity and disparities. For example, if a provider advises a patient that a specific instructional or educational document will be placed in the patient's electronic health record without verifying the patient has a means of accessing that information, the patient will be incorrectly assumed to have received the written materials which may result in harm to the patient. At a minimum, rollout of these requirements is not suggested to be made in advance of the timelines set forth in the Federal "Internet for All Initiative."

Even after the "Internet for All Initiative" has been fully carried out, there remain a substantial number of American adults who are not technologically savvy. According to a September 2021, publication by Pew Research Center[15], 30% of U.S. adults need others to set up their devices and show how to use them or express they are not at all or only slightly confident in using online devices. Additionally, 34% of U.S. adults between the ages of 50 and 64, 54% of U.S. adults between the ages of 65 and 74, and 68% of U.S. adults aged 75 and older express they are not at all or are slightly confident in using online electronic devices. AAAHC suggests that this data supports that inequities against the elderly and the less educated would be created by implementing a measure reliant upon patient EHR access, and that patient non-access to their EHR is largely a measure outside of the provider's control.

[15] Mcclain C, Vogels, EA, Perrin A, et al. September 1, 2021. The internet and the pandemic. Pew Research Center, at https://www.pewresearch.org/internet/2021/09/01/the-internet-and-the-pandemic/

Information security must also be ensured. If all patient health information is maintained in a single location, the potential for unauthorized access to that information is significantly increased. Medical devices that utilize software, such as pacemakers and insulin pumps, have the potential to be targeted in a cyberattack[16]. In fact, 500,000 pacemakers were subject to a voluntary recall by the FDA due to vulnerabilities to hacking[17]. CMS and the federal government as a whole cannot ignore the facts that medical and hospital systems are increasingly targets of ransomware attacks[18,19], the majority of health care breaches originate with third-party vendors[20], the health care industry faces the highest breach-related costs[21], and the fact that Americans lack trust in the ability for health care institutions to protect their personal data[22] and should take necessary steps to address such issues prior to implementing additional EHR requirements for providers.

While AAAHC recognizes, supports, and values advances in technology, AAAHC is also acutely aware of the costs associated with IT and digitization improvements and urges CMS to evaluate the burden of increased digitization on facilities. It is also important for CMS to remain cognizant of the fact that, although office-based providers now have an EHR implementation rate above 70%, only approximately 40% of AAAHC-accredited ASC facilities have EHR systems in place, which creates an additional burden on specialist providers that CMS should account for within the Promoting Interoperability performance measure. Requirements for all electronic records systems to align with a specific series of fields or structured data approaches could be extremely burdensome for facilities, and most significantly for providers and facilities serving highest-need populations. Increased costs may divert funds away from patient safety and quality activities such as accreditation and ongoing education. AAAHC believes that each organization's governing body is responsible for budgeting the resources it needs to best serve its patients; and therefore, our Standards are not prescriptive to requiring EHR implementation or a specific structure of the data within facility electronic medical records.

AAAHC applauds CMS for their vision on interoperability and the value this will bring to patient care and operational performance. The cost to implement such systems, however, may be high and require additional resources such as hardware, support, and training. This raises the potential of limited success in implementation and further increases the burden of cost and resources. AAAHC recommends that further testing and consultation with providers will provide better insight into opportunities for improvement in this area. If CMS chooses to require digitization, AAAHC encourages CMS to provide sufficient support, resources, and time for providers to comply.

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[16] U.S. Food and Drug Administration. Cybersecurity, August 29, 2022, at https://www.fda.gov/medical-devices/digital-health-center-excellence/cybersecurity
[17] Kuehn BM. Pacemaker Recall Highlights Security Concerns for Implantable Devices. Circulation. 2018 Oct 9;138(15):1597-1598. doi: 10.1161/CIRCULATIONAHA.118.037331. PMID: 30354523.
[18] BakerHostetler. 2019. Managing enterprise risks in a digital world: privacy, cybersecurity, and compliance collide, at https://f.datasrvr.com/fr1/019/33725/2019_BakerHostetler_DSIR_Final.pdf
[19] U.S. Department of Health and Human Services, Office for Civil Rights. Breach portal: notice to the Secretary of HHS breach of unsecured protected health information, at https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf
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[21] IBM. 2022. Cost of a data breach report, at https://www.ibm.com/security/data-breach
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While AAAHC Standards do not require electronic records, they do incorporate consistency, confidentiality, and the inclusion of specific documentation such as allergies, appropriateness of care, and continuity of care within each facility's chosen records system and structure.

MIPS Value Pathways (MVPs) CY2023 Reporting

Request: MVPs (MIPS Value Pathways) will be available for voluntary reporting beginning with the CY 2023 MIPS performance period, and CMS intends for MVPs to become the only method to participate in MIPS in future years. CMS continues to contemplate how to support specialty clinician reporting for APM participants who report to MIPS through the APM Performance Pathway (APP) and potentially MVPs and is also considering how MVPs should evolve to better promote higher value care and APM participation by both primary care and specialist clinicians. Current MVPs are Anesthesia, Chronic Disease Management, Emergency Medicine, Heart Disease, Lower Extremity Joint Repair, Rheumatology, and Stroke Care/Prevention.

Response: AAAHC supports the implementation of MVP subset measures and activities tied to a specific specialty, clinical condition, or episode of care based on the assumption that the MVP measures would (i) reduce provider reporting burdens by minimizing the number of measures required to those most relevant to a provider's services and (ii) focus on relevant measures related to patient safety and quality of care. AAAHC supports streamlining the reporting requirements for all providers with practice specific measures, activities, and interoperability while maintaining reporting flexibilities and alternatives for providers, ensuring that multispecialty groups with a single TIN are not subject to a burdensome increase in reporting requirements.

CY2023/CY2025 MVP Revisions

Request: CMS finalized seven MVPs that will be available for reporting beginning with the CY2023 performance period/CY2025 MIPS payment year. CMS now proposes to include the IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation improvement activity in all previously finalized MVPs and newly proposed MVPs in alignment with policy finalized in the CY2017 MIPS final rule (81 FR 77179 through 77180): MIPS eligible clinicians in a practice that is certified or recognized as a patient-centered medical home or comparable specialty practice, as determined by the Secretary and codified at 414.1480(b)(3)(ii), may attest to this activity and receive an improvement activities performance category score of 100 percent.

Response: AAAHC supports the proposal to incorporate Medical Home recognition into all MVPs as Medical Home Accreditation and Certification is applicable to both primary care and specialty clinicians and has been proven to help providers and facilities provide high quality care.

Beyond Medical Home, AAAHC also offers Advanced Orthopaedic Certification (AOC), which may be well-suited to serve as an additional improvement activities recognition for MVPs such as Improving Care for Lower Extremity Joint Repair. AAAHC AOC Standards focus on transitions of care from patient pre-assessment through discharge and rehabilitation, leadership effectiveness and care integration into the delivery of orthopaedic services, and includes requirements for performance measurement and benchmarking.

Screening for Social Drivers of Health

Request: CMS is seeking feedback on the potential future inclusion of two new measures in the APP measure set: MUC21-136: Screening for Social Drivers of Health and MUC21-134: Screen Positive Rate for Social Drivers of Health. The National Quality Forum (NQF) provided conditional support for these two social determinants of health measures during the 2021-2022 cycle and indicated the measures would be appropriate for consideration in the Shared Savings Program. CMS proposes to increase screening for social drivers of health/health related social needs to improve healthcare costs, utilization, and outcomes - improving overall health equity - adoption of an evidence-based Drivers of Health (DOH) measure to support identification of specific DOH associated with inadequate healthcare access and adverse health outcomes among patients through systematic collection of DOH data. CMS also seeks comment on the following two potential approaches for measuring health equity in MIPS and MVPs: assessing the collection and use of self-reported patient characteristics and assessing patient-clinician communication.

Response: As stated in the previous section regarding SDOH measures, AAAHC prides itself on assisting health care organizations that serve underserved populations, such as the Indian Health Service, HRSA, and Medicare populations, to achieve a higher quality of care. Through our Standards, AAAHC requires that facilities address disparities across a variety of socioeconomic factors. AAAHC Standards already require that facilities and providers offer translation services, ensure discharge (i.e., someone to drive the patient home), maintain policies on patient and staff education, conduct ongoing review of data to identify trends or occurrences in physician care that affect patient outcomes, and establish internal benchmarks. AAAHC supports strengthened focus on Social Drivers of Health.

AAAHC finds that Medical Home principles, and many of the Standards required of a Medical Home practice, naturally reduce disparities in health care. AAAHC believes that SDOH screening will be easiest and most effective for providers if a template screening tool is provided and encourages CMS to consider the time and resources required for providers to implement any new requirements. After implementation, CMS can use Screen Positive Rate data to impact and improve care for underserved populations through data analysis to identify locations with highest positivity rates, reviewing community resources being offered in that area, and supporting additional program developments based on the information supporting community need.

Most importantly, AAAHC requests that CMS ensure all measures and data are actionable and able to be impacted by intervention. Measures and data should be prioritized, within the control of the entity or provider, and constructed to minimize burden, keeping in mind that the greatest level of burden will likely fall onto those communities with the fewest resources. Therefore, a plan of action should be created prior to measure implementation, since having data without providing additional resources and plans for improvement fails to meet the equity intention in the creation of the measures. AAAHC recommends that CMS also include a response option of “no referral available” to determine locations with the greatest need for additional resources.

Clinician Reporting on Language Access

Request: CMS is considering the development of a patient-reported outcome measure that assesses the receipt of appropriate language services and/or the extent of clinician-patient communication in line with the 02/2018 Guide to Developing a Language Access Plan which outlines steps organizations can take to provide high-quality and appropriate language assistance services to all individuals they serve, Given the variance in patient needs and organizational resources, CMS is seeking feedback on the appropriateness of requiring all clinicians to report on such measure(s).

Response: AAAHC does not support the proposed MIPS Language Access measure and cautions CMS against unnecessary burden. AAAHC Standards require that interpretation services be available and patient care and education is provided in appropriate languages and literacy levels. AAAHC believes similar measurement is already included in CAHPS, DOH, and the Optimizing Chronic Care Management MVP. As measures already exist to capture similar data and as CMS intends to sunset MIPS to drive clinicians into MVP participation, and although AAAHC agrees that comprehensive language and communication services are important to facilitate compliance with effective patient care, AAAHC suggests that dedicating CMS resources to the development of a new MIPS quality and composite measure for Language Access is unnecessary and wasteful if this data is already being obtained through alternative sources.

Patient Access to Health Information Measure RFI

Request: CMS is seeking a broad array of public comments regarding how to further promote equitable patient access and use of their health information without adding unnecessary burden on the MIPS eligible clinician or group. Moving beyond providing the information and technical capabilities to access their data, are there additional approaches to promote patient access and use of their health information? Recent studies have raised concerns about the presence of racial bias and stigmatizing language within EHRs that could lead to unintended consequences if patients were to obtain disparaging notes regarding their medical care. What policy, implementation strategies, or other considerations are necessary to address existing racial bias or other biases and prevent use of stigmatizing language? What are the most common barriers to patient access and use of their health information that have been observed? Are there differences by populations or individual characteristics? For example, are there barriers caused by lack of accessibility to patients due to disability or limited English proficiency? CMS welcomes input on how to encourage and enable patient access to and use of their health information to manage and improve their care across the care continuum.

Response: Patient education and awareness of their ability to access their EHR will play a key factor in promoting increased patient access, provided the patient has the tools, knowledge, and ability to do so. CMS provides a variety of resources within the Coverage To Care (C2C) initiative, and it is possible that an additional tool related to EHR access might support the promotion of equitable access. AAAHC suggests it might be more effective to add a measure to the CAHPS survey querying whether the patient has recently accessed their EHR and initiating the provision of educational tools and awareness resources automatically for patients responding “no”. Another consideration may be to delay this initiative until the patient is able to access their EHR through a singular EHR access point as opposed to being required to access different record sets through varying provider EHR systems.

As patient access to EHR increases, CAHPS, SDOH, health equity, and other patient-reported data can be collected directly through the EHR system. Related to clinician measures, AAAHC believes CMS must keep in mind that clinicians can only advise patients of the ability to access their EHR and cannot be held responsible for patients choosing not to access or lacking the ability or savvy to access. Further, AAAHC proposes that mandating patient access to EHR and the fact that most EHR content will be documented in English creates a bias in itself.

In response to concerns regarding the inclusion of biased and stigmatizing language within the patient record, the medical record is owned by the patient. AAAHC Standards require both patient access to their complete medical record and nondiscrimination. Whether the patient's record is in electronic or paper form should bear no difference to whether a patient has access to such remarks. It is of greater importance that patients have full access to their record and the ability to correct inaccurate information than to protect providers from the consequences of facing their biases.

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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