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September 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
Attention: CMS-1771-P
PO Box 8011
Baltimore, Maryland 21244-1850

Dear Administrator Brooks-LaSure:

On behalf of the American Health Information Management Association (AHIMA), I am responding to the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, as published in the July 29, 2022 Federal Register (CMS-1770-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. The AHIMA 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.

Following are our comments and recommendations on selected sections of the PFS proposed rule.

II-F –Evaluation and Management (E/M Visits) (87FR45986)

AHIMA supports CMS' proposed adoption of most of the American Medical Association's (AMA) CPT changes that become effective January 1, 2023.

CMS stated in the proposed rule that they are proposing the creation of G codes for prolonged services to be used instead of new CPT code 993X0 because they disagree with the CPT instructions regarding the point in time at which the prolonged code should apply. We urge CMS to adopt the G code as an interim solution while working with the AMA to make appropriate revisions to the CPT code and the CPT instructions to satisfy CMS' requirements. Alternatively, CMS could consider adopting the CPT code, but applying the Medicare-specific time definitions for prolonged services shown in Table 18 in the proposed rule. This approach would allow providers to use the same code for prolonged services across

payers, and CMS' concerns about the CPT instructions could be addressed by establishing Medicare-specific time requirements for the use of this code.

CMS indicated in the proposed rule that they are seeking comments on whether there is a need to keep CPT code 99318 (which describes evaluation and management of a patient involving an annual nursing facility assessment) for Medicare purposes even though it is being deleted from the CPT code set, effective January 1, 2023. **AHIMA does not believe it would be appropriate for CMS to continue to use a code that has been deleted from the CPT code set.** Once a code has been deleted, it is no longer valid or available for use.

II-J –Payment for Skin Substitutes (87FR46027)

We support CMS' objective of creating a consistent approach for paying for skin substitutes across the physician office and hospital outpatient department settings.

We do **not** support CMS' proposed change in terminology from "skin substitutes" to "wound care management" or "wound care management products." While we agree these products are technically not a substitute for skin, we believe CMS' proposed change would create more confusion rather than provide clarity. The term "skin substitute" is widely used for these products across the healthcare industry and is the term used in the CPT code set. We believe CMS' terminology should align with generally accepted, industry-wide terms, as to do otherwise would lead to confusion regarding the intended meaning and interpretation of CMS' term, the comparable term used by the rest of the healthcare industry, and possibly other related terms.

We do not agree that confusion with other codes would be avoided because the proposed terms describe a category of items or products rather than a type of service. Confusion, misinterpretation, and misuse of codes are still likely to occur if CMS' terminology varies significantly from the widely accepted term. While the proposed rule only addressed potential confusion with the CPT care management and E/M codes, CMS' proposed terminology change could cause confusion regarding the distinction between the CPT active wound care management codes and the application of skin substitutes. CPT active wound care management codes 97597-97610 describe very different procedures from the application of skin substitutes, but CMS' proposed terminology change to "wound care management" or "wound care management products" sounds very similar.

The new terminology proposed by CMS is not necessarily more accurate or meaningful than the existing term. A new term is less meaningful if a completely different term is in widespread use. While CMS is proposing to replace the existing term because they believe the current term is an overly broad misnomer, "wound care management" and "wound care management products" are not clearer or more specific. These terms are ambiguous and misleading. The term "management" is misleading because it generally describes the act of providing a service rather than describing a product. Also, there are a variety of items or products that are used as part of wound care management that are not intended to be included in this category of products. For example, standard dressings are an item used in wound care management, but they are not a skin substitute.

We urge CMS to retain the existing terminology of "skin substitutes."

D. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (87FR45885)

a. Changes to the Medicare Telehealth Services List (87FR45885)

AHIMA continues to support CMS' pursuit of making the telehealth relaxations currently allowed under the COVID-19 Public Health Emergency (PHE) permanent and thank them for working to ensure audio-only telehealth remains accessible to all patients, regardless of geographic location. We urge CMS to continue to preserve audio-only telehealth access that beneficiaries currently utilize under the public health emergency on a permanent basis. Audio only telehealth not only benefits in the reduction of disease spread but it also enables patients in both rural and urban areas who may not have access to stable high-speed internet or are unable to be in an area, such as a private home, where audio/visual telehealth is acceptable to access.

Eliminating the ability for large segments of the patient population to engage in telehealth furthers the health equity gap. Not supporting continued permanent audio-only telehealth places another barrier between the patient and the ability for them to easily attain care – in this case through telehealth. In order to close the health equity gap it is crucial for CMS work to reduce as many barriers as possible that would prevent a patient from searching for and attaining the care they need. AHIMA urges CMS to ensure access to telehealth equity through audio only telehealth remains permanent and encourage CMS to use its current authorities to extend the ability for providers to utilize audio only telehealth on a permanent basis.

5. APM Entity level participation for MIPS Eligible Clinicians Participating in MIPS APMs (87FR46312)

b. APM Entity level reporting of Promoting Interoperability Performance Category (87FR46257)

AHIMA continues to support CMS' work to evolve and further the implementation of Alternate Payment Models (APMs) in healthcare and support their inclusion within the voluntary participation in the Promoting Interoperability program.

B. Advancing the Trusted Exchange Framework and Common Agreement (TEFCA) – Request for Information (87FR46262)

What are the most important use cases for different groups that could be enabled through widespread information exchange under TEFCA? What key benefits would be associated with effectively implementing these use cases, such as improved care coordination, reduced burden, or greater efficiency in care delivery?

AHIMA continues to support the development and implementation of the TEFCA. We believe the TEFCA presents a unique opportunity to further the status of interoperability in the US and we remain positive regarding the potential the framework possesses. The TEFCA represents a unique challenge and opportunity for the US healthcare system to finally realize the true interoperability future that it aimed to achieve when the HITECH Act was enacted. Use cases for the TEFCA include widespread cross state health data exchange, increased care coordination, reduction in patient data exchange delays, increase in patient matching, and real patient data control.

The TEFCA, as outlined by ONC and the Recognized Coordinating Entity (RCE) the Sequoia Project, has the potential to connect public health care systems, providers, and patients to a network of health data. Networks enabled by the TEFCA will allow members, through both a voluntary fee-based membership for providers, public health, and health information networks and individual access services (IAS) for

patients, the ability to potentially send and receive health data. However, without the Qualified Health Information Network (QHIN) application period open and an unclear timeline for when TEFCA implementation and use will be achieved, it is difficult to determine the reality of the proposed use cases. AHIMA will continue to work and support the TEFCA to ensure these use cases become a reality when implementation is truly achieved. We encourage CMS to remain an active participant in the TEFCA process and to partner with ONC to ensure CMS use cases are accounted for.

What are key ways that the capabilities of TEFCA can help to advance the goals of CMS programs? Should CMS explore policy and program mechanisms to encourage exchange between different interested parties, including those in rural areas, under TEFCA? In addition to the ideas discussed previously, are there other programs CMS should consider in order to advance exchange under TEFCA?

While not fully realized, the TEFCA when fully operational, will allow providers to exchange health data robustly and easily. This allows for providers to potentially reduce compliance burden under the Promoting Interoperability program. At this time AHIMA would not recommend CMS pursue any additional program mechanisms that leverage the TEFCA until the pathway and timeline for TEFCA implementation is clear. Additionally, as previously stated by other members of HHS leadership, membership in the TEFCA should remain voluntary and be an option to increase data exchange in the US, not a mandate. Mandating TEFCA participation places a significant monetary and technical burden on providers, especially small providers – such as the rural providers mentioned in the request for information – who do not possess the technical ability or funding levels of large integrated health systems.

Additionally, as previously stated above, the timeline for implementation for TEFCA remains unclear. Until the TEFCA has achieved successful data exchange and implementation, AHIMA encourages CMS to remain involved in the development of the framework but refrain from mandating any type of TEFCA participation.

How should CMS approach incentivizing or encouraging information exchange under TEFCA through CMS programs? Under what conditions would it be appropriate to require information exchange under TEFCA by interested parties for specific use cases?

AHIMA strongly recommends CMS pursue a voluntary incentive structure to participate in the TEFCA, as opposed to a penalty structure. As proposed in this rule, pursuing an optionality to participate in TEFCA once the network is ready and MIPS eligible clinicians can fully utilize the TEFCA framework would be appropriate. As previously stated, the TEFCA has long been positioned by members of current and former HHS officials as a voluntary network for participation without a mandate to join. AHIMA urges CMS to carry forward that promise by incentivizing participation in TEFCA and not penalizing those unable to join the TEFCA due to cost or technical limitations. Additionally, if CMS were to pursue an incentive structure, AHIMA strongly encourages CMS to provide a pathway for those unable to participate in TEFCA to also enjoy the benefits put forward through the incentives.

What concerns do commenters have about enabling exchange under TEFCA? Could enabling exchange under TEFCA increase burden for some interested parties? Are there other financial or technical barriers to enabling exchange under TEFCA? If so, what could CMS do to reduce these barriers?

AHIMA continues to fundamentally believe in the goals and purposes of the TEFCA, but – as stated above – we harbor concerns related to the timeline for operation and utilization of the framework

network itself. As stated previously, the TEFCA is too far removed from moving into an operations phase for it to be clear when and how the framework for exchange will function. Other major concerns or considerations will not be known until the framework itself is operational with active data exchange. Until the rollout pathway is clear and actual data is being exchanged, CMS should continue to monitor the TEFCA and public feedback related to the framework. AHIMA also urges CMS to closely collaborate with ONC on all issues related to the TEFCA and its implementation.

4. Promoting Interoperability Performance Category (87FR46287)

d. Promoting Interoperability Performance Category Measures for MIPS Eligible Clinicians (87FR46288)

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

The nation's Prescription Drug Monitoring Program (PDMP) continues to improve and has transitioned from a program that was successful in only a handful of states nationwide into one that is nearly supported in all 50 states and the District of Columbia. As CMS demonstrates within this year's IPPS proposed rule, all 50 states now have a PDMP within them and the integration between different facets of health IT and PDMPs continues to rise year-to-year. AHIMA continues to support the continued enhancement of PDMP integration into the health system and the development of specific tools, such as RxCheck. AHIMA also continues to engage with ONC to learn about the development of these tools and how best we can aid in furthering the maturity and use of PDMPs.

Despite the increase in PDMP development and integration throughout the nation, more needs to be done. CMS notes in Table 82 that only 35 of the 50 PDMPs having integration ability with the Pharmacy Dispensing Systems (PDS) and seven PDMPs are only able to engage with one of the EHR, HIE or PDS. This data shows that the PDMP network needs more development nationwide before we are at a more fully realized integration and seamless utilization of electronic prescribing and prescription drug monitoring. While we applaud HHS for providing federal matching funds to support PDMP development activities in 2019 and 2020, more funding is needed to ensure PDMPs can become robust and are simple enough to promote utilization throughout the medical system. Additionally, the nation still lacks true cross-state PDMP-to-PDMP data exchange. This means multi-jurisdictional MIPS eligible clinicians or those that function in border cities must maintain connections to multiple PDMPs. HHS should continue to work to create a nationwide PDMP network that MIPS eligible clinicians are eligible to utilize. A national network simplifies the ability for MIPS eligible clinicians to access PDMP data and promotes the exchange of that data nationwide to paint a more complete picture of a patient's prescription drug history.

As a result of the current status of PDMP utilization nationwide and the need for continued investment, AHIMA urges CMS to delay making the Query of PDMP Measure required until at least the CY 2024 PFS. This additional time will allow the nation's PDMP infrastructure to continue to develop. AHIMA supports the measure remaining as optional allowing those MIPS eligible clinicians who live in states with robust PDMPs to attest to utilization, while also not penalizing those MIPS eligible clinicians who do not have strong PDMP infrastructures in their states.

If CMS were to finalize the change to making the Query of PDMP measure permanent, AHIMA supports the three exclusions proposed for MIPS eligible clinicians otherwise unable to meet the voluntary requirements of the Query of PDMP measure.

ii. Proposal to Change the Query of PDMP Measure to Include Schedules II, III, and IV

AHIMA supports the inclusion of Schedule II, III, and IV drugs in the Query of PDMP Objective if CMS works to ensure MIPS eligible clinicians who lack a state PDMP infrastructure to engage in this reporting are allowed an exception from the program as stated above. As previously stated, AHIMA believes PDMP infrastructure is rapidly expanding but is not at a level of ubiquity needed to ensure all MIPS eligible clinicians will be able to meet PDMP reporting requirements with limited burden. AHIMA also supports the potential expansion of this requirement to include Schedule V drugs in future iterations of this measure.

e. Health Information Exchange (HIE) Objective: Proposed Addition of an Alternative Measure for Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) (87FR46292)

iii. Proposed Enabling Exchange Under TEFCA Measure

AHIMA continues to support the efforts made by ONC and the RCE, the Sequoia Project, to operationalize the TEFCA. The TEFCA is a needed interoperability network that can help hasten the nation's advancement to nationwide interoperability. Despite continued success of TEFCA development, AHIMA urges CMS to refrain from adding the voluntary new measure Enabling Exchange Under TEFCA under the Health Information Exchange objective.

While AHIMA supports the development of TEFCA and encourages its membership to engage in TEFCA, at this time it is unclear when, or if, the TEFCA network will be fully operational in time for MIPS eligible clinicians to attest to this measure. The RCE continues to release documentation supporting the advancement of TEFCA but has yet to release the final application for organizations to apply to be Qualified Health Information Networks (QHINs) or the final Standard Operating Procedure (SOP) for QHIN onboarding.¹ Without these two resources it is unclear when QHINs will be actively exchanging data or when providers will be able to apply to join a QHIN or the cost associated with doing so. The proposed measure also outlines that attestation would involve MIPS eligible clinicians having to attest to "participating as a signatory to a Framework Agreement" and "using the functions of CEHRT to support bi-directional exchange ... under this Framework Agreement." At this time, AHIMA is unable to provide comment on either of these attestation requirements given that we do not know what these agreements would entail or what the CEHRT functionality requirements to enable this exchange are at this time. This is especially true given that the CEHRT products MIPS eligible clinicians are required to implement under other HHS programs are FHIR enabled, while the TEFCA is not expected to implement QHIN-Facilitated FHIR API Exchange until mid-2023.²

With unanswered questions related to how the TEFCA will function and when MIPS eligible clinicians will be able to receive details on how to participate, it is premature for CMS to begin including the TEFCA in the Promoting Interoperability Program, even on a voluntary basis. AHIMA requests CMS remove this

¹ <https://rce.sequoiaproject.org/tefca-and-rce-resources/>

² https://rce.sequoiaproject.org/wp-content/uploads/2022/01/FHIR-Roadmap-v1.0_updated.pdf

optional measure indefinitely until a timeline of when the TEFCA will be ready to exchange information is clear. During the May Health IT Advisory Committee (HITAC) Meeting, the RCE outlined that it could take more than a year for QHINs to complete onboarding once they are approved to join the TEFCA. That timeline would mean that not only would MIPS eligible clinicians be unable to join the TEFCA via a QHIN, but that it might not even be clear who the functional QHINs are, until the end of calendar year 2023. If CMS decides to move forward with this measure, AHIMA urges CMS to wait to implement this optional measure until the TEFCA transitions from the “TEFCA Transition Council” advisory group to the full “TEFCA Governing Council.” This transition would signal the QHINs are operational and ready to govern the TEFCA themselves.³

Additionally, AHIMA reminds CMS of comments made by administration officials, such as National Coordinator Micky Tripathi, on how participation in the TEFCA is voluntary and that participation would be spurred by “incentives.”⁴ As CMS continues to develop measures related to health information exchange, AHIMA strongly urges CMS to refrain from mandating participation in TEFCA in the future. Not only would such a future decision contradict long standing comments from ONC, but it would also leave vulnerable the MIPS eligible clinicians that simply do not have the funds to participate in TEFCA or lack access to a QHIN that could enable that access.

f. Modifications to the Public Health and Clinical Data Exchange Objective (87FR46295)

ii. Proposed Revision to Active Engagement

AHIMA recommends CMS reconsider its proposal to make reporting Active Engagement mandatory for the reporting of all measures under the Public Health and Clinical Data Exchange objective. The public health measures included as part multiple HHS programs, including the Promoting Interoperability Program, continue to evolve every year with the yearly release of the CMS payment rules. With this continued yearly development, we recommend CMS allow MIPS eligible clinicians at least one year of stable reporting of the public health measures without any changes prior to implementing this active engagement reporting requirement. Additionally, we recommend CMS wait one year after the initial implementation of the mandatory active engagement requirement before requiring MIPS eligible clinicians to increase Duration of Active Engagement and Validation year over year. By doing a more measured approach to implementing these requirements, CMS ensures MIPS eligible clinicians will be able to accurately report on Active Engagement and ensures CMS is able to receive the types of responses they are hoping to receive.

E. Public Health Reporting and Information Blocking

CMS notes in its proposed changes to the Public Health and Clinical Data Exchange Objective that MIPS eligible clinicians who fail to submit data to public health authorities could be considered information blockers. AHIMA continues to support implementation of the information blocking regulations contained within the 21st Century Cures Act. Currently the authority for implementing the appropriate disincentives for providers who violate information blocking requirements is with the HHS Secretary and there has been no final rule released by the Office of the Inspector General (OIG) detailing how the investigation of information blocking claims would take place. As a result, AHIMA strongly urges CMS to

³ <https://rce.sequoiaproject.org/wp-content/uploads/2022/01/SOP-Transitional-Council-FINAL.pdf>

⁴ <https://www.healthcaredive.com/news/onc-head-micky-tripathi-on-info-blocking-complaints-provider-penalties-and/620860/>

remove language from the CY 2023 PFS final rule implying providers who do not, or are unable, to share information with public health agencies are potential information blockers. Leaving this language in place implies providers subject to information blocking could face a negative Medicare adjustment and be subject to information blocking penalties if they fail the Public Health and Clinical Data Exchange objective under the Promoting Interoperability Performance Category. Implying information blocking disincentives are a part of the Promoting Interoperability Performance Category framework without HHS formally announcing the provider disincentive policies creates regulatory confusion for provider actors. It is crucial HHS, and its sub-agencies, maintain a clear and concise communications posture to ensure provider actors are fully able to comprehend their compliance burden. Failure to do so jeopardizes the entire information blocking implementation pathway and would create unnecessary burden throughout the actor community.

g. Proposed Changes to the Scoring Methodology for the Performance Period in CY 2023 (87FR46298)

AHIMA supports the proposed scoring changes as proposed by CMS for MIPS eligible clinicians. While we support the scoring changes, we urge CMS to further alter the scoring methodology to align with our proposed revisions to the Promoting Interoperability Performance Category above.

i. Patient Access to Health Information Measure – Request for Information (RFI) (87FR46311)

Would allowing patients to add information to their records be useful in promoting patient access and utilization? Are there other incentives that would promote patient access? Are there potential unintended consequences in allowing patients to add information to their records? What could be done to mitigate any potential unintended consequences? Are there certain tools found to be useful in promoting patient access and use of their health information?

It is crucial to allow patients to review and suggest edits to their health records to correct inaccuracies within those records. Allowing patients to add information to their record through a digital means is just one way to accomplish this goal. As it currently stands, there are limited technology solutions allowing patients to view and amend their record. AHIMA recommends CMS work with ONC to develop and implement the technical capabilities necessary to increase patient engagement through allowing them the ability to amend or update their records.

What policy, implementation strategies, or other considerations are necessary to address existing racial bias or other biases and prevent use of stigmatizing language?

Addressing racial bias and promoting equity in healthcare and health IT is a goal of both AHIMA and CMS. Current work with both the Gravity Project and the ONC United States Core Data for Interoperability (USCDI) process are just two of the areas where AHIMA is supporting the health IT community in promoting racial equity and removing racial bias from health IT. AHIMA recommends CMS remain actively engaged in this work to guide its development and determine the best avenue for regulatory alignment. Similarly, to promote nationwide health equity, AHIMA recommends CMS work with the Office of Management and Budget (OMB) to update the demographic data collection standards to be more inclusive and match with several states who have already advanced these standards to be more inclusive.

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?

AHIMA urges CMS to work with ONC to further determine the technological barriers to patients accessing their health data by an electronic means. Patients face numerous challenges when it comes to accessing their data ranging from a potential lack of access to stable highspeed broadband internet, to complications relating to the process of utilizing patient portals. Multiple requirements exist throughout the Certification Program for Certified Health IT products related to inclusion and disability access and encourage CMS to work with ONC to determine the opportunities and limitations those requirements present.

If patient portals connected to a network participating in the recently launched TEFCA, would this enable more seamless access to individual health information across various patient portals?

AHIMA continues to support development of the TEFCA and all opportunities it provides to support increased patient access to their health information. The TEFCA remains an opportunity for widespread data interoperability, but at this time it is unclear how the TEFCA will function once it is operational or the ability for the framework to enable access to multiple patient portals through one login. CMS should continue to monitor the TEFCA's development throughout this year and reevaluate the ability for the framework to remove patient burden in next year's IPPS rule.

What challenges do MIPS eligible clinicians face when addressing patient questions and requests resulting from patient access of patient portals or access of data through use of a mobile app? What can be done to mitigate potential burden?

AHIMA recommends CMS continue monitoring the challenges related to the patient access of data through patient portals and mobile apps. The 21st Century Cures Act final rules from ONC and CMS do not require the app enabled application programming interfaces (APIs) to be implemented until 2023. After those APIs are appropriately implemented a clearer picture related to patient access challenges will be available to CMS. As CMS continues to monitor these issues now and, in the future, we encourage CMS to ensure it solicits feedback from a wide swath of stakeholders, most importantly from HI professionals who are the face of data release and often field patient questions and concerns related to the access of their data.

For patients who access their health information, how could CMS, HHS, and health care providers help patients manage their health through the use of their personal health information?

AHIMA recommends CMS confer with partners across HHS and the US Government to determine the number of patients able to manage their health through the use of their personal health information, the number of patients who actively manage their electronic health information and those who currently use that information to manage their health. Once this scope of knowledge is known, AHIMA urges the US Government to engage in an education campaign to help patients understand why actively managing their health data is important for protecting their health. An education campaign such as this could serve to drastically increase the number of patients that are actively engaged in the use and exchange of electronic health information.

Do you believe the API and app ecosystem is at the point where it would be beneficial to revisit adding a measure of patient access to their health information which assesses providers on the degree to which their patients actively access their health information? What should be considered when designing a measure of patient access of their health information through portals or apps?

AHIMA strongly recommends CMS not pursue implementing a measure to the Promoting Interoperability Program on measuring patient access to their health information. Currently, the 21st Century Cures Update Edition CEHRT products that enable third-party app access via API are not due to be delivered to providers until December 31, 2022 and providers are not required to attest to the implementation of these updated products until the final 90-day period in FY 2023. Additionally, the access via these APIs is enabled without special effort, meaning patients can access their information without contacting their provider. Due to the way these APIs are being implemented it is not possible for providers to measure, track or know how often or through what means a patient is accessing their health information. Implementing a measure, such as the one proposed in this RFI, would drastically increase burden on MIPS eligible clinicians as they would need to create a means to capture and report this data without a similar mandate from the federal government placed on those that develop the products. CMS should look for other ways to gauge patient engagement and refrain from implementing a measure such as the one proposed.

If AHIMA can provide any further information, or if there are any questions regarding this letter and its recommendations, please feel free to contact Sue Bowman, senior director of coding policy and compliance, at (312) 233-1115 or sue.bowman@ahima.org, or Andrew Tomlinson, director of regulatory affairs, at (312) 223-1086 or andrew.tomlinson@ahima.org.

Sincerely,



Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer