College of Healthcare Information Management Executives

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The College of Healthcare Information Management Executives (CHIME) writes in response to the Centers for Medicare & Medicaid Services (CMS) *Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies;* proposed rule placed on display in the Federal Register on Aug. 17, 2020.

CHIME is an executive organization dedicated to serving chief information officers (CIOs), chief medical information officers (CMIOs), chief nursing information officers (CNIOs) and other senior healthcare IT leaders. With nearly 3,400 members, CHIME provides a highly interactive, trusted environment enabling senior professional and industry leaders to collaborate; exchange best practices; address professional development needs; and advocate for the effective use of information management to improve the health and healthcare in the communities they serve.

We are grateful for the opportunity to comment on the CY2021 Physician Fee Schedule (PFS) and the provisions contained within it. The PFS is one of the key rules to be released by CMS every year impacting everything from health IT adoption to telehealth. This year, more than any year past, the provisions contained within the PFS will shape care for years to come, proposing significant changes to the Medicare telehealth program, outlining the path forward for the Medicare Merit-based Incentive Payment System (MIPS) Value Pathway (MVP) program and continuing the incremental update of the Promoting Interoperability (PI) program.

COVID-19 has brought unprecedented widespread hardship to the provider community. Over six months into the pandemic, providers are still grappling with the changes regarding how care is delivered and the financial impact on those unable to go to the doctor. Many of the provisions within the CY 2021 PFS help lessen the burden providers will face from COVID-19 and help position the health system for the intense, rapid change it will go through as the pandemic eventually winds to an end. Others run the risk of increasing the burden placed on an already stretched thin provider population fighting for their very survival while helping patients fight for their lives.

Providers continue to need all the help they can get and that includes through the expansion of proposals contained in the PFS and with granted relief through other proposals. **Throughout CHIME's comments you will see several themes which are summarized below including:**

- **Expanding Medicare telehealth coverage to include all services that do not require a physical exam, to include audio-only services as permanently covered, and to include a more robust payment parity system;**
- **Ensuring that interoperability proposals, including the expansion of MVP and PI, are common sense and focused on helping providers achieve further interoperability while not increasing burden; and**
- **Requesting CMS to continue efforts to relax and delay enforcement deadlines on new programs until the nation is able to permanently move past the COVID-19 pandemic.**

These recommendations ensure that no provider will be left behind during the COVID-19 pandemic and that even those dealing with the direst of rolling infection waves will remain compliant with all CMS programs. We are thankful for the relaxations already provided by the Administration and CMS and ask for you to continue to keep a patient and provider centric focus as you release the final version of the PFS, as well as other key pieces of rulemaking this year.

Below you will find more detailed comments related to specific provisions contained within the CY 2021 PFS.

Telehealth

The CY2021 PFS contains numerous telehealth proposals aimed at expanding patient access to Medicare Telehealth. Telehealth continues to be a major focus of the healthcare community as COVID-19 has thrust the issue to the foreground through the need presented by social distancing requirements. Both Congress and the Administration acted swiftly at the beginning of the pandemic relaxing requirements and expanding the availability of telehealth for Medicare and Medicaid patients nationwide. This expansion though is only temporary, especially for the relaxation of the distance site requirement allowing beneficiaries in both rural and urban areas to access Medicare Telehealth services, as it is tied to the Public Health Emergency (PHE).

We are grateful for the work CMS has done related to continuing the permanent expansion of Medicare telehealth in rural areas, but more needs to be done. Providers across the nation made significant sunk cost investments in telehealth platforms and patients have been utilizing the services[1]. It's clear the infrastructure and desire are there for telehealth to become a permanent fixture of the American healthcare system. In order to achieve that permanency though, **CMS must work with Congress to remove the distant site and geographic requirements that prevent patients from accessing these crucial services within their homes.** Without the removal of these requirements there is no hope for telehealth's continued expansion. Providers won't be able to financially support this care modality if all of their patients cannot access it. By removing these geographic requirements, telehealth's long-term accessibility and financial stability can be assured.

Within the PFS, CMS proposes expanding the telehealth services list in two forms. The first expansion is a permanent inclusion of a selection of existing services and Healthcare Common Procedure Coding System (HCPCS) codes now included on a Category 1 basis. The services range everywhere from evaluation & management (E/M) codes and group psychotherapy to home visitation. The second expansion is on a temporary basis through the end of the calendar year in which the PHE expires. This expansion features services included on a Category 3 basis (codes

[1] https://www.hhs.gov/about/news/2020/07/28/hhs-issues-new-report-highlighting-dramatic-trends-in-medicare-beneficiary-telehealth-utilization-amid-covid-19.html

considered temporary for emerging services and technologies) ranging from long-term care services to emergency department visits.

As part of the expansion, CMS also asks for comment on the inclusion of several individual services related to their inclusions in telehealth.

CMS has also previously acknowledged it does not have the statutory authority to include audio only telehealth as a permanent piece of the Medicare telehealth program.

Recommendations:

1. **The expansion of telehealth needs to proceed on a permanent basis with the inclusion of all existing services that do not require a physical exam being included as an option for Medicare telehealth under Category I status. Providers should be trusted to make the decision on whether a service is eligible for a tele-visit and by limiting the services that are included under the Medicare telehealth program it limits the providers' ability to decide what's best for their patients.**
2. **If CMS does not include all services not requiring a physical exam in their permanent expansion of telehealth, then CHIME recommends CMS, at a minimum, include emergency visits as a permanent part of the Medicare telehealth program. Great success has been found utilizing telehealth as a substitute for in-person emergency visits. Telehealth can not only reduce the burden placed on emergency rooms by handling routine issues with telehealth visits, but they also help reduce the spread of common hospital room viruses, beyond even COVID-19, such as the seasonal flu. By allowing for emergency visits to be handled via telehealth, CMS enables immense cost savings by allowing routine issues requiring limited or no physical exams to be handled in short appointments requiring limited infrastructure or provider time.**
3. **As part of this continued expansion, CHIME also recommends CMS develop a fee schedule specifically for telehealth services. This new fee schedule will create a streamlined, easier to access process for understanding and updating the reimbursement and included services lists.**
4. **CMS has stated in the past that it does view itself as having the authority to include audio-only telehealth services in the Medicare telehealth program. However, a review of the Social Security Act section 1834(m)[2] shows that the authorizing regulation for telehealth only states that the "Secretary shall pay for telehealth services that are furnished via a telecommunications system." There is no further definitional requirement for a telecommunications system to include both audio and video technology. Several pieces of CMS guidance state that interactive telecommunications systems do not include telephone calls, but it is CHIME's belief that this is an interpretation made by CMS. We urge CMS to reexamine its guidance and include the use of audio-only mediums as part of an interactive telecommunications system. By allowing audio-only telehealth, CMS ensures those in rural and underserved areas – struggling with poor or inaccessible highspeed internet – and those unable to access a video system can still access Medicare telehealth services.**
5. **We encourage CMS to release additional guidance on the proper way to code telehealth services and the correct modifiers to be used when it comes to coding appropriate telehealth services. Several members have highlighted the issue of**

[2] https://www.ssa.gov/OP_Home/ssact/title18/1834.htm

"bounce-backs" in claims processing for telehealth services because of incorrect coding. Additional education could help reduce the number of these "bounce-backs" due to coding or modifier errors, as well as the administrative burden on providers.

6. **As it relates to payment, several members from the rural health center (RHC) and federally qualified health center (FQHC) communities have indicated they are not currently reimbursed in the same fashion for in-person services as they are for telehealth services. We urge CMS to ensure all providers are reimbursed in the same format for services rendered, otherwise these vital safety net providers may not be able to offer telehealth services because they simply aren't able to operate on the payment model.**
7. **As it relates to remote patient monitoring (RPM), we encourage CMS to require that RPM be limited to patients with an established patient relationship to the provider. However, this policy should include a robust exception process to ensure those in rural, or underserved areas can access RPM consistently. This is increasingly important as specialists and other life altering care modalities are not always reachable in-person for patients. As a result, these patients should not be precluded from participating in RPM because of distance and thus should operate under an exception so as not to widen the digital divide.**
8. **Finally, as it relates to telehealth, we encourage CMS to work with the Federal Communications Commission (FCC) and other relevant agencies to ensure there is widespread expansion of broadband services to ensure patients and providers nationwide are able to access and provide telehealth services.**

Promoting Interoperability Program

CMS proposes several changes to the Medicare Promoting Interoperability Program for CY2021. Many of these changes relate to scoring and requirements placed on providers for the plan year. CHIME applauds CMS for maintaining relative uniformity within the program given the already discussed burden COVID-19 is placing on providers.

Within the PFS proposed rule, CMS proposes leaving the query of a prescription drug monitoring program (PDMP) measure optional offering ten bonus points for those providers who meet that criteria, an increase of five points. The updated scoring also proposes a new Health Information Exchange (HIE) alternate measure related to HIE Bi-Directional Exchange worth 40 points. Outside of scoring, the PI program also proposes shifting the deadline by which providers must implement the revised 2015 edition certified electronic health record technology (CEHRT) compliance date to August 2, 2022, aligning the provider deadline with the developer deadline governed by the Office of the National Coordinator for Health Information Technology (ONC). Finally, the proposed rule indicates that CMS will continue to monitor the PI program for additional updates in the future to align PI with the recently released – and previously referenced – 21st Century Cures Interoperability and Information Blocking Rules.

Recommendations:

1. **CHIME supports the continued optionality of the query of PDMP scoring measure. As it relates to increasing the bonus points and the future for this measure, we urge CMS to consider several factors that impact many providers' abilities to achieve full scoring for this optional category. Many providers will be left out of this category and thus unable to even attempt to earn these points given that not all providers prescribe**

controlled substances. Additionally, the PDMP infrastructure nationwide does not lend itself to a one-size fits-all methodology. The utilization and robustness of PDMPs varies widely from state-to-state and, as a result, some providers will be left on the outside looking in for this scoring category by no fault of their own. Additionally, some providers who work on state lines and service patients in multiple states do not have the tools needed to ensure a PDMP query is impactful given the lack of reliable cross-state PDMP access. As a result, if CMS were to proceed with the five-point increase in this optional category, we urge CMS to create additional opportunities for providers unable to meet this criterion due to challenges outside their control to earn optional bonus points. Additionally, we urge CMS to dedicate further resources to increase PDMP adoption, use and utility as the nation moves forward with a multi-pronged strategy to solve electronic prescribing of controlled substance (EPCS) challenges.

2. **The new optional alternative HIE scoring category has the chance to further advance the interoperability of health data in the nation, but is significantly hampered by both the COVID-19 pandemic and challenges around the implementation of key pieces of nationwide health information infrastructure. As a result, we support the inclusion of this measure as optional, however, believe there needs to be significant advances in the nation's ability to bi-directionally exchange health data before this scoring measure is made permanent. Additionally, CHIME requests CMS clarify and make clear the HIE being measured through the PI program relates to *any* exchange of health information between HIE entities, meaning the measure does not restrict the exchange to only information sent and received from state HIEs or local health authority HIEs. We encourage CMS to follow the HIE definition adopted as part of the 21st Century Cures Act Information Blocking and Interoperability rules, meaning exchanging data across a health information network such as CareQuality or CommonWell would be considered "participating in HIE." Additionally, this measure must remain optional for the foreseeable future, a timeframe no shorter than two years from publication of this final rule, as the COVID-19 pandemic has significantly hampered the ability for providers to implement and prepare for the information blocking rules released by CMS and ONC. The ONC and CMS rules are aimed at increasing the bi-directional exchange this measure is looking to score and providers have the potential to be unduly punished for failing to implement bi-directional HIE exchange because of circumstances outside of their control. Additionally, at the time of this letter's drafting, ONC's information blocking compliance date rule is awaiting final clearance from the Office of Management and Budget. This indicates HHS believes on a broader scale that providers need additional time to implement the very infrastructure needed to comply with this scoring measure.**
3. **By moving the compliance date for providers to implement their revised 2015 edition CEHRT to align with the developer deadline, CMS is potentially setting up a worst-case scenario of developers failing to deliver completed technology until their August 2, 2022 compliance date and providers thus being unable to comply with their implementation deadline. This scenario leaves no room for a safe and well-executed implementation of updated technology and would cause developers to meet their compliance deadline requirements contained within the ONC information blocking and interoperability rules, while leaving providers non-compliant with the requirements contained within the CY 2021 PFS. It is imperative CMS give providers time to implement their technology as this is not as simple as ripping and replacing outdated technology with the updated CEHRT installations. Providers, in most cases,**

need to bring their whole system off-line in order to update the software. This is a process that can take several weeks, or even months. It is not feasible for a provider to completely lose access to their EHR technology throughout a whole practice. With this in-mind, we strongly urge CMS to delay this requirement for providers by 18-to-24 months. This allows providers the time needed to properly implement their technology, while ensuring that developers have the time they need to perfect their products without rushing implementation.

4. **As CHIME has previously stated above, but would like to reiterate again, in order for the information blocking provisions described by ONC and CMS to be implemented properly, providers need additional flexibility to move through the COVID-19 pandemic. The pandemic has, taken up significant bandwidth from the staff at provider groups and those often tasked with the implementation of information blocking requirements are the very staff being furloughed and laid-off due to financial constraints caused by the pandemic. With this in-mind, we encourage CMS to refrain from any alignment activities with the PI program and information blocking requirements for at least two years until the CY 2023 PFS. This ensures the healthcare continuum has enough time to move through the end of the pandemic and recover from the devastation it has caused.**

MIPs Value Pathways (MVP)

CMS outlines the future for the MVP program throughout the CY 2021 PFS. Of major focus, CMS outlines that the MVP program will be implemented in the future with the process for proposing, developing and selecting MVPs beginning in 2022. Additionally, CMS indicates that on an annual basis they intend to host public facing development webinars aimed at educating interested parties of the process to submit a candidate MVP.

As part of this information dissemination throughout the PFS, CMS also asks for comment on creating a transparent process, as well as how best to ensure that providers are engaged in the process.

CHIME previously responded to proposals for the MVP program in the CY2020 PFS comment process. In those comments, CHIME highlighted the need for additional clarity on how MVP will impact the PI category under MIPS, urged CMS to make the MVP program voluntary and requested CMS to take into consideration the ONC/CMS information blocking and interoperability rules and the impact they will have on the MVP program.

Recommendations:

1. **CHIME continues to believe the MVP program needs to remain optional for the foreseeable future. The COVID-19 pandemic has stretched thin providers' bandwidth for reading, understanding and responding to reporting requirements imposed on them by HHS. In addition to the reporting providers already need to do under the numerous HHS and CMS programs, new reporting criteria are being added to their responsibilities on what seems like a monthly basis. Recently, HHS and CMS imposed mandatory COVID-19 reporting requirements[3] on hospitals under the threat of a loss**

[3] https://www.hhs.gov/about/news/2020/06/04/hhs-announces-new-laboratory-data-reporting-guidance-for-covid-19-testing.html

of their Conditions of Participation (CoP) and media reports[4] have indicated more reporting requirements may be coming. CHIME has already responded to these reporting requirements, highlighting the burden they are placing on providers, but are choosing to highlight them again to encourage CMS to take into account all the requirements placed on providers before implementing new ones. The MVP program is in its infancy with measures and implementation plans yet to be released. Without a full breadth and knowledge of what is coming, providers are unable to plan for changes to important programs like MIPs. With that said, CHIME wants to reiterate the need for the MVP program to remain optional for the foreseeable future, allowing providers to appropriately plan and engage in the program once they are stable and through the COVID-19 pandemic. Our members desire a level of certainty above all else when it comes to these types of mandates. Uncertainty breeds confusion, it creates burdens for providers, and creates significant challenges in planning ahead from both a financial and compliance standpoint.

2. **With the major shift CMS intends the MVP program to bring to the MIPs program, CHIME requests the ability to better shape the program itself, not just the measures contained within it. As previously stated, providers are already subject to reporting requirements from several HHS programs. Many of those programs require reporting on several duplicative categories and providers now face more of the same as the MVP program and looming information blocking programs threaten to impose more duplicative mandates. CMS has the opportunity to shape the MVP program in a way that would begin to lessen the duplicative reporting requirements by soliciting feedback from the public. Public input would allow CMS to better understand the reporting requirements and how they are responded to in the real world. This input could be valuable in helping CMS lessen the reporting burden on providers, while simultaneously significantly reducing the reporting collection burden placed on CMS staff. Gathering further information from the public, specifically the providers who will be reporting through this program, will only make the MVP program stronger with a greater chance of adoption and success.**
3. **CHIME also recommends CMS delay the listening session process for developing measures as it relates to the MVP program from 2022 to 2023. This delay would allow for the above-mentioned public feedback process to be implemented and allow for the public to have the ability to give feedback on the MVP program direction on the whole, not just on the measures that will be proposed.**
4. **CHIME also recommends that the public comment and listening session process throughout the course of the MVP program take place on a quarterly cadence. This allows for more transparency into the program and for CMS to have more opportunities to address a wider range of topics.**

Electronic Prescribing for Controlled Substances (EPCS)

As part of the CY2021 PFS CMS has proposed delaying the EPCS requirements by one year giving providers until January 1, 2022 to implement requirements under the Drug Enforcement Administration (DEA)/CMS EPCS program.

Recommendations:

[4] https://www.npr.org/sections/health-shots/2020/09/24/916310786/trump-administration-plans-crackdown-on-hospitals-failing-to-report-covid-19-dat

1. **CHIME applauds CMS for delaying the implementation of the electronic prescribing of controlled substances (EPCS) program by one year to further allow providers to respond to the COVID-19 pandemic. We further encourage CMS to monitor the burden the pandemic is placing on providers and adjust the implementation date of these requirements as appropriate.**
2. **CHIME also encourages CMS to use the additional time as an opportunity to publish and increase the education for providers around best practices for implementing and complying with the requirements contained within the EPCS requirements.**

The PFS is a landmark piece of regulation released annually. This year is no different with the CY2021 changes impacting care for years to come and shaping how care will be delivered as the nation continues to fight the COVID-19 pandemic. CHIME remains steadfast in ensuring regulatory changes keep both the patient and the provider at the center ensuring that nothing compromises the quality of care delivered and received. We hope you will find those values reflected in our above comments and will work with us to ensure no patient and no provider is left behind as the care continuum continues to push us further into the future.

If you would like to speak further with CHIME or our members about how we can best work together to shape and implement the most effective PFS in CY 2021 and beyond, please feel free to reach out to our Director of Federal Affairs at atomlinson@chimecentral.org.

Sincerely,

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