AAAHC

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

September 9, 2024

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1809-P
P.O. Box 8010
Baltimore, MD 21244-8010

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

RE: **Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities (RIN 0938-AV35)**

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: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities (RIN 0938-AV35, CMS-1809-P).

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 6,700 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 CMS deemed status program, making AAAHC the leading Medicare-approved, non-hospital accreditation organization in the country. AAAHC's extensive experience includes accrediting both publicly and privately funded ambulatory health care organizations. AAAHC provides accreditation services to HRSA Federally Qualified Health Care centers, United States Coast Guard, Indian Health Centers, community health centers, Tribal/Urban Indian Health Centers, student health centers, ambulatory and office-based surgery centers, retail clinics, employer health networks, managed care organizations, dental group practices, correctional healthcare facilities, and others.

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XIV. Cross-Program Proposals for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs (89 FR 59437)

B. CMS Commitment To Advancing Health Equity Using Quality Measurement (89 FR 59437)

1. Proposal To Adopt the Hospital Commitment to Health Equity (HCHE) Measure for the Hospital Outpatient Quality Reporting (OQR) and Rural Emergency Hospital Quality Reporting (REHQR) Programs and the Facility Commitment to Health Equity (FCHE) Measure for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program Beginning With the CY 2025 Reporting Period/CY 2027 Payment Determination or Program Determination (89 FR 59439)

AAAHC believes that health equity cannot be ignored and applauds CMS's goal to urge ambulatory surgery centers to address health care equity by implementing fundamental practices and protocols. While the goal is admirable, AAAHC hopes to ensure that CMS examines and accounts for other factors that influence health equity such as underlying structural or cultural barriers, available resources, and organizational policies and procedures. It is also important to consider accessibility based on services provided, fee structure, and the vast demographics within and across communities, while also seeking to understand what drives patients to make decisions about where they receive care.

AAAHC cautions that collecting and publicly reporting such measures may not achieve the desired goals and may rather further call out disparity without identifying a cause and without necessary context. Without a wholistic view of organizational culture, internal policies, specialties, and community demographics, it may not be possible to accurately and fairly evaluate organizations against this measure.

CMS has itself recognized that this measure was not developed for ASCs, has not been tested in ASCs, and may not be wholly applicable to the ASC structure. ASC and hospital environments are significantly different in areas including resource availability, workflow, and staffing structures. The introduction of new measures to be applied across both facility types must account for these differences. AAAHC questions if the burden of implementation of such measures and the potential for skewed results outweighs the desired outcome due to the lack of evidence-based research and inaccuracy of non-risk adjusted data. AAAHC requests that CMS conduct research into how these measures can be more accurately applied and evaluated before mandating measure reporting by ASC facilities, especially where the burden created by implementation of this proposal will fall heaviest upon ASCs already facing the tightest resources and that have not yet been able to implement an EHR.

Organizations that are approved to provide care to beneficiaries choose to serve populations at highest risk for facing inequities in healthcare and the impacts of social determinant health factors. Forcing these facilities to redirect their resources into measure reporting that is not directly applicable to their facility type and has not yet been proven to provide actual representation of improved quality care seems to fall in stark contrast with the discussion and proposal CMS makes in section XIV.C. regarding the immediate removal of measures that negatively impact patient care.

As stated in previously submitted AAAHC commentary regarding Social Drivers of Health (SDOH) measures, AAAHC prides itself on assisting health care organizations that serve underserved populations, such as the Indian Health Service, HRSA, and surgical centers that provide care to beneficiaries, to achieve a higher quality of care. Through our Standards, AAAHC requires that facilities address disparities across a variety of factors. AAAHC Standards already require that facilities and providers offer translation services, ensure safe 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 encourages CMS to consider the time and resources required for different provider and facility types to implement any new requirements and to prioritize the provision of appropriate support towards the resolution of existing SDOH factors. For example, CMS can use hospital Screen Positive Rate data to impact and improve care for underserved populations to identify locations with highest positivity rates, review community resources offered in that area, and support additional program developments based on the information supporting community need.

Ambulatory care settings are generally smaller than hospitals, see fewer patients than hospitals, provide a more narrow scope of services, and offer specialized care. These differences allow a closer and more patient-centered focus on pre- and post-surgical care, making surgical service equitable care and outcomes more appropriate and meaningful to these settings than the proposed FCHE, SDOH, and Screen Positive measures.

Although ASCs are typically not considered "medical homes," AAAHC finds that the principles of the medical home, and many of the standards that are required of a medical home can begin to address disparities in health care within the ASC setting. In fact, many of these principles and processes are often already an aspect of the care provided in the ASC. Some examples of areas in which ASCs are likely already engaged in practices to support patients with negative social determinates of health are reflected in AAAHC Standards requiring patient education materials to be provided in appropriate languages and literacy levels for the population served. Additionally, AAAHC offers Advanced Orthopaedic Certification (AOC) for ASCs that requires evidence the facility has knowledge of community resources that support the needs of the patient and their family and evidence the facility recognizes the community's service limitations and has the ability to coordinate alternate resources.

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, while 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 the ability to provide additional resources and plan for improvement fails to meet the equity intention behind creation of the measures.

2. Proposal To Adopt the Screening for Social Drivers of Health (SDOH) Measure for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs Beginning With Voluntary Reporting for the CY 2025 Reporting Period Followed by Mandatory Reporting for the CY 2026 Reporting Period/CY 2028 Payment or Program Determination (89 FR 59443)

AAAHC believes our response to XIV.B.1. also applies to the SDOH Measure CMS is proposing to adopt.

3. Proposal To Adopt the Screen Positive Rate for Social Drivers of Health (SDOH) Measure for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs Beginning With Voluntary Reporting for the CY 2025 Reporting Period Followed by Mandatory Reporting Beginning With the CY 2026 Reporting Period/CY 2028 Payment or Program Determination (89 FR 59448)

AAAHC believes our response to XIV.B.1. also applies to the Screen Positive Rate for SDOH Measure CMS is proposing to adopt.

C. Proposal To Modify the Immediate Measure Removal Policy for the Hospital Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs Beginning With CY 2025 (89 FR 59449)

AAAHC supports the immediate suspension of measures that give rise to patient safety concerns. Patient safety and quality of care should always be prioritized above data collection.

XV. Hospital Outpatient Quality Reporting (OQR) Program (89 FR 59450)

C. Program Measure Proposals (89 FR 59451)

b. Proposal To Adopt the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery Patient Reported Outcome-Based Performance Measure (Information Transfer PRO–PM) Beginning With Voluntary Reporting For the CY 2026 Reporting Period Followed by Mandatory Reporting Beginning With the CY 2027 Reporting Period/CY 2029 Payment Determination (89 FR 59452)

AAAHC supports extending patient response periods for PRO-PM measures. Extended response windows encourage continued patient follow up by health care facilities and improve the continuity of care. This may be most important for accurately capturing care results in extended recovery situations, such as total knee replacements.

XVI. Rural Emergency Hospital Quality Reporting (REHQR) Program (89 FR 59461)

C. Program Measure Proposals (89 FR 59462)

1. Proposal To Adopt Health Equity Quality Measures in the REHQR Program (89 FR 59462)

AAAHC believes our response to XIV.B.1. also applies to the proposed adoption of health equity quality measures in the REHQR program.

XVII. Ambulatory Surgical Center Quality Reporting (ASCQR) Program (89 FR 59466)

E. Form, Manner, and Timing of Data Submission (89 FR 59470)

2. Measure-Specific Data Submission and Reporting Requirements (89 FR 59470)

AAAHC believes our response to XIV.B.1. also applies to the measure-specific data submission and reporting requirements for the FCHE, SDOH, and Screen Positive Rate for SDOH that CMS is proposing to adopt.

Additionally, AAAHC reiterates its support for measure development, as measures inform Standards development and improvements in patient care. AAAHC, however, encourages CMS to carefully consider and only implement those measures providing the greatest value to patient safety and quality of care, as additional mandatory measures must be balanced against the potential additional administrative burden increased measure reporting may place on ASCs. While AAAHC supports the value that measures can bring, we also believe it is important to recognize the increased burdens and the consequence of diverting revenue away from patient safety investments when dictating how ASCs must budget by requiring resources for the implementation of new mandatory measures if such measures are not directly related to patient safety.

G. Request for Information (RFI)— Development of Frameworks for Specialty Focused Reporting and Minimum Case Number for Required Reporting (89 FR 59471)

While both the "Specialty-Select" Framework and the alternative, "Specialty Threshold" Framework, have the potential to create quality measure reporting requirements that are more closely aligned with the procedures performed at an individual ASC, additional information is required regarding the proposed frameworks. For example, the proposed Specialty Threshold Framework is not clear about when the case count for each measure is to be calculated. Likewise, the Specialty-Select Framework is unclear concerning the consequences to an ASC that lacks sufficient measures to meet the number that would be specified in future rulemaking. Both frameworks deduce that claims-based measures are not administratively burdensome, but AAAHC believes that any increase to measure requirements creates additional burden upon the healthcare facility.

XVIII. Medicaid Clinic Services Four Walls Exceptions (89 FR 59474)

B. Provisions of the Proposed Regulations (89 FR 59477)

AAAHC supports expanding the Four Walls Exceptions beyond unhoused individuals to include additional populations facing the same barriers to access as the unhoused population. CMS has identified four population criteria to meet the Four Walls Exception, being high rates of behavioral health diagnoses or difficulty accessing behavioral health services, lack of transportation, historical mistrust of the health care system, and high rates of poor health outcomes and mortality. AAAHC's responses to the specific provisions of this proposal are provided in the sections below.

1. IHS/Tribal Clinics (89 FR 59479)

CMS has stated that urban Indian organizations (UIOs) are not included within the exception as most UIO facilities participate in the FQHC services benefit program and so are unlikely to need the exception, while other UIO facilities may qualify under the behavioral health or rural area exceptions. AAAHC proposes that CMS consider instituting an application or appeals process to ensure that health facilities which serve a population that meets the four specified population criteria but do not fall under the proposed exception also have the ability to provide care services outside of the health facility to help ensure access to necessary care for all beneficiaries.

2. Behavioral Health Clinics (89 FR 59480)

CMS acknowledges that types of behavioral health clinics within a state may vary and provides that facilities must be primarily organized for the care and treatment of outpatients with a behavioral health disorder to qualify for this exception. However, outpatient health care facilities not primarily organized for behavioral health disorder treatment may provide a significant amount of outpatient behavioral health services, especially in those areas most in need of access to these services. AAAHC proposes that CMS consider instituting an application or appeals process to ensure that health facilities which serve a population that meets the four specified population criteria but do not fall under the proposed exception also have the opportunity to provide care services outside of the health facility to help ensure access to necessary care for all beneficiaries.

4. Additional Four Walls Considerations (89 FR 59485)

Additional populations not specifically addressed within the Exceptions proposed by CMS, but that are recognized as impacted by the four proposed exception criteria at higher rates, include minority, differently abled, LGBTQ+, low income, female, and elderly populations.[1] Therefore, AAAHC proposes that CMS consider instituting an application or appeals process to ensure that health facilities serving a population that meets the four specified population criteria, but that do not fall under the proposed or optional exception, have the opportunity to offer services outside of the health facility.

[1] National Conference of State Legislatures. (2021, May 10). *Brief: Health disparities overview*. https://www.ncsl.org/health/health-disparities-overview; Office of Disease Prevention and Health Promotion. (n.d.) *Social Determinants of Health Literature Summaries: Poverty*. Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty; National Library of Medicine. (2013). *U.S. health in international perspective: shorter lives, poorer health*. https://www.ncbi.nlm.nih.gov/books/NBK154469/; Fountain House. (2022, August 30). *4 out of 10 Americans can't access mental health care when they need it – community-based support is an immediate solution*. https://www.fountainhouse.org/news/4-out-of-10-americans-cant-access-mental-health-care-when-they-need-it-community-based-support-is-an-immediate-solution; National Council for Mental Wellbeing. (n.d.) *Study reveals lack of access as root cause for mental health crisis in America*. https://www.thenationalcouncil.org/news/lack-of-access-root-cause-mental-health-crisis-in-america/; Johnson, Steven Ross. (2024, January 11). *Millions of Americans lack reliable transportation. It may affect their health*. U.S. News. https://www.usnews.com/news/health-news/articles/2024-01-11/millions-of-americans-lack-reliable-transportation; John Hopkins University. (2024, January 19). *Unreliable mass transit and American public health*. https://hub.jhu.edu/2024/01/19/cdc-report-unreliable-transportation-in-america; U.S. Department of Transportation. (2013, December 17). *Health and equity*. https://www.transportation.gov/mission/health/health-equity; Health Affairs. (2021, July 29). *Health policy brief: public transportation in the US: a driver of health and equity*. https://www.healthaffairs.org/content/briefs/public-transportation-us-driver-health-and-equity; Harvard T.H. Chan School of Public Health. (2023, February 7). *Marginalized communities likely to distrust healthcare system, polling finds*. https://www.hsph.harvard.edu/news/hsph-in-the-news/marginalized-communities-likely-to-distrust-healthcare-system-polling-finds; Genetics in Medicine. (2022, July). *Prevalence and prediction of medical distrust in a diverse medical genomic research sample*. ScienceDirect. https://www.sciencedirect.com/science/article/pii/S1098360022006979

XX. Provisions Related to Medicaid and the Children's Health Insurance Program (CHIP) (89 FR 59487)

A. Continuous Eligibility in Medicaid and CHIP (42 CFR 435.926 and 457.342) (89 FR 59487)

AAAHC supports the proposed continuous eligibility requirements for low-income children who are eligible for Medicaid or CHIP and applauds CMS for the efforts being made to ensure that children have continuous health care coverage in all states through the age of 19 and regardless of ability to pay premiums or enrollment fees.

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

Sincerely,

Noel M. Adachi
President & CEO

Jan Davidson, MSN, RN, CNOR
Board Chair