MHA Michigan Health & Hospital Association | Leading Healthcare

September 13, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1751-P, Medicare Program; calendar year (CY) 2022 Payment Policies under the Physician Fee Schedule and Other changes to Part B payment policies; Medicare Shared Savings Program; Quality Payment Program; Medicare coverage of opioid use disorder services; Medicare provider enrollment policies; requirements for prepayment and post-payment medical review activities; requirement for electronic prescribing for controlled substances for a covered Part D drug; Medicare Ground Ambulance Data Collection System; Medicare Diabetes Prevention Program (MDPP) expanded model; and amendments to the physician self-referral law regulations

Dear Administrator Brooks-LaSure:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Medicare Physician Fee Schedule (MPFS) for CY 2022. The MHA comments will be focused on the MPFS conversion factor, appropriate use criteria, telehealth services, electronic prescribing of controlled substances (ECPS) for Part D drugs and closing the health equity gap.

Payment Update

The MHA is disappointed in the CMS decision to reduce the MPFS conversion factor to $33.58, a decrease of $1.31 from the calendar year 2021 conversion factor of $34.89, during the public health emergency (PHE). The updated conversion factor is budget neutral to account for changes in relative value units and the expiration of the 3.75% payment increase provided in the 2021 Consolidated Appropriations Act. This conversion factor reduction combined with the relative value unit changes for specific services will have a greater payment impact to providers than the budget neutrality adjustment of -0.14%. **The MHA requests CMS review clinical labor pricing and redistributive effects negatively impacting certain specialties.** The MHA is concerned with the payment impact decreasing for specialties that rely primarily on supply or equipment items, such as interventional radiology (-9%), vascular surgery (-8%), and radiation oncology and radiation therapy centers (-5%).

Appropriate Use Criteria

The MHA supports the CMS decision to delay the appropriate use criteria (AUC) penalty phase for noncompliance to Jan. 1, 2023, or the first of January following the end of the PHE, whichever is later. The AUC program was established to ensure providers order the most appropriate tests for their Medicare patients by consulting a clinical decision support mechanism. However, the MHA has concerns regarding program effectiveness given 7 years have passed since the program's inception by the Protecting Access to Medicare Act of 2014. The extended program delays and the recent efforts by the CMS to examine other existing quality improvement and payment models justify a reevaluation of the AUC program. **The MHA requests the CMS work with Congress to evaluate the validity of the AUC program given the significant time lapse between program inception and implementation.** The

MHA is concerned the AUC program is outdated and would require significant time and resources to advance past the current testing period. Advancing the AUC program to the penalty phase would add unnecessary administrative burden to providers who would have to manage AUC processing edits and appealing denied claims.

Telehealth Services and Other Services Involving Communications Technology

The MHA applauds the CMS decision to expand telehealth access for behavioral health services and retain Category 3 telehealth services until the end of CY 2023. Category 1 services are like services that are currently on the Medicare telehealth list, whereas Category 2 services are not similar to services on the list, and, as such, CMS requires supporting evidence of the clinical benefit of a service to add it to the list. In the CY 2021 PFS final rule, CMS added a third category of criteria for adding services to the Medicare telehealth list on a temporary basis following the end of the COVID-19 PHE. This "Category 3" describes services added during the PHE for which there is clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence to consider the services as permanent additions under Category 1 or Category 2 criteria. Providers adapted quickly to convert in-person visits to virtual care visits at the start of the COVID-19 pandemic and continue to demonstrate the value and importance of offering virtual care options for providers and patients. The extension of Category 3 telehealth services until the end of CY 2023 allows providers time to submit evidence for permanent addition on a Category 1 or Category 2 basis. However, **the MHA requests the CMS be consistent and add all the interim PHE telehealth services to Category 3, so these services will not be removed from the telehealth service list at the end of the PHE.**

The CMS is proposing to withhold payment from providers if they fail to conduct an in-person, non-telehealth service within six months prior to providing an initial mental health telehealth service, and at least once every six months thereafter. These in-person requirements apply only to mental health services not allowed under other provisions, such as substance use disorders covered by the SUPPORT Act. **The MHA requests the CMS extend the six month in-person visits to a one-time a year in-person visit.** This extension would assist patients who have difficultly traveling to appointments, so they do not lose access to their mental health telehealth services if they fail to complete the six-month in-person visit. According to a University of Michigan Institute for Healthcare Policy & Innovation study, rural beneficiaries used a disproportionately lower level of telehealth services compared to non-rural beneficiaries during the COVID-19 PHE. Adding additional in-person visits that are not deemed medically necessary by the provider would exacerbate the telehealth disparities between rural and non-rural patients by increasing the requirements to receive mental health telehealth services. Providers and patients can determine the frequency of in-person visits dependent on the needs of the patient. **If CMS retains the six-month in-person visits, the MHA requests the CMS allow the proposed required in-person, non-telehealth service be furnished by another provider of the same specialty within the same group as the provider who furnishes the telehealth service.** This flexibility would reduce scheduling burdens and promote timely access to care for patients who struggle with coordinating transportation, employment or childcare/eldercare needs to make in-person visits.

The MHA supports the CMS developing a service-level modifier to identify mental health services furnished via audio-only connection but does not support implementing additional documentation to justify the clinical appropriateness of audio-only services. **The MHA would request CMS evaluate expanding beyond the proposed mental health audio-only services to accommodate patients with other conditions who lack access to affordable and reliable broadband to support two-way audio/visual communications**. Audio-only visits have become a valuable tool in maintaining patient access to care. According to the Michigan Broadband Report, an estimated 368,000 rural Michigan households do not have broadband access and nearly 2 million Michigan households (48%) have access to only one fixed, terrestrial internet service practitioner. Expanding services allowed for audio-only visits will alleviate the inequity between those who have access to telecommunication technologies at an affordable price and those who do not. Failure to prevent disruption to audio-only services will exacerbate patient access issues among Michigan's older and vulnerable patient population.

The MHA requests the CMS permanently adopt the PHE flexibility allowing providers to satisfy direct supervision requirements for diagnostic tests, physician services and hospital outpatient services through real-time audio/video technology. Providers have successfully adapted to using this technology during the PHE and can decide if audio/video or in-person direct supervision is appropriate depending on the provider and/or facility situation.

Electronic Prescribing of Controlled Substances (EPCS) for Part D Drugs

In the CY 2021 MPFS final rule, the CMS implemented Section 2003 of the SUPPORT Act that requires electronic prescribing of Schedule II-V controlled substances under Medicare Part D. All prescribers were required to conduct EPCS using the National Council for Prescription Drug Programs (NCPDP) SCRIPT 2017071 standard with a mandatory compliance date of Jan. 1, 2022 (rather than the SUPPORT Act's deadline of Jan. 1, 2021) to allow flexibility considering the COVID-19 PHE. In the CY 2022 MPFS proposed rule, the CMS proposes revisions to this timeline by extending the EPCS compliance date to Jan. 1, 2023. The CMS maintains Jan. 1, 2021, as the implementation date of the EPCS requirements, meaning that the agency encourages providers to adopt the required standard as soon as possible but delays any enforcement activity until Jan. 1, 2023. **The MHA supports the CMS proposal to delay EPCS enforcement until Jan. 1, 2023 and encourages the CMS to not overextend prescriber penalties that would inadvertently discourage appropriate prescriptions of controlled substances.** The MHA believes the CMS should take additional time to gather more stakeholder feedback on the most effective and appropriate types of penalties for EPCS non-compliance.

The MHA also encourages the CMS to reevaluate the EPCS exemption for prescribers working under a research protocol. These prescribers may fall under the exemption for those who prescribe 100 or fewer Part D controlled substance prescriptions per year, but this can not be guaranteed. The MHA believes requiring prescribers working under a research protocol would add unduly burdensome costs of installing EPCS equipment and software relative to its benefit in terms of improving the security of controlled substance prescriptions.

Closing the Health Equity Gap

The COVID-19 pandemic shed new light on inequities in healthcare as certain populations were impacted much more significantly by the virus. **The MHA strongly supports efforts by the CMS to close this gap.** Collecting demographic and social determinants of health data is an important first step in advancing health equity initiatives, and CMS can support the provider community by expanding recommended data categories and appropriately compensating providers' time and resources to expand data collection efforts.

Upon the 2017 launch of the "Patients over Paperwork" Initiative, the CMS' goal was to reduce unnecessary regulatory burden and enable providers to concentrate on their primary mission of improving patient health outcomes which is supported by the MHA and other stakeholders.

The CMS outlines several areas of potential expansions of the CMS Disparity Methods. The MHA has concerns in expanding even more ways to calculate differences in outcomes among patient groups within and across hospitals as this may ultimately increase burden and negatively impact the patient experience. The idea of including a statistical modeling technique using indirection estimation to make hospital and population-level estimates on patient race and ethnicity could unintentionally introduce measurement bias, especially if the source data used to infer population-level race and ethnicity are inaccurate.

As the CMS considers additional measurement to address health equity, **the MHA urges the CMS to honor its "Patients Over Paperwork" initiative and streamline, align, and focus on those measures that matter most for patient care and outcomes**. We recommend leveraging existing solutions and datasets, while standardizing and streamlining data collection processes and ensuring consistency of definitions, categories and variables such as race and ethnicity across all federal programs to reduce administrative burden and enable clinicians to focus on patient care. **The MHA requests the CMS collaborate with the Office of the National Coordinator and the Office of Management and Budget**

(OMB) to expand the recommended race and ethnicity categories beyond the current OMB race and ethnicity categories. Providers should be encouraged and appropriately compensated to collect demographic data that is right for their community. This could include expanding ethnicity data collection beyond the OMB standards of Hispanic or Latino; Not Hispanic or Latino or allowing patients to select more than one race category.

The CMS must also develop support for providers for capturing, using and exchanging information within and across service lines. The current system is siloed, fragmented and uncoordinated, which limits transparency and the ability to share and use information as patients move across the healthcare continuum.

A final challenge worth noting is that there are inadequate healthcare-based solutions for addressing social determinants of health. Platforms are available for purchase but some of these systems are too costly for hospitals and remain out of reach.

The MHA urges the CMS to consider the following recommendations and looks forward to providing additional input when a future proposed rule is released:

- **Choose, adopt, and adequately incentivize the use of a single standard data set** that captures necessary and sufficient information on non-clinical patient characteristics. **This should be minimally burdensome to providers** and we recommend the adoption of standardized screening tools such as PRAPARE, AAFP's EveryONE project, or the CMS ACH Health-Related Social Needs screening tool, or the use of z-codes.

- **Distribute resources into community safety net programs to properly address social needs identified in data collection**. We urge the CMS to continue expanding the portfolio of programs and resources to support data analyses and quality improvement activities to bridge hospital-level efforts with post-acute and community-based programs and models to close health equity gaps due to lack of resources and accessibility to help strengthen the standardized collection of social needs data.

- **Expand disparity methods to include stratified results beyond current dual eligibility stratification since stratifying by dual eligibility status alone is not sufficient**. This is an easily accessible proxy measure that in no way captures the breadth of social determinants. We urge the CMS to include race and ethnicity, language preference, veteran status, health literacy, sexual orientation, and disability status which will enable a more comprehensive assessment of health equity to further identify and develop actionable strategies to promote health equity.

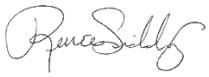
- **Reconsider creation of a facility equity score**: Although this is modeled from the Health Equity Summary Score (HESS) developed for the Medicare Advantage plans, the development of this score was virtually conceptual and not currently being utilized. By combining multiple measures and risk factors using output from the CMS disparity methods there would be a resulting "composite like" score. **The MHA believes a vague "composite-like" measure is not actionable or useful and cannot be feasibly and accurately calculated.**

- Consider a potential future measure regarding **organizational commitment to health equity.** We believe that consideration should be given to an attestation-based structural measure of a disparities impact statement (DIS) or organizational pledge that outlines how infrastructure supports the delivery of care that is equitable for all patient populations.

Closing

The MHA appreciates this opportunity to provide comments to the CMS on the proposed CY 2022 MPFS rule. If you have questions regarding this comment letter, please contact Renée Smiddy, rsmiddy@mha.org.

Sincerely,



Renée Smiddy
Senior Director, Policy