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September 11, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services

Submitted electronically: http://www.regulations.gov

RE: Calendar Year 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1786-P) – AHIP Comments

Dear Administrator Brooks-LaSure:

Everyone deserves access to effective, affordable, and equitable mental health support and counseling. Health insurance providers, care professionals, and government agencies must work together to set high-quality standards and guidelines to ensure patients see measurable results.

AHIP appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) Calendar Year (CY) 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System (OPPS) Proposed Rule. AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to making health care better and coverage more affordable and accessible for everyone. Thank you for the opportunity to comment.

Mental Health Is Essential to Whole-Person Health
AHIP is committed to working together to improve access to mental health and substance use disorder care for every patient who needs it. We support CMS's efforts to expand access to mental health care by creating an intensive outpatient program (IOP) benefit, implementing provisions of the Consolidated Appropriations Act (CAA) of 2023. AHIP also agrees with CMS's proposal to include medications for opioid use disorder treatment in the bundled payments for IOP services furnished by opioid treatment programs to promote personal, effective care. AHIP further supports the proposal to use partial hospitalization program data to inform IOP rates until CMS collects sufficient data on the costs of furnishing this new benefit.

While this new benefit is a step in the right direction, we believe more needs to be done to support patients with acute mental illness or substance use. We encourage CMS to better integrate behavioral health care into the Innovation Center's alternative payment model (APM) demonstrations, which could further incentivize coordinated care and help address challenges such as social barriers and stigma. Moreover, the incorporation of quality measurement within these models can promote evidence-based care and better patient outcomes. We encourage CMS to explore a behavioral health specific demonstration that could provide start-up funds for practices to implement the Collaborative

Care Model (CoCM), including measurement-based care, to advance adoption and improve outcomes.

Technology Holds Promise to Improve Quality and Quality Measurement
We appreciate CMS's ongoing partnership and commitment to the Core Quality Measure Collaborative (CQMC), including its work on advancing digital measurement. We also support CMS's commitment to leveraging measurement to improve health care quality, access, and equity. Health information technology and digital quality measurement offer ways to assess novel concepts, drive change, and reduce burden on all stakeholders.

Interoperability and system-wide data sharing will be essential in implementing digital quality measurement and could reduce patient harm by ensuring all parties have access to information to help avoid unnecessary, duplicative, or potentially contraindicated care. We appreciate CMS's efforts to work with the Office of the National Coordinator for Health Information Technology (ONC) to propose data elements necessary for quality measurement in the United States Core Data for Interoperability (USCDI) and develop the USCDI+ for Quality data element list. We urge CMS to work with ONC to enable data sharing between providers and payers through application programming interfaces to further enable digital quality measurement. We also encourage CMS and ONC to ensure data exchange for the purposes of quality measurement is integrated into the voluntary Trusted Exchange Framework and Common Agreement (TEFCA). This would provide greater data access, promote aligned measures, and increase efficiency.

We also support CMS's goal of ensuring the use of artificial intelligence is safe and ethical. If used responsibly, AI has the potential to improve health care affordability, access, and outcomes. However, we question whether provider performance programs are the right place to monitor the use of AI as these programs should be focused on evidence-based processes and patient outcomes.. There are currently no clinical guidelines or best practices on which to measure optimal processes and no standards, benchmarks, or expected rates against which to measure outcomes. Instead, we recommend CMS work with other agencies such as the Food and Drug Administration, the Centers for Disease Control and Prevention and ONC as well as the private sector to ensure monitoring of patient harm is adequately addressed in their programs.

Thank you for the opportunity to comment on these important issues. AHIP stands ready to engage collaboratively with the Administration and other health care stakeholders to find solutions to increase access to high quality care for all Americans. If you have any questions, please contact me at (202) 778-3246 or at dlloyd@ahip.org.

Sincerely,

Danielle A. Lloyd

Danielle A. Lloyd
Senior Vice President, Private Market Innovations & Quality Initiatives

II.C PROPOSED CHANGES TO THE HOSPITAL WAGE INDEX

For purpose of the CY 2024 OPPS, the post-reclassified wage index policies finalized in the FY 2024 IPPS would be reflected in the final CY 2024 OPPS wage index beginning on January 1, 2024. Thus, the finalized policy to include data from 42 CFR § 412.103 hospitals that reclassified from urban to rural in the calculation of the inpatient rural wage index would be incorporated into the OPPS as well.

As we articulated in our comments on the rural wage index policy in the FY 2024 IPPS proposed rule, **AHIP continues to be concerned about Medicare fee-for-service (FFS) policies made outside of the Medicare Advantage (MA) Rate Announcement cycle.** Incongruent policies can impact the accuracy of MA benchmarks and risk adjusted payments. One key part of an MA plan's bid is an estimate of projected costs that the plan will incur based on policies under the original Medicare program. MA plans are able to make actuarially-sound projections of the costs they will incur, and the capitated payments they will receive from CMS, because overall payment levels in original Medicare are generally established each year before MA benchmarks are set and bids are submitted. MA plans need to rely on a predictable and established set of program rules to make business decisions and capital investments.

Going forward, we encourage CMS to consider the downstream impact of its policies on MA plans. While budget neutrality may mitigate the impact of CMS's rural wage index adjustments overall, it does not prevent significant swings, whether increases or decreases, in specific areas. The redistributional nature differentially effects not only individual hospitals but also individual MA plans because of the impact on the FFS benchmarks. Such policies can negatively affect small, regional plans that do not provide services across a broad enough number of Metropolitan Statistical Areas to dampen the effects. Currently, whether a beneficiary chooses to receive coverage through FFS or MA, all beneficiaries have access to the same standard Part A and Part B Medicare benefits. When FFS payments are increased after MA bids have been submitted, MA plans have limited mechanisms to account for any increased costs. It is critical that any changes to the FFS program that form the basis of the MA payment system are accurately factored into Medicare FFS rates to avoid fewer benefits and higher costs for the individuals and persons with disabilities who rely upon the MA program.

VIII. PAYMENT FOR PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT SERVICES

The Consolidated Appropriations Act (CAA) of 2023 established an intensive outpatient program (IOP) benefit under Medicare starting on January 1, 2024. CMS proposes to implement the IOP benefit for patients with acute mental illness or substance use disorder (SUD) for services like those furnished under the existing partial hospitalization programs (PHPs) but at a lower intensity. For comparison, CMS proposes an IOP benefit that requires a minimum of nine hours of services per week, while PHPs are required to furnish a minimum of 20 hours of services per week.

AHIP and its members supported Congress' expansion of the Medicare benefit under the CAA to increase access to needed care and support the proposed rule. IOP services are an important part of the behavioral health continuum of care and connect those who need this level of care to high-quality, affordable settings. AHIP and its members agree that there is a need to cover care for

patients who require more intensity than exclusive outpatient programs can provide but may not require the intensity of services delivered in a PHP. The IOP benefit should provide sufficient flexibility for providers to tailor programs according to community needs while still providing consistency in benefits. Additionally, to maximize the reach of these programs, CMS should incorporate training and dissemination of best practices to providers to ensure providers can leverage available resources.

Like PHPs, IOPs would be paid on a per diem basis using a specified group of behavioral health codes. We recognize CMS has limited data to calculate IOP rates given this is a new benefit. Thus, we understand the need for a temporary solution. **AHIP supports the proposal to use PHP data to inform IOP rates until CMS collects sufficient data on the costs of furnishing the new benefit.** However, AHIP does not support a geographic adjustment for reimbursement of IOP services furnished in rural health clinics (RHCs). Current RHC reimbursement methodology for the Original Medicare program does not have a mechanism for applying a geographic adjustment, and adding the geographic adjustment as an additional factor will result in inconsistency and unnecessary complexity.

We would like to take this opportunity to note, that while we support this new benefit as a step in the right direction, we do not believe it fully addresses the needs of patients with acute mental illness or substance use. **We continue to encourage CMS to better integrate behavioral health care into the Innovation Center's alternative payment models (APMs).** More so than FFS, the aligned incentives across sites of service embedded in APMs can promote better coordinated care as well as help address social barriers to care, and challenges associated with stigma. Moreover, the close connection to quality measures within these models can encourage the provision of evidence-based care and improve the closure of gaps in care resulting in better patient outcomes. For example, as noted in our comments on the Physician Fee Schedule Proposed Rule, **AHIP suggests CMS consider a behavioral health specific demonstration that could provide start-up funds for practices to implement the Collaborative Care Model (CoCM), including measurement-based care, to advance adoption and improve outcomes.** Such a demonstration could also test refinements of the model by exploring legal waivers to address workforce issues and integrate the use of emerging technology.

Finally, as with any new policies, we encourage the agency to monitor for unintended consequences and for bad actors who may seek to exploit patients with unproven or even counterproductive therapies.

VIII. G. MODIFICATIONS RELATED TO MEDICARE COVERAGE FOR OPIOID USE DISORDER (OUD) TREATMENT SERVICES FURNISHED BY OPIOID TREATMENT PROGRAMS (OTPS)

IOP services are required under the provisions of the CAA to be available through hospital outpatient departments, community mental health clinics, federally qualified health centers, and rural health clinics. CMS proposes to extend IOP coverage to include OTPs as a site of care and to establish weekly payment adjustments via an add-on code for IOP services furnished by OTPs for the treatment of opioid use disorder (OUD). CMS solicits feedback on inclusion of medications in the weekly bundled OTP services.

We support the proposal to extend IOP coverage to OTPs. OTPs are vital elements of the OUD treatment infrastructure, especially to those in underserved communities who have been hit extremely hard by the opioid epidemic. It is important to ensure that barriers to care are alleviated and that those in need have access to the appropriate care and services, including the new IOP services. Allowing the IOP benefit to be provided at more sites of care, such as OTPs, will help facilitate patient access and further drive value for them.

Additionally, we agree with the inclusion of medications for the treatment of OUD (MOUD) in the weekly bundled payments for OTP services. All necessary and appropriate MOUD should be included in the bundle, including take-home supplies of methadone, buprenorphine, and naloxone, as needed. Individualized approaches to patient care, at the discretion of the provider and in collaboration with the patient, will improve outcomes by making care more convenient, reducing stigma, and allowing patients to better manage the functions of daily life.

XIV. B. Hospital Outpatient Quality Reporting (OQR) Program Quality Measures
The Hospital OQR Program is a pay-for-reporting quality program for the hospital outpatient department (HOPD) setting and requires hospitals to meet program requirements or receive a reduction of 2.0 percentage points in their annual payment update. CMS proposes modifications, additions, and deletions to the OQR measure set.

Modifications
CMS proposes to modify three measures currently included in the IQR program.

- *COVID-19 Vaccination Coverage Among Healthcare Personnel*— is modified to align with the updated Centers for Disease Control and Prevention National Healthcare Safety Network measure specifications. Vaccinations offer powerful protection against COVID-19 and consumers deserve to have information on rates of vaccination coverage among personnel at facilities where they may be served. Ensuring HCP are up-to-date on COVID-19 vaccinations could play a powerful role in preventing the spread of COVID-19 in health care facilities. Updating the measure specifications to address the current FDA approvals and the receipt of all recommended booster doses would promote patient safety and help consumers have accurate information to support their choice of a healthcare provider. **AHIP supports the proposed modification to the COVID-19 Vaccination Coverage Among Healthcare Personnel measure**. However, CMS should educate stakeholders on the still evolving requirements for COVID-19 vaccination. CMS should also ensure vaccination rate measures include appropriate exclusion criteria to account for necessary exemptions to ensure providers are not penalized for complying with state and federal laws that allow vaccine refusals. Finally, CMS could encourage hospitals to stratify their data to explore patterns in personnel who are not getting vaccinated to who are refusing to get vaccinated to support counseling and targeted interventions to encourage vaccine acceptance and improve vaccination rates.

- *Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery*—is modified to limit the allowable survey instruments that a HOPD may use to assess changes in patient's visual function to further standardize data collection and reduce facility burden. Greater standardization of the underlying data would facilitate comparisons across providers and support consumers in their choice of providers. **AHIP**

supports the proposed modification to the Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery measure.

- *Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients*—is modified to align with updated clinical guidelines to begin colorectal cancer screening at age 45 instead of age 50. Alignment with revised clinical guidelines is key to raising awareness among clinicians and reenforcing the provision of evidence-based care. **AHIP supports the proposed modifications to the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients**.

Additions

CMS proposes to adopt three new measures for the OQR program.

- *Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty*— We support greater use of patient-reported outcomes-based performance measures (PRO-PMs) as an essential component of moving to value-based care and supporting consumer choice in a healthcare provider. PRO-PMs are essential to understanding if value-based payment (VBP) models are delivering improved outcomes from the patients' perspective and on what matters most to them. We agree this measure would provide important insight into the quality of care of not only a common procedure, but one that is "shoppable." **AHIP supports the addition of the Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty measure.**

- *Hospital Outpatient /ASC Facility Volume Data on Selected Outpatient Surgical Procedures*—We agree that the implementation of a volume metric could provide valuable insights about quality and support consumer choice. Furthermore, we strongly support measures that allow comparisons across potential sites of care to support consumer decision making and ensure comparable outcomes sites. We appreciate CMS's modifications to the measure specifications to provide more granular information. However, we recommend that CMS explore ways to develop complementary measures of patient outcomes, including PRO-PMs, that could pair with a volume measure to provide a more complete picture of quality at a given facility. **AHIP supports the addition of the Hospital Outpatient /ASC Facility Volume Data on Selected Outpatient Surgical Procedures.**

- *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults*— This electronic clinical quality measure would promote safety by ensuring that patients are exposed to the lowest possible level of radiation while avoiding overuse by protecting against unnecessary imaging due to results that cannot be read. **AHIP supports the addition of the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults measure.**

Removal

CMS proposes one removal.

- *Left Without Being Seen*— would be removed citing limited evidence linking the measure to improved patient outcomes, higher scores on the measure may reflect poor access to timely clinic-based care rather than intrinsic systemic issues within the ED, and unintended effects on LWBS rates caused by other policies, programs, and initiatives may lead to skewed measure performance. **We agree with the proposal to remove the measure.** It can reflect factors outside a provider's influence such as access to timely primary care in the community and a patient's decision to seek care at an emergency department for non-emergent conditions. However, CMS should consider exploring ways to measure access to care and an alternative measure to ensure patients have access to timely emergency care when needed.

XIV. C. Hospital OQR Program Quality Measure Topics for Potential Future Consideration

CMS seeks public comment on potential measurement topic areas, innovative measurement approaches, and new data sources for use in quality measurement to inform the focus of measure development within the Hospital OQR Program. CMS identified three priority areas for comment:

- Promoting Safety (Patient and Workforce),
- Behavioral Health, and
- Telehealth.

Promoting Patient Safety

CMS notes improving safety through levers such as quality measurement is a critical objective of the National Quality Strategy. To support the agency's goals of improving safety, CMS seeks comments on patient and work force safety measures including sepsis care as well as measurement of system-wide all-cause harm, in addition to the safety of observation care, procedures and services, medication errors, technology, and workforce.

AHIP appreciates CMS's efforts to advance patient safety. We agree measurement is an important tool to drive improvements in safety.

Approaches to New Data Sources to Capture Harms

As technology advances and new data sources become readily available and interoperable, measurement of new concepts will become possible. Moreover, data to calculate quality measures could be collected and pooled across sources and payers to create a larger sample to allow for more accurate measurement of events such as patient harms that occur infrequently but can be devastating to the patient and drive-up costs across the system. For example, multi-payer data could support revised versions of the previously removed present-on-admission healthcare acquired condition (HAC) measures.

However, to successfully harness new data sources, it needs to be interoperable and incorporated into digital quality measures (dQMs). This can only be accomplished with a more robust underlying data infrastructure. For example, electronic health records must be able to collect this information in standardized formats and share that information across trusted partners using exchange standards. The electronic collection and exchange of data and dQM results through

formats such as APIs could reduce the time and resources required to extract data from patient charts or other forms such as the surveys used to generate patient-reported outcome measures.

In addition, the use of data standards would ease the reporting of data and results to health insurance providers. As noted in our comments on the Provider Access API provisions in the CMS Interoperability and Prior Authorization NRPM, current data sharing requirements are one-directional. While plans are required to share data with providers, there are no requirements for providers to share with plans. Creating a bidirectional Provider-Payer Access API could allow the sharing of data for quality measurement. CMS should work with the Office of the National Coordinator for Health Information Technology (ONC) to ensure the bidirectional flow of data based on the Information Blocking final rule provisions.

Mature standards for both content and exchange will be critical to advancing the interoperable data flow necessary to support quality measurement. ONC has launched the United States Core Data for Interoperability plus (USCDI+) Quality initiative to identify the data elements necessary to report dQMs. CMS could also work with ONC to update and implement the USCDI+ for Quality data elements list to ensure that the data elements necessary to calculate measures are in a standardized and interoperable form. CMS could also work with ONC to add key data elements for quality measurement to the baseline USCDI, where appropriate. CMS could leverage the proposed USCDI+ to build new measures from the proposed elements for serious event reporting. Using industry-supported data elements that all payers could access and facilitating interoperable data exchange could help overcome challenges such as small numbers.

The voluntary Trusted Exchange Framework and Common Agreement (TEFCA) could also facilitate the process of quality measurement. We believe TEFCA could reduce the burden of quality measurement while enabling the measurement of new concepts that could not previously be assessed. We believe that TEFCA holds potential to facilitate adoption of digital quality measurement and enable the safe sharing of information across parties. TEFCA could enable participating plans and providers to seamlessly share information to support the provision of high-quality care and allow payers to implement multi-payer measures of harms to address issues of small numbers. The electronic, bidirectional sharing of clinical information is one of the most promising use case opportunities for using TEFCA from our perspective. Accessing data would be faster, easier, cheaper, and more comprehensive. By facilitating the exchange of clinical data, and leveraging established standards such as FHIR, TEFCA could allow health plans to better support measurement of low-volume events such as serious adverse events.

Highest Priority Outcomes for Ensuring Safety

We support CMS's efforts to improve the measurement of outcomes in the hospital outpatient setting. While process and structure measures can help promote a "floor" of quality, outcome measures are essential to assess what matters most to patients and ensure high-value health care. As CMS considers new measure concepts to assess safety for the OQR program, we recommend considering the development of measures assessing utilization such as avoidable readmissions or repeated visits that could indicate a patient has an unresolved concern or a condition that is worsening.

As suggested by the Measure Applications Partnership (MAP)[1], CMS could explore measures of effective use and shared decision making. Reducing inappropriate care by preventing unsafe or low-value care and targeting where care may not be consistent with the latest clinical evidence could help promote patient safety. Unsafe, low-value, or care that is not evidence-based can contribute to potential harm to patients and unnecessary costs. Shared decision making is an important strategy in involving patients in their treatment choices and ensuring patients understand the benefits and risks of each option.

CMS could also explore patient reported outcomes-based performance measures (PRO-PMs) and patient experience measures. AHIP supports greater use of PRO-PMs as an essential component of moving to value-based care. PRO-PMs will be essential to understanding if APMs are delivering improvement on the outcomes that matter most to consumers. However, CMS should be cognizant of the potential burden of PRO-PMs and the challenges that can come with longitudinal follow-up. PRO-PMs should be implemented in ways that minimize burden and CMS should explore ways that technology can leveraged to reduce the burden and assist in capturing patient responses.

CMS could also explore ways to ensure patients are not harmed by inequities in the healthcare system such as stratifying measures by social risk factors to identify and address disparities in care.

CMS could also explore ways to leverage the Promoting Interoperability program to encourage increased use of interoperable data in hospital outpatient departments. Improving the interoperability of health care data and promoting the use of certified electronic health record technology (CHERT) could also reduce harm from errors, duplicative care, or inappropriate treatment. For example, CMS could consider adding measures to the Promoting Interoperability program for hospital emergency departments (EDs) to create comparable requirements with inpatient departments to encourage interoperability in hospitals as a whole.

Risks and Benefits of Greater Use of Artificial Intelligence

Artificial Intelligence (AI) has the potential to offer American patients and consumers great improvements in health care affordability, access, and outcomes through new technologies and solutions. However, AI use must also be responsible and safe. We agree that as the use of AI grows, there is a need to protect consumers and mitigate risks such as adverse bias through techniques like transparency and explainability.

Safe and ethical AI use could be transformative for health care. As examples, AI has proven effective at detecting lung cancer and has been used in breast cancer screening methods.[2] It has also been used in developing medicines, particularly for rare diseases and personalized treatments.[3] However, we must balance innovation with patient protections and transparency. Underlying biases in the data used to develop algorithms could negatively impact certain

[1] https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=94893

[2] A. Brooks, "The Benefits of AI: 6 Societal Advantages of Automation" Rasumessen University (Nov. 4, 2019) available at: https://www.rasmussen.edu/degrees/technology/blog/benefits-of-ai/. See also, S. Bansal, "10 Advantages and Disadvantages of Artificial Intelligence" available at: https://www.analytixlabs.co.in/blog/advantages-disadvantages-of-artificial-intelligence/.

[3] S. Daley, 32 Examples Of Ai In Healthcare That Will Make You Feel Better About The Future (updated July 29, 2020) available at: https://builtin.com/artificial-intelligence/artificial-intelligence-healthcare.

subpopulations. For example, AI developed using total cost of care data could leave out individuals who experience challenges accessing care and who could benefit from additional care management and services.[4] Additionally, human cognitive bias in the development, deployment, or use of AI could also result in disparate impact if not appropriately mitigated. It is also important to note that AI, when applied responsibility, can help reduce human errors or biases in certain tasks.

AI could also facilitate measurement itself in the future. For example, it could auto-populate certain elements of the measures from the EHRs. As another example, as natural language processing (NLP) technology develops it could help identify and capture data from unstructured fields such as clinician notes. This data could be used to create efficiencies and support measures addressing concepts like SDOH screening and could be used to develop novel measures assessing areas that could not previously be measured.

We agree that as the use of advanced analytics, machine learning, and AI grows, whether as part of clinical care or measurement, there is a need to address potential risks while working to optimize the use of these technologies. However, we challenge the notion of using provider performance measurement programs to assess the use of AI. Provider programs should be focused on clinical outcomes, which ostensibly would reflect poor safety results associated with the use of AI. The goal of performance measurement is not to measure the means but the ends.

Even if CMS were to focus on the impact to care processes and outcomes, it is premature to take such action. There are currently no best practices or clinical guidelines on which to measure optimal processes and no standards, benchmarks, or expected rates against which to measure outcomes. If CMS were to choose an area of focus to foster the development of these required foundational components, diagnostic accuracy and imaging quality could be a good place to start. AI is very quickly being integrated into such services and may soon be the standard of care. These are also very discrete services where it may be more possible to assess "accuracy" as opposed to a range of outcomes that may occur for other services. However, we note that quality measures generate trend information to advise practice, not surveillance information on which to take immediate action. So, again, the traditional performance measurement system may not be the best path forward to address immediate risks and patient harms.

In addition, while such programs sometimes measure the process of care, they do not measure the inputs (e.g., which products or technologies are used). For example, the safety of the use of electronic health records in the process of medical care is not assessed by CMS within performance measurement programs. However, ONC issued the SAFER Guides to enable healthcare organizations to address EHR safety in a variety of areas and has conducted research analyses that have been shared publicly to disseminate learnings for industry action. ONC has also proposed taking steps to begin requiring transparency of AI in decision support tools connected to certified health IT.

Moreover, ONC's work is one of many efforts underway to provide guidance and monitor AI by governmental entities such as the Food and Drug Administration, Office of Science and

[4] Oberymeyer, et al. Dissecting racial bias in an algorithm used to manage the health of populations. *Science*. 2019; 366(6464): 447 – 453.

Technology Policy, Federal Trade Commission, the National Institute for Science and Technology, and National Association of Insurance commissioners. In particular, the Food and Drug Administration's Software as a Medical Device evaluation process has been tailored to accommodate the approval of medical technologies that are constantly changing based on machine learning. Adverse event reporting and monitoring is a key component of the FDA's work.

CMS could work with other government agencies, like the FDA, to ensure monitoring for harms is integrated into various other programs in the future. For example, following the model of the Centers for Disease Control and Prevention's National Healthcare Safety Network. CMS could convene stakeholders to develop a framework for identifying which patient outcomes could be most affected by AI and explore where quality measurement may be appropriate versus post-market surveillance by agencies such as the FDA.

Regardless, any assessment or requirements of AI should use a risk-based framework with high-risk services prioritized over low-risk services. As the health care system integrates AI into practice, we must balance potential risks to patients with the benefits of innovation.

Behavioral Health

CMS seeks comments on future measure concepts for use in the OQR program related to behavioral health. The agency notes its particular interest in measures assessing availability and access, coordination of care, patient experience, patient-centered clinical care, prevention and treatment of chronic conditions, prevention of iatrogenic harm (that is, harm resulting from medical care), equity across all domains, and suicide prevention.

CMS is seeking comments on:

- priorities for measuring outcomes of outpatient behavioral health services, particularly by setting within the HOPD; and
- quality measure approaches to improve behavioral health access in outpatient settings.

As CMS identifies priorities for measuring outcomes for behavioral health services in hospital outpatient departments, we encourage CMS to align with the work of the Core Quality Measures Collaborative (CQMC). To promote measure alignment, AHIP and CMS convened the CQMC to identify priority measures for use across public and private payers. As a first step to alignment, the CQMC identified 10 core sets of measures in clinical areas known to have high costs, variations in quality, and misaligned measures. We recommend CMS consider measures in the CQMC's Behavioral Health core measures set to support alignment across programs, inform consumer decision making, and reduce measure burden.[5]

Additionally, CQMC recently analyzed measure gap areas within each of the core measure sets. We encourage CMS to leverage this existing work in identifying priority areas for measure inclusion. Some of the measure gap areas include:

[5] https://p4qm.org/sites/default/files/2023-06/CQMC-Behavioral-Health-Core-Set-v3.0.pdf

- Coordinated care; including bidirectional integrated behavioral healthcare and general health care, and primary care;
- Patient reported outcomes, including patient experience with psychiatric care;
- Suicide risk measures;
- Anxiety disorder measures;
- Depression remission measures; and
- Opioid overdoses in the ED.

CMS could also consider using measures in NCQA's HEDIS program as applicable to promote alignment across payers and providers. Additionally, as CMS expands coverage for IOP and PHP programs, the agency could consider modifying measures in the Inpatient Psychiatric Program Quality Reporting Program (IPFQR) to ensure comparable outcomes across care settings and promote alignment across programs.

As CMS considers the development of additional behavioral health measures for the OQR program, we urge the agency to ensure additional measures drive meaningful improvements in care and outcomes for patients. CMS should focus on measures that drive the adoption of best practices such as measurement-based care rather than implementing measures that will add administrative burden without meaningful improvements for patients. For example, while we applaud the goals of universal suicide screening measures, there is little evidence that these measures would reduce risk for patients or ensure patients receive the care they need. Instead, CMS could focus on measures that ensure patients are referred to appropriate follow-up care.

We also caution CMS to carefully consider definitions when developing behavioral health measures for the OQR program. While we support the goal of promoting access to care, a behavioral health access measure should be appropriately broad to capture the broad spectrum of behavioral health providers and allow flexibility for patients to work with providers that best fit their needs. For example, telehealth services may work better for some patients who value the ease of scheduling, the privacy associated with accessing care from home, or have HRSNs that prevent them from accessing care in-person, while other patients may prefer from in-person care. Measures should also consider the numerous types of clinicians who can provide services to avoid inadvertently creating access barriers by incentivizing HOPDs to only refer patients to certain types of care.

Telehealth

CMS notes that telehealth use increased during the COVID-19 public health emergency (PHE) and that usage of telehealth remains high. CMS is considering developing a measure of telehealth quality that could be used in the OQR program in the future.

As CMS mentions, telehealth provides a variety of benefits to patients and health systems, though there is variability in telehealth's effectiveness across different outpatient services, as some conditions and situations may necessitate in-person care or services. Highlighting the potential shortcoming of telehealth, though, ignores the great potential of virtual care, as was seen during the COVID-19 public health emergency. By granting flexibilities that allowed greater use of telehealth, CMS enabled patients and providers to build the evidence base of what can be a successful, high-quality, high-value telehealth visit.

Over the course of three years, stakeholders, including CMS, have collected data on telehealth utilization and under what circumstances patients and providers can achieve the best results. Some of these situations include outpatient services, such as a check-in with a provider following surgery to show the status of a wound or to report that there have been no complications since discharge; the visits are necessary, but do not require the physical "laying of hands" via an in-person visit. While telehealth was previously perceived to be a tool for acute issues, many patients have successfully established "hybrid" relationships that incorporate virtual visits – and even virtual-only relationships – to their care for ongoing chronic conditions, which may require routine visits to evaluate progress. Some providers incorporate digital data, collected through remote physiologic monitoring and remote therapeutic monitoring or the virtual transmission of data from a piece of equipment, such as a CPAP machine or continuous glucose monitor (CGM).

Telehealth makes care more convenient and accessible to patients, eliminating travel time and other geographic barriers to accessing care. Consequently, geographic limitations for providers are also eliminated – the workforce can extend beyond driving distance and can bring care to those who may not have the flexibility to come into an outpatient hospital department. Though CMS does indicate that telehealth can exacerbate equity gaps by widening the divide between those who have access and/or choose to use technologies and those who do not, telehealth also has the capacity to close equity gaps by bringing care to the people and communities that may not typically have access to specialty care, such as rural or other underserved regions.

Telehealth has proven to be an extremely effective tool in connecting patients with care for behavioral health and substance use disorder treatment. Management of chronic conditions that require routine check-ins and evaluation of asynchronous data, such as diabetes (with data collected via CGMs) and sleep apnea (CPAP machines), are examples of high-value telehealth. Dermatology and rashes and skin conditions can be conveniently evaluated by telehealth. Check-ins after surgery can often be conducted via telehealth, including wound evaluation and evaluations of mobility and flexibility, such as following a joint replacement surgery. While imaging and blood tests, for example, require in-person services, they can be coordinated via telehealth where the test itself is conducted at a more convenient location than the hospital outpatient setting.

From a quality perspective, it is important to continue to collect data to identify the best uses of telehealth. As mentioned, a decade ago telehealth was largely utilized for acute care needs; today, the use of technology to access care has shifted dramatically, with mental health conditions comprising the majority of claims.[6] **We encourage CMS to continue to allow flexibilities to foster innovation while at the same time assessing outcomes across settings to ensure beneficiaries are receiving high-value care as telehealth evolves.**

To identify the best uses of telehealth and to maximize value of visits, CMS must build a robust quality measurement infrastructure to track how telehealth is being used and how it can be improved. Importantly, telehealth should not be held to a different standard of care than in-person care; high-quality care is high-quality care, regardless of the care setting, and the expectations from a visit should be no different in a different medium. However, there may be

[6] https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/may-2023-national-telehealth.pdf

different tools needed to capture the outcomes of a virtual visit to ensure that patients are receiving the highest quality care. Some tools that should be considered for evaluating the quality of a visit may include: provider experience surveys, patient experience surveys, evaluations of wait times and time spent with a provider, and outcomes measures, including needed in-person follow-up, rates of complications, and patient-reported outcomes.

Equity concerns and health disparities must be evaluated, too, by asking patients if they would have gotten care from another setting (if not virtual) and how robust virtual networks are to certain underserved communities, such as low-income, those of older age, or of certain races or ethnicities. Low digital health literacy is a significant obstacle in achieving telehealth equity, and many older adults with low digital health literacy experience gaps in access to the health care they need. These efforts can be included under broader quality improvement programming, designed to reduce disparities and advance equity.

We encourage CMS to collaborate with other stakeholders to further build the evidence base, work to best integrate telehealth into measures to permit cross setting comparisons, and evaluate the circumstances in which telehealth can flourish.

XV. B. Ambulatory Surgery Center Quality Reporting (ASCQR) Program Quality Measures

The ASCQR Program is a pay-for-reporting quality program for the ASC setting and requires ASCs to meet program requirements or receive a reduction of 2.0 percentage points in their annual fee schedule update. CMS proposes to make modifications and additions to the ASCQR measure set.

Modifications

Similar to the agency's proposals for the OQR program, CMS intends to modify three measures currently used in the program:

- COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP);
- Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery;
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients.

As noted in section XIV. B., **AHIP supports the modifications to these measures** to ensure compliance with current evidence, promote alignment in measurement across settings, and facilitate comparisons among providers and settings.

Additions

In alignment with the proposal in the Hospital OQR Program, CMS proposes to add two measures to the ASCQR program:

- Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty measure;
- Hospital Outpatient /ASC Facility Volume Data on Selected Outpatient Surgical Procedures.

As noted in section XIV. B., **AHIP supports the addition of these measures for both the OQR and ASCQR programs**. Providing additional information on outcomes and volume will support consumers in their choice of a provider and allow comparisons of the quality of care among hospital outpatient departments and ASCs.

XVI. B. Rural Emergency Hospital Quality Reporting (REHQR) Program Quality Measures

The CAA established a REHs, a new Medicare provider type, that must submit quality measure data that will be made available to the public on a CMS website.

Initial Measures

CMS proposes four initial measures for the REHQR program.

- *Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients*— could provide information on whether patients have timely access to care in the emergency department of a REH. Given the remote nature of these facilities, prompt evaluation and ED throughput could have important impacts on patient outcomes. **AHIP supports the inclusion of the Median Time from ED Arrival to ED departure for Discharged ED Patients measure.**

- *Abdomen CT Use of Contrast Material*— We recognize the importance of avoiding potential overuse of services, however, factors such as time to treatment and patient severity could impact clinician decision making. **While AHIP supports the inclusion of the Abdomen CT Use of Contrast Material measure, CMS should consider how to appropriately display and communicate the implications of this measure for public reporting.**

- *Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy*— We support the inclusion of outcome measures. Furthermore, this measure will help ensure REHs provide services of comparable quality to other settings and support consumers in their choice of a healthcare provider. A measure assessing hospital visits within seven days would ensure the visitation rate is proximal to the procedure while promoting a robust enough volume to support valid measurement. **AHIP supports the inclusion of the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure.**

- *Facility Risk-Standardized Hospital Visits Within Seven Days After Hospital Outpatient Surgery*— We support the inclusion of outcome measures. Furthermore, this measure will help ensure REHs provide services of comparable quality to other settings and support consumers in their choice of a healthcare provider. A measure assessing hospital visits within seven days would ensure the visitation rate is proximal to the procedure while promoting a robust enough volume to support valid measurement. **AHIP supports the inclusion of the Facility Risk-Standardized Hospital Visits Within Seven Days After Hospital Outpatient Surgery measure.**

Future Measure Concepts

CMS requests comments on the use of eCQMs, care coordination measures, and a tiered approach for quality measures and reporting requirements to incentivize REH reporting.

An essential function of rural hospitals is to stabilize a patient experiencing a medical emergency and transfer them to a facility that can provide the care required. We agree CMS should explore the addition of measures assessing care coordination and transfer times. Similarly, admission and readmission measures would provide important information on the quality of care provided at an REH.

We encourage CMS to explore the addition of more outcome measures for the REHQR program over time. CMS should also explore ways to add additional measures addressing telehealth, maternal health, mental Health, and ED Services. We encourage CMS to continue to explore alignment with the measures in the OQR and IQR programs. CMS could also consider measures in the CQMC Obstetrics and Gynecology and Behavioral Health core measures sets as appropriate to support alignment with private sector measurement efforts.

We agree eCQMs could allow for novel measurement while reducing the burden of measurement; however, CMS should ensure such measures are feasible and can be reported by all providers. REHs may face unique challenges accessing EHR technology and may have limited resources to dedicate to using EHRs to support measurement. REHs may also be located in areas with limited broadband internet access. Before adopting eCQMs for the REHQR program, CMS should explore their feasibility with participating providers or add eCQMs as optional measures initially.

We support the concept of a tiered approach to reporting in the REHQR program. The tiered approach to measurement outlined in the proposed rule would allow REHs to focus on reporting measures applicable to the services they offer. This would minimize the burden of the reporting while producing useful, actionable data.

XVIII. PROPOSED UPDATES TO REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC A LIST OF THEIR STANDARD CHARGES

AHIP shares CMS's commitment to ensuring meaningful transparency information is available to consumers. Americans deserve access to personalized, actionable health care information to empower them to make better informed decisions. Health insurance providers are committed to delivering clear, concise, and customized information to every patient and person they serve. Workable solutions should ensure that health care information is personalized, accurate, and easy to understand – focusing on treatments and services for which people can shop and make choices about.

We recognize that CMS is seeking input from stakeholders as part of the OPPS rulemaking specifically on the hospital standard charges policies. However, we are concerned that decisions made in this rule may establish precedence for similar changes to the requirements of health insurance providers. Thus, we provide the perspective of our members on these policies below.

AHIP underscores the substantial investments both health care providers and health insurance providers have made in implementing the price transparency requirements under the Standard Charges policies, Transparency in Coverage (TiC) rule, and additional changes required by the No Surprises Act. It is essential to approach any potential future changes thoughtfully, considering the significant efforts and resources involved as well as the other major information technology demands underway such as implementation of the Interoperability rule. We caution against approaches that result in frequent changes to price transparency requirements, which create administrative burdens, drive up costs, and can be confusing to consumers.

Additionally, as CMS considers changes to transparency requirements issued through rulemaking, we highlight the ongoing congressional activity related to price transparency and urge efforts to avoid duplicative or conflicting requirements.

XVIII. B. Proposal to Modify the Requirements for Making Public Hospital Standard Charges at 45 CFR 180.50

CMS proposes to codify several definitions:

- "CMS template" means a CSV format or JSON schema that CMS makes available for purposes of compliance with the requirements of §180.40(a).
- "Consumer-friendly expected allowed amount" means the average dollar amount that the hospital estimates it will be paid by a third-party payer for an item or service.
- "Encode" means to enter data items into the fields of the CMS template.
- "Machine-readable file" means a single digital file that is in a machine-readable format.

Hospitals would be required to encode its standard charge information in a CSV or JSON format and conform to a CMS template layout and other specified technical instructions (like a data dictionary).

Health insurance providers have successfully implemented requirements under the TiC final rules, including posting MRFs and consumer-facing cost estimator tools. Health insurance providers have made significant investments to comply with MRF requirements and schemas as finalized in regulations and on the GitHub website. While we support CMS' goal of alignment, we urge CMS to not pursue uniformity or alignment in a manner that would be disruptive to existing requirements that have already been successfully implemented.

We support CMS's proposal to allow both a CSV format or JSON schema. Different organizations have taken different approaches and switching formats now would be very costly. The schema approach used for health insurance provider MRFs is working well and we caution against the rigidity of required templates. Moreover, applying templates for health insurance providers would create significant new costs without added value for consumers. Finally, we would be very concerned about applying the requirement for a single file as the health insurance provider files can be extraordinarily large given the comprehensive nature of the required data elements.

XVIII. D. Seeking Comment on Consumer-Friendly Displays and Alignment with Transparency in Coverage and No Surprises Act

Below, we respond to certain requests for comment in areas in which we have input based on our experience with the TiC files.

QUESTION: How, if at all, and consistent with its underlying legal authority, could the HPT consumer-friendly requirements at § 180.60 be revised to align with other price transparency initiatives?

Commercial health insurance providers are facing duplicative requirements for machine readable files (MRFs) and cost estimators and to-be-determined requirements for advanced explanation of benefits (AEOBs). Furthermore, CMS took a very different approach to transparency for plans in federal programs relying on application programing interfaces (APIs) resulting in many health insurance providers subject to disparate requirements despite the same ultimate goal of consumer data access and pricing transparency. While there are similarities, the requirements for hospitals are also separate and distinct. In partnership with the private sector, CMS should develop a cohesive roadmap across plan types to build the necessary infrastructure for an incremental approach to successfully accomplishing consumer-centric transparency requirements.

AHIP believes alignment between transparency initiatives will best position the industry to strengthen consumer trust, reduce burden and duplication for stakeholders, and improve the end product. A harmonized reporting approach fosters a more holistic understanding of health care costs and practices, enabling policymakers, the industry, and consumers to evaluate data reported by both hospitals and issuers alike. For example, common definitions, descriptions, and file types could be valuable. However, we caution against forced templates. The goal may be the same across files, but the underlying requirements are different. For example, the health insurance provider files contain all items and services across all provider types. Plans will need flexibility from CMS to evolve the files over time to help reduce file size and other advancements.

AHIP and its members remain committed to advancing true price transparency. We welcome the opportunity to work with hospitals and CMS to improve alignment, minimize consumer confusion, and deliver dependable cost information that empowers consumer financial decision-making.

QUESTION: How aware are consumers about healthcare pricing information available from hospitals? What elements of health pricing information do you think consumers find most valuable in advance of receiving care? How do consumers currently access this pricing information? What are consumers' preferences for accessing this price information?

We believe it is too early to assess consumer awareness of health care pricing information and success in utilizing this data effectively. Hospital cost estimators are still very new, especially since not all hospitals were able to comply initially, and it would be hard to determine if they have yet met their intent.

Hospital cost estimator tools only offer actionable information to a small percent of the population—the uninsured or cash pay individuals. Thus, a large percentage of consumers should

not rely on hospital cost estimator tools. Hospital cost estimator tools are essentially meaningless to insured consumers. Cost estimator tools offered by health insurance providers are the only source of real-time, accurate, personalized, information for insured consumers. Currently, health insurance providers in the commercial market estimate that about half of enrollees have obtained log-in credentials to access personalized cost-sharing information through a web-based tool. We can report, however, given that health insurance providers already had web-based cost estimator tools and have been tracking their use, that they have seen a significant increase in the number of enrollees obtaining credentials that enable them to access pricing information.

While we have not collected information on consumer awareness of information available through MRFs, whether posted by hospitals or health insurance providers, we do not anticipate consumers will be able to access or use these files. The publication of thousands of lines of raw MRF data does little to help consumers comprehend their out-of-pocket costs or drive informed decision-making. These files were geared toward research and business analytics firms that have been able to access the data. We continue to remain concerned that these files will undermine market competition.

MRFs and cost estimator tools as defined in the TiC regulations are by and large intended for fee-for-service pricing models. This is out of sync with CMS and health insurance providers' positive progress to transition toward value-based payment programs. Some health insurance providers are moving toward more episodic estimates in their tools that are more consumer centric, but there are no consensus-based industry standards on which to base these to achieve consistency for consumers. It is also difficult to determine how to display alternative payment arrangement data in a manner that meets federal requirements. Moreover, the information must be thoughtfully presented to ensure users, consumers or otherwise, understand these arrangements. Otherwise, this could lead to unintended consequences, such as driving consumers away from providers who participate in alternative payment arrangements. For example, these models often group together health care items services into single payments to drive cost efficiency, care coordination, and improved patient outcomes. Thus, comparing these more comprehensive values to individual items and services is an apples to oranges comparison that may be misleading. CMS should bring stakeholders together to consider possible options for the future to bring these various tools in line with consumer expectations and fairly compare both FFS and alternative payment structures.

QUESTION: Given the new requirements and authorities through TIC final rules and the NSA, respectively, is there still benefit to requiring hospitals to display their standard charges in a "consumer-friendly" manner under the HPT regulations?

Hospitals should continue to be required to post charges in a consumer-friendly manner for the benefit of the uninsured. The advantage of these estimator tools is that it can be used to shop across providers prior to scheduling an appointment with a particular provider. The GFEs could then be obtained once an encounter is scheduled that would provide a more fulsome picture including, for example, other clinicians who may also be involved.

QUESTION: How effective are hospital price estimator tools in providing consumers with actionable and personalized information? What is the minimum amount of personalized

information that a consumer must provide for a price estimator tool to produce a personalized out-of-pocket estimate?

Hospital cost estimator tools will never be as accurate for insured individuals as those offered by health insurance providers. Health insurance providers alone have key pieces of information for a specific enrolled individual on their benefits, cost-sharing, accumulators, etc., necessary to make an accurate, personalized cost-estimate reflecting their specific benefit package and experience. The Administration should not to draw consumers away from the more accurate and widely available health insurance provider tools that will inherently be more accurate for the insured. CMS should seek to create awareness and leverage hospital estimators for the uninsured and health insurance provider estimators for the insured.

QUESTION: How are third parties using MRF data to develop consumer-friendly pricing tools? What additional information is added by third parties to make standard charges consumer-friendly?

To our knowledge, neither the hospital nor the health insurance provider files are being used at any scale to develop consumer-facing tools. The organizations we know of that are using these files include researchers and market intelligence vendors.

QUESTION: Should we consider additional consumer-friendly requirements for future rulemaking, and to the extent our authorities permit? For example, what types of pricing information might give consumers the ability to compare the cost of healthcare services across healthcare providers?

Health insurance provider web-based cost estimator tools already allow enrollees to comparison shop across providers. As the industry begins to implement AEOB requirements, plans could incorporate lower-cost, higher-quality alternative providers into the information shared with enrollees when available.

We underscore that the intent of AEOBs is to focus on scheduled services. AEOBs can serve a separate and unique function for consumers to obtain more customized cost estimates for scheduled services.

When it comes to shopping for services, we believe that the health insurance providers and their cost estimator tools are the best source of information for the insured because the information can be customized to incorporate specific plan benefit information.

QUESTION: Is there an industry standard set of healthcare services or service packages that healthcare providers could use as a benchmark when establishing prices for consumers?

Again, we remain concerned that the various price transparency tools could dampen market competition. We do not believe it is appropriate to seek to facilitate pricing benchmarks. However, moving forward it would be more consumer-centric to consider how to establish episode-based service packages. To some extent, this will be accomplished through the AEOBs by combining a facility rate with those of multiple clinicians. However, this will still be for a

point in time rather than over a period of time, which may be more informative. While there are some existing methods and products, they are proprietary in nature. CMS should bring stakeholders together to consider how larger service packages might be developed, made publicly available, and incorporated into the transparency policies.

XXVI. C. HEALTH EQUITY COMMENT SOLICITATION

CMS wants to better understand how OPPS and ASC policies impact particular beneficiary populations from an equity perspective, including their equity impacts on people from racial and ethnic minority groups, people with disabilities, people who identify as LGBTQ+ individuals with Limited English Proficiency, members of rural communities, and people otherwise adversely affected by persistent poverty or inequality. CMS seeks input on how they should structure equity impact analyses, which health equity questions CMS should examine, and what new categories or measures should be added.

We appreciate CMS's focus and leadership on health equity. Achieving health equity is also a priority for AHIP and our health insurance provider members, and we take our collective responsibility to improve health equity seriously. To inform CMS's future OPPS and ASC impact analyses that focus on health equity, **we recommend CMS conduct research to better understand how beneficiaries are made aware of outpatient services and whether this leads to disparities in accessing outpatient services**. Questions could include:

- Is information and education on outpatient services customer-facing, accessible, understandable, and culturally and linguistically appropriate? For example, is information on outpatient services presented and available for all beneficiaries to see (e.g., in the waiting room)?
- Are all beneficiaries being referred to outpatient services by providers or do disparities exist in referrals by provider type and by beneficiary population?
- Do disparities in referrals from providers exist due to biases (e.g., not referring Black beneficiaries to dermatologists)?
- Are socioeconomic circumstances taken into account when discussing outpatient services but is there still true shared decision making such that treatment options are not withheld due to socioeconomic circumstances but all information on affordability and accessibility of treatments are presented so that beneficiaries can make informed decisions based on their socioeconomic circumstances?
- How much does mistrust in health care impact whether different beneficiaries utilize outpatient services?

We also recommend CMS investigate outpatient services themselves. For example, **are they culturally and linguistically appropriate** such that existing outpatient services are ones that different beneficiary groups want and need? **Are existing outpatient services accessible and affordable to all beneficiary groups** such that there are sufficient numbers of practitioners and/or facilities per geographic area who offer outpatient services at affordable prices or are there sufficient outpatient facilities or practitioners who accept Medicaid and/or beneficiaries earning low incomes? **These questions could help CMS determine whether unequal access to and utilization of outpatient services lead to disparities in outcomes.** CMS should also examine whether certain outpatient services or treatments are not prioritized, given the beneficiaries they impact the most. For example, are sickle cell treatments or Hepatitis C

treatments prioritized less than other outpatient services because they tend to more significantly impact racial and ethnic minority populations?

In its research and evaluation approach, **we recommend CMS consider member experience measures, including CAHPS measures and additional measures that more exclusively focus on discriminatory or negative experiences when seeking or receiving care. We also recommend that CMS ensure analyses that focus on utilization by geographic areas are not skewed by socioeconomic circumstances or inequities that pose barriers to people accessing and utilizing services**—underutilization of services should not automatically be viewed as lack of need for those services.

Finally, **CMS should outline specific health equity goals that it expects providers to meet** so that providers have clear guidance and direction.