NATIONAL HEALTH COUNCIL

September 9, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

**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 (CY 2025 OPPS proposed rule)**

Dear Administrator Brooks-LaSure:

The National Health Council (NHC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to the CY 2025 OPPS proposed rule.

Created by and for patient organizations over 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, equitable, and sustainable health care. Made up of more than 170 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

**Support for Health Equity Measures**

The NHC strongly supports the proposed measures focusing on health equity, including the Screening for Social Drivers of Health (SDOH) and the Commitment to Health Equity measures across various quality reporting programs. These initiatives are essential for recognizing and addressing social determinants such as socioeconomic status, education, and other factors that significantly impact patient health outcomes. By incorporating these measures into both inpatient and outpatient quality reporting, CMS

is promoting a more equitable health care system and ensuring that interventions are targeted to reduce health disparities.

Expanding the Screening for SDOH to outpatient settings reflects CMS' understanding of the importance of social factors in shaping health outcomes.[1] This expansion will enable health care providers to identify at-risk populations and develop targeted interventions. The Commitment to Health Equity measure provides a structured framework for health care organizations to integrate equity into their strategic and operational goals, fostering a culture of accountability and continuous improvement.[2,3,4,5,6,7]

These measures will allow health care providers to identify and address non-medical factors that influence health outcomes, thereby prioritizing equity in patient care.[8] By integrating SDOH into care planning and encouraging transparent and accountable

[1] National Health Council. (2022). *Access, Affordability and Quality: A patient-focused blueprint for real health equity.* Retrieved from https://nationalhealthcouncil.org/wp-content/uploads/2022/01/Access-Affordability-and-Quality-A-Patient-Focused-Blueprint-for-Real-Health-Equity.pdf

[2] Centers for Medicare and Medicaid Services. (2021). CMS framework for health equity 2021-2030. Retrieved from: https://www.cms.gov/media/529636

[3] Artiga, S. and Hinton, E. (2018). Beyond health care: The role of social determinants in promoting health and health equity. Retrieved from https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

[4] Bailey, Z., Krieger, N., Ag**é**nor, M., Graves, J., Linos, N., and Bassett, M. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *The Lancet*, *389(10077),* 1453-1463.

[5] Department of Health and Human Services. (2019). 2020 update on the *Action Plan to Reduce Racial and Ethnic Health Disparities.* Retrieved from https://cg-b88759ce-d31b-439a-9898-092a58f9927c.s3.us-gov-west-1.amazonaws.com/s3fs-public/documents/Update_HHS_Disparities_Dept-FY2020.pdf

[6] Hacker, K., Auerbach, J., Ikeda, R., Philip, C., and Houry, D. (2022). Social determinants of health – An approach taken at CDC. *Journal of Public Health Management Practice, 28(6)*, 589-594.

[7] Centers for Medicare and Medicaid Services. (2024). Quality in motion: Acting on the CMS national quality strategy. Retrieved from https://www.cms.gov/files/document/quality-motion-cms-national-quality-strategy.pdf

[8] James, C., Moonesinghe, R., Wilson-Frederick, S., Hall, J., Penman-Aguilar, A., and Bouye, K. (2017). *MMWR Surveillance Summaries. 66(23)*, 1-9.

practices, CMS is taking a comprehensive approach to improve patient outcomes and reduce disparities.[9,10,11,12]

To realize these benefits fully, it is critical to ensure that the implementation of these measures is supported by robust data collection and reporting mechanisms.[13,14,15] High-quality data on SDOH and health equity efforts are vital for understanding the scope of disparities and identifying areas for improvement.[16] We encourage CMS to continue refining these data collection processes to ensure they capture meaningful and actionable information. Additionally, providing health care organizations with the necessary tools and resources to collect and analyze this data will be crucial for the successful implementation of these measures.[17,18,19]

Adequate resources, including funding for training, technology, and personnel, are essential for implementing SDOH initiatives, particularly in outpatient settings and rural or underserved areas. Without adequate resources, there is a risk that the benefits of SDOH initiatives may not be realized uniformly across all health care settings.

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[9] Magnan, S. (2017). Social determinants of health 101 for health care: Five plus five. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington DC.

[10] Taylor, L., Tan, A., Coyle, C., Ndumele, C., Rogan, E., Canavan, M., Curry, L., and Bradley, E. (2016). Leveraging the social determinants of health: What works? *PLOS ONE*, 11(8), e0160217.

[11] Henning-Smith, C. and Kozhimannil, K. (2018). Rural-urban differences in Medicare quality outcomes and the impact of risk adjustment. *Medical Care, 55(9)*, 823-829.

[12] Moy, E., Garcia, M., Bastian, B., Rossen, L., Ingram, D., Faul, M., Massetti, G., Thomas, C., Hong, Y., Yoon, P., and Iademarco, M. (2017). Leading causes of death in nonmetropolitan and metropolitan areas—United States, 1999–2014. *MMWR Surveillance Summaries*, *66(1),* 1-8.

[13] National Academies of Sciences, Engineering, and Medicine. (2019). *Integrating social care into the delivery of health care: Moving upstream to improve the nation's health.* Washington, DC: The National Academies Press.

[14] Substance Abuse and Mental Health Services Administration. (2023). Behavioral health equity. Retrieved from https://www.samhsa.gov/behavioral-health-equity

[15] Berchick, E., Hood, E., and Barnett, J. (2018). Health insurance coverage in the United States: 2017. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

[16] Schickedanz, A., Hamity, C., Rogers, A., Sharp, A., and Jackson, A. (2019). Clinician experiences and attitudes regarding screening for social determinants of health in a large integrated health system. *Medical Care, 57(Suppl 6 2), S197-S201*.

[17] Department of Health and Human Services. (2020). Healthy People 2030: Social determinants of health. Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health

[18] U.S. Government Accountability Office. (2020). Maternal mortality and morbidity: Additional efforts needed to assess program data for rural and underserved areas. Retrieved from https://www.gao.gov/assets/gao-21-283.pdf

[19] Substance Abuse and Mental Health Services Administration. (2020). National guidelines for behavioral health crisis care best practice toolkit. Retrieved from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Finally, the NHC urges CMS to continue prioritizing health equity in future rulemaking.[20] While the integration of health equity measures into quality reporting programs is a positive step, ongoing efforts are needed to maintain momentum and address emerging challenges. CMS should continue engaging with stakeholders, including patient organizations, health care providers, and community groups, to ensure that these measures remain relevant and effective. By fostering continuous collaboration, CMS can adapt to evolving needs and ensure that health equity remains at the forefront of health care policy.

**Behavioral Health Access**

The NHC supports CMS' proposals aimed at expanding access to behavioral health services, particularly in rural and underserved areas. The mental health crisis in the United States has highlighted the urgent need for accessible and comprehensive behavioral health services. CMS' proposed updates to payment policies for Partial Hospitalization Programs (PHPs) and Intensive Outpatient Programs (IOPs) are critical steps toward improving mental health care delivery and addressing this pressing issue.

Behavioral health services are vital for individuals suffering from mental health disorders and substance use disorders. PHPs and IOPs provide structured and intensive care options that are less restrictive than inpatient hospitalization, making them essential components of the continuum of care.[21] By updating payment policies for these programs, CMS is ensuring that providers are adequately reimbursed, which is crucial for maintaining and expanding these services.

The NHC recognizes the impact these updates will have on rural and underserved areas. Access to behavioral health services in these regions is often limited by geographical, financial, and logistical barriers. Enhancing payment policies for PHPs and IOPs will enable more health care providers in these areas to offer essential mental health services, thereby improving access for populations that are disproportionately affected by mental health disparities.

However, while these proposed updates are a positive development, the NHC recommends that CMS consider additional measures to support the integration of behavioral health services into primary care settings. Integrated care models, where behavioral health services are provided alongside primary care, have been shown to improve health outcomes, enhance patient satisfaction, and reduce health care costs.[22]

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[20] White House. *Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.* Washington, DC: The White House, January 20, 2021. https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

[21] National Academies of Sciences, Engineering, and Medicine. (2019). *Integrating social care into the delivery of health care: Moving upstream to improve the nation's health.* Washington, DC: The National Academies Press.

[22] Overbeck, G., Davidsen, A., and Kousgaard, M. (2016). Enablers and barriers to implementing collaborative care for anxiety and depression: A systematic review. *Implementation Science Communications, 11(1)*, 165.

By fostering closer collaboration between primary care and behavioral health providers, CMS can further enhance access to comprehensive care and ensure that patients receive holistic treatment for their physical and mental health needs.[23]

The integration of behavioral health services into primary care settings is particularly important for addressing the stigma often associated with seeking mental health care.[24] When behavioral health services are available within primary care environments, patients may feel more comfortable and less stigmatized when accessing these services. This can lead to earlier intervention, better adherence to treatment plans, and improved overall health outcomes.[25]

Furthermore, the NHC encourages CMS to explore innovative care delivery models and payment structures that incentivize the integration of behavioral health services. This could include value-based payment models that reward providers for delivering high-quality, coordinated care, as well as funding for training and technical assistance to support the implementation of integrated care practices.

**Updates to Payment Policies**

The NHC supports the proposed changes to Ambulatory Payment Classification (APC) groups. These changes are designed to better reflect the actual costs and resource use associated with different outpatient procedures, thereby enhancing the accuracy and fairness of the payment system. Properly structured APC groups ensure that outpatient facilities receive appropriate reimbursement for the services they provide, which is essential for maintaining high-quality care and patient satisfaction.

The NHC supports CMS' updates to its payment policies for pass-through devices and drugs, which are crucial for supporting the adoption of high-cost therapies and innovative medical devices. These updates, particularly the continuation and expansion of pass-through payment status for FDA-designated Breakthrough Devices, are essential for ensuring that these cutting-edge technologies can be rapidly and effectively integrated into clinical practice. The NHC supports this approach, as it mitigates financial barriers and helps providers adopt new treatments that improve patient outcomes.[26] Additionally, CMS' proposed refinements to how new procedure codes, especially those involving device implantation, are reimbursed, along with

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[23] Reist, C., Petiwala, I., Latimer, J., Raffaelli, S., Chiang, M., Eisenberg, D., and Campbell, S. (2022). Collaborative mental health: A narrative review. *Medicine, 101(52)*, e32554.

[24] Phelan, S., Salinas, M., Pankey, T., Cummings, G., Allen, J., Waniger, A., Miller, N., Lebow, J., Dovidio, J., van Ryn, M., and Doubeni, C. (2023). Patient and health care professional perspectives on stigma in integrated behavioral health: Barriers and recommendations. *Annals of Family Medicine, 21(Suppl 2),* S56-S60.

[25] Dunn, J., Garneau, H., Filipowicz, H., Mahoney, M., Seay-Morrison, T., Dent, K., and McGovern, M. (2021). What are patient preferences for integrated behavioral health in primary care? *Journal of Primary Care & Community Health, 12*.

[26] Sexton, Z., Perl, J., Saul, H., Trotsyuk, A., Pietzsch, J., Ruggles, S., Nikolov, M., Schulman, K., and Makower, J. (2023). Time from authorization by the US Food and Drug Administration to Medicare coverage for novel technologies. *JAMA Health Forum, 4(8)*, e232260.

adjustments to APC groupings, demonstrate a commitment to aligning reimbursement with the true costs of advanced treatments. These changes are vital for sustaining the availability of high-cost, low-volume therapies and for fostering continued innovation in health care. Overall, these updates will benefit patients by expanding access to advanced treatments and support health care providers by ensuring they are adequately compensated for delivering these high-tech services. The NHC encourages CMS to continue refining these policies to support the sustainable integration of innovative medical technologies into the health care system.

The NHC appreciates CMS' inclusive approach in soliciting feedback on the new Health care Common Procedure Coding System (HCPCS) codes. We believe this process is crucial for adapting the payment system to evolving clinical practices and emerging medical technologies. Accurate coding and appropriate reimbursement are essential for ensuring that health care providers can deliver high-quality care without facing financial disincentives.

We appreciate CMS' efforts to gather public input before finalizing the 73 new HCPCS codes made effective on April 1, 2024, and the 127 new codes made effective on July 1, 2024. This transparent process is crucial for ensuring that the perspectives of a wide range of stakeholders, including patient organizations, health care providers, and industry representatives, are considered. The NHC encourages CMS to continue this approach in the future to maintain a collaborative and informed decision-making process.

Furthermore, we recommend that CMS conduct thorough impact assessments of the new HCPCS codes to ensure that they reflect the actual costs and resource use associated with the procedures and therapies they represent. This will help avoid any unintended consequences that might arise from misaligned reimbursement rates, such as barriers to access or financial strain on providers.

By maintaining an open dialogue with stakeholders and rigorously evaluating the new codes, CMS can ensure that the HCPCS coding system remains robust and responsive to the needs of the health care community. The NHC's members are ready to assist in this process by providing detailed feedback and data to support the appropriate categorization and reimbursement of new HCPCS codes.

**Medicaid Clinic Services and Four Walls Requirement**

The proposed exceptions to the Medicaid clinic services four walls requirement are a positive step toward improving access to care in Indian Health Service (IHS) and Tribal clinics, behavioral health clinics, and rural clinics. By allowing these clinics to provide services outside the traditional clinic walls, CMS is addressing barriers to care that affect vulnerable populations. The NHC supports these exceptions as they have the potential to enhance the delivery of health care services to some of the most underserved communities in the United States. Expanding these flexibilities to additional settings could further enhance access to care and ensure that more patients receive the comprehensive services they need.

The existing four walls requirement has long been a barrier to providing comprehensive and flexible health care services, particularly in rural and Tribal areas where access to care is already limited. This requirement often prevents clinics from offering services that could be more effectively delivered in community settings or via mobile health units. By introducing these exceptions, CMS acknowledges the need for adaptable health care solutions that address patient needs, thereby improving access and continuity of care.[27]

For IHS and Tribal clinics, these exceptions could be especially beneficial. American Indian and Alaska Native populations face some of the highest rates of chronic diseases and health disparities in the country.[28,29] Allowing these clinics to extend their services beyond the traditional clinic walls would enable them to reach more patients, provide more timely care, and address health issues in a culturally appropriate manner. This flexibility is important for overcoming geographical and logistical challenges that have historically hindered health care delivery in these communities.

Behavioral health clinics could also benefit from these proposed exceptions. Mental health and substance use disorders are pervasive issues that require accessible and flexible care models.[30] The ability to provide services outside the clinic walls may facilitate more effective outreach and intervention strategies, particularly in community settings where patients may feel more comfortable seeking care. This approach could lead to earlier diagnosis, better adherence to treatment plans, and overall improved mental health outcomes.

Rural clinics, which often struggle with resource constraints and patient access issues, could find these exceptions invaluable. The flexibility to deliver care in non-traditional settings may help alleviate transportation barriers, reduce missed appointments, and ensure that patients receive the care they need in a timely manner. This is particularly relevant for rural populations who may have to travel long distances to access health care services.[31]

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[27] Abudiab, S., de Acosta, D., Shafaq, S., Yun, K., Thomas, C., Fredkove, W., Garcia, Y., Hoffman, S., Karim, S., Mann, E., Yu, K., Smith, M., Coker, T., and Dawson-Hahn, E. (2023). Beyond just the four walls of the clinic: The roles of health systems caring for refuge, immigrant and migrant communities in the United States. *Frontiers in Public Health, 11:1078980.*

[28] Office of Minority Health. (n.d.). American Indian/Alaska Native Health. Retrieved from https://minorityhealth.hhs.gov/american-indianalaska-native-health#:~:text=American%20Indians%2FAlaska%20Natives%20also,%2C%20liver%20disease%2C%20and%20hepatitis.

[29] Indian Health Service. (2019). Disparities. Retrieved from https://www.ihs.gov/newsroom/factsheets/disparities/

[30] National Association of Counties. (2024). From crisis to solutions: Policy catalysts for improved outcomes. Retrieved from https://www.naco.org/resource/crisis-solutions-policy-catalysts-improved-outcomes

[31] Shour, A. and Onitilo, A. (2023). Distance matters: Investigating no-shows in a large rural provider network. *Clinical Medicine & Research, 21(4)*, 117-191.

The NHC recommends that CMS work closely with state Medicaid programs to facilitate the implementation of these exceptions and to monitor their impact on access to care, health outcomes, and overall costs. Collaboration with state programs is essential to ensure that these changes are effectively integrated into existing health care systems and that clinics receive the support they need to expand their service delivery models. Additionally, ongoing monitoring and evaluation will be crucial for assessing the effectiveness of these exceptions, identifying any unintended consequences, and making any necessary adjustments to optimize their impact.

**Obstetrical Services in Hospitals and Critical Access Hospitals**

The proposed updates to the Conditions of Participation (CoP) for obstetrical services represent a positive step in efforts to improve maternal health outcomes across the United States. These updates are timely, considering the ongoing concerns about maternal morbidity and mortality rates, particularly among underserved and minority populations.

The NHC supports the establishment of baseline health and safety standards for obstetrical services in hospitals and critical access hospitals, particularly within the Medicaid program. These standards are important to ensure that all patients, especially those with chronic conditions and disabilities, receive high-quality, safe, and effective care during pregnancy and childbirth. Given that Medicaid covers over 40% of births in the United States, implementing these standards could help improve maternal health outcomes and reduce disparities.[32] The NHC urges CMS to continuously refine these standards based on the latest evidence and best practices, ensuring they meet the needs of all patients, including those from underserved communities who face higher risks of complications during pregnancy.

The updated CoPs focus on key areas of maternal care, such as quality assessment, performance improvement, and staff training on evidence-based best practices. Addressing these areas is crucial for improving maternal health outcomes and tackling the high rates of maternal morbidity and mortality that persist in the U.S., particularly among minority populations.[33] African American women, for example, are over four times more likely to experience pregnancy-related deaths compared to white women.[34] These disparities are driven by a range of factors, including access to quality health care, socioeconomic conditions, and underlying health disparities. By enhancing training and focusing on continuous improvement, health care providers can better manage

[32] Kaiser Family Foundation. (2024). Births financed by Medicaid. Retrieved from https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/

[33] Hill, L., Artiga, S., and Ranji, U. (2022). Racial disparities in maternal and infant health: Current status and efforts to address them. Retrieved from https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/

[34] Njoku, A., Evans, M., Nimo-Sefah, L., and Bailey, J. (2023). Listen to the whispers before they become screams: Addressing Black maternal morbidity and mortality in the United States. *Healthcare, 11(3)*, 438.

high-risk pregnancies, recognize and respond to complications promptly, and deliver culturally competent care.[35]

The NHC recommends that CMS monitor the impact of these updates to obstetrical services on small and rural hospitals, particularly those serving underrepresented populations, to ensure that safety improvements are effectively implemented while supporting these hospitals in maintaining high-quality care and essential services.

**Prior Authorization Process**

The NHC appreciates the proposed reduction in review timeframes for prior authorization requests for Hospital Outpatient Department (HOPD) services from 10 business days to seven calendar days. This change is significant for several reasons, all of which underscore its importance for both patients and health care providers. However, while this reduction is a positive step, the NHC encourages CMS to explore opportunities for even shorter review times, particularly for urgent or high-risk services where delays could have more severe consequences on patient health.

CMS' proposal to align the Medicare Fee-For-Service (FFS) prior authorization review timeframe with the timeframes established in the CMS Interoperability and Prior Authorization final rule is a welcome step toward streamlining processes across different payers and reducing provider burden.[36] We are particularly supportive of CMS' approach to maintaining the two-tiered system where urgent, expedited requests are reviewed within 72 hours, while standard requests are addressed within seven calendar days. This risk-based approach is crucial for ensuring that patients requiring urgent care do not face unnecessary delays, and we encourage CMS to continue evaluating whether even faster review times might be feasible for certain high-risk services in future rulemaking.

Moreover, the reduction in review timeframes will alleviate the administrative burdens on health care providers. The current 10-business-day review period often creates bottlenecks in the workflow of health care facilities, leading to inefficiencies and increased administrative costs. Health care providers spend considerable time and resources navigating the prior authorization process, which detracts from their ability to focus on direct patient care.[37] By shortening the review period to seven calendar days,

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[35] Health Resources & Services Administration. (2024). How we improve maternal health. Retrieved from https://www.hrsa.gov/maternal-health

[36] Centers for Medicare & Medicaid Services. (2024). *Medicare and Medicaid programs; Patient Protection and Affordable Care Act; Advancing interoperability and improving prior authorization processes for Medicare Advantage organizations, Medicaid managed care plans, state Medicaid agencies, Children's Health Insurance Program (CHIP) agencies and CHIP managed care entities, issuers of qualified health plans on the federally-facilitated exchanges, merit-based incentive payment system (MIPS) eligible clinicians, and eligible hospitals and critical access hospitals in the Medicare Promoting Interoperability Program* (Final rule). Federal Register. https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

[37] American Medical Association. (2023). 2022 AMA prior authorization (PA) physician survey. Retrieved from https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

CMS is streamlining the prior authorization process, allowing providers to allocate resources more effectively and enhance the quality of care they deliver. Exploring further reductions in review times, particularly for high-risk services, could amplify these benefits and improve patient outcomes.

Additionally, this policy change reflects a commitment to improving the overall patient experience.[38] Reduced wait times and enhanced efficiency in service delivery are key factors in patient satisfaction. By implementing this change, CMS is demonstrating a responsive regulatory approach that considers the operational challenges faced by health care providers and seeks to mitigate them. This approach benefits providers and ensures that patients receive timely and efficient care, thereby enhancing the overall health care experience.

Furthermore, the NHC encourages CMS to continue exploring similar initiatives that balance regulatory oversight with the practical needs of both patients and providers. It is essential to maintain oversight to ensure the quality and appropriateness of care, but this must be done in a way that does not hinder access or create unnecessary administrative burdens. The proposed reduction in prior authorization review timeframes is a step in the right direction, and we urge CMS to continue seeking innovative solutions that enhance the efficiency and effectiveness of health care delivery. Striving for even shorter review times where clinically appropriate, especially for high-risk services, could further enhance patient care and reduce the burden on health care providers.

**High-Cost Drugs and Tribal Facilities**

The NHC supports the proposal to provide separate add-on payments for high-cost drugs provided by IHS and Tribal facilities. This policy is a critical step towards ensuring equitable access to advanced treatments for beneficiaries served by these facilities, many of whom are among the most vulnerable and underserved populations in the United States.

The high cost of advanced pharmaceuticals often poses significant barriers to access, particularly in IHS and Tribal facilities, which operate under constrained resources and serve populations with unique health challenges.[39] By introducing separate add-on payments for these high-cost drugs, CMS is acknowledging and addressing the financial challenges these facilities face in providing state-of-the-art care.

This policy has the potential to make a meaningful impact on health equity. American Indian and Alaska Native populations experience some of the highest rates of chronic

[38] Chino, F., Baez, A., Elkins, I., Aviki, E., Ghazal, L., and Thom, B. (2023). The patient experience of prior authorization for cancer care. *JAMA Network Open, 6(10)*.

[39] Hill, L. and Artiga, S. (2023). Health coverage among American Indian and Alaska Native and Native Hawaiian and other Pacific Islander people. Retrieved from https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-among-american-indian-and-alaska-native-and-native-hawaiian-and-other-pacific-islander-people/

diseases and face substantial health disparities compared to other groups.[40,41,42] Ensuring that IHS and Tribal facilities can afford and provide the latest high-cost medications is crucial for closing these health gaps and improving outcomes for these communities.

Moreover, the NHC recognizes that this proposal extends beyond financial support to honor commitments to these communities. The add-on payments will enable IHS and Tribal facilities to offer treatments that can prevent complications, improve quality of life, and even save lives, aligning with broader public health goals of reducing disparities and enhancing population health.

This policy may establish a precedent for addressing the high costs of other essential medical services and treatments in underfunded health care settings. It demonstrates a commitment to a health care system that prioritizes patient needs and equitable access, regardless of geographical or socio-economic barriers.

The NHC encourages CMS to ensure that the implementation of these add-on payments is seamless and that there is ongoing evaluation to monitor the policy's effectiveness. Continuous dialogue with IHS and Tribal facilities will be essential to make adjustments as needed and to ensure that the policy meets its intended goals of enhancing access and reducing disparities.

**Medicare Special Enrollment Period and Definition of Custody**

The NHC supports CMS' proposal to narrow the definition of "custody" in Medicare's payment exclusion rule, which would allow individuals released from incarceration but still on parole, probation, or home detention – a population that includes a significant number of people with chronic conditions and disabilities – to maintain access to their Medicare coverage and enroll during the special enrollment period.[43,44,45] This change is crucial in ensuring that formerly incarcerated individuals do not face unnecessary

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[40] Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care* (B. Smedley, A. Stith, and A. Nelson, Eds.). Washington DC: National Academies Press.

[41] Office of Minority Health. (n.d.). American Indian/Alaska Native Health. Retrieved from https://minorityhealth.hhs.gov/american-indianalaska-native-health#:~:text=American%20Indians%2FAlaska%20Natives%20also,%2C%20liver%20disease%2C%20and%20hepatitis.

[42] Indian Health Service. (2019). Disparities. Retrieved from https://www.ihs.gov/newsroom/factsheets/disparities/

[43] Russ, E., Puglisi, L., Eber, G., Morse, D., Taxman, F., Dupuis, M., Ashkin, E., and Ferguson, W. (2021). Prison and jail reentry and health. *Health Affairs.*

[44] Mallik-Kane, K., Paddock, E., and Jannetta, J. (2018). *Health care after incarceration: How do formerly incarcerated men choose where and when to access physical and behavioral health services?* Retrieved from https://www.urban.org/research/publication/health-care-after-incarceration

[45] Apel, R. and Sweeten, G. (2014). The impact of incarceration on employment during the transition to adulthood. *Social Problems, 57(3),* 448-479.

barriers to accessing essential health care services upon reentry into the community.[46] By extending Medicare coverage and enrollment opportunities to those under non-incarcerated supervision, CMS is promoting equitable access to health care, reducing the risk of health disparities, and supporting the successful reintegration of these individuals into society.[47,48,49] We encourage CMS to continue refining policies that address the unique health care needs of justice-involved populations, as these measures play a critical role in improving public health and reducing recidivism.

**Screening and Preventive Services**

The NHC supports CMS' proposal to expand coverage for colorectal cancer screening methods, including computed tomography colonography (CTC). This expansion represents a significant advancement in early detection efforts and is likely to improve patient outcomes across diverse populations. By broadening the range of covered screening methods, CMS is facilitating greater access to potentially life-saving diagnostic tools, which is crucial for increasing survival rates and successful treatment outcomes.[50]

The NHC views this proposal as a promising step toward making less invasive and more patient-friendly screening options widely available. Including CTC as a covered method, along with follow-on colonoscopies after blood-based biomarker tests, reflects CMS' commitment to comprehensive, patient-centered care. We encourage CMS to continue expanding such initiatives, as they not only improve the effectiveness of early detection but also address disparities in access to preventive care, particularly for underserved and minority populations.

Additionally, this expansion supports broader public health goals by reducing the overall burden of cancer through preventive care. By increasing screening rates and ensuring timely diagnoses, CMS is helping to lower health care costs associated with advanced-stage cancer treatments, ultimately leading to better health outcomes and more efficient use of health care resources.

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[46] Western, B. and Sirois, C. (2017). *Racial inequality in employment and earnings after incarceration*. Retrieved from https://scholar.harvard.edu/files/brucewestern/files/racial_inequality_in_employment_and_earnings_after_incarceration.pdf

[47] Orozco, M. (2023). Health care coverage for the incarcerated population to reduce opioid-related relapse, overdose, and recidivism rates. Retrieved from https://fas.org/publication/health-care-coverage-for-the-incarcerated-population-to-reduce-opioid-related-relapse-overdose-and-recidivism-rates/

[48] Jácome, E. (2021). How better access to mental health care can reduce crime. Retrieved from https://siepr.stanford.edu/publications/policy-brief/how-better-access-mental-health-care-can-reduce-crime

[49] Russ, E., Puglisi, L., Eber, G., Morse, D., Taxman, F., Dupuis, M., Ashkin, E., and Ferguson, W. (2021). Prison and jail reentry and health. *Health Affairs.*

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## Quality Reporting and Transparency

The NHC commends CMS for continuing to enhance quality reporting programs and for introducing new measures that promote transparency and patient safety. These initiatives are fundamental to building a health care system that is both accountable and responsive to the needs of all patients. The proposed updates to the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs are particularly noteworthy, as they ensure that quality metrics reflect current clinical practices and patient needs.

Quality reporting is essential for improving patient care and outcomes. By consistently updating and refining these programs, CMS demonstrates a commitment to maintaining high standards in health care delivery. The introduction of new measures, such as those focusing on patient safety and health equity, underscores the importance of not only tracking performance but also addressing areas where disparities exist. This is crucial for achieving equitable health care outcomes across diverse populations.

The emphasis on transparency in these quality reporting programs cannot be overstated. Transparency allows patients to make informed decisions about their health care, promotes trust in the health care system, creates data for advocates to develop policy improvements, and drives health system transformation by holding providers accountable. The proposed updates, which include measures to enhance the accuracy and comprehensiveness of reported data, will provide patients, providers, and policymakers with a clearer picture of health care quality and performance.

Furthermore, the inclusion of specific measures tailored to different care settings, such as rural emergency hospitals and ambulatory surgical centers, ensures that quality reporting is relevant and applicable to the unique challenges and practices in these environments. This approach recognizes the diversity within the health care system and the need for customized solutions to meet varying patient and provider needs.

Quality reporting also plays a critical role in addressing health disparities. By incorporating measures that highlight disparities in care and outcomes, CMS can identify and address gaps in the health care system. This is particularly important for minority populations and underserved communities who often face significant barriers to accessing high-quality care. By focusing on equity in quality reporting, CMS helps to ensure that all patients receive the best possible care, regardless of their background or circumstances.

## Continuous Eligibility in Medicaid and CHIP

The NHC strongly supports CMS' proposal to implement 12 months of continuous eligibility for children under 19 enrolled in Medicaid and CHIP, as mandated by the Consolidated Appropriations Act of 2023. This policy is crucial for preventing gaps in coverage that can lead to delayed care, increased emergency room visits, and poorer health outcomes. Continuous eligibility is crucial for preventing gaps in coverage that can lead to delayed care and poorer health outcomes, particularly for low-income and minority children who are disproportionately affected by such disruptions. By ensuring

that these vulnerable populations maintain uninterrupted access to preventive care and chronic disease management, CMS is advancing health equity and improving overall health outcomes.[51,52]

Moreover, the NHC encourages CMS to consider extending continuous eligibility provisions to other vulnerable populations, such as those experiencing economic instability or transitioning out of incarceration. Expanding continuous eligibility would not only promote health equity but also support broader public health goals by reducing barriers to care for individuals at critical junctures in their lives.

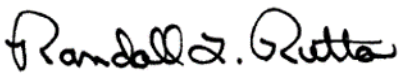
To support these initiatives, it is vital that CMS collaborates closely with state Medicaid programs to provide the necessary resources and guidance for implementing continuous eligibility effectively. This includes training for administrative staff, investments in technology to track eligibility seamlessly, and outreach efforts to inform families about the benefits of continuous coverage.

By taking these steps, CMS can ensure that continuous eligibility serves as a robust tool for enhancing health equity, improving care continuity, and fostering better health outcomes for children and other vulnerable populations.

**Conclusion**

The NHC appreciates the opportunity to provide input on the CY 2025 OPPS proposed rule. Please do not hesitate to contact Eric Gascho, Senior Vice President of Policy and Government Affairs, at egascho@nhcouncil.org if you or your staff would like to discuss these comments in greater detail.

Sincerely,



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Chief Executive Officer

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