September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: [CMS-1770-P] - CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Comments submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure:

The Audiology Quality Consortium (AQC) appreciates the opportunity to comment on [CMS-1770-P], CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies. The AQC is comprised of representatives of nine audiology organizations: American Speech-Language-Hearing Association, American Academy of Audiology, Academy of Doctors of Audiology, Academy of Rehabilitative Audiology, Association of VA Audiologists, Directors of Speech and Hearing Programs in State Health and Welfare Agencies, Educational Audiology Association, Military Audiology Association, National Hearing Conservation Association.

The mission of the AQC is to:

- Collaborate on the analysis and recommendation of audiology quality measures for use in the Centers for Medicare and Medicaid Services (CMS) Merit-Based Incentive Payment System (MIPS) and with other health care payers;
- Monitor the status of audiology quality measures for reporting under MIPS and other health care payers;
- Respond to proposed rules and measure changes by CMS and other measure owners on behalf of the audiology community;
- Educate audiologists regarding audiology quality reporting and MIPS requirements.

The AQC supports the participation of audiologists in quality measurement reporting. We appreciate the continued inclusion of a designated specialty measures set for audiology and the multiple options for participation in the Merit-based Incentive Payment System (MIPS) that

take into consideration the unique care provided by audiologists to Medicare beneficiaries. We look forward to continued dialogue with CMS regarding options for successful audiology participation as the traditional MIPS program transitions to the new MIPS Value Pathways (MVP) framework. Audiologists are professionals qualified in the education, prevention, identification, diagnosis and treatment of hearing loss. As such, our participation in CMS quality initiatives is important to demonstrate the quality care provided by audiologists to Medicare beneficiaries. In this proposed rule, we appreciate CMS' initial steps to provide direct access to audiology services, and we strongly support needed statutory changes that would classify audiologists as practitioners under the Medicare program.

The current Medicare regulatory definition places audiologists in the "Other Diagnostic Procedures" benefit classification, which is limited to the exclusive diagnostic-only areas of hearing and balance healthcare. Developing measures of quality and outcomes for this narrowly defined benefit classification, as well as participating in interdisciplinary measures that require outcomes or treatment management of the patient, is challenging within these regulatory confines. We are encouraged by CMS' attempts to ensure flexibility in the types of measures required for reporting, and again, we would like to work with CMS to ensure that audiologists have the ability to participate in future iterations of the MIPS program.

We appreciate the continued exemption of audiology from the *Cost* and *Promoting Interoperability* categories in 2023 though have concerns about reporting under the *Promoting Interoperability* category beginning in CY 2024.

<u>New Measures for Audiology Measures Set</u>

In this proposed rule, CMS proposes to add two new measures to the Audiology Measures set under the MIPS program:

*Screening for Social Drivers of Health: Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

* Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user.

The AQC appreciates that CMS has provided an additional two measures for inclusion in the designated measures set for audiology. It is important for mandated reporters to have a choice of measures to report, as CMS requires reporting of at least 6 measures.

We acknowledge that CMS has included audiologists with other clinician types in the proposed measure for Screening for Social Drivers of Health. Providing standardized tools for operationalizing this measure will be crucial for successful reporting, but more importantly, to ensure respect for patient comfort and privacy in the discussion of sensitive and very personal

information. We request that CMS provide educational resources to facilitate the implementation of this new measure across varied clinical settings.

CMS proposes to remove QID261 from the audiology measures set:

*Acute or Chronic Dizziness: Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with acute or chronic dizziness.

CMS proposes to remove this quality measure from MIPS because of the limited patient population and that it does not allow for the creation of benchmarks to provide a meaningful impact to quality improvement. The AQC is disappointed that CMS has proposed removal of this measure.

The measure remains very relevant given the rapid increase in the aging population. According to the U.S. Census Bureau, the 65-and-older population grew by over a third (34.2% or 13,787,044) during the past decade, and by 3.2% (1,688,924) from 2018 to 2019 (Census Bureau 2019 Population Estimates). It is estimated that 1 in 10 of older adults see a general practitioner regarding dizziness at least 1 time per year (Stam et al 2016), and a ¼ to ½ of all dizzy cases are vestibular in nature (Holmes & Padgham 2011; Neuhauser 2007). Vestibular dysfunction is associated with increased risk for falls (Agrawal et al 2013; Agrawal et al 2009; Herman et al 2000). Over ½ report a fall as a result of their dizziness (To-Alemanji et al 2016). Patients have a 12 fold increase for falling when they are clinically symptomatic (Agrawal et al 2013) and vestibular dysfunction is 3 times more common in the elderly, with 85% of those over 80 years old having some form of balance dysfunction (Agrawal et al 2009).

Falls result in injury, restricted mobility, and are cause of death for elderly (Agrawal et al 2009). In fact, reducing fall related deaths among older adults is an objective (IVP-08) of Healthy People 2030.

U.S. referral rates for dizziness are only about 9% of all cases (Holmes & Padgham 2011). It takes on average, 4.5 physicians visits before a diagnosis (Luxon 2007). The mean time from onset to diagnosis was found to be as high as 740 days (Monzani et al 2001), with 93 weeks between referral to treatment for some vestibular pathologies (BPPV) (Fife & Fitzgerald 2005). Adams & Marmor 2022, reviewed data from 805,454 patients seen medically for dizziness through emergency rooms and clinics. From this data, they found no consistency in care or treatment.

As CMS knows, delays in care may result in harm to patients and unnecessary expenditures for testing and ineffective therapy (e.g., MRI, overuse of repositioning maneuvers, diagnostic inefficiency, lab work) (To-Alemanji et al 2016; Li et al 2000). A broad spectrum of disorders makes diagnosis more difficult, as well as the variety of management strategies seen across general practitioners, leading to the fact that 40-80% of all dizziness cases remain unexplained unless they are seen in a specialty clinic (Stam et al 2016).

Audiologists are an important part of the fall-prevention teams by providing effective, efficient, evidence-based care for balance, dizziness, and vertigo patients. Audiologists provide assessment to help lead to a diagnosis (triage for vestibular vs. non-vestibular), and proper assessment informs effective treatment. Early and correct diagnosis can lead to a reduction of direct and indirect medical costs. According to the Centers for Disease Control and Prevention (CDC), falls among older adults are very costly, with approximately $50 billion spent each year on medical costs related to non-fatal fall injuries. (Cost of Older Adult Falls (cdc.gov) accessed 8/21/2022).

Through inexpensive, timely, evidence-based, patient-centered care, audiologists are uniquely positioned to alleviate patient and economic burdens of dizziness. Audiologists gather information for differential diagnosis, evaluate the impact of the problem, and provide effective counseling strategies. The AQC encourages CMS to retain this important measure.

Promoting Interoperability

The AQC has appreciated CMS' flexibility in the re-weighting of performance categories to ensure maximum opportunities for successful quality program participation. Some mandated program participants, such as audiologists, may have no eligible scored measures in a performance category (e.g. *promoting interoperability and cost),* and thus would face barriers to successful participation without the CMS re-weighting policy.

In this proposed rule, CMS proposes to remove the exemption for audiologists from the *Promoting Interoperability* category beginning in CY 2024. CMS suggests the current re-weighting policy may discourage audiologists from reporting measures under the category. We believe some audiologists have not fully adopted electronic health record (EHR) systems due to multiple factors including cost, the applicability of such platforms to audiology practices (many are physician-focused), and the fact that audiologists were never considered eligible professionals in the Medicare EHR Incentive Program. We recognize that interoperability and digital quality measurement are integral components of quality and payment models moving forward, and as such, will work to educate the profession about the need to transition to EHRs.

CMS' own data, as referenced in the proposed rule text, suggest there are very few audiologists reporting under the *Promoting Interoperability* category since the start of audiology participation (2019). Further analysis of such data may reveal most reporters are in large health systems with established EHR technology and administrative resources not readily available to private practice audiologists.

We request that CMS delay including audiologists in the *Promoting Interoperability* category until at least CY 2025. This will allow time for the audiology community to educate providers about the importance of investing in EHR systems. In addition, we believe it will take time for the handful of vendors that offer EHR systems for audiology to comply with CMS requirements.

Several AQC member organizations reached out (unofficially) to vendors that offer EHRs for audiology. Though anecdotal, we obtained a mix of feedback on vendor readiness to comply with CMS requirements. Generally, more time may be necessary for vendors to meet CMS requirements.

Finally, the AQC requests that audiologists be offered similar financial and educational opportunities as those offered to physicians during the introduction and adoption of the Meaningful Use program. Audiologists will need a sufficient trial and operations period before being penalized for reporting deficiencies.

We call CMS' attention to the fact that audiologists would not be eligible to participate in 2 of 4 *Promoting Interoperability* objectives: 1) e-Prescribing and 2) Public Health and Clinical Data Exchange. Both objectives and associated measures are beyond the scope of practice of audiologists. As currently structured, the *Promoting Interoperability* program requires reporting on all measures in each of the 4 objectives unless an exclusion is claimed. We ask CMS to automatically exclude providers whose scope of practice, would not allow reporting of these objectives.

Thank you for your kind consideration of these views. If you have questions or require additional information, please contact Deborah Carlson, PhD, AQC Chair, at dlcarlso@UTMB.edu.

Sincerely,

Chair, Audiology Quality Consortium

Comments endorsed by:

Academy of Doctors of Audiology
Academy of Rehabilitative Audiology
American Academy of Audiology
American Speech-Language-Hearing Association
Association of VA Audiologists
Directors of Speech and Hearing Programs in State Health and Welfare Agencies
Educational Audiology Association
Military Audiology Association