September 6, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-1656-P
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program (CMS-1656-P)

Dear Acting Administrator Slavitt:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the above referenced Hospital Outpatient Prospective Payment System (OPPS) proposed rule for Fiscal Year (FY) 2017. Our comments focus on the following sections:

- Electronic Health Record (EHR) Incentive Programs
- Payment to Off-Campus Outpatient Departments
- Proposed Hospital Value-Based Purchasing (VBP) Policies

The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Electronic Health Record (EHR) Incentive Programs

CMS proposes to make a number of changes to requirements under the EHR Incentive Program – or Meaningful Use (MU). These changes include shortening the reporting period in calendar

year (CY) 2016 from the full CY to any continuous 90-day period; adding policy on measure calculations that fall outside of the 90-day reporting period; and updating reporting requirements for eligible professionals (EPs) that are new participants in the program in 2017 as well as offering a one-time significant hardship exception for these new participants.

ACP Comments:
The College has previously called for the shortened 90-day reporting period for 2014 and 2015 as well as for 2016 and is very appreciative and supportive of CMS' proposal to shorten the reporting period in CY 2016. This proposal shows that CMS has been responsive to stakeholders' legitimate concerns as experience has shown that physicians need time to upgrade or switch EHR systems and to work on new EHR process measures along with measures that have increased thresholds from previous years. Every practice needs to set aside months of time to convert systems, transfer data, retrain staff, and start from the beginning to re-analyze and rework the roles and workflows to accommodate the new and changed requirements. A 90-day reporting period gives physicians sufficient time to find shortcomings, implement corrective actions, and catch up – unlike quality measurement in which the full CY is needed for the reliability of the data. **ACP is also supportive of CMS' proposal to include in the MU measure numerator actions or encounters that may fall outside of the 90-day reporting period timeframe but fall within the full CY of the reporting period.** In certain scenarios, for patients being measured in the denominator, it is not always clinically relevant that their specific encounter fall within the 90-day reporting period and ACP appreciates the inclusion of this measure calculation policy.

ACP supports the inclusion of a one-time significant hardship exception for new participants (or those who have not successfully attested) in the EHR Incentive Program in CY 2017 who intend to transition into the Merit-based Incentive Payment System (MIPS) – excluding them from payment adjustments in 2018. However, the College urges CMS to clearly communicate the availability of this hardship exception to all program participants prior to the 2017 reporting period. It is especially important that these new participants – who intend to transition into MIPS – have the opportunity to focus on the measures and requirements specified for the proposed advancing care information (ACI) performance category in 2017.

Lastly, the College has concerns with the proposals under section XVIII(C)(2)(b) that outline Stage 3 requirements for all EPs for 2018 and subsequent years attesting under a State's Medicaid EHR Incentive Program. Medicaid EPs take care of the sickest and most disadvantaged population of patients and are the clinicians most vulnerable to stringent regulatory requirements. The Stage 3 requirements include burdensome thresholds and measures that CMS determined were no longer needed in the proposed ACI category under MIPS (e.g., Clinical Decision Support and Computerized Provider Order Entry). As ACP noted in our comments on the Medicare Access and CHIP Reauthorization Act (MACRA) proposed rule,[1] the College believes that proposed ACI category still needs significant changes focused on the value of the measures and whether they assist practices in applying health information technology (health IT) to improve the quality and value of care rather than focusing on the performance levels of

[1] https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf

the measures. It is unfair that EPs participating in the Medicare EHR Incentive Program will transition to an easier set of requirements under the proposed ACI category of MIPS while EPs under the Medicaid EHR Incentive Programs will have to meet harder Stage 3 requirements in 2018. **Therefore, the College recommends CMS apply the same proposed ACI requirements for both Medicare clinicians participating in MIPS and Medicaid clinicians participating in the Medicaid EHR Incentive Program.**

Relocation of Off-Campus PBDs Excepted under Section 1833(t)(21)(B)(ii) of the Act

The Bipartisan Budget Act of 2015 (BBA) is estimated to save $9.3 billion over a 10-year period. Section 603 of the BBA establishes a site neutral payment policy in for all newly acquired off-campus outpatient provider-based departments (off-campus PBDs). This provision is an important step in equalizing Medicare payments across site of service and will be a major factor to reducing unnecessary health care spending while providing greater patient access to care.

Key to the creation of Section 603 is stemming consolidation in the health care marketplace. Policymakers are recognizing the negative effects that hospital acquisition of independent physician practices has on health care costs and access to care. Section 603 of the BBA was intended to curtail consolidation, preserve patient choice in care settings, and decrease costs in the Medicare system.

ACP Comments:

Allowing relocation for “excepted” off-campus PBDs would provide an avenue for entities to purchase additional physician practices and move into larger facilities while continuing to charge patients and Medicare higher costs. The College feels that CMS accurately interpreted the section of the BBA regarding the location of the off-campus PBD with “excepted” status is the location at the time of enactment, thus prohibiting relocation of “excepted” facilities. **Therefore, the College encourages CMS to include its proposed policy on the relocation of “excepted” off-campus PBDs in the final rule.**

CMS is seeking comments on whether the Agency should develop a clearly defined, limited relocation exception process, similar to the disaster/extraordinary circumstance exception process under the Hospital VBP program for hospitals struck by a natural disaster or experiencing extraordinary circumstances (under which CMS allows a hospital to request a Hospital VBP Program exception within 90 days of the natural disaster or other extraordinary circumstance) that would allow off-campus PBDs to relocate in very limited situations. **The College recommends that CMS develop a limited relocation exception process for which off-campus PBDs can apply to CMS on a case-by-case basis with special circumstances that warrant exclusion from the BBA “excepted” status.** There may be some PBDs who must relocate away from the current location through no fault of their own; this might include PBDs that are significantly impacted by a natural disaster such as a hurricane or earthquake, severe financial distress (bankruptcy), etc.

Expansion of Clinical Family of Services at an Off-Campus PBD Excepted under Section 1833(t)(21)(B)(ii) of the Act

The BBA Section 603 describes how hospital outpatient departments (HOPDs) shall not include a department of a provider that was billing under the exception status items and services furnished with respect to the covered PBD services furnished prior to the date of the enactment.

ACP Comments:

CMS correctly surmises from Section 603 of the BBA that allowing "excepted" facilities to expand beyond their current scope of services will perpetuate the acquisition of community-based practices by hospitals and fail to achieve the BBA's intent of curtailing consolidation and achieving savings in the Medicare system.

Payment differentials in Medicare have put community clinics at a direct disadvantage in the delivery of the same care provided in HOPDs, resulting in a significant shift of outpatient care from the community setting to the HOPD. The College does not support provider-based billing for care delivered in an outpatient, hospital-system owned practice when that care is not dependent on the hospital facility and its associated technologies. Rather, in line with the College's high value care initiative,[2] the College supports delivery of care in the most efficient setting, while maintaining quality of care. **Therefore, ACP supports CMS' proposed restriction on the scope of services "excepted" off-campus PBDs are able to furnish and bill at the higher OPPS rate.**

Proposed Hospital Value-Based Purchasing (VBP) Policies

CMS uses the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey in the hospital VBP to evaluate patient experience of care as part of the Care/Care Coordination domain. One of the nine survey dimensions focuses on pain management, utilizing the following questions:

- During this hospital stay, did you need medicine for pain?
- During this hospital stay, how often was your pain well controlled?
- During this hospital stay, how often did the hospital staff do everything they could to help with your pain?

Due to the use of these pain management measures in the calculation of patient experience of care, many stakeholders have suggested that this may place pressure on hospital staff to prescribe more pain medications such as opioids to achieve a higher HCAHPS score, which may further contribute to the opioid overdose epidemic. To address these concerns, CMS proposes to remove the pain management dimension from the calculation of the HCAHPS survey score beginning with the FY 2018 program, which has a performance period of January 1, 2016 through December 31, 2016. The Agency is in the process of developing alternative questions for the pain management dimension, and CMS intends to propose to adopt the alternative questions in future rulemaking.

[2] https://www.acponline.org/clinical-information/high-value-care

ACP Comments:

The College strongly supports the proposal to remove the pain management dimension from the calculation of the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain in the HCAHPS Survey score. ACP supports moving toward patient- and family-centeredness measures that do not create unintended adverse consequences. However, given the potential for the current HCAHPS pain management measures to create financial incentives that could inadvertently incentivize inappropriate opioid administration and prescribing, the College supports removing the current measures from the calculation of the HCAHPS scores. Patients experience varied types of pain, with various goals of management, depending on features of the clinical situation, such as: underlying diagnosis, acute vs. chronic nature of the pain, life expectancy, prior narcotic use, dependence, and/or abuse history, and other factors which must be taken into account by the prescribing clinician. As CMS continues the development of alternative pain management measures, ACP encourages CMS to revise the pain-related HCAHPS questions to better reflect the appropriateness of pain management interventions, with particular attention to the difference between acute and chronic pain as well as the goals and risks of the clinical situation.

Thank you for considering ACP's comments. Please contact Shari M. Erickson, MPH, Vice President, Governmental Affairs and Medical Practice, by phone at 202-261-4551 or e-mail at serickson@acponline.org if you have questions or need additional information.

Sincerely,

Robert McLean, MD, FACP, FACR
Chair, Medical Practice and Quality Committee
American College of Physicians