Advancing High Performance Health

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Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Slavitt:

AMGA welcomes the opportunity to comment on the "Medicare Program: 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-0115-P) proposed rule.

AMGA, founded in 1950, represents more than 450 single and multi-specialty medical groups and integrated delivery systems representing approximately 177,000 physicians who care for one-in-three Americans. Our members, in sum, continue to work toward achieving the triple aim of improving the experience of care, improving the health of populations, and reducing spending or the per capita costs of healthcare. We therefore have a strong interest in several of the regulatory changes the Centers for Medicare and Medicaid Services (CMS) has put forward in this proposed rule.

Changes to Certain Scope-of-Service Elements for Chronic Care Management (CCM) Services

CMS has proposed minor changes to several chronic care management (CCM) scope of service elements that will apply to CCM services furnished to hospital outpatients under the OPPS. These include the electronic sharing of care plan information that would need to be accomplished in a timely manner but not necessarily on a 24 hour a day/7 days week basis as is currently required. CMS would drop the beneficiary authorization requirement for the electronic communication of his or her medical information with other treating providers as a condition of payment for CCM services, and would allow practitioners to document in a beneficiary's medical record that information regarding CCM services was explained verbally and to note whether the beneficiary accepted or declined CCM services instead of obtaining written agreement. AMGA has consistently supported reducing the operational burden associated with CCM documentation requirements and is pleased to see the agency has taken this issue into consideration. Removing the additional administrative step of obtaining written patient consent before administering these important services helps ensure providers can disseminate essential care in a more timely manner without the additional effort of completing paperwork before treating beneficiaries.

EHR Incentive Program

CMS is proposing a continuous 90-day Electronic Health Record (EHR) reporting period from January 1, 2016 to December 31, 2016 for all returning Eligible Professionals (EPs), eligible hospitals and Critical Access Hospitals (CAHs) that have previously demonstrated meaningful use in the Medicare and Medicaid EHR Incentive programs.

The agency is also proposing to eliminate the Clinical Decision Support (CDS) and the Computerized Provider Order Entry (CPOE) objectives and measures for eligible hospitals, including Critical Access Hospitals attesting under the Medicare EHR Incentive Program. CMS also is proposing to reduce the thresholds for a subset of the remaining objectives and measures in Modified Stage 2 for 2017 and Stage 3 for 2017 and 2018.

AMGA has long advocated for a 90-day reporting period for EHR participants as the transition to calendar year reporting is made. As CMS is well aware it takes time for providers to coordinate vendors and third-party interoperability partners. Expecting all hospitals to be ready and able to work together simultaneously with their IT partners is not realistic. A 90-day reporting period allows for more time for the deployment, configuration, implementation and effective use of certified EHR technology. AMGA is pleased to see that CMS apparently took these concerns into consideration when drafting this proposal.

Implementing Section 603 of the Bipartisan Budget Act of 2015

Section 603 of the Bipartisan Budget Act of 2015 prohibits certain off-campus hospital Provider-Based Departments (PBDs) from continued billing under the OPPS. The intent of this provision is, in part, to reduce comparatively higher OPPS spending and beneficiary cost sharing for services provided at these locations. Moreover, the provision, as MedPAC and others argued, is to reduce hospital acquisition of physician practices. In implementing Section 603 CMS proposes to identify who are, and who are not, excepted PBD providers, what are, or are not, excepted care delivery items and services and a billing and paying policy for non-exempted or non-OPPS reimbursed items and services.

AMGA's comments are limited to three aspects of the proposed Section 603 regulations. CMS should allow, as proposed, off campus PBDs to relocate and keep their exempted status in instances of necessity. CMS notes in instances of natural disasters and extraordinary circumstances. AMGA believes there may be additional reasons of necessity for relocation. As discussed in the 2014 Inpatient Prospective Payment System (IPPS) final rule, CMS should be open to evaluating and granting a limited number of relocation requests particularly if they provide evidence demonstrating significant improvement in existing or exempted patient care. Since these circumstances are difficult if not impossible to predict, CMS should leave the agency at least the option. AMGA supports the proposal to allow an excepted off-campus PBD to keep its status if the hospital, in its entirety, is sold or merges with another hospital. CMS is seeking comment on whether it should specify a time frame before November 2, 2015 in which services were billed under the OPPS for those services to have excepted status. MedPAC proposes an approximately three year window, or calendar 2013 through November 1, 2015. AMGA believes this is reasonable.

The HCAHPS Pain Management Dimension of the Hospital VBP Program

CMS is proposing, beginning in FY 2018, to remove the Pain Management dimension of the Hospital Consumer Assessment of Health Plans Survey (HCAPHS) in the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain. In the proposed rule, CMS states that while adequate pain control is a critical aspect of patient care, the agency has concerns that pain management-related survey questions in the Hospital-Value Based Purchasing (HVBP) program may be unduly influencing physicians to over-prescribe pain medications. CMS, therefore, is proposing to remove the pain management dimension of the HCAPHS in the HVBP program. CMS states the agency is developing and field testing alternative pain management questions and will solicit comments regarding these at some point in future rule making.

AMGA has several substantive concerns with this proposed action. First, CMS states it is unaware of any empirical evidence that demonstrates HCAHPS responses have adversely or inappropriately influenced prescribing patterns for pain. CMS states, "we are not aware of any scientific studies that support the association between scores on the Pain Management dimension questions and opioid prescribing practices." CMS justifies this proposal by, instead, stating, "some stakeholders believe . . . the Pain Management dimension questions . . . creates pressure on hospital staff to prescribe more opioids in order to achieve higher scores on this dimension." The proposed action should be based solely upon empirical evidence. Since there are no known "scientific studies," CMS should withdraw this proposed action.

In addition, AMGA has three inter-related concerns. First, there is no evidence those actually prescribed opioid analgesics are primarily responsible for opioid abuse or account for the majority of opioid related deaths. According to the Centers for Disease Control (CDC), between 2013 and 2014 for example, synthetic opioids accounted for 80% of opioid-related deaths primarily due to the increased availability of illicitly manufactured fentanyl. It's worth noting as well in 2013 and in 2014 the Medicare population accounted for less than 6% of total drug overdose deaths.1

Second, it has been well documented that racial/ethnic minorities are significantly more likely to report severe pain and more likely to be consistently under-treated for acute and chronic pain than non-Hispanic whites. For example, in the emergency room setting Hispanic and African American patients are two to three times more likely than non-Hispanic whites to not receive analgesia even after controlling for pain severity and other patient characteristics.2 Third, the rise in opioid abuse has largely been the result of increased consumption by non-Hispanic whites, i.e., not minorities. The CDC estimates that between 2004 and 2013 heroin use among non-Hispanic whites increased by 114 percent. For Hispanic and African Americans, however, the rate decreased by 15 percent.3

Inadequate pain treatment is already a significant problem for minority patients. The rise in opioid abuse and opioid-related deaths are neither the result of those appropriately prescribed the use of opioid analgesics nor the problem of already under-treated minority patients. As the proposed rule states, "pain control is an appropriate part of routine patient care that hospitals should manage." It would be more productive for CMS to make every effort to inform Medicare providers of the CDC's recently published, "Guideline for Prescribing Opioids for Chronic Pain."4 Proposing to eliminate learning to what extent providers adequately managed pain, particularly pain suffered by minority patients, is, we believe, counterproductive.

Requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the Ambulatory Surgical Center Quality Reporting (ASCQR) Program

CMS is proposing changes to both its Hospital Outpatient Quality Reporting (OQR) Program and Ambulatory Surgical Center Quality Reporting (ASCQR) Program. The agency proposes to add a total of seven measures to each program beginning in Calendar Year (CY) 2020. Two claims-based measures and five survey based measures to the OQR program and two measures collected via a CMS Web-based tool and five OAS CAHPS survey-based measures to the ASCQR program.

AMGA generally supports the move toward outcome measures, that is the two claims-based OQR measures concerning emergency department visits and hospital admissions. For both the OQR and ASCQR program, CMS proposes to display publicly measurement performance on the Hospital Compare Website or via other CMS websites as soon as possible after measure data has been submitted to CMS. AMGA applauds CMS's move toward a more transparent process for quality reporting. Making the publication of healthcare data more transparent will better educate both patients and providers, and lead to significant changes and improvement in the delivery system.

Thank you for your consideration of our brief comments. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director for Regulatory and Public Policy, at dintrocaso@amga.org or at 703.842.0774.

Sincerely,

Donald W. Fisher
Ph.D. President and CEO

Notes

1. Rose A. Rudd, "Increases in Drug and Opioid Overdose Deaths - United States, 2000-2014," CDC Morbidity and Mortality Weekly Report (January 1, 2016). At: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm.
2. Jean M. Mossey, "Defining Racial and Ethnic Disparities in Pain Management," Clinical Orthopeadics and Related Research," (July 2011): 1859-1870. At: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3111792/.
3. Christopher M. Jones, et al., "Vital Signs: Demographic and Substance Use Trends Among Heroin Users, United States, 2002–2013," CDC Morbidity and Mortality Weekly Report (July 7, 2015). At: http://www.cdc.gov/mmwr/pdf/wk/mm64e0707.pdf.
4. "CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016" (March 15, 2016). At: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.