September 6, 2016

Andrew Slavitt, MBA
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Acting Administrator Slavitt:

The American Osteopathic Association (AOA), on behalf of the 123,000 osteopathic physicians and osteopathic medical students it represents, is pleased to share insight on the Centers for Medicare and Medicaid Services (CMS) Hospital Outpatient Prospective Payment Systems (OPPS) calendar year (CY) 2017 proposed rule (CMS-1656-P) (hereafter ‘proposed rule’).1

1. AOA supports the viability of multiple practice models for physicians including across sites of care.

AOA believes that payments from all payers should reflect the resources required to provide patient care in each setting. Payments for all sites of care should account for costs incurred in that setting, and should take into account the nature of the patient population served, types of providers, and other factors such as the provision of care coordination, access to after-hours care, emergency care, quality activities, and regulatory compliance costs.

We support efforts made to collect comprehensive and reliable data regarding the extent of actual cost differences among sites of service, the impact of current site of service differentials on patient access, the extent to which recent site of service shifts are attributable to payment differentials, and the potential impact of the elimination or reduction of such differentials on providers’ ability to cover their reasonable costs. Pending collection of such data, we urge CMS to avoid reductions in payment that create or aggravate existing site of service differentials for services that are demonstrably similar in terms of nature, scope, and patient population. Further, we suggest that Medicare patients be provided access to data regarding differences in copayment requirements among various sites of service.

2. AOA supports changes to strengthen, streamline, and align the meaningful use (MU) program with real world practice.

AOA supports the integration and use of electronic health records (EHRs) in the health care system. As MU program goals transition to the Advancing Care Information (ACI) program under the Medicare Access and CHIP Reauthorization Act (MACRA), we offer the following suggestions to support program alignment across sites of care, to reduce burden on eligible hospitals and critical access hospitals (CAHs), and allow greater resources to be focused on patient care. We support:

- CMS’ proposal to eliminate the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures for eligible hospitals and CAHs.
- The reduction of measure thresholds for eligible hospitals and CAHs in 2017 and 2018 to more than 10 percent from more than 35 percent. This will reduce reporting burden and provide a more realistic objective for hospitals to meet.

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1 Federal Register / Vol. 81, No. 135 / Friday, July 14, 2016 / Proposed Rules
• The proposed changes to the objectives and measures under Modified Stage 2. Specifically, for View, Download, Transmit (VDT), we support reducing the threshold from more than 5 percent to at least one patient.

• The proposed changes to the measures under Stage 3:
  o Patient Access: Reduce the threshold from more than 80 percent to more than 50 percent for measures.
  o Patient-Specific Education: Reduce the threshold from more than 35 percent to more than 10 percent.
  o View, Download, Transmit: Reduce the threshold from 5 percent to at least one patient.
  o Secure Messaging: Reduce the threshold from more than 25 percent to more than 5 percent.
  o Patient Care Record Exchange: Reduce the threshold from more than 50 percent to more than 10 percent.
  o Request/Accept Patient Care Record: Reduce the threshold from more than 40 percent to more than 10 percent.
  o Clinical Information Reconciliation: Reduce the threshold from more than 80 percent to more than 50 percent.
  o Public Health and Clinical Data Registry: Alter the reporting requirement to any combination of three measures from any combination of six measures.

Varied requirements, measure definitions, and measure metrics across programs can cause complexities that add to administrative burden for physicians and hospitals. As such, we encourage CMS to consider changes to Medicaid that mirror the proposed changes to Medicare. We understand that proposed timeframes and State activities present obstacles to synchronous change. However, we urge CMS to plan for changes to Medicaid that reflect the changes proposed in this rule, as well as those under consideration for the MACRA program. In fact, should the Medicaid program not be altered to reflect these changes, the very burdens on hospitals and physicians that CMS seeks to limit will not benefit from the full effect of the intent of the proposed policies. Additionally, we support changes to these programs that align naming conventions across all stakeholders and sites impacted by MACRA.

As some physicians practice in multiple settings, they may be subject to both MU in the hospital as well as ACI in the non-facility setting. As success in the MU program demonstrates use of health IT, we encourage CMS to ensure that ACI performance thresholds and scoring align with MU. This will increase consistency across settings as well as reduce burden on providers.

Regarding the reporting period, we support the proposed reduction for the 2016 reporting period from the full calendar year to any continuous 90-day period within it for returning participants. This would align the MU program for hospitals with MACRA, as well as with CMS' proposal for a 90-day reporting period for clinical quality measures (CQMs). As these proposed changes may result in confusion about data collection periods, we appreciate CMS' clarification that for any measure reported in the 90-day reporting period, the numerator must occur within the calendar year in which the EHR reporting period occurs. We further suggest the 90-day reporting period be adopted for ACI under MIPS in 2017 to align with the 90-day period for the Clinical Practice Improvement Activities (CPIA) performance category. Further, we offer that the MU 90-day reporting period should count toward successfully reporting quality for both PQRS and the VBPM in 2016.

The requirements set forth by MU continue to be a challenge for hospitals and physicians. We support hardship exemptions that recognize these challenges and enable hospitals and physicians to continue to focus on patient care and transitioning to a new value-based system without penalty. In addition to the proposed hardship exemption criteria, we encourage CMS to expand them to account for additional circumstances outside the providers' control that prevent them from successfully attesting in the MU program.
3. **AOA supports the removal of the current pain management questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).**

Osteopathic physicians are trained in a “whole person” approach to care, which involves treating all aspects of a patient’s illness or injury, including the use of nonpharmacologic treatment strategies for acute or chronic pain, such as osteopathic manipulative treatment (OMT). With the focus on the whole patient as the guiding philosophy of osteopathic medicine, we believe that treatment strategies must be comprehensive and able to address each individual patient’s needs. Physicians must be able to provide this care for their patients according to their medical training and best practices, and these decisions should not be subject to external pressures imposed by federal laws or regulations. The elimination of such external pressures by completely removing pain management questions under the HCAHPS survey beginning in 2018 will help ensure that physicians have the ability to treat their patients in the most appropriate manner. This will provide necessary relief from policies that may put undue pressure on providers to prescribe opioids when other treatment options may be more appropriate.

In addition, we urge CMS to eliminate pain as a “fifth vital sign” from all professional standards. The current culture of pain as a fifth vital sign minimizes investigation into causes of pain, and incentivizes methods of addressing pain in manners that may not support the patient’s longer term health. As well, it has set up a cultural expectation in many patients that the effectiveness of a treatment is judged by its ability to eliminate all pain; in contrast, in some cases the best clinical treatment may be to manage pain while maximizing the patient’s return to function. Osteopathic physicians support a comprehensive approach to treating pain that includes pharmacologic and non-pharmacologic approaches as well as broad and long-term considerations of the patient’s health and wellbeing.

We appreciate the opportunity to share these comments with CMS and invite any questions to Ray Quintero, Senior Vice President of Public Policy, at rquintero@osteopathic.org and 202-349-8753.

Sincerely,

Boyd R. Buser, DO
President