AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St., Chicago, IL 60611-2864 ph (312) 202-8000 | (800) 621-1773 | www.osteopathic.org

June 13, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Verma:

On behalf of the American Osteopathic Association (AOA) and the nearly 130,000 osteopathic physicians and osteopathic medical students we represent, thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) *Medicare Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year (FY) 2018 Rates and Other Issues* proposed rule (CMS 1677-P) (hereafter, 'proposed rule').[1]

1. AOA supports the expansion of resources for uncompensated care.

The promotion of residency training programs in rural communities is an important element to recruiting, retaining, and increasing the numbers of physicians who would practice in these settings after their education and training. We are pleased that CMS proposes to increase Disproportionate Share Hospital (DSH) payments to hospitals in rural and underserved areas. Payment increases to these hospitals support the availability of vital services, which can in turn help mitigate physician shortages. In addition, these increases can support reducing healthcare disparities for vulnerable patient populations through increased access to care at safety net hospitals, which provide a significant level of care to low-income, uninsured, and vulnerable populations.

2. AOA supports increasing the Indirect Medical Education (IME) payment adjustment.

We appreciate that the resident-to-bed ratio has been statutorily required to calculate the IME percentage add-on payment. As our nation faces physician shortages, we urge policymakers to provide additional funds to train future physicians. We urge CMS to consider additional funding mechanisms that would supplement the current adjustment factor of 5.5 percent for every approximately 10 percent increase in a hospital's resident-to-bed ratio.

[1] Federal Register, Vol. 82, No. 81, pages 19796-20231.

3. AOA supports efforts to account for socioeconomic status (SES) in the Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing Program (HVBP), and Hospital-Acquired Conditions Reduction Program (HAC).

AOA supports the inclusion of risk adjustment for socioeconomic and demographic factors within hospital quality improvement initiatives such as the HRRP, HVBP, and HAC. Safety net hospitals and hospitals in underserved areas are likely to bear the brunt of the program's financial penalties because they serve a higher percentage of vulnerable patient populations that face a greater likelihood of having multiple chronic conditions and due to higher rates of poverty and a lack of community support services, are less able to effectively manage them even with physician support. As CMS works to improve the program, the agency should focus the penalty on admissions that are directly avoidable and related to the initial admission.

We appreciate that CMS recognizes the important role socioeconomic data play in patient care and we support current efforts to assess the use and impact of socioeconomic data. However, we think the agency's contention that it does not want to mask potential disparities or minimize incentives to improve outcomes of disadvantaged populations creates a vicious cycle. Unless socioeconomic and demographic factors are taken into account, hospitals that serve a higher percentage of vulnerable patient populations are placed at an unfair financial disadvantage for factors outside of their control. As a result, their ongoing efforts to further improve patient care are undermined, which exacerbates disparities and creates barriers to better outcomes.

4. AOA supports the removal of the pain management questions under the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

CMS has stated that if the proposed Communication About Pain composite measure is not finalized, it would continue to use the pain management questions. As we oppose the continued use of pain management questions, we support the finalization of the Communication About Pain composite measure with an amendment. In particular, we do not agree that the frequency of communication is as valuable a metric as the occurrence of communication. As such, we would recommend changing HP2 and HP3 to remove "how often" and altering the possible answers to yes/no rather than the current list: never, sometimes, usually, always.

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 the current 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.

5. AOA supports CMS' effort to ensure all applicable hospitals receive payment adjustments based on the two-midnight policy.

We applaud CMS for rescinding its 0.2 percent payment reduction for hospitals both prospectively and retroactively under its two-midnight policy. Overall, the AOA believes the decision of whether a patient is an inpatient or an outpatient should be based on the judgment of the physician and the patient's medical condition. Restoring payments is a step in the right direction of alleviating financial pressure on our nation's hospitals, especially in rural and underserved locations. We appreciate CMS' efforts to identify all hospitals that received payment cuts as a result of the two-midnight policy and restore a 0.6 percent payment increase to compensate for the 0.2 percent cut in FYs 2014, 2015, and 2016.

6. AOA supports opportunities for physician-owned hospitals to deliver healthcare.

Physicians, patients, and the healthcare system benefit from having a multitude of care delivery models and sites of service. This open marketplace provides opportunities for physicians to deliver care in innovate ways that best address patients' healthcare needs. We support physician-owned hospitals as one such care model. Physician-owned hospitals help to meet a growing demand for healthcare services, and serve patients with varied clinical and socioeconomic statuses, much as other hospitals do. We were dismayed that the Affordable Care Act (ACA) included provisions to limit the expansion of physician-owned hospitals and would be pleased for CMS to support the growth of physician-owned hospitals.

7. AOA appreciates CMS' efforts to minimize requirements on physician certification for payment of inpatient critical access hospital (CAH) services.

We appreciate that the requirement that physician certification must be completed, signed, and documented in the medical record no later than one day before the date on which the claim for payment for the inpatient CAH service is submitted is statutory and that CMS does not have discretion to modify it. As such, we support CMS' effort to mitigate the burden of this requirement by directing Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), the Supplemental Medical Review Contractor (SMRC), and Recovery Audit Contractors (RACs) to make this certification requirement a low priority.

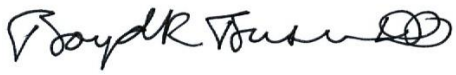
8. AOA supports efforts to align electronic health record (EHR) incentive program reporting periods and measures, and appropriate exemptions from the EHR incentive programs.

We support CMS' efforts to align hospital Medicaid and Medicare reporting periods with those of eligible providers in other settings of care under the Merit-Based Incentive Payment System (MIPS) under the Medicare Access and CHIP Reauthorization Act (MACRA). This 90-day period will provide sufficient data to CMS for EHR metrics, and will be less burdensome than a full year reporting period. In addition, we support efforts to align the measures across Medicaid and Medicare EHR incentive programs, and with MIPS requirements. This streamlined approach may create short term challenges to adjust to changes, but will result in a less complex system in the long term and will better align with how care is provided across settings. Further, we support exemptions from the EHR incentive program for eligible providers and hospitals whose EHR technology was decertified. We appreciate CMS' invitation to provide comment on the timeframe in advance of the reporting period by which the EHR would need to be decertified and the suggestions of 12 months or during the applicable reporting period. We believe that as soon as 12 months in advance of the reporting period may be reasonable for most stakeholders. However, we note that implementing and fully adopting a new EHR system in a large network may require more than 12 months. As such, we urge CMS to consider cases in which longer than a 12 month lead time may be appropriate.

* * * *

We appreciate the opportunity to share these comments and would be pleased to provide additional insight as you develop this program. To do so, or for additional information, please contact Nick Schilligo, Vice President for Public Policy, at nschilligo@osteopathic.org, or (312) 202-8185.

Sincerely,



Boyd R. Buser, DO
President