September 6, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1656-P
200 Independence Ave., SW
Washington, DC 20201

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-1656-P)

Dear Administrator Slavitt,

The American Academy of PAs (AAPA), on behalf of the more than 108,500 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) regarding the Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs proposed rule.

PAs practice medicine, are authorized to prescribe in all 50 states and the District of Columbia and support the team approach to care. They play an essential and integral role in improving the health of Medicare beneficiaries. PAs deliver primary and specialty care to Medicare patients. They deliver much of that care in our nation's hospitals and hospital outpatient departments. It is within that context that we provide our comments.

Site Neutral Payments

CMS proposes to implement Section 603 of the Bipartisan Budget Act of 2015, which requires that specific items and services provided by certain off-campus provider-based departments (PBDs) not be covered as outpatient department services under the Outpatient Prospective Payment System (OPPS). Instead, as a transitional policy, CMS proposes to reimburse for most of these services under Medicare's Physician Fee Schedule until a more applicable payment system can be determined.

CMS does identify "excepted items and services" that can continue to be billed under the OPPS. These include all items and services furnished in an emergency department, items and services furnished and billed prior to November 2, 2015 (the date the Bipartisan Budget Act of 2015 was signed and became law), and items and services furnished in a hospital department that is within 250 yards of a remote location of the hospital.

CMS adds three additional requirements in its proposed rule. First, CMS indicates that items and services beyond those within the clinical family of services provided and billed prior to November 2, 2015 will not be excepted services. Second, if an off-campus PBD relocates to a different physical address, it loses its "excepted" status. Finally, if there's a change in ownership in the excepted off-campus PBD, excepted status may be maintained as long as the new owners accept the existing Medicare provider agreement from the prior owner.

AAPA believes that a billing change of this magnitude, which will represent a significant shift in CMS reimbursement policy, requires an extensive dialogue and review as to the net impact on all affected stakeholders. Not only will this change in billing policy potentially modify reimbursement levels for a significant number of facilitates and health professionals, but it consists of nuance in the forms of exceptions and specified rules. Facilities, health professionals, and billers and coders will need to engage in an in-depth discussion of CMS' policy specifics to better understand both what will be required of them, as well as the potential effect of the financial impact on their bottom line and their ability to deliver high quality patient care.

Significant changes to long-standing policy should never be underestimated in the confusion they could create or the extent of their impact. These changes will also occur parallel to other major changes proposed by CMS, such as the implementation of the Quality Payment Program. While AAPA understands that CMS is attempting to reimburse at the same rate for similar work and save the program money, we urge CMS to further consider the potential effects of such a policy on provision of care to patients.

AAPA asserts CMS' implementation of Section 603 requires in-depth and widespread discussion with all affected stakeholders. Further, we request CMS re- examine the potential impact of the implementation of Section 603 on patient care.

Electronic Health Record (EHR) 90-day Reporting Period

In its proposed rule, CMS proposes a 90-day EHR reporting period for eligible practitioners, eligible hospitals and critical access hospitals to allow for flexibility in the program of when to report. This 90-day period could be any continuous 90-day span throughout the calendar year. AAPA approves of this increased flexibility as it recognizes the fact that health professionals and hospitals are being inundated

with requirements and mandates as part of the transformation to a value-based healthcare system and must be given adequate time to effectively implement those requirements.

AAPA strongly approves of CMS' proposed policy to have a 90-day EHR reporting period to increase the flexibility of reporting.

Services Removed from the Inpatient Only List

CMS proposes to remove six surgical services from its Inpatient Only (IPO) list. Removal of these services from the IPO list would allow them to be performed in an outpatient setting such as an Ambulatory Surgical Center. The rationale for the removals is their similarity to other surgical services not currently on the IPO list. AAPA supports removing services from the list that can be performed in non-inpatient settings in a safe manner. Allowing surgical services and procedures to be performed in outpatient settings may increase patient access to these services in addition to potentially saving the patient time and money. As outpatient facilities continue to advance in their capability to perform surgical services, we encourage CMS to continue to review its IPO list for potential services that can be removed, as long as CMS ensures rigorous standards for the safe performance of any services performed in an outpatient setting. It should be noted that taking services off the IPO list provides the ability, but does not mandate, that they be performed in an outpatient setting. Ultimately, the judgment of the surgeon should determine the specific clinical setting for the performance of any procedure.

AAPA supports the removal of services from the IPO list that can be safely performed in an outpatient setting, and encourages CMS to identify other such services that can meet a similar threshold of safety.

Pain Management and HCAHPS

In the proposed rule, CMS indicates its intention to remove the pain management dimension from the HCAHPS survey for the hospital Value-Based Purchasing program. This is being done "in an abundance of caution" to remove any incentive for health professionals to over-prescribe pain medication in order to receive a better score from patients who would have otherwise penalized the practitioner for not supplying more opioids. AAPA recognizes the importance of reducing incentives for over-prescribing, especially in light of the significant opioid epidemic our country now faces[1].

However, we caution that CMS also be mindful of the fact there are patients with a genuine need for pain medications. CMS should implement policies to ensure those patients in need of such medication are able to access appropriate pain medication for their condition.

[1] U.S. Department of Health and Human Services. About the Epidemic. Accessed August 22, 2016. http://www.hhs.gov/opioids/about-the-epidemic/

AAPA favors CMS' choice to remove pain management from its HCAHPS survey if it helps mitigate the country's severe opioid addiction problem by reducing over-prescribing. However, we also encourage CMS to continue to act to ensure patients receive an appropriate level of pain medication through methods that do not encourage excessive prescribing.

AAPA appreciates the agency's consideration of our comments and looks forward to working with CMS to ensure the best possible care for all Medicare beneficiaries. If you have any questions about our comments or concerns please do not hesitate to contact Michael Powe, AAPA vice president of Reimbursement & Professional Advocacy at 571-319-4345 or michael@aapa.org.

Sincerely,

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