



September 24, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Re: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 123,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the 2019 Hospital Outpatient Prospective Payment System (OPPS) proposed rule.

PAs practice medicine in all specialties and settings. Thirty five percent of all PAs are employed by hospitals.¹ Many of the services provided by PAs are delivered in hospital outpatient settings. Consequently, PAs and the patients they serve will be greatly affected by the proposed modifications to reimbursement policies made under the OPPS. These effects will be magnified as the PA profession continues to play an increasingly important role in the healthcare delivery system. Data from the [Bureau of Labor Statistics](#) found that PAs are the third fastest growing healthcare profession, with a projected growth rate of 37% between 2016 and 2026.² It is within this context that we draw your attention to our comments.

Site Neutrality

CMS believes it is not prudent or appropriate to pay more for services in one setting than another unless the cost of care and resources utilized warrant that increased payment. CMS is concerned pay differentials may have incentivized the use of one site of service over another and may have led to an increased volume of some services being performed in settings that would solicit a higher payment. Consequently, CMS seeks to pay a Physician Fee Schedule (PFS)-equivalent rate for clinic visit services provided in “nonexcepted off-campus provider-based departments,” as opposed to the higher OPPS

¹ https://www.aapa.org/news-central/2018/08/everthing-want-know-hospital-employed-pas/?utm_source=medwatch&utm_campaign=news_central_article&utm_medium=email

² <https://www.bls.gov/ooh/fastest-growing.htm>

rate. CMS believes such a change would limit unnecessary increases in the volume of clinic visit services in outpatient departments, in addition to saving an estimated \$760 million for Medicare (\$610 million) and beneficiaries (\$150 million). Beneficiary savings would be derived from copayment decreases, which CMS expects to drop from approximately \$23 on average per visit to approximately \$9.

AAPA understands the importance of site-neutral payments in migrating to a value-based payments system that would achieve payment fairness. We appreciate the value of reimbursement policy modifications that transition away from payments based on the number of services provided and toward payment systems based on care quality and patient outcomes, with appropriate adjustments for variation in patient acuity levels, co-morbidities and other factors impacting care delivery. Such changes would reduce incentives for unnecessary and inefficient care that results in higher costs in favor of care that most directly benefits patients. AAPA also recognizes the significance of a reduction in patient financial burden which would result from such a change.

While AAPA supports the agency's efforts to institute reimbursement fairness for similar services provided in similar settings, we encourage CMS as part of its efforts to transparently make the economic case for the specific level of reimbursement reduction selected. AAPA also encourages CMS to minimize the potential unintended consequences of proposed payment changes for those facilities that serve vulnerable or higher-risk patient populations. We suggest CMS conduct a data-driven, evidence-based examination of the cost inherent in delivering care in these settings and into the effect of the proposed payment changes on the quality of patient care delivered at affected facilities. Factors such as severity of illness of the patient populations, increased financial burdens on facilities due to added administrative or overhead costs, the effect of reduced facility revenue on the ability to provide care, patient demographics, and geographic conditions in either rural areas or areas that experience care shortages, should be considered. Clear justification is necessary for the level of any payment decrease and whether that level is uniformly appropriate based on where and how these facilities provide care, or whether further risk adjustment based on relevant factors is warranted.

In a separate effort by CMS to increase site neutrality, the agency indicates that payment for services in new clinical families of services, that is, services that exempted off-campus PBDs did not furnish prior to a previously established period, will be paid at the lower PFS rate, instead of the higher OPPS rate. CMS intends to make this change to prevent a facility from expanding the services it provides in order to receive a higher rate of reimbursement. AAPA's concerns with CMS' site neutrality efforts are not about the principle of payment fairness, which we support, or the type of services provided, but rather about transparently determining the appropriate level of reimbursement and ensuring the availability of timely and appropriate care for vulnerable populations.

Removal of Pain Communication Metrics from Hospital Reporting

In "an abundance of caution," CMS intends to remove the pain communication questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey under the Hospital Inpatient Quality Reporting (IQR) program. These questions, regarding communications with patients about pain, had previously replaced questions about how well patients believed their pain was controlled. In conversations with stakeholders, CMS believes, like the questions they replaced, the presence of these pain communication questions may place pressure on hospitals and health professionals to prescribe opioids in exchange for higher HCAHPS scores.

While AAPA recognizes and supports the importance of soliciting and factoring in feedback on patient experience, we understand, similar to the removal of previous opioid-related questions, the elimination of pain communications questions from the HCAHPS survey is being done to remove any incentive for health professionals to over-prescribe pain medication in order to receive a better score from patients. While we want to reiterate CMS' own admission that there have been no scientific studies suggesting health professionals are modifying their prescribing activities in exchange for better scores, AAPA recognizes the importance of reducing incentives for over-prescribing, especially in light of the significant opioid epidemic our country now faces.

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

Interoperability

While the adoption of EHRs has grown significantly, CMS believes routine usage of health information technology for the purposes of exchanging health data has not yet been achieved. In the past, CMS sought to promote EHR interoperability by modifying requirements, promoting access, and providing financial incentives. However, in an effort to advance the adoption and increase utilization of electronic data systems, CMS is requesting information on promoting interoperability and electronic health information exchange through revision of CMS patient health and safety guidelines required of those participating in Medicare and Medicaid, such as through the hospital Conditions of Participation (CoPs).

AAPA recognizes the value of EHR interoperability in improving the efficiency and quality of patient health information and data to assist care delivery, as well as to enhance the patient experience and to support care coordination. If providers are required to use interoperable systems and electronically exchange health information as a condition to participate in Medicare and Medicaid, as would be the case by modifying the CoPs and other health and safety requirements, it is essential that barriers to utilization be removed.

AAPA cautions, as participation in CMS programs may now be dependent on appropriate usage of EHR systems, there must be concurrent recognition by CMS that authorization to fully utilize EHRs and billing systems must be extended to all health professionals that deliver medical care. Appropriate access by health professionals to online systems is in line with principles laid out in ONC's Trusted Exchange Framework, which is cited in the proposed rule. If health professionals, such as PAs, are prevented from fully accessing and utilizing EHR systems, their ability to provide care that is efficient, safe, and coordinated may be jeopardized. With any proposed changes to the health and safety requirements, any restrictions in EHR systems utilization by PAs or other health professionals may compromise their ability to participate in Medicare and Medicaid which would severely decrease patient access to care. To address this issue, CMS must consider including specific access, functionality, and flexibility criteria for health professionals, such as PAs, in future requirements for Certified EHR Technology.

It is also important to understand that financial constraints may have hindered the adoption of EHR systems by some health professionals and institutions. If the stakes for non-compliance with EHR standards are going to be raised, small or rural entities that, due to financial constraints, do not have electronic systems in place to fully satisfy these requirements must be given temporary flexibility on meeting these conditions. One option would be to phase in these requirements for entities that

demonstrate resource constraints have been prohibitive to adopting adequate electronic systems. Another option would be to provide enhanced technical assistance to smaller practices and institutions that still do not have the relevant infrastructure or software due to financial barriers.

AAPA is also pleased that CMS, when announcing its Blue Button 2.0 interface, expresses concern regarding patient confusion surrounding claims information received by patients electronically. AAPA shares this concern and suggests one reason for increased patient confusion may be improper attribution of health professional services. For example, a patient may receive claims information that does not properly identify the health professional from whom they received treatment, such as identifying a physician on the claim form instead of a PA due to “incident to” billing. This may lead to additional time on behalf of the patient trying to clarify inaccurate information they received. Inaccurate attribution may also limit the ability of health professionals to obtain information used to “analyze population health trends, outcomes, and costs,” another goal noted in the rule of the Trusted Exchange Framework. Consequently, CMS should support data transparency by modifying requirements under billing mechanisms such as “incident to” to ensure the health professionals who deliver care are identified in the patient’s claims records. The increased accuracy of this data will help address patient confusion concerns and strengthen the functionality of health information.

Thank you for the opportunity to provide feedback on the OPPS proposed rule. AAPA welcomes further discussion with CMS regarding our position and comments. For any questions you may have in regard to our comments and recommendations, please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at 571-319-4345 or michael@aapa.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Jonathan E. Sobel". The signature is fluid and cursive, with a large initial 'J' and 'S'.

Jonathan E. Sobel, DMSc, MBA, PA-C, DFAAPA, FAPACVS
President and Chair of the Board