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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

June 13, 2017

Submitted electronically via: www.regulations.gov

Ms. Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1677-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: Proposed Rule for the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates (CMS-1677-P)

Dear Administrator Verma:

The National Business Group on Health is pleased to respond to the Centers for Medicare and Medicaid Services' (CMS) proposed rule on revisions to the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals and to implement changes arising from continued experience with these systems for FY 2018, as published in the Federal Registrar on April 28, 2017.[1] We applaud your leadership and that of the Secretary and urge you to continue to transform the delivery of health services to Medicare beneficiaries through expansion of the adoption of alternative payment and delivery models outside of the fee-for-service (FFS) model and performance-based payment in the legacy FFS model as Medicare transitions away from it. These efforts dovetail with and strengthen parallel efforts by private insurers and employer plans to transform health care delivery. Additionally, we appreciate CMS's efforts to streamline performance measurement and reporting to reduce administrative burdens for providers while still providing useful information on performance to patients, payers, and providers and promoting improvements in the delivery of health care services.

The National Business Group on Health represents 413 primarily large employers, including 70 of the Fortune 100, who voluntarily provide group health and other

[1] Proposed revisions to the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals, available at: https://www.gpo.gov/fdsys/pkg/FR-2017-04-28/pdf/2017-07800.pdf. Published April 28, 2017. Accessed May 15, 2017.

employee benefits to over 55 million American employees, retirees, and their families. Being mostly self-funded, our employer members as well as many other employers, have a vested interest in more effective, efficient health care and promote health plan designs that encourage delivery of the right care at the right time and in the right place; an emphasis on promoting health and primary and preventive care; improving value while reducing the cost of care; and, delivering services to the highest level of customer satisfaction.

As a result, employers are increasingly engaging with providers, either directly or in conjunction with their health plan partners, to improve care coordination, quality and delivery. According to the 2017 NBGH Large Employers' Plan Design Survey, 24% of employers actively promote accountable care organizations (ACOs) to their employees, 26% offer high-performance provider networks, 90% cover telehealth services, and 85% promote centers of excellence (COEs) for select high-cost, complex procedures. Moreover, many more are contemplating these and other initiatives to optimize the delivery system through their health plans in 2018 and future years. We appreciate that CMS is committed to these same principles as we jointly strive to transform the health care delivery system. To the extent that Medicare continues down this path, it reinforces employer efforts and our efforts become mutually reinforcing. As payers, we appreciate that the Department of Health and Human Services (HHS) continues to work in concert with partners in the private, public, and non-profit sectors, through various initiatives, including the Learning Action Network (LAN), to transform the nation's health delivery system. We look forward to continuing this partnership.

We thank CMS for the opportunity to provide comment on payment policy improvements that we believe hold potential to continue to not only transform payment policy but also improve care delivery and coordination. Below, we provide recommendations on specific items in the proposed rule as well as responses to the request for information.

Response to CMS's Request for Information (RFI):

Supporting better payment policies is increasingly critical as rising costs affect the ability of beneficiaries, governments, insurers, and employers to afford care.

Bundled Payments for Inpatient and Post-Acute Care (PAC)

We encourage CMS to continue to explore expansion of bundled payments for acute inpatient and post-acute care. Integrating inpatient and PAC payment systems in a thoughtful manner through bundled payments more effectively drive the efficient use of healthcare resources, improves care transitions, promotes care coordination, encourages better chronic condition management, improves quality of healthcare and also helps providers transition from an FFS care model to a more global, team-based approach to health care delivery.

According to the Medicare Payment Advisory Commission (MedPAC), "A bundled payment either for the hospital stay (combining physician and hospital payment) or for the stay plus a period of PAC, coupled with quality outcome metrics, could help replace inefficient and unneeded care with a more effective mix of services. Bundled payments could also give providers that are not ready, or are unable to participate in more global payment models like ACOs, a way to gain experience coordinating care spanning a spectrum of providers and settings, thus facilitating progress toward larger delivery system reforms."[2]

In addition, bundling payments promises savings to Medicare. A 2013 CBO report to Congress estimated that bundling inpatient services plus those associated with related readmissions within 30 days of discharge would reduce Medicare spending by $17 billion through 2023, and that adding PAC services provided within 90 days of discharge would produce savings of $47 billion through 2023.[3]

Therefore, we urge CMS to accelerate the adoption of integrated inpatient and PAC bundled payments in the Medicare FFS program.

Bundled Payment Delay

While we understand that CMS instituted the delays in the start date of new episode payment models ("EPMs"), the Cardiac Rehabilitation Incentive Payment Model ("CR Incentive Model"), and the Comprehensive Care for Joint Replacement Model ("CJR Model") until January 1, 2018 to provide participants more time to prepare and to align payment periods with the calendar year, [4] we are concerned that delaying these mandatory payment models sends the wrong message about the transition to alternative payment models away from the FFS model in Medicare. Moreover, the strong evidence of cost savings and quality improvement warrants vigorous adoption and expansion of bundled payments in Medicare without further delay.

The delays come at a time when employers are increasingly urging their health plan partners, and in some cases working directly with providers, to bundle services for specific conditions to improve care coordination and outcomes, as detailed below.

[2] Context for Medicare Payment Policy and Recommendations. Statement of Mark E. Miller, Ph.D., Executive Director, Medicare Payment Advisory Commission, before the Subcommittee on Health, Committee on Energy and Commerce. December 9, 2014. Accessed on June 8, 2017 via: http://www.medpac.gov/docs/default-source/congressional-testimony/testimony-context-for-medicare-payment-policy-and-recommendations-energy-and-commerce-.pdf?sfvrsn=0

[3] Options for Reducing the Deficit: 2014 TO 2023, Health Option 10: Bundle Medicare's Payments to Health Care Providers. November 13, 2013. Accessed June 8, 2017 via: https://www.cbo.gov/budget-options/2013/44898

[4] Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model; Delay of Effective Date. Accessed on June 6, 2017 via: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-05692.pdf

Large employers have been among the leaders in adopting bundled payments, particularly in cardiology, orthopedics, and oncology as our NBGH survey previously cited shows. In one approach, several companies have recently launched the Employers Centers of Excellence Network (ECEN), which helps employers identify quality providers, negotiate bundled payments, and encourage employees to select participating providers.

Key highlights of the program results, excerpted from a recent issue of the Harvard Business Review (HRB) include:[5]

- While nearly all of the 450 spine patients who presented to one of the participating centers had been recommended for surgery by providers in their home markets, only 62% of the patients were found to be suitable candidates for surgery by the COE sites. Instead of unnecessary surgery, activity-based therapies, pain injections, physical therapy, or weight loss were recommended by our providers. 16% of patients recommended for total joint replacement by a home provider were recommended not to have surgery by COE centers. Avoiding unnecessary surgery is a significant driver of the program's long-term benefits.
- The program has led to lower patient out-of-pocket costs and excellent patient satisfaction scores. The average employee who had joint replacement surgery performed by one of the ECEN centers personally saved approximately $3,300 in copayments and other fees as compared to those patients who get the same care under traditional insurance. In an analysis of 12 month's experience, 100% of an employee's ECEN joint surgery patients reported that they would refer co-workers or family to the program for a similar surgery. Data from another company's experience has shown similarly high employee satisfaction.
- Twelve-month claims data comparing one employer's associates who have surgery with local providers under traditional insurance as compared to those who have surgery as part of ECEN demonstrated striking findings. 9.1% of patients having joint surgery with local providers needed discharge to a skilled nursing facility after surgery, compared to 0% of those getting care with ECEN. 5.9 % of those having lumbar spine surgery with local providers needed skilled nursing care after surgery, while 0% of ECEN patients needed that care. In addition, standard health plan participants had a 6.6% chance of being readmitted to the hospital within 30 days after joint surgery as compared to just 0.4% of ECEN patients. Savings from avoiding unnecessary surgery alone was estimated at $1.3 million. For the highest volume spine procedures, 52% of patients recommended for surgery by home providers are found by the COE

[5] Jonathan R. Slotkin, MDOlivia A. RossM. Ruth ColemanJaewon Ryu, MD. Why GE, Boeing, Lowe's, and Walmart Are Directly Buying Health Care for Employees. Harvard Business Review. June 08, 2017. Accessed June 9, 2017 via: https://hbr.org/2017/06/why-ge-boeing-lowes-and-walmart-are-directly-buying-health-care-for-employees?utm_campaign=hbr&utm_source=twitter&utm_medium=social

providers to not be appropriate surgical candidates. More than 90% of those patients heed that recommendation and do not go on to have surgery at home through traditional insurance. Early estimates around the newer ECEN spine program have indicated savings of an additional $1 million to $2 million per year.

We urge CMS to reconsider this delay. At a minimum, we urge CMS not to delay the bundled payment models past January 2018. Finally, we urge CMS to maintain that these models, once implemented, be mandatory and not voluntary.

We also encourage CMS to consider other potential bundles for future rule-making, which could include expansion of orthopedic-related bundles and bundles appropriate for oncology care. Finally, we ask that CMS evaluate the potential to incentivize beneficiary selection of providers who agree to bundled payments by reducing cost-sharing for those beneficiaries.

Site-Neutral Payments

CMS has also focused considerable effort on promoting payment policies that are neutral with respect to the site of care for the same services when they can be done in various settings without compromising quality. We believe that financial incentives should not influence the site of care when multiple settings are appropriate for patients and do not adversely affect the quality of care. Following this payment policy would encourage competition, reduce expenditures for Medicare beneficiaries, and strengthen incentives to provide services at the lowest-cost sites of care that are appropriate.

We support CMS's efforts to continue to implement and expand site-neutral payment policies for same services where payment differentials are not warranted between HOPDs and ASCs. Similarly, we urge CMS to consider parallel site-neutral policies for payments for the same services provided in HOPD and independent physician offices.

According to MedPAC, Medicare may pay nearly 80% more to hospital outpatient departments (HOPDs) than ambulatory surgery centers (ASCs) for the same procedure. The location where the services are delivered, the costs of operating in that setting, and the different patient populations served are all factors that determine the rate, such that the same service provided in a variety of clinical settings may sometimes be paid at dramatically different rates.

MedPAC has identified 66 outpatient service payments—including three groups of cardiac imaging services—for which equalizing reimbursement rates would save

$900 million annually.[6] The report also identified 12 groups of services commonly performed in ASCs that would generate about $600 million in annual savings if HOPD rates are lowered to the level of ASCs.[7]

In addition, variable rates for the same services in HOPDs, including in physician practices acquired by hospital systems, vs. independent physician offices is a growing issue. The Government Accountability Office (GAO) has noted that payment differences have encouraged hospitals to acquire physician practices, leading to higher rates for office visits.[8] The acceleration of vertical integration by ever-growing health systems has led to an increase in disproportionate reimbursement at off-campus HOPDs that has not been linked to an increase in resources demanded for same services nor an overall improvement in quality of patient care. Select examples, according to the Medicare Payment Advisory Commission (MedPAC), include:

- Medicare reimburses $453 for a level II echocardiogram performed in an off-campus HOPD vs. $189 in a doctor's office.
- Similarly, Medicare reimburses $1,383 for a colonoscopy performed in an off-campus HOPD vs. $625 in a doctor's office.

The GAO report stated that such payment variations "urgently need to be addressed because many ambulatory services have been migrating from physicians' offices to the usually higher-paid outpatient department setting, as hospital employment of physicians has increased."[9]

Private payers and employers have taken steps in plan design to mitigate the impact on their plan participants and to encourage their members to use various shopping tools to find lower-priced providers and sites of care for many standard outpatient services. Additionally, employers, working with their third party administrators (TPAs), are revising contracts with providers to no longer recognize the site-of-service differential for the evaluation and management code (e.g., charging a separate "facility fee" for office visits).

Last year, when section 603 of the Bipartisan Budget Act (BBA) of 2015 was being debated, we submitted comments to the House Subcommittee on Health, Committee on Energy and Commerce supporting site-neutral reimbursement for the same services performed at physician-based off-campus hospital outpatient

[6] Medicare and the Health Care Delivery System. Report to Congress by the Medicare Payment Advisory Committee. June 2013. Accessed on June 6, 2017 via: http://www.medpac.gov/docs/default-source/reports/jun13_entirereport.pdf?sfvrsn=0
[7] Ibid.
[8] Government Accountability Office, Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform, Dec. 18, 2015, retrieved from www.gao.gov on June 6, 2017.
[9] Ibid.

departments (HOPD) with those in other settings. We also expressed concern that grandfathering arrangements in existence or in mid-build prior to enactment of the BBA will inhibit the growth of cost effective and innovative payment and delivery systems such as Accountable Care Organizations (ACOs) and other alternative payment models. Allowing existing arrangements to remain grandfathered 1) raises questions of fairness, 2) could provide a regulatory protection from competition for the grandfathered entities and 3) could inhibit the growth of lower cost alternatives in the affected areas.

Therefore, we urge CMS to work with Congress to consider eliminating the provision to grandfather existing arrangements upon enactment of any such modification to the existing law (42 U.S.C. § 1395l(t)(21). At a minimum, we urge both entities to consider a scheduled phase-out of the grandfathering of the existing arrangements over a reasonable time period.

Physician-Owned Hospitals
We thank CMS for inviting comments on the appropriate role of physician-owned facilities, including specialty hospitals, ambulatory surgery centers, and independent diagnostic testing facilities.

We urge the CMS and Congress to maintain the prohibition on both the creation of new and the expansion of existing physician-owned hospitals and outpatient facilities, which has been in place since March, 2010.[10]

Our recommendation is based on the substantial body of research demonstrating that physician ownership and self-referral are associated with increased utilization, higher overall costs, and diversion of complex patients and Medicaid beneficiaries away from physician-owned facilities toward other facilities. We also encourage CMS to conduct more research examining the impact of physician-owned hospitals and outpatient services facilities on quality and patient outcomes.

A MedPAC analysis prior to the enactment of the Affordable Care Act (ACA) found that the typical physician-owned cardiac hospital is associated with a roughly 6 percent market-wide increase in the rate of cardiac surgeries per 1,000 Medicare beneficiaries.[11] The analysis hypothesizes that the increase in surgical volume could be due to increased surgical capacity, which leads to increases in surgical volumes and the fact that some physicians' clinical recommendations are directly affected by financial incentives, which cause a broad shift toward more surgeries. MedPAC concluded that, whether the increase in surgeries stems from increased capacity,

[10] Patient Protection and Affordable Care Act. H.R. 3590, Section 6001, Pub. Law No. 111-148, 111th Congress, 2010.
[11] Report to the Congress: Physician-Owned Specialty Hospitals Revisited. August 2006. Medicare Payment Advisory Commission. Accessed June 9, 2017 via: https://www.asipp.org/documents/PhysicianOwnedSpecialtyHospitals.pdf

financial incentives to self-refer, or some combination of these factors, increased surgeries can increase overall Medicare spending.

Other studies have also found that the volume of services is higher in areas with physician-owned specialty hospitals than in areas without specialty hospitals. A 2007 study found that rates of complex spinal fusion surgery and epidural procedures for workers with back injuries increased significantly as physician ownership increased from 1999 to 2004. The same study found that rates of complex spinal fusion surgery were higher for Medicare beneficiaries living in areas with physician-owned hospitals as compared to areas without physician ownership (northeastern states).[12] Two other studies in 2006 reported similar growth in utilization in areas after specialty cardiac hospitals opened compared to cardiac programs in general hospitals.[13,14]

A 2010 study analyzed the volume of services provided in ambulatory surgical centers (ASCs) in Florida from 2003 to 2005. The study found greater use of five common outpatient procedures in physician-owned ambulatory surgical centers compared to non-physician-owned ASCs. Further, the study also found that, after accounting for baseline differences in volume, surgeons that acquired ownership in ASCs increased their volume of services compared to before they held ownership.[15]

Comments and Recommendations for Specific Aspects of the Proposed Rule:

Hospital Readmission Reduction Program
We strongly support Medicare's Hospital Readmissions Reduction Program (HRRP), which penalizes hospitals with excess 30-day readmissions after treatment for health conditions such as pneumonia, myocardial infarction, and heart failure. HRRP has been enormously successful in reducing readmissions and has begun to bridge the void of care coordination after hospital discharges, mitigating costly and suboptimal patient experience.

In response to analyses that have found that "readmission rates and penalties continue to be higher among hospitals that have higher proportions of low-income Medicare

[12] J. Mitchell. August 2007. Utilization Changes Following Market Entry by Physician-Owned Specialty Hospitals. Medical Care Research and Review 64(4): 395–415.
[13] B. Nallamothus, M. Rogers, M. Chernew, et al. March 7, 2007. Opening of Specialty Cardiac Hospitals and Use of Coronary Revascularization in Medicare Beneficiaries. Journal of the American Medical Association 297(9): 962-8.
[14] J. Stensland and A. Winter. Jan-Feb 2006. Do Physician-Owned Cardiac Hospitals Increase Utilization? Health Affairs 25(1): 119-29.
[15] J. Hollingsworth, Z. Ye, S. Strope, et al. April 2010. Physician-Ownership of Ambulatory Surgery Centers Linked to Higher Volume of Surgeries. Health Affairs 29(4): 683-9.

patients,"[16,17] Congress recently enacted legislation requiring CMS to incorporate a socioeconomic adjustment to the measurement of hospital performance, factoring in each hospital's share of inpatients who are dually qualified for Medicare and full Medicaid. In this proposed rule, CMS proposes several changes to adjust for the impact of socio-economic factors, factors largely beyond a hospital's control.

However, while we recognize the importance of a socioeconomic adjustment, we urge CMS to continue to move forward in expanding HRRP as it considers adjustments for socioeconomic differences.

Reducing readmissions through better coordination and planning of post-discharge care should be a goal for every patient's care regardless of their socioeconomic status. With that in mind, we support the approach that CMS has described with regard to accounting for dual-eligibles and stratifying hospitals into quintiles (five peer groups), which allows for more precision and helps adjust for socioeconomic status in the HRRP. We believe that these two changes will go a long way toward adjusting for socioeconomic factors.

Additionally, as CMS considers other changes to the HRRP program, we encourage CMS to examine the relationship between increased use of observation status, rather than admitting patients, and avoidance of readmissions penalties.

Hospital Acquired Conditions (HAC) Reduction Program

Minimizing infection risks, injuries, and adverse events in the health care setting are an essential part of optimizing "The Triple Aim" of the Affordable Care Act. HACs cause harm and adversely affect patients' lives, while also increasing hospital length of stay (LOS) and total hospital costs. With that, we strongly support the goal of the HAC program, which has reduced HACs by 21 percent since 2010 and averted more than 3 million adverse events. Additionally, approximately 125,000 fewer patients died in hospitals due to HACs, and more than $28 billion in health care costs were saved due to the decline in HACs.[18] Further, in 2015 alone, an estimated 37,000 deaths due to HACs

[16] Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program. Issue Brief. March 2017. Kaiser Family Foundation. Accessed via: http://files.kff.org/attachment/Issue-Brief-Fewer-Hospital-U-turns-The-Medicare-Hospital-Readmission-Reduction-Program on May 4, 2017.

[17] Medicare Payment Advisory Commission, "Chapter 4: Refining the Hospital Readmissions Reduction Program," Report to the Congress: Medicare and the Health Care Delivery System, June 2013; National Quality Forum, "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors," Technical Report, August 15, 2014. Sheingold, S., R. Zuckerman, and A. Shartzer, "Understanding Medicare Hospital Readmission Rates and Differing Penalties Between Safety-net and Other Hospitals," Health Affairs, 35, No.1, January 2016; Kahn, C., T. Ault, L. Potetz, T. Walke, J. Chambers, and S. Burch, "Assessing Medicare's Hospital PayFor-Performance Programs And Whether They Are Achieving Their Goals," Health Affairs, 34, No.8, August 2015; Joynt, K. and A. Jha, "A Path Forward on Medicare Readmissions" New England Journal of Medicine Vol. 368, No. 13, 2013.

[18] National Scorecard on Rates of Hospital-Acquired Conditions 2010 to 2015: Interim Data From National Efforts To Make Health Care Safer. Content last reviewed December 2016. Agency for Healthcare

were avoided. By comparison, that's more than the 35,000 Americans who lost their lives that year in motor vehicle accidents.

We strongly support CMS's consideration of adoption of future measures for payment adjustment to continue to reduce HACs, including falls with injury, adverse drug events (ADEs), glycemic events and ventilator associated events (VAEs), as the NQF has identified all of these as gap areas for the program.

Finally, MedPAC has expressed concern about the statutory design of the HAC Reduction Program because it penalizes 25 percent of hospitals every year, even if all hospitals significantly reduce HAC rates.

Thus, we support the Commission's recommendation that CMS work with policy makers to determine a fixed performance target as a benchmark, one that encourages additional improvements but which would assure that all hospitals that reduce HACs to at least the benchmark rate will avoid penalties.

Hospital Value-Based Purchasing (VBP)
We are supportive of a strong VBP program as key to increasing the impact of performance on reimbursement in the legacy FFS program and in moving away from paying for volume to paying for value. We support CMS' continuing efforts to refine measures to better reflect safety, quality, patient satisfaction and costs and efficiency. Apart from an emphasis on clinical quality and safety, we appreciate and strongly support CMS' intention to focus more strongly on cost as an element of value in the VBP program.

We support the adoption of the Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN Payment) for the Efficiency and Cost Reduction domain beginning in 2022
Pneumonia is one of the leading causes of hospitalization for Americans aged 65 and over, and pneumonia patients incur roughly $10 billion in aggregate health care costs.[19] The pneumonia measure follows the addition of two cardiac episodic spending measures—30-day episodic spending for Acute Myocardial Infarction and Heart Failure—both of which will be part of the VBP Efficiency and Cost Reduction domain in FY 2021. The pneumonia measure will enter that same domain the following year.

Proposed Changes to Clinical Quality Measures (CQMs)
We appreciate CMS's efforts to streamline certain reporting for eligible hospitals and critical access hospitals (CAHs) by standardizing reporting periods, terminology and

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Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html

[19] 0Lindenauer PK, Lagu T, Shieh M, Pekow PS, Rothberg MB. Association of diagnostic coding with trends in hospitalizations and mortality of patients with pneumonia, 2003–2009. JAMA. 2012;307(13):1405–1413.

metrics available for selection. The administrative burden of reporting has increased significantly, often takes time away from patient care, and contributes to clinician burnout.

We encourage CMS to continue to consider ways to build the collection of CQMs into the process of care and continue to re-examine, refine, and reduce measures where appropriate to streamline the measurement of care and collection of data without adversely impact outcomes and quality.

Advances in technology, including EHRs, have the potential to ease the burden of quality reporting, while simultaneously increasing access to accurate and real-time information to support quality improvement. To achieve this, the CQMs generated from EHR data must be based upon information that is feasible to collect in an automated fashion, preferably collected during the process of care, generate valid and reliable results, and demonstrate a benefit that outweighs the costs.

Proposed Changes to the Medicare and Medicaid EHR Incentive Programs

We appreciate that CMS must develop a definition of “substantially all,” because the 21st Century Cures Act amended Section 1848 A7D of the Social Security Act to provide that no payment adjustment may be made under Section 1848 A7A for 2017 and 2018 in the case of an eligible professional (EP) who furnishes substantially all of his or her covered professional services in an ambulatory surgical center (ASC).

We support a definition that would define an ASC-based EP as performing 90% or more of covered professional services as the minimum percentage of an EP’s covered professional services that must be furnished in an ASC setting for the EP to be considered as furnishing “substantially all” of his or her covered professional services in an ASC.

Because the statute would allow these EPs to be exempted from 2017 and 2018 meaningful use (MU) payment adjustments and would eliminate reporting burdens for EPs with limited office time, we encourage the agency to set the higher threshold.

Hospital Inpatient Quality Reporting (IQR) Program

We support CMS’s proposal to change the HCAHPS pain management questions. We have expressed concern previously that the emphasis on patient satisfaction with pain management during inpatient care may have the unintended consequence of increasing the prescribing of opioids. While we appreciate the changes, some other modifications that CMS should examine include questions about whether hospital staff talked about alternatives to medication for pain management and clearly communicated the addictive potential of opioid medications. While revising the questions alone is not a silver bullet solution to the prescription opioid epidemic, we do believe this change is a key step in the right direction, as part of a comprehensive solution to preventing the unintended consequences of opioid use.

The potential for this unintended consequence has been documented by at least one recent study, in which physicians voiced the belief that the use of patient satisfaction ratings had negative effects on their clinical care, especially on opioid prescribing.[20] In addition, there is a lot of anecdotal evidence from physicians and hospital administrators that it has contributed to the problem.

Thus, while we support the rationale for including pain management as an overall understanding of patient satisfaction associated with the quality of care, we encourage CMS to consider additional modifications to this portion of the survey to reduce the potential for over-prescribing of opioids in the inpatient setting

Rural Community Hospital Demonstration

We believe that telemedicine and mHealth could offer better ways for rural hospitals to provide greater access to needed, high quality care to rural patients. The demand for telehealth in rural areas is high, particularly given that patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas. This uneven distribution of physicians has an impact on the health of the population.[21] The uses for telehealth in rural areas include remote consultations, in-home monitoring, outsourced diagnostic analysis, and remote specialist consultations. All of these would have the impact of increasing access, significantly reducing wait time for quality care, and improving overall health outcomes. A 2012 report by the Institute of Medicine for the National Academies of Sciences[22] found that telehealth increases quality of care, and reduces costs by reducing readmissions and unnecessary emergency department visits for rural communities.

Still, roughly 66 percent of rural hospitals had no telehealth services or were only in the process of implementing a telehealth application when the RUPRI Center for Rural Health Analysis reviewed 4,727 hospitals in the 2013 HIMSS Analytics database.

When considering the unique challenges associated with rural areas, including lack of access to appropriate broadband support, we urge CMS to evaluate and develop plans to mitigate the two key barriers when implementing its pilot program: 1) broadband access challenges to support the necessary broadband infrastructure for telemedicine, and 2) consider expanding the scope of telemedicine services for which Medicare reimburses for rural hospitals, particularly rural critical access hospitals.

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[20] Zgierska A, Rabago D, Miller MM. Impact of patient satisfaction ratings on physicians and clinical care. Patient preference and adherence. 2014;8:437-446. doi:10.2147/PPA.S59077.

[21] Hing, E, Hsiao, C. US Department of Health and Human Services. *State Variability in Supply of Office-based Primary Care Providers: United States 2012*.

[22] Institute of Medicine. 2012. *The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary*. Washington, DC: The National Academies Press. doi:https://doi.org/10.17226/13466.

Again, thank you for considering our comments and recommendations to CMS's proposed rule for the IPPS for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

Sincerely,

Brian J. Marcotte
President and CEO