Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

September 6, 2016

Mr. Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G
Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-1656-P

Re: 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

Dear Mr. Slavitt,

The Catholic Health Association of the United States (CHA) is pleased to submit these comments to the Centers for Medicare and Medicaid Services (CMS) on the above notice of proposed rulemaking (NPRM).

We appreciate your staff's ongoing efforts to administer and improve the payment systems for acute inpatient hospital services, especially considering the agency's many competing demands and limited resources. As we discuss in greater detail below, CHA believes the proposals for implementation of Section 603 of the Bipartisan Budget Act of 2015 (Section 603) included in the NPRM are substantially at odds with both the language of and the congressional intent behind the law. Because we believe that Section 603 raises a great number of issues that must be addressed in depth by the agency and that must be informed by stakeholder feedback, and because some of the proposals in the NPRM would have significant negative impacts on providers as well as beneficiary access to care, **we urge CMS to delay implementation of Section 603 for at least one year to simplify and clarify its policies and to ensure that all Medicare providers are reimbursed for the services they provide.** CHA offers the following comments on this and several aspects of the proposed rule.

1. **Implementation of Section 603 of the Bipartisan Budget Act of 2015 Relating to Payment to Certain Off-Campus Outpatient Departments of a Provider**

Section 603 of the Bipartisan Budget Act of 2015 (Public Law 114–74) excludes from the definition of covered hospital outpatient department services "applicable items and services" furnished on or after January 1, 2017 by certain off-campus outpatient departments of a provider (generally those that did not furnish billed covered outpatient department services before November 2, 2015). The law provides that for payment for such services furnished by what CMS refers to in the rule as "off-campus provider-based departments" (PBDs) under a Part B payment system other than the OPPS ("applicable payment system" under Part B). CMS proposes to implement Section 603 as follows:

(1) To create and define the term "excepted items and services" to determine whether items and services are excepted from the Section 603 applicable payment system policy and paid under the OPPS.
(2) To define off-campus PBDs and establish requirements for those off-campus PBDs to maintain excepted status (both for the facility and for the items and services it furnishes).
(3) To establish payment policies for non-excepted items and services.

- Proposed 2017 Payment Policy for Non-excepted Off-Campus PBDs

CMS observes that the statute calls for applicable items and services to be paid for under the "applicable payment system" under Part B, but the law does not describe or define what applicable payment system means (other than it is not the OPPS). CMS also observes that rules regarding provider and supplier enrollment, conditions of participation, coverage, payment, billing, cost reporting, and coding vary across the institutional payment systems. While CMS intends to develop a mechanism for an off-campus PBD to bill and be paid for furnishing non-excepted items and services under the "applicable payment system," it states that there is no straightforward way to do that before January 1, 2017.

CMS proposes to use the Medicare Physician Fee Schedule (PFS) as the Part B applicable payment system for the majority of non-excepted services furnished during 2017. Physicians furnishing services in off-campus provider-based departments (PBDs) would be paid based on the professional claim and at the non-facility rate for services for which they are permitted to bill. However, CMS proposes not to make any separate facility payment to the hospital for non-excepted services furnished during 2017. CMS believes there is not a way for off-campus PBDs to bill for non-excepted services furnished during 2017, and the agency is not even sure it can develop a methodology to permit billing for these services beginning in 2018.

CHA has deep concerns with CMS' payment proposal for 2017. The proposal to pay physicians and non-physician practitioners eligible to bill under the MPFS at the non-facility rate for non-excepted services is not sound policy and raises more issues than it settles. First, there is

no compensation to the facility for the costs it incurs, especially in the case of physicians who are not employed by the non-excepted off-campus PBD. Second, the proposal lacks detail or guidance on a significant number of important issues. While it is reasonable to conclude that CMS would continue its policy to only reimburse a provider or supplier for the costs it incurs in furnishing the service, as proposed, the applicable payment system appears to leave open a number of situations where no payment can be made to the physician and for which no payment could be made to any provider or supplier for certain services.

1. *No Facility Payment in 2017*

CHA strongly objects to any policy that precludes payment under the program to any Medicare provider or supplier who lawfully and pursuant to the provider or supplier agreement furnishes services to a Medicare beneficiary, absent clear statutory authority to do so. Nothing in Section 603 indicates any congressional intent to give CMS discretion to deny payment to off-campus PBDs for non-excepted services that are furnished consistent with the provisions of the provider agreement. Section 603 is a direction to the Secretary to use or develop an alternative payment calculation methodology; it is not authority to eliminate coverage of or payment for otherwise compensable items and services furnished by Medicare providers enrolled in approved status under the program. Had Congress intended to prohibit payment to non-excepted off-campus PBDs for items and services, such as nursing services, imaging services, chemotherapy services, surgical services and other reasonable and necessary services furnished to Medicare beneficiaries until such time as the agency could determine a payment mechanism for the costs they incur for non-excepted items and service, the statute would have had to state that directly, in clear unequivocal language.

While we understand the challenges faced by CMS, this is not sufficient rationale to deny payment to providers who furnish services to Medicare beneficiaries pursuant to the law and regulations. The agency and Medicare providers and suppliers enter into agreements whereby providers furnish services to Medicare beneficiaries for which they are compensated by agency contractors. CMS would be failing to meet its contractual obligations under the agreement if it denied payment for services rendered and for which non-excepted off-campus PBDs incur costs.

If the agency believes it is incapable of making the requisite adjustments to its payment systems due to technical or timing issues to make payments beginning in 2017 to off-campus PBDs for non-excepted items and services, then the clear and **only** solution is to delay implementation of Section 603 until such time as the agency has either made the necessary modifications or developed an alternative system to permit payment for services rendered. There is ample precedent for a delay in the implementation of Section 603. The implementation of the OPPS itself was delayed for 18 months because of technical issues relating to systems and the challenges the agency faced in light of the programing issues related to "Y2K." More recently, the agency delayed implementation of the revised payment methodology for clinical diagnostic laboratory services imposed under section 216 of the Protecting Access to Medicare Act of 2014 by one year due to the complexity of a number of issues.

2. Payment under the PFS

CMS proposes to use the PFS as the applicable payment system under which the physician would be paid at the non-facility rate, which reflects the costs incurred when a physician provides a service in the office, such as clinical staff, equipment and supplies. CHA believes this proposal creates more questions than it answers and would be unworkable. CMS appears to assume that hospitals will receive reimbursement for its costs from the physician who was paid the non-facility rate. How will this occur? How will the hospital's costs and the reimbursement from the physician be documented? What if the physician fails to pass through the funds? And if the physician does not share the reimbursement with the hospital, the physician will have been paid for costs she did not incur. CHA is very concerned that CMS is creating a situation that is likely to trigger violations of the anti-kickback and physician self-referral laws.

In addition, not all services have non-facility rates or are payable at all under the PFS. For example, "incident to" services do not have a facility rate, but when they are furnished in a hospital setting, they are paid under the OPPS. Since the physician would not incur any costs for incident to services furnished in a non-excepted off-campus PBD, and payment could no longer be made under the OPPS, under the agency's proposed policy there would be no payment for these services. For certain diagnostic services that include both a technical and professional component (e.g., a chest x-ray) furnished in an off-campus PBD, other than in the dedicated emergency department, the physician would not be able to bill for the technical component since he or she did not incur any of the costs for the equipment. It is also worth noting that the difference between the facility and non-facility rate for the professional component for the service is negligible.

Additionally, the proposed rule is unhelpful in addressing issues relating to payment for clinical diagnostic laboratory services; it speaks with certainty only to three or four examples where the services are currently separately billable. However, the language of the proposed rule is confusing; it reads as follows: "Under our proposal, if a laboratory test furnished by a non-excepted off-campus PBD is eligible for separate payment under the clinical laboratory fee schedule (CLFS), the hospital may continue to bill for it and receive payment under the CLFS." The sentence seems to indicate that the test for separate payment is whether separate payment may be made under the CLFS rather than the OPPS. CHA does not understand what the proposed payment rule is and whether all clinical diagnostic laboratory tests will be paid for separately, and if not, how they will be paid. The succeeding sentence relating to the ability of a practitioner to submit the bill under the PFS is similarly confusing since presumably payment would be made under the CLFS.

The proposal is entirely silent on the issue of Part B drugs furnished by a non-excepted off-campus PBD. Thus, providers have no idea whether they may continue to bill for Part B drugs and, if they could, how they would do so. Additionally, we cannot determine whether the packaging threshold policies would still apply. If the packaging thresholds would still apply, we

cannot discern how payment would be calculated for a drug that is priced below the threshold, and whether a drug above the threshold would continue to be paid separately, and if so, at what rate.

Observation services and the partial hospitalization program (PHP) are not payable under the PFS and is unclear how they will be paid in the setting of a non-excepted PBF. Among the many objectionable consequences of the payment policy, this proposal is surprisingly harmful to a very vulnerable subset of the Medicare beneficiary population. An emergency department is not a suitable setting for PHP services, and hospital outpatient department-based PHPs are the most effective setting in which to deliver needed care under a care continuum model for this vulnerable population. Absent regular and sustained access to these programs in off-campus PBDs, beneficiaries will resort to emergency department visits or could risk inpatient admission for their conditions. The agency's suggestion that providers can change their status to a community mental health center (CMHC) in order to be paid ignores a number of complexities and consequences of such a change, including loss of 340B eligibility which would further reduce access to care for the most vulnerable populations our community facilities serve.

In summary, CMS has left stakeholders largely uninformed about how its payment proposals would operate, and the proposals themselves would have severe adverse consequences for Medicare beneficiaries and for the ability of our facilities to serve the most vulnerable populations**. CHA opposes the payment proposal for FY 2017, which could have substantial negative impacts on access to care as well as on the financial viability of off-campus PBDs. CMS should delay implementation for at least one year until the agency can work closely with stakeholders to address the many unanswered questions and unintended consequences of its proposals.**

- Proposed Qualification Date for Excepted Status

Under the statute, applicable items or services provided by an off-campus PBD are not payable under the OPPS. An off-campus PBD is one that is neither on the hospital campus nor within 250 yards of a remote location of a hospital facility. However, an off-campus PBD "that was billing under this subsection with respect to covered OPD services furnished prior to November 2, 2015" (the date of enactment) is excepted from this provision and may continue to be paid under the OPPS.

Congress did not address the situation where an off-campus PBD was under development at the time of the date of the enactment of the Bipartisan Budget Act of 2015. Given the circumstances of the statute's enactment, there was very little advance notice of the policy for facilities that had already expended considerable time and resources for the planning, construction and furnishing of off-campus PBDs, who were caught completely unaware that the payment methodology for the services furnished at these new or expanded facilities would be changed. Our members effectively use off-campus PBDs to provide services in areas where access to care by the

medically underserved and vulnerable populations is limited. **CHA believes CMS has the discretion to accommodate facilities that were under development on November 2, 2015, so that they can be treated as excepted off-campus PBDs. We urge CMS to use its discretion to craft a rule to protect the many facilities that had already dedicated substantial time and resources to the development and construction of an off-campus PBD before November 2, 2015.**

CMS proposes to interpret the language of the exception to require that a facility must have submitted a bill before November 2, 2015, to qualify for excepted status. CHA believes this to be a misinterpretation of the statute. Qualification for the exception should be based on when billable services were provided, rather than the date on which a bill for those services was submitted to the Medicare contractor.

The phrase containing the deadline (i.e., November 2, 2015, the date of enactment) immediately follows the phrase relating to the furnishing of covered OPD services. Thus the plain reading is that the deadline modifies the phrase to which it is closest, that is, the requirement that the off-campus PBD furnish a covered OPD service. That this is the correct reading is reinforced by the practical realities of Medicare billing. Hospitals have up to one year to submit a bill for payment under the OPPS. Congress intended to distinguish between facilities in existence and actually furnishing covered OPD services on the date of enactment and new facilities created after enactment, and to continue paying the former under the OPPS. A facility should not be penalized because its billing department did not submit bills for a couple of weeks or more. Additionally, there is no opportunity to game the system by applying the deadline to the furnishing of the covered OPD service. The date of the service will appear on the bill that is submitted to the contractor. **CHA urges CMS to finalize a rule that provides an exception from Section 603 for hospitals that provided billable services before November 2, 2015, regardless of when the bill was submitted.**

- Proposed Relocation Policy

CMS proposes that an excepted off-campus PBD would lose its excepted status if it is moved or relocated from the physical address (including a change in the unit number of the address) listed on the provider's hospital enrollment form as of November 1, 2015.

CHA believes that the proposed policies on relocation are inconsistent with the plain meaning of the statute and will have a substantial adverse impact on the ability of providers to improve access to care for communities that are medically underserved or have vulnerable populations. Our efforts to serve the needs of communities, including the poor, the uninsured and the medically underserved, have been greatly enhanced through the use of our off-campus PBDs. These facilities afford opportunities for care and care coordination for Medicare beneficiaries, including dual eligible populations, on a scale that is unachievable by

smaller clinics or other care settings because we are able to furnish a range of services, especially more complex items and services, that are otherwise unavailable for those populations.

As noted above, the statute excepts off-campus PBDs that were furnishing covered OPD services before November 2, 2015. Had Congress sought to limit any relocation, it would have indicated that policy in the statute. The statute however is silent on the subject of relocation. What little congressional intent that can be discerned before the enactment of Section 603 shows clearly that Congress was concerned with new off-campus PBDs—it did not speak to or show any intent to otherwise limit the category of providers for which it provides exceptions in the statute. Nothing in the statute requires CMS to impose this restriction on relocation, and in light of Congress' silence on relocation it is questionable whether CMS has the authority to impose restrictions on the ability of an off-campus provider to relocate to another address. **Existing off-campus PBDs should be exempt entirely from Section 603.**

Indeed, there are many valid reasons a provider may need to move or change its physical address, as CMS noted in the proposed rule. The reason may be as unexpected as a natural disaster or a fire; it may be attributable to requirements imposed under law, including federal, state or local laws and regulations; and it may also be attributable to the ordinary course of business, such as the expiration of a lease. Main providers also move which will require relocating the off-campus PBD, and it is certainly not unusual for a PBD to wish to move to an another unit or office suite in the same medical office building. An off-campus PBD may also relocate to expand the scope of services to medically underserved or other vulnerable patient populations. All these examples are legitimate and reasonable rationales for a provider to relocate and the proposed policy on relocation will place off-campus PBDs in untenable situations. For example, if the proposed policy is finalized, landlords will be fully aware that an excepted off-campus PBD will lose its excepted status if it moves and in a strong position to demand far higher rents or concessions than would otherwise have been the case during normal lease negotiations. The proposed policy would further constrain the ability of our facilities to provide care to patients in the communities we serve.

If CMS finalizes a relocation policy, it should establish in regulations a list of circumstances under which an excepted off-campus PBD that moves would retain its excepted status. The regulations should also include flexibility for the Secretary, in consultation with stakeholders, to identify additional circumstances under which excepted status would be protected. CHA believes the list of circumstances must include at a minimum the examples noted above, and that CMS should further engage with stakeholders to identify other fact patterns under which relocation would not jeopardize the excepted status of the off-campus PBD.

- Proposed Expansion of Services Policy

CMS proposes that an excepted off-campus PBD will only continue to be paid under the OPPS for services within the "clinical families of services" it furnished before November 2, 2015.

Services provided after that date by an excepted off-campus PBD that are not part of one of the clinical family of services previously furnished would not be payable under the OPPS, notwithstanding the excepted status of the facility itself. CMS has proposed definitions for its newly created "clinical families of services."

CHA has concerns with this proposal. First, as discussed above, the better reading of the statute is that excepted off-campus PBDs should be completely outside of the reach of Section 603. Second, this proposal if finalized will create confusion and undue burden for those excepted off-campus PBD's that begin to provide services in a new "clinical family" and would therefore have to bill under two different payment systems. Indeed, a single patient could receive both excepted and un-excepted services in a single encounter creating significant administrative and billing burdens for the facility. Third, and most important, CMS is not adequately taking into account the role off-campus PBDs play in the communities they serve as a crucial and often only point of access for health care services. Hospitals have to be able to meet the changing medical needs of their communities; they must also be able to adapt to changes in technology or the best practice guidelines. The ability of physicians and facilities to serve their communities will be severely limited if decisions about what services they can afford to furnish are established in regulation. CHA is concerned that as proposed this policy would limit patient access to quality care in many areas and would result in the inefficient increase in emergency department visits, including at main providers, when an off-campus outpatient department would be far better suited to efficiently meet those health care needs. **CHA opposes this proposal and urges CMS not to finalize a limitation in the OPPS-reimbursable services that excepted off-campus PBDs may provide.**

- Proposed Change of Ownership Policy

Under the proposal, an excepted off-campus PBD would retain excepted status under a change of ownership if two tests are met: (1) The ownership of the main provider is also transferred, and (2) the new owner accepts the Medicare provider agreement. The proposed rule also makes it clear that an excepted off-campus PBD would forfeit its excepted status if a new owner acquires one or more PBDs without also acquiring the main provider or if it declines to accept the existing provider agreement.

While we agree that the transfer of ownership of both the main provider and any or all excepted off-campus PBDs should not impact the excepted status of the PBDs, we believe that the proposal for forfeiture of excepted status where only a PBD is transferred or acquired ignores the realities of the commercial marketplace, especially if the proposed implementation of Section 603 is finalized in its current form. It is normal practice for a hospital in financial difficulty to transfer their off-campus PBDs to better performing hospitals so the patients in the community that the PBD serves can continue to receive essential health care services at the PBD. However, if the PBD would lose OPPS reimbursement the potential purchasers may find its acquisition financially unviable and its resulting closure would cause a needless loss of ready access to

quality care for its community. **We reiterate our view that existing off-campus PBDs should be exempt entirely from Section 603 and strongly recommend that CMS revise its proposal to permit an excepted off-campus PBD to be transferred or acquired without its main provider and still retain its excepted status.**

- 340B Eligibility

The NPRM is silent on the effect of its proposals on 340B eligibility of off-campus PBDs that are covered entities as defined in section 340B(a)(4) of the Public Health Service Act. It is our view that nothing in the proposal to implement Section 603 bears on continued 340B eligibility of these off-campus PBD covered entities since the off-campus PBD is still provider-based. We commend CMS for clarifying that an off-campus PBD as defined for purposes of paragraphs (1)(B)(v) and (21) of section 1833(t) of the Act is provider-based pursuant to the definition of a department of a provider under section 413.65(a)(2) of the regulations.

Some stakeholders have expressed concerns that the Health Resources and Services Administration (HRSA), through its Office of Pharmacy Affairs (OPA), may have a different interpretation. **To that end, we urge CMS to coordinate with HRSA and OPA to ensure that those agencies understand that Section 603 represents only a change in the payment calculation methodology for off-campus PBDs and that it is in no way intended to, nor will it have any, impact on 340B eligibility.** Medicare cost reports of main providers will continue to properly reflect costs and revenues in the appropriate lines of the cost reports for all its PBDs.

On a related matter, CMS at several points in the proposed rule suggests that off-campus PBDs could simply change their provider status to become another provider type, such as an ASC, group practice, or a CMHC. This suggestion fails to acknowledge several significant negative impacts of such a change, including the loss of 340B covered entity eligibility as well as substantial reductions in reimbursement amounts from other payers including state Medicaid programs. These losses would severely impact costs which in turn would limit the ability of these facilities to provide needed care for the patients in our communities who are in many cases among the most vulnerable. The suggestion also ignores the time and resources required to make such a change, including renegotiation of agreements with our physicians, practitioners, auxiliary staff and other suppliers.

- Delay

While we appreciate that the legislation did not afford CMS much time to craft a proposal to implement Section 603, we believe that the complexity of the issues involved as well as the inherent flaws and inadvertent consequences of a number of the proposals contained in the NPRM require a delay in the implementation of Section 603 of at least one year. Additionally, some of the more important aspects of the payment proposal for 2017 were not addressed adequately in the NPRM, thus the proposal does not constitute sufficient notice of

what the agency intends for stakeholders. CHA would be an eager participant in discussions with CMS on the implementation of Section 603 and its potential impact on the vulnerable patient populations we serve.

As noted earlier, CMS has delayed implementation of a statutory provision that included a definite start date in the legislative text. The reasons for the CMS delays of the OPPS and of the new payment methodology under the CLFS apply in the context of the implementation of Section 603 as well. **We urge CMS to delay implementation for at least one year and to develop its implementation proposal in close consultation with stakeholders.**

2. Hospital Outpatient Quality Reporting (OQR) Program; Ambulatory Surgical Center Quality Reporting (ASCQR) Program

CMS proposes three new measures for addition to the OQR Program beginning with 2020 payment. CHA does not support the addition of any of these three measures at this time.

The measure "Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy Treatment" has not been endorsed by the National Quality Forum (NQF), and CHA agrees with the Measure Applications Partnership (MAP) that this measure should only be considered for the OQR Program pending NQF endorsement which includes consideration of risk adjustment for sociodemographic status (SDS) adjustments. This measure assesses the rate at which patients receiving outpatient chemotherapy have a hospital admission or visit the emergency department with any of ten diagnoses within 30 days of treatment. This is exactly the type of measure for which SDS adjustment should be made; patients without access to appropriate housing and food and other support after chemotherapy treatment would seem more likely to have unexpected hospital and emergency care. We urge CMS to evaluate this measure for SDS adjustment and submit it to the NQF for endorsement. Once that process is complete it can be re-proposed for consideration in the OQR Program.

While the proposed measure Hospital Visits after Hospital Outpatient Surgery has been endorsed by the NQF (#2687), this measure has not been assessed for SDS adjustment. As with the chemotherapy measure discussed above, when patients make visits to an emergency department or are admitted for an observation stay or an inpatient stay within seven days of surgery it does not always mean there was a failure in hospital care at the time of surgery. Sometimes conditions at home are insufficient to support the patient's post-surgery plan of care. While discharge planners may identify issues and arrange for support it may not always be possible when issues relate to inadequate housing or nutrition or lack of other support needed for a complication-free recovery. Before this measure is added to the OQR Program, CMS should assess this measure for SDS factors and resubmit it to NQF for review and endorsement.

CHA agrees that patient experience of care is an important indicator of the quality of care. However, we do not support the proposed addition to the OQR Program of questions from the outpatient and ambulatory surgery consumer assessment of healthcare providers and

systems (OAS CAHPS). The OAS CAHPS has not been endorsed by NQF, and it was only made available to hospitals for voluntary use earlier this year. This measure requires a significant investment by hospitals, which would have to contract with a CMS-approved vendor to collect the survey data and report it to CMS. Before imposing this requirement, CMS should ensure that the NQF endorsement process is completed and more experience gained with the survey so that issues can be ironed out before it is proposed as a mandatory measure.

3. Changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs

CHA supports the proposal to establish a 90-day reporting period for 2016 for eligible professionals, hospitals and CAHs who have previously demonstrated meaningful use. As the proposed rule acknowledges, the previously finalized calendar-year reporting period is unrealistic in light of the modifications to certified EHR technology (CEHRT) and other changes adopted under the 2015 EHR Incentive Program final rule. In fact, CHA encourages CMS to continue a 90-day reporting period at least through 2017, if not longer; the changes required to work toward 2018 implementation of Stage 3 objectives and measures are ongoing and it is not reasonable to require full-year EHR reporting until those changes are all in place and providers have sufficient experience to accurately report Stage 3 measures.

CHA also supports the proposals to reduce the measure thresholds for 2017 and 2018. The current thresholds pose enormous challenges for hospitals to meet, as vendors are not yet ready to implement many of these measures, and EHR adoption and interoperability has not yet reached the threshold for the type of routine health information exchange envisioned under the CEHRT standards. Keeping the lower thresholds in place for at least the next two years will allow vendors and hospitals to catch up and make the changes needed to implement the most recent CEHRT requirements and to begin to gain experience with reporting the measures. It will also give time for CMS to identify and iron out definitional and operational issues with the Stage 3 measures.

4. Changes to the Inpatient Hospital Value-Based Purchasing (VBP) Program Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Pain Management Dimension

CMS proposes to remove the three-question HCAHPS Pain Management dimension from the hospital VBP Program while it develops alternative questions on pain management, due to confusion about the intent of these questions and the public health concern about the ongoing prescription opioid overdose epidemic.

Effective pain management is an essential element of patient well-being and a key element in the provision of palliative care services to patients and families facing serious illness. The Catholic health ministry is strongly committed to providing patients with excellent palliative care services, which focus on providing relief from the symptoms, pain and stress of a serious illness.

Palliative care is appropriate whatever the diagnosis and at any stage in a serious illness, and can be provided together with curative treatment. The goal is to improve quality of life for both the patient and the family.

We support CMS in its intent to develop, validate and adopt appropriate replacement pain management questions for the HCAHPS and urge the agency to proceed expeditiously. We suggest the questions should focus on whether a patient's pain has been assessed, whether treatment and pain management options (not limited to opioids) were discussed, and whether pain was reassessed for effectiveness of the intervention. We suggest CMS consult with experts in pain management and palliative care as it develops the replacement questions.

In closing, thank you for the opportunity to share these comments in regard to the proposed CY 2016 OPPS rule. We look forward to working with you on these and other issues that continue to strengthen the country's hospitals and health care system. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

Michael Rodgers
Senior Vice President
Public Policy and Advocacy