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September 6, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1656-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: CMS-1656-P – Medicare Program; CY 2017 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing (VBP) Program; Proposed Rule
81 Fed. Reg. 45604 (July 14, 2016)

Dear Acting Administrator Slavitt:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the proposed rule implementing the calendar year (CY) 2017 Medicare Hospital Outpatient Prospective Payment System. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

We offer thoughts and comments on specific areas of the proposed rule as follows:

XIII. Requirements for the Hospital Outpatient Quality Reporting (OQR) Program

B. Hospital OQR Program Quality Measures

5. Proposed New Hospital OQR Program Quality Measures for the CY 2020 Payment Determination and Subsequent Years

a. OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy Measure

CMS proposes to add seven new Hospital Outpatient Quality Reporting (OQR) program quality measures to its payment determination for CY 2020 and beyond. One of the new proposed measures is OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy.

ACS CAN supports the addition of this measure to the payment determination, and applauds CMS for recognizing cancer care as a priority area for outcome measurement. This measure is particularly important as the number of cancer patients receiving chemotherapy in hospital outpatient settings is increasing. We believe including an oncology measure is an important step in holding hospitals accountable for the care they provide to chemotherapy patients – particularly because many of the reasons these patients are admitted to hospitals or visit the ED are for symptoms and side effects that

can and should be anticipated and treated in non-acute settings. Reducing hospital admissions and ED visits will improve health outcomes and quality of life for chemotherapy patients, and the first step in doing so is to begin measuring the prevalence of these incidents.

However, we are concerned that the measure examines a 30-day period after discharge and suggest that CMS may wish to shorten the measure's time period to appropriately link the ED visit and/or hospital admission to the chemotherapy treatment. This shortened timeframe would more appropriately align the ED/hospital admission to the administration of chemotherapy.

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

CMS is proposing to eliminate the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures for eligible hospitals and critical access hospitals (CAHs) attesting under the Medicare Electronic Health Records (HER) Incentive Program for Modified Stage 2 and Stage 3 for 2017 and subsequent years. The rationale for the proposed changes are primarily the result of the high attestation rates under the meaningful use program. CMS has stated these changes would not apply to eligible hospitals and CAHs that attest to meaningful use under their State's Medicaid EHR Incentive Program. The proposals aim to continue the advancement of certified EHR technology utilization, particularly among those EPs, eligible hospitals and CAHs that have not previously achieved meaningful use, and result in a program more focused on supporting interoperability and data sharing for all participants under the Medicare and Medicaid EHR Incentive Programs.

Overall, ACS CAN supports the direction of the proposals included in the proposed rule. We believe these changes will better leverage Health Information Technology (IT) as a tool that can improve the quality, delivery and experience of care for cancer patients. In particular, ACS CAN is pleased to see CMS place greater emphasis on ensuring interoperability and data sharing for all participants under the Medicare and Medicaid EHR Incentive Programs, which will encourage greater levels of health information exchange across providers and care settings. People with cancer often receive fragmented and uncoordinated care, because their treatments frequently require multiple clinicians including, surgeons, oncologists, primary care physicians, and other specialists. Providing care that is coordinated requires access to all of a patient's data by all of her providers, an essential function that EHRs can provide. ACS CAN believes this is a critical component to delivering high quality cancer care and previously submitted public comments on Stage 3 of the Medicare and Medicaid EHR Incentive Program with support of additional program modifications to foster a health care environment that encourages health information exchange.[1]

While ACS CAN is supportive of the overall approach of the proposed rule to increase meaningful health information exchange, we urge you to not eliminate the CDS objectives and measures for eligible hospitals and CAHs attesting under the Medicare EHR Incentive Program in Modified Stage 2 and Stage 3 for 2017 and subsequent years. Although ACS CAN recognizes CMS' consideration of CDS and its

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[1] ACS CAN. Public comments on Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 3 Notice of Proposed Rulemaking (CMS-3310-P). May 9, 2015, available at http://www.acscan.org/content/wp-content/uploads/2015/06/ACS%20CAN%20comments%20on%20Medicare%20and%20Medicaid%20Programs;%20Electronic%20Health%20Record%20Incentive%20Program.pdf.

associated measures as "topped out," we strongly recommend that the CDS criterion be included as a required objective and measure to ensure the most current evidence-based care is available to every patient. This is necessary because of the rate of discoveries in genomics and molecular medicine that can determine the most appropriate treatment options based on the patient's genetic profile to better prevent, diagnose and treat cancer. This is commonly known as personalized medicine.

Beyond diagnostic support at the point of care, ACS CAN believes the removal of the CDS measure undermines patient-centered use of clinical decision support, such as shared decision making tools, patient education and reference materials, health risk appraisals, links to secure messaging, patient reminders, medication instructions, pre-visit preparation, disease management interventions, and CDS within the patient portal. In ACS CAN's Stage 3 comment letter on Meaningful Use, we drew particular emphasis to the importance of providing cancer patients and their families with understandable information about:

- their cancer diagnosis,
- their prognosis,
- the benefits, harms, and costs of various treatment options, and
- revisiting and implementing advance care plans.

ACS CAN believes these are critical elements to improving quality and patient experience of care, and thus strongly disagrees with CMS' proposal to eliminate CDS as a measure and objective.

XIX. Proposed Additional Hospital Value-Based Purchasing (VBP) Program Policies

Currently, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) asks three questions related to pain management. These questions are included in the Hospital Value-Based Purchasing (VBP) Program's pain management dimension. CMS proposes to remove the pain management dimension from the VBP program, citing concern that the current pain management questions unintentionally encourage over-prescribing of opioids.

ACS CAN shares the Department's concern about the public health burden that exists today as a result of inappropriate use of opioids and the associated harms. However, pain is one of the most feared symptoms for cancer patients and survivors, with nearly 60 percent of patients in active treatment and 30 percent of patients who have completed treatment experiencing pain.[2]

We agree with CMS that the current pain management questions included in the HCAHPS survey may not be the best measure to determine a beneficiary's pain management experience. We are pleased that the preamble notes CMS' intent to draft alternative questions for the pain management dimension. As CMS undertakes this effort, we urge the agency to include survey questions that seek to measure the beneficiary's experience with pain management to determine whether the beneficiary's pain was assessed, whether the beneficiary understood the interventions offered to address her pain, and whether she had the opportunity to discuss alternative pain management interventions (if appropriate).

[2] Institute of Medicine. (2011). Relieving Pain in America: A Blueprint for Transforming Preventions, Care, Education and Research. National Academy of Sciences.

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the proposed regulations implementing calendar year (CY) 2017 Medicare Hospital Outpatient Prospective Payment System. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org or 202-585-3261.

Sincerely,

Kirsten Sloan
Senior Policy Director
American Cancer Society Cancer Action Network