



AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

September 2, 2014

Administrator Marilyn Tavenner
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2015

Dear Administrator Tavenner:

On behalf of the nearly 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to comment on CMS's recent proposed rule that would update payment rates for physicians in 2015 and modify other payment policies, including quality reporting requirements.

AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses and other health and spiritual care providers deeply committed to improving quality of life for patients facing serious or life-threatening conditions, as well as their families. As many of the proposed policies in this rule affect practicing hospice and palliative medicine physicians across settings, they hold the potential to have a sizable impact on the care those patients receive. AAHPM acknowledges CMS's commitment to ensuring that impact is positive, and we stand ready to contribute to this effort to the greatest extent possible.

Using OPPS and ASC Rates in Developing PE RVUs

We are increasingly concerned with CMS's intent to use hospital cost reports to revise the Medicare physician fee schedule (MPFS) practice expense (PE) methodology. We strongly disagree with CMS's assertion that hospital cost report data are more reliable than data provided by non-facility providers, particularly when a service is significantly and disproportionately physician office-based. We urge the agency to abandon the notion that hospital cost reports serve as an appropriate proxy for physician office PEs, and we strongly encourage CMS to consider alternative validation mechanisms.

In addition, CMS's desire to better understand the impact of the shift in services from the physician office to the hospital outpatient department – along with the growing trend in hospital employment of physicians, as well as the acquisition of physician offices by hospitals and subsequent redesignation of those offices as hospital outpatient departments (HOPDs) – is certainly warranted, given the significantly higher program spending and beneficiary cost sharing (without a notable change in patient care or quality) for the migrating services.

To understand this trend, CMS is proposing to establish a new HCPCS modifier to be reported with every code for physician and hospital services furnished in off-campus facilities of a hospital. We do not believe this is the most effective way to collect the needed data. The administrative burden to practices associated with the proposal is significant, as is the likelihood that the modifier would be inappropriately and/or inadequately applied to claims. In addition, the misapplication of the modifier could create more confusion in the claims data than CMS anticipates. We maintain that CMS's database already includes the information the agency needs; it is only a matter of writing a query that would identify and match HOPD and MPFS claims for the same patient, on the same date of service, for a select set of procedure codes of interest to CMS.

As an alternative, and as proposed last year in the 2014 Medicare Physician Fee Schedule, CMS could establish a new place of service code for off-campus provider-based clinics, which AAHPM would support.

In the interim, however, CMS could consider revising its regulations that allow hospitals to redesignate physician practices as HOPDs. Specifically, CMS could create a process that requires agency approval for such redesignations based on a modified set of criteria. This would provide CMS an opportunity to determine whether a redesignation is appropriate and meets CMS's modified requirements for such a change. CMS could also place a moratorium on all redesignations until data can be collected and analyzed to inform future policy decisions. CMS could consider further revising its redesignation criteria based on data collected through the aforementioned processes.

Medicare Telehealth Services

AAHPM commends the agency's ongoing efforts to expand Medicare's telehealth footprint by increasing the number of beneficiaries eligible for telemedicine definitions and including additional services on the telemedicine list.

Telemedicine has the potential to improve access to important palliative medicine services, yet codes for such care have not been proposed for inclusion thus far. Given the clinical benefits that could be realized by beneficiaries, particularly those who have complex health conditions, chronic pain, and lack access to in-person treatment options, we urge CMS to consider the following codes for inclusion on the telehealth list:

Prolonged Services (Inpatient)

CPT 99356 and 99357

CMS has already proposed to adopt prolonged service codes for the outpatient setting, and we believe the addition of the related inpatient codes would be appropriate.

Medication Therapy Management (MTM) Services

CPT 99605 – 99607

MTM is a tremendously important activity for improving the health and wellness of Medicare beneficiaries, particularly those with multiple chronic health conditions. Improving MTM continues to be emphasized by the Medicare program through various initiatives, including those required under the Affordable Care Act. Toward that end, we believe including these service codes on Medicare’s telehealth list will only further those efforts.

We further encourage CMS to include its newly adopted chronic care management codes on the Medicare telehealth list to enable payment for the provision of this service for patients unable to travel to a physician office.

Valuing New, Revised and Potentially Misvalued Codes

AAHPM appreciates CMS’s proposal to increase transparency in the establishment of relative value units (RVUs) through a revised process that would provide for improved notice and comment. Medical specialty societies and congressional leaders have urged CMS to take any and all steps necessary to ensure that the rulemaking process for changes in the MPFS under the misvalued codes initiative is transparent and allows for sufficient input by stakeholders well before the new values are implemented. Regrettably, CMS’s proposal is overly complex, potentially burdensome, and goes well beyond the principal request of the medical specialty societies and Congress – that is, for CMS to publish reimbursement changes for misvalued codes in the proposed rule, as opposed to waiting until the final rule.

While we recognize that CMS needs time to employ its rate-setting methodologies that are part of the physician fee schedule, it is our belief that CMS has enough time to incorporate revised values for misvalued codes into the proposed rule given the rate-setting methodologies are mostly automated calculations. We note that CMS receives RVU recommendations for misvalued codes from the American Medical Association/Specialty Society Relative Value Scale Update Committee (AMA RUC) just days after the Spring meeting (typically in April), which is at least two months in advance of the release of the annual MPFS proposed rule.

Rather than simply addressing the predominant concern, CMS proposes to disrupt the entire process for establishing RVUs by proposing significant and potentially burdensome modifications that would also affect RVUs for new codes and technologies. Physicians and other providers that are reimbursed under the MPFS have an expectation of what their payments will be for most established services, whereas with new codes and technologies, there would be little (if any) expectation, as reimbursement may or may not have been made previously.

We urge CMS to abandon its proposal, and simply begin publishing revised RVUs for misvalued services in the proposed rule.

Chronic Care Management

We continue to support the agency's efforts to ensure payment for non-face-to-face work associated with coordinating care for chronically ill beneficiaries. CMS has made a concerted effort to emphasize the value of this important work by finding mechanisms to fund non-face-to-face services. We commend the agency for eliminating certain restrictions on billing the new chronic care management (CCM) services, for choosing not to adopt broad practice standards for providing CCM services, and for allowing CCM services to be performed "incident to." Nonetheless, AAHPM is concerned that CMS's proposed payment rate and requirement for electronic health records (EHRs) would limit practitioners' ability to provide these services.

With regard to the proposed payment amount, AAHPM does not believe it will be adequate to support the patient population for whom the service is intended. Patients that require CCM services are atypically complex; they have multiple chronic health care conditions managed by medications with a high risk of interaction and adverse events, and are more likely to have an emergency room visit or hospitalization. Our members care for the sickest among these patients who require high-contact, interdisciplinary, uniquely individualized care management to maximize quality of life, limit low-value interventions (like avoidable hospitalizations), and deliver the best care possible. Numerous studies have demonstrated the ability of these services to deliver both higher quality and lower cost.

In addition, emphasizing the use of EHRs when interoperability standards have not been developed, adopted and incorporated into certification requirements for EHR technology seems misguided. CMS is already aware of the current challenges associated with the availability of 2014 Edition certified EHR technology (CEHRT), which has created multiple other challenges for practices. Until these issues are resolved, we do not believe CMS should require practices to be meaningful users of EHRs in order to be reimbursed for care coordination services.

Given the aforementioned concerns and our mutual goal of improved care coordination for all Medicare beneficiaries, we urge CMS to finalize the modifications vetted by a coalition of medical specialty societies representing the physicians most likely to provide such services. Specifically:

- Acknowledge that *complex* chronic care management for patients at highest risk requires a more resourceintense set of interventions than *standard* chronic care management
- Modify the GXXX1 code proposed for CCM services to reflect *standard* chronic care management, as outlined in the coalition's letter
- Begin to make payment on established CPT codes—specifically 99487, 99488 and 99489—for the services described in the proposed rule. These codes have been valued by the Relative Value Scale Update Committee (RUC) using a very robust survey, and reflect the experience of practitioners who deliver these services every day.
- Remove the requirement for participating practices to use 'certified' EHRs.

Again, we applaud CMS's efforts to support high-value, non-face-to-face services for beneficiaries with chronic illness and appreciate the provisions written in the proposed rule. We strongly believe that the improvements outlined above will allow the final rule to advance our shared objectives as well as the "triple aim."

Reports of Payments or Other Transfers of Value to Covered Recipients

AAHPM appreciates the need for public transparency of industry-physician financial relationships and supports the intent of the Open Payments (Sunshine Act) program. However, we are concerned about CMS's proposal that would eliminate the "bright line" exception for accredited Continuing Medical Education (CME) activities that is currently afforded to physicians through CMS's existing regulations. One of the most challenging aspects of compliance with the Sunshine Act is accounting for "indirect payments" made through third parties, yet it is that with which CMS proposes to replace the CME exception.

CME is an effective and necessary tool to aid AAHPM members in the acquisition and retention of knowledge, attitudes, skills, behaviors and clinical outcomes necessary to provide high-quality, patient-centered care. Eliminating the CME exception could have significant, negative ramifications, hindering physicians' ability and willingness to participate in accredited CME events out of concern that a speaking honorarium, travel fees, or any other payment or transfer of value received by physicians for participating in accredited CME events would become subject to public reporting.

As you know, with the promulgation of the Sunshine Act, the acceptance of funds from industry by physicians has come under extreme scrutiny. Consequently, many health care organizations – including employers, medical specialty societies, and publishers of medical and scientific literature – have initiated their own rules and requirements related to the acceptance of payments or transfers of value by physicians from manufacturers. For example, some teaching hospitals do not allow their physician employees to accept any funds or transfers of value as a condition of their employment. Many medical professional societies have also revised their bylaws to ban board, committee and task force members, and other society leadership from accepting any funds or transfers of value from manufacturers. Organizations that publish medical and scientific journals have also implemented rules for their physician medical editors and journal article reviewers that ban them from accepting any funds or transfers of value from manufacturers.

Physicians take their employment and other volunteer commitments very seriously, as these positions are considered a great honor within their professional communities. In fact, many physicians have been elevated into these distinguished roles as a result of their clinical research and participation in accredited CME events, among other things. CMS's proposal, if finalized, would have a negative and detrimental impact on physicians' ability to serve as faculty at many teaching hospitals; serve as volunteers in their professional associations; serve as medical editors and journal article reviewers; and, ultimately, share their knowledge, skills and expertise with their colleagues to improve the quality and cost of health care. By eliminating the CME exception, CMS is putting physicians in a position where they will be unsure of which activities will be reportable and which will not, thus limiting their ability and willingness to participate in accredited CME events.

Again, we recognize that there is some redundancy with the CME exception with other provisions, given the exclusion for certain indirect payments where the manufacturer is "unaware" of (that is, "does not know") the identity of the covered recipient. Nonetheless, it is

our sense that the CME exception provides the level of clarity physicians truly appreciate when it comes to CMS's Open Payments program and its impact on their participation and engagement in accredited CME activities. As noted before, accounting for "indirect payments" is already challenging and the "knowingly" standard is likely to be more even more problematic for industry if accredited CME events are no longer excluded.

Similarly, CMS's proposal does not provide manufacturers with any assurances that, if they decided not to report indirect payments or transfers of value that they become aware of *after* an accredited CME event, those manufacturers would not be subject to penalties. Manufacturers with overzealous transparency compliance officers are more likely to report all instances to avoid financial penalties.

In addition, while we understand that CMS would prefer to distance itself from serving as the arbitrator for determining which entities are CME accreditors, and which are not, we note that CMS regularly engages in such activities through its other "deeming" activities. We do not see that maintaining a list of those groups that meet the agency's standards for accrediting CME events as being patently different in that regard. If CMS has concerns about its level of expertise in making decisions about the standards to which it should hold CME accreditors, it should use the rulemaking process to gather input from experts and other stakeholders who could assist with this activity. CMS frequently engages in the development of similar standards, and this activity would be no different.

We have carefully considered CMS's proposal and multiple alternatives. While we initially supported a slight modification of CMS's proposal (as evidenced by our co-signature on an August 5, 2014, letter to CMS that was generated by the AMA), further review and discussion with AAHPM's education staff, leadership, and relevant committees have led us to a *different* position. **Specifically, we have concluded that we do not support the elimination of the CME exception. Instead, we urge CMS to maintain the CME exception and expand the list of CME accreditors.**

Further, this proposed action reverses a decision that CMS had previously reached after reviewing hundreds of stakeholder comments in a comprehensive rulemaking process. This decision, if finalized, would significantly disrupt the practice of CME and the confidence of doctors, educators, and others. We urge CMS to reconsider its proposal to eliminate this exception, and instead, appropriately expand the list of certified CME accrediting/issuing agencies that adhere to firewalls between education and promotion (like the ACCME's *Standards for Commercial Support: Standards to Ensure Independence in CME Activities*) beyond the five currently cited in regulation.

Finally, as CMS continues to implement the Open Payments system, we urge the agency to review ongoing issues reported by physicians attempting to register and to expand the registration timeframe accordingly to ensure covered recipients have ample opportunity to register, review, and dispute data on the Open Payments System before publication. AAHPM also requests that CMS provide clarifying guidance that manufacturers and group purchasing organizations (GPOs) are not authorized to unilaterally dismiss disputes by physicians or teaching hospitals. Given the inconsistent interpretations of the Sunshine Act evidenced by manufacturers

to date, information collected in the Open Payments system should be flagged as disputed in the public database until resolution is reached between the parties.

Physician Compare Website

In this rule, CMS lays out a roadmap for a rapid expansion of publicly reported performance data, including releasing data in early 2015 on a select set of Physician Quality Reporting System (PQRS) measures reported by individuals in 2013 and releasing data on *all* individual measures reported in 2015 by late 2016.

AAHPM appreciates CMS's efforts to improve the accuracy and format of the Physician Compare website. We also appreciate that CMS proposes to "continue to reach out to stakeholders in the professional community, such as specialty societies, to ensure that the measures under consideration for public reporting remain clinically relevant and accurate" and to use concept testing to verify how well consumers understand each measure under consideration for public reporting. Nevertheless, we question how CMS can accomplish these goals in the short timeframe proposed for publicly reporting data. While AAHPM supports CMS's desire to get information into the hands of patients and make them more informed health care decision-makers, releasing too much data too quickly can have the reverse effect and result in information that is both confusing and of little value. We urge CMS to take a more gradual approach to public reporting and to evaluate the release of more limited data prior to widespread implementation to ensure they are accurate and presented in a format that is easy to understand, meaningful, and actionable for both patients and physicians.

AAHPM also urges to CMS to extend the proposed 30-day preview period before data is released to the public in order to give physicians more time to review the data, identify errors and gather the evidence needed to refute any errors. Furthermore, we request additional details on the recourse that would be available to a physician who identifies a problem or error during this preview period.

Physician Quality Reporting System (PQRS)

Existing Measure Gaps

There are currently no measures in PQRS that specifically address the broad category of palliative care for patients of any age, without being disease-specific. As a result, there are very few physicians who identify with a specialty of Hospice and Palliative Care who are reporting measures through PQRS. This is especially concerning as we transition into the all-penalty phase of this program.

During the 2015 PQRS call for measures, AAHPM requested that CMS consider including three additional measures, which are specific to Hospice and Palliative Care, in order to increase access and participation in PQRS by our clinicians. We would like to reiterate the critical importance of adding the following measures to the program to increase participation by our clinicians:

- *Palliative Care: Advance Care Planning* — This measure from the NCQA/PCPI was adopted from PQRS Measure #47, and it extends the denominator population to capture people under the age of 65 who are at the end of life.

- *Palliative Care: Dyspnea Screening and Management* — This measure is from the NCQA/PCPI. Dyspnea is a symptom frequently seen in patients near the end of life. Assessment and treatment of symptoms such as dyspnea are critical for optimal palliative care. Identification and treatment (if necessary) of dyspnea improves quality of life at the end of life.
- *Patients Treated with an Opioid who are Given a Bowel Regimen* — NQF Measure #1617 is another important measure since opioids are commonly used in the management of moderate to severe pain, and constipation is a common adverse effect. Additionally, this measure is included in the final rule for hospice quality reporting, as part of the 7-item Hospice Item Set (HIS).

To make progress in the area of physician quality, it is critical that CMS invest in the development and testing of patient- and family-centered palliative care measures, including those that aim to fit treatments to patient goals, such as measures encouraging discussion/confirmation of advance directives. Ideally, these palliative care measures would be broadly applicable across multiple settings, not just ambulatory settings. Most importantly, we highlight the need for a common denominator that comprehensively captures the patient population appropriate for palliative care. No measure currently used under federal quality reporting programs focuses on this population exclusively.

In addition, we urge CMS to invest in development of a dictionary of data elements needed to ensure accurate and coordinated palliative care quality measurement. As we have expressed through previous rulemaking opportunities, most EHRs still do not capture much of what is needed to measure palliative care quality. Incentive programs to develop standardized data elements and corresponding quality measures in partnership with large electronic medical record vendors (EPIC, Cerner) and other government agencies would spur this development.

CMS has repeatedly identified person- and family-centered care and the promotion of effective communication and coordination of care as top priorities in its efforts to improve patient, family and caregiver experience of care; encourage shared decision-making; and improve quality of life for patients with chronic illnesses and disabilities. The three measures AAHPM suggests CMS consider for inclusion in PQRS address these goals and could be used to track performance and monitor improvement of both palliative care and end-of-life care.

The development of palliative care measures is also aligned with the National Quality Forum (NQF) priority area of end-of-life care (as delineated by NQF's consensus statement for the delivery of quality palliative care). Additionally, such measures address issues identified by a National Institutes of Health (NIH) State of the Science panel on improving end-of-life care. The NQF and NIH priority areas address gaps in quality care measurement as defined by the Institute of Medicine in its report *Approaching Death: Improving Care at the End-of-Life* (published in 1997 and currently being updated). Further, these areas align with national priorities set by NQF's National Priorities Partnership, which identified inappropriate/unwanted non-palliative services at end of life under a priority area targeting overuse of health care resources. The Measure Applications Partnership (MAP) has also identified high-priority measurement gaps

related to symptom management effectiveness, quality of life, and concordance between patient goals and treatments.

The NQF National Voluntary Consensus Standards for Palliative Care and End-of-Life Care project also reinforced the importance of having performance measures for palliative care in its final report, which stated:

"Assessing the quality of palliative care and end-of-life care programs by using measures that reflect the current evidence base is crucial to ensure safe, cost-effective care. Palliative care programs in U.S. hospitals have grown by 125 percent in the last decade; by 2030, there will be 72.1 million older persons in the United States, more than twice the number as 2000. The need for high-quality and safe palliative care and end-of-life care services will only continue to grow as the population ages. Attention recently has been focused on increasing the quality and availability of palliative care and end-of-life care services, both for acutely ill patients and those with life-limiting illnesses. Studies have found that palliative care programs across the trajectory of a patient's illness, including end-of-life care, can result in improved quality of care, including higher patient satisfaction; improved communication; fewer admissions to intensive care units, emergency departments, and acute care hospitals; more referrals to hospice; and overall reduced costs."

AAHPM recognizes that the measures we propose above are process measures and that CMS is trying to move away from such measures. However, they represent a much-needed starting point to begin the systematic assessment of quality in the field of palliative care and could be used to track performance and monitor improvement of both palliative care and end-of-life care. Further, as previously stated, there are simply no measures in the PQRS program that specifically address the broad category of palliative care for patients of any age, without being disease-specific.

We would like to highlight that AAHPM has invested significant resources in the identification and potential development of more robust measures through our "Measuring What Matters" (MWM) project. This consensus project, a partnership between AAHPM and the Hospice and Palliative Nurses Association (HPNA), aims to identify a recommended portfolio of cross-cutting performance measures for all hospice and palliative care programs. To date, a technical advisory panel has rated published measures on their scientific soundness and referred a set of measures (n=34) for review to a Clinical User Panel (CUP). The CUP rated those measures based on three dimensions of meaningfulness (i.e., how *meaningful* it is for patients/families; how *actionable* it is for providers/organizations; and how large of a *potential impact* it may have). The CUP achieved consensus on its top 12 initial published measures, which have been posted on AAHPM's website for member, patient, and general public feedback. AAHPM encourages CMS to monitor the activities of this initiative as it considers additional measures for the PQRS in future years. Currently, the project is proposing measures for internal quality improvement in clinical settings, a necessary first step before proposing measures for accountability. During phase two of MWM, we will be discussing creating a unified set of measures with one common denominator. More information is available at: <http://aahpm.org/quality/measuring-what-matters>

Proposed Measure Additions

Given the small number of measures on which our members can report, AAHPM also appreciates CMS's proposal to add the following measures to the PQRS for 2015:

- ALS Patient Care Preferences: Percentage of patients diagnosed with ALS who were offered at least once annually assistance in planning for end-of-life issues (e.g., advance directives, invasive ventilation, hospice).
- Depression Response at 12-months: Progress Towards Remission: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at twelve months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.
- Closing the Referral Loop – Receipt of Specialist Report: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

However, these measures are still only tangentially related to our specialty and do not address the challenges discussed earlier regarding the current lack of measures that focus on palliative or hospice care specifically.

Proposed Changes to PQRS Reporting Requirements

CMS proposes to increase the requirements for satisfactory PQRS reporting in 2015 to avoid a 2017 penalty of 2%. In addition to requiring eligible professionals (EPs) to report on at least nine measures covering three National Quality Strategy (NQS) domains, an EP who has at least one face-to-face encounter with a Medicare patient must also report on at least two cross-cutting PQRS measures. As mentioned earlier, there is currently a paucity of PQRS measures that are directly relevant to hospice and palliative care providers, and most of our members find it difficult to meet the nine-measure requirement in a meaningful manner. As such, AAHPM appreciates that, at the very least, the proposed set of cross-cutting measures includes some that are relevant to our members, including:

- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- Documentation of Current Medications in the Medical Record
- Care Plan
- Medication Reconciliation
- Pain Assessment and Follow-Up Functional Outcome Assessment

AAHPM specifically appreciates that CMS is proposing to continue to allow EPs to report the Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan measure; the Documentation of Current Medications in the Medical Record measure; the Care Plan measure; and the Pain Assessment measure via either claims or registries. With the enormous shortfall of available measures on which our members can report, it is critical that they have multiple reporting options to choose from, including the most accessible option, which is claims. We urge CMS to reconsider its decision to not include claims-based reporting as an option for the other measures. Without the option of reporting these measures through claims, our members may have very little to report.

The cross-cutting measure set would also be an excellent place to promote palliative care measures, and we therefore request that CMS consider the palliative care measures AAHPM recommends above for inclusion in this set.

Qualified Clinical Data Registry

AAHPM supports the Quality Clinical Data Registry (QCDR) reporting mechanism since it gives specialty societies the flexibility to report on measures that are most relevant and meaningful to their members and to make use of data that they may already be collecting for other purposes. Although we are not yet in a position to become one, we are working with other palliative and hospice care groups to evaluate the possibility of applying in the future. Going forward, we urge CMS to consider policies that ensure the collection of valid and reliable data, but also make this option feasible for a range of specialties in various stages of registry development.

Physician Value-Based Payment Modifier

While AAHPM understands that the Affordable Care Act (ACA) requires that CMS phase the value modifier (VM) in over a three-year period beginning in 2015 and that it apply to all physicians by 2017, we believe implementing this program at such a rapid pace leaves CMS and the public with very little time to evaluate the results of earlier years of implementation and practically no time to make changes to the program based on lessons learned. The VM is yet another regulatory requirement that will only compound the burden that practicing physicians already face and further erode the physician-patient relationship if carried out too aggressively.

In this rule, CMS proposes to not only apply the VM to all physicians in 2017, but to double the penalty to 4%. Although group practices with two to 10 EPs and solo practitioners would be held harmless from downward *performance-based* payment adjustments in 2017, they are still at risk for a *non-participation* penalty that is two times as large as the penalty applied to larger practices (10-99 EPs) and four times as large as the penalties applied to the largest of practices (100+ EPs) during their initial year in the program. This is very concerning considering the distinct lack of PQRS measures relevant to our specialty that may prevent our members from satisfying the reporting requirements.

AAHPM urges CMS to use its existing authority to ease new participants into the program by either holding them completely harmless from penalties, reducing the initial payment penalty, or requiring less stringent reporting requirements during the initial year.

Quality Measures

CMS proposes to continue to base the VM largely on PQRS measures, as well as other acute and chronic care prevention measures that have very little to do with our specialty. AAHPM reiterates its concerns about our specialty having a distinct lack of relevant measures in light of rapidly increasing penalties associated with the VM and the cumulative nature of total payment penalties facing physicians over the next few years, which could exceed 10%.

Furthermore, while AAHPM appreciates CMS's promotion of patient satisfaction measures, we warn against prescribing a particular set of measures that may not be relevant to all physicians. We appreciate that CMS proposes to make the reporting of CG-CAHPS measures in 2015 for

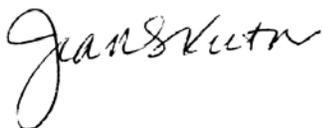
purposes of the 2017 VM *optional* for groups with two or more EPs. However, other aspects of the rule seem to indicate the agency's desire to make CAHPS reporting a required component of federal quality initiatives in the future, including the VM and Physician Compare. We urge CMS to look beyond the CG-CAHPS measure set and to consider other patient experience measures that may be more relevant to the hospice or palliative care patient. For example, AAHPM is supportive of the CAHPS Hospice Survey, which could be modified for physician-level reporting in the future. The CAHPS Hospice Survey borrows heavily from the Family Evaluation of Hospice Care (FEHC), a post-death survey that asks questions about families' perception of the care provided to the patient, as well as their own hospice experience. CMS also relied heavily on the clinical expertise of hospice and palliative care providers and the personal expertise of patients and caregivers as it developed this tool. AAHPM would be happy to work with CMS to adapt this survey for physician-level reporting.

Cost Measures

AAHPM also has general concerns about CMS's continued reliance on broad cost measures for this program, as they assess the total amount billed per patient and not the treatment of the individual provider. While tracking costs (and quality) across the care continuum is important for developing policies to improve our care delivery system, these general assessments are not appropriate for individual physician accountability since they incorrectly assume that physicians have control over the care plan and treatment decisions of other physicians who also treated the patient over the reporting year.

The challenges CMS presents in this proposed rule create new opportunities for AAHPM to advance its core mission of expanding access of patients and families to high-quality palliative care and advancing the discipline of Hospice and Palliative Medicine through professional education and training, development of a specialist workforce, support for clinical practice standards, research, and public policy. We are eager to collaborate with CMS to address the many challenges discussed here. In the meantime, AAHPM's leadership is available to provide additional information or comment. Please address questions to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,



Jean S. Kutner, MD MSPH FAAHPM
AAHPM President