Society of Hospital Medicine
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September 8, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Acting Administrator Slavitt:

The Society of Hospital Medicine (SHM) is pleased to submit comments on CMS-1631-P Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016.

SHM represents the nation's nearly 48,000 hospitalists, who are experts in primary care for hospitalized patients. In this role, they provide a significant amount of care to Medicare and Medicaid beneficiaries, ensuring safe and efficient delivery of care during hospital stays and transitions in and out of the hospital. The unique position of hospitalists within the healthcare system affords a distinctive role in facilitating both individual physician-level and systems/hospital-level performance agendas.

SHM offers the following comments on the proposals contained in the CY 2015 Physician Fee Schedule proposed rule:

Advance Care Planning Codes

SHM strongly supports and commends CMS' proposal to make CPT codes 99497 and 99498 active codes, which will allow Medicare payment for advance care planning (ACP) consultations.

Hospitalists are critical team leaders for coordinating care, and are often highly involved in end of life care for patients in acute care hospitals and, increasingly, in post-acute facilities. They are often asked to help patients plan their end of life care needs and then ensure the healthcare system meets those needs. Patients are frequently prompted by a hospitalization to address end of life care decisions. Many hospitalists' patients are acutely ill and are facing these critical decisions in real time. As a result, many patients may wish to explore other potential treatment options that had not previously been available or contemplated. Thus, too often, hospitalists participate in end of life care conversations that are long overdue, which increases uncertainty and adds further stress to patients and their families at a time when they are most vulnerable. For these reasons, billing for ACP codes should be flexible and

recognize that such conversations are necessary throughout the continuum of care a patient receives.

SHM seeks to ensure all seniors have opportunities to have ACP discussions with their providers. We are concerned that ACP services paid under local coverage determinations (LCDs) may result in inadvertent regional and local variances in the application of these codes. Such variation would be to the detriment of patient care and patient wishes. We recommend that, at a minimum, CMS provide robust guidance to Medicare contractors on the application of and payment for these ACP codes.

SHM also recommends that CMS should not impose limitations around the site of service where these codes may be billed and at what frequency. We urge CMS to recognize that ACP is not a one-time interaction, but a process that occurs over time and as clinical realities unfold throughout the patient's experience.

In the proposed rule, CMS cites an example of a heart failure/diabetic patient: "In addition to discussing the patient's short-term treatment options, the patient expresses interest in discussing long-term treatment options and planning, such as the possibility of a heart transplant if his congestive heart failure worsens and advance care planning including the patient's desire for care and treatment if he suffers a health event that adversely affects his decision-making capacity. In this case the physician would report a standard E/M code for the E/M service and one or both of the ACP codes depending upon the duration of the ACP service." This example would be just as appropriate, and perhaps even more likely to arise, in the inpatient setting as in outpatient.

Making separate payment for ACP will not only allow for these services to be more readily available to beneficiaries, but will also allow Medicare to track how these services are being furnished and to assess their impact on the quality of life and effectiveness of care. Programs such as PQRS already ask physicians to report on whether or not they addressed ACP with patients. Payment for this service will logically align with these quality reporting mechanisms and promote higher quality and value in the system.

Like many other "non-procedural" activities, ACP is not only undervalued, but there is currently *a lack of value* assigned to this important cognitive service. CMS' proposal stands to reverse this trend and open the pathway for patients and their physicians to have these conversations. **SHM fully supports and applauds this decision.**

<u>Physician Compare Website</u>

SHM supports CMS' efforts to make useful and meaningful information about the quality and efficiency of providers available to beneficiaries as they make decisions about their healthcare. However, we stress that the information available on Physician Compare must be accurate and relevant in order to ensure that consumers are not misinformed, and that physician practices are not unintentionally harmed. Given this perspective, SHM offers the following comments on the specific proposals for Physician Compare.

Value Modifier

CMS proposes to add a green check mark for those groups and EPs who are receiving an upward adjustment under the value-based payment modifier. SHM does not support the inclusion of a check mark for the value modifier at this time.

For hospitalists, the value-based payment modifier has significant flaws that create the appearance of inadequate performance. The specialty breakdown within the cost composite of the value-based payment modifier does not have enough specificity to determine differences between primarily outpatient internal medicine and family practice physicians from those who practice primarily in inpatient settings. Therefore, hospitalists automatically appear more costly than their office-based outpatient peers. These structural issues will result, more frequently than not, in hospitalists receiving a neutral or downward adjustment in the value-based payment modifier. As a way to help alleviate some of these issues, SHM applied for a Medicare specialty billing code in May, 2014 and we look forward to hearing a positive response from CMS. Having a distinct comparison pool will ensure fair and more accurate assessments of hospitalists' costs and efficiency.

SHM is also concerned with the public reporting of a program that will change significantly in the upcoming years. With the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requiring the cessation of separate penalties under the value-based payment modifier and a restructuring of how penalties will be assessed, it does not make sense to begin publicly reporting performance on this program at this time. This rapid change in how and what can be publicly communicated will risk confusing consumers and providers alike.

Patient Experience of Care Measures

CMS proposes to make CAHPS for PQRS information publicly available on Physician Compare. SHM cautions that this should only be implemented if the providers who cannot and should not be collecting CG-CAHPS survey responses are not inadvertently penalized in the method of publicly reporting these results. Hospitalists are not in a position to be able to collect and report CG-CAHPS data due to the nature of their practice. Given CMS' move towards mandatory reporting of CAHPS for PQRS, it would make sense for Physician Compare to include an explanation for why groups are not reporting on these patient experience measures, instead of only displaying a blank box or generic "not applicable."

Board Certification

CMS proposes to add additional Board Certification information to Physician Compare, including information from the American Board of Optometry and the American Osteopathic Association. We broadly support these additions.

We note, as we have in previous years, that hospitalists are in a unique position to be Board Certified as either internal medicine or family practice physicians. Unlike their outpatient peers, hospitalists do not serve in an office-based primary care role and are not generally chosen by a patient as their provider. We estimate 48,000 hospitalists are practicing nationwide, distinct from general outpatient internal medicine or family practice providers. For hospitalists who choose to pursue a Focused Practice in Hospital Medicine (FPHM) Maintenance of Certification (MOC), it makes sense to report this achievement on Physician Compare. This would be a start toward better distinguishing hospitalists from their outpatient internal medicine or family practice counterparts.

The consumer community would be well-served by information on Physician Compare that defines the unique and important role of hospitalists in providing patient care, managing costs, and improving safety in the hospital, and increasingly, post-acute environments. Without it, results from Physician Compare may be confusing and counterintuitive. We encourage the use of more nuanced identification

of subspecialized providers on Physician Compare to ensure patients are getting the most accurate and relevant information about their providers. As a way to help alleviate these issues, SHM applied for a Medicare specialty billing code in May, 2014 and we look forward to hearing a positive response from CMS.

Seeking Public Comment for Possible Future Rulemaking

CMS requests public comments on future changes for Physician Compare, including the incorporation of cost measures from the value-based payment modifier. SHM cautions against using the cost measures from the value-based payment modifier until there are adequate adjustments to the comparison pools. The specialty breakdown within the cost composite of the value-based payment modifier does not have enough specificity to determine differences between primarily outpatient internal medicine, and family practice physicians, from those who practice primarily in inpatient settings. Therefore, hospitalists almost invariably will appear more costly than their outpatient peers – an inappropriate comparison at best. These structural issues will yield, more frequently than not, hospitalist groups to appear high-cost when they may actually be performing comparably or even better than average if compared with their hospitalist peers.

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

The CAHPS for PQRS Survey

SHM appreciates CMS' clarification that hospitalists are not required to report on the CAHPS for PQRS survey measures. Hospitalists are not appropriate candidates for surveying through the CG-CAHPS, as they do not have the office-based practice the survey questions envision. Public reporting through the CG-CAHPS survey will not provide useful information about hospitalists, therefore, we urge CMS to ensure only providers to whom the survey is relevant are required to participate.

Measures Proposed for Removal from the Existing PQRS Measure Set Beginning in 2016

CMS proposes to remove two measures that have inpatient codes in the denominator and as such are potentially reportable by hospitalists:

- PQRS 033 Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge
- PQRS 040 Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

We acknowledge CMS' rationale for removing these measures, but note that this decision further reduces the number of potentially reportable measures for hospitalists. This, in turn, makes successful participation in PQRS ever more difficult for hospitalists, as has been the trend in recent years.

We also strongly encourage CMS to develop more detailed information about the MAV process and recommend that CMS allow practices prospective access to the MAV while they are deciding how and what measures to report. Many hospitalist practice groups will be unable to identify 9 measures with which to report in the coming years. A group may, in good faith, identify only 5 or 6 applicable measures and should feel confident that they will not be penalized despite their efforts. MAV should only be used

as a means to identify gamesmanship and cheating, and should not be used to penalize good faith PQRS reporting.

Request for Input on the Provisions Included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) - MACRA Implementation

SHM appreciates that CMS is engaging stakeholders as early as possible in the process of implementing MACRA. This involvement will be critical in creating a more sensible and streamlined physician payment system.

General Comments about MACRA

SHM believes the implementation of MACRA, and in particular the MIPS, is a unique opportunity to rework and improve upon policies of the various pay-for-performance programs. As PQRS, Meaningful Use, and the VBPM have been unrolled over the past few years, numerous programmatic issues have arisen for a variety of providers.

For hospitalists, many of these problems stem from their roles as facility-based providers. For example:

- The flawed definition of hospital-based EP under Meaningful Use has resulted in many hospitalists being held accountable for establishing and maintaining their own EHR system – an impossible task given a hospitalist's practice setting. They are currently experiencing unwarranted penalties due to the impossibility of this demand. This is the case despite the fact that hospitalists are playing integral roles in helping their hospitals achieve Meaningful Use and are using the hospital systems that they help to implement.
- In PQRS, most of the measures are oriented around outpatient office visits or procedures, and are not reportable by hospitalists.
- In the VBPM, costs incurred by hospitalists are compared against outpatient internal medicine and family practice providers, yielding an inaccurate and unfair cost comparison profile.

We strongly discourage CMS from wholesale adoption of existing policies for the PQRS, VBPM, and Meaningful Use into the MIPS. Instead, we encourage close engagement with specialties to ensure providers of all types are accurately and meaningfully assessed.

a. The Merit-based Incentive Payment System (MIPS)

Clinical Practice Improvement Activities

Clinical practice improvement activities are one of the performance categories used in determining the composite performance scores under the MIPS. Clinical practice improvement activities are defined as activities that EP organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that CMS determines are likely to result in improved outcomes.

We are concerned that most of the sub-categories outlined within MACRA seem to be directed toward office based primary care physicians and other outpatient specialties. As facility-based providers, hospitalists will need these sub-categories to be interpreted in ways that account for facility-level clinical or quality improvement activities. For example, this could be achieved by including hospital-level clinical or quality improvement activities as applicable to one or more subcategories.

Hospitalists are leaders in developing and implementing successful quality improvement initiatives within their institutions and should be eligible to receive credit for these efforts under MACRA. A few examples of these efforts include working to improve care transitions for hospitalized patients, reducing the rates of venous thromboembolism (VTE) and hospital acquired infections, and improving glycemic control in patients. SHM has developed a number of quality improvement programs that could be considered qualifying Clinical Practice Improvement Activities if adopted by a hospital and implemented by a hospitalist group.

b. Alternative Payment Models (APMs)

Section 101(e) of MACRA, Promoting Alternative Payment Models, introduces a framework for promoting and developing APMs and providing incentive payments for EPs who participate in APMs. CMS is "broadly seeking public comment on the topics in this section."

Hospitalists generally do not have control over whether or not their affiliate institution participates in or even allows participation in a particular APM. Therefore many hospitalists, regardless of their desire to participate in alternative payment arrangements, will not be eligible for the 5% APM participation bonus from 2016-2021. SHM would like to work with CMS to establish APM proposals that are relevant not only to specialist professionals, but also feasible for hospital-based and other facility-based professional participation.

Additionally, many hospitalists are either salaried employees of a hospital or contracted to provide services for the hospital. These employment structures will make it difficult, if not impossible, to trace percentages of APM revenue directly to individual or groups of hospitalists. SHM supports the concept that participants need to be invested substantially and demonstrably in an APM, and in many instances revenue percentages may work as an indicator, but for some practices, revenue, or even percentage of patients alone, are unlikely to be a good marker for committed participation.

To address these difficulties, we encourage CMS to consider how to expand and evolve APMs, including ACOs and Bundled Payment, to include and incentivize the participation of all providers, including those who practice within facilities (employed or contracted) and at multiple locations. Another option could be established that would allow the 5% bonus to be earned by facility-based providers if they are able to demonstrate concerted efforts toward goals such as decreasing resource use and improving quality with their compensation tied in some appropriate way (or applicable percentage exceeding nominal financial risk) to such efforts. Acknowledging that one size does not fit all, creative efforts should be made within the bounds of MACRA that would allow for providers to demonstrate their vested interest and involvement as APM participants.

Medicare Shared Savings Program

SHM fully supports the exclusion of Skilled Nursing Facilities (SNF) from the definition of primary care services for the purpose of attribution of patients to an ACO, and greatly appreciates the responsiveness of CMS in addressing this problem. Hospitalists are increasingly providing care in SNFs as they focus on transitions from facility to facility. Since many SNF facilities need to accommodate patients from several ACOs, provider exclusivity in this setting is financially and structurally prohibitive.

We urge CMS to finalize its proposal to exclude CPT codes 99304-99318 with Place of Service Code 31 from the attribution methodology. Appropriate ACO assignments based on a patients primary care

provider is the main goal of the exclusivity provision, and the removal of SNF care from the definition will ultimately help achieve this end.

Value-Based Payment Modifier and Physician Feedback Program

Application of the VM to Physicians and Nonphysician EPs that Participate in the Pioneer ACO Model, the CPC Initiative, or Other Similar Innovation Center Models or CMS Initiatives

CMS proposes to apply waivers from the VBPM for participant TINs in Pioneer ACOs, the CPC Initiative and other similar models to avoid disrupting the delivery system and payment transformation taking place under these projects and in recognition of the quality assessment already built into these programs. SHM supports this effort to reduce duplicative reporting burden and prevent distraction from the goals of these programs. However, we strongly urge CMS to extend this waiver to physician group practices participating in the Bundled Payment for Care Improvement (BPCI) initiative. While taking risk on a bundled payment may not, on its face, be as broad or cover as many patients as an ACO, the up-front costs incurred, care redesign efforts, and focus on cost/quality are just as significant for many physician practices participating in BPCI.

CMS lays out the following criteria for granting this waver: (1) the model or initiative evaluates the quality of care and/or requires reporting on quality measures; (2) the model or initiative evaluates the cost of care and/or requires reporting on cost measures; (3) participants in the model or initiative receive payment based at least in part on their performance on quality measures and/or cost measures; (4) potential for conflict between the methodologies used for the VM and the methodologies used for the model or initiative; or (5) other relevant factors specific to a model or initiative. Physician groups participating in BPCI meet these criteria, and even if BPCI does not fully meet each element, CMS recognizes that a model or initiative does not have to satisfy or address all of these criteria to be considered a similar model or initiative within the Innovation Center. We urge CMS to use its authority to grant these VBP waivers more broadly to include physician groups participating in BPCI.

Solicitation of Comments: Perceived Need for Regulatory Revisions or Policy Clarification Regarding Permissible Physician Compensation

The Stark Law as a Barrier to Health Care Reform

For providers, there are still barriers to developing fully coordinated and efficient systems, due to current gainsharing and anti-kickback statutes. MACRA established some steps to change the CMP law, but these changes do not go far enough to comfortably allow gainsharing and positive incentive arrangements. While SHM recognizes the need to have safeguards for patients and for the Medicare Trust Fund, there also need to be opportunities for the expansion of safe harbors and clear protections from penalties for providers who enter into gainsharing arrangements designed to improve care delivery, patient experience of care, and which in turn result in more efficient resource use and better health for patients. Any new safe harbors or exceptions need to be clear, consistent, and take into account the realities of practice. Providers know what kind of arrangements need to be established to truly and aggressively tackle improving care, reducing waste, and increasing efficiency – solutions should be implemented based on provider need, rather than narrow definitions.

Further barriers prevent efforts to better include patients in improving the quality and cost of care. As an example, gainsharing incentives could be expanded to include patients. Gainsharing arrangements

are structured to incentivize physicians, in currently limited ways, to take part in higher quality, cost-conscious care, but at this point in time, patients are not included in these incentives. If patients were to also receive a reward in some form of gainsharing arrangements for maintaining their health and following the care their doctor prescribes (e.g., filling prescriptions, taking their blood pressure and reporting results to their doctors, showing up to follow-up visits, etc.), many more patients would actively participate in their care. More active participation would lead to better transitions between facilities, and better coordination of care between doctor and patient.

Patients with multiple chronic conditions may particularly benefit from this concept, as they are often taking multiple medications and visiting multiple facilities. If patients are incentivized, and in turn more active and responsive to their own long-term conditions and care needs, physicians too, will be more quickly informed and able to adjust their care/medications and to align the appropriate resources for the patient. True high value care requires all players to be invested and communicative throughout the spectrum of care – this includes the patient.

Conclusion

SHM appreciates the opportunity to provide comments on the proposed 2016 Physician Fee Schedule and the development of the physician pay for reporting and pay for performance programs under MACRA. If you require any additional information or clarification, please contact Josh Bowell, Director of Government Relations at jboswell@hospitalmedicine.org or 267-702-2635.

Sincerely,

Robert Harrington, Jr., MD, SFHM
President, Society of Hospital Medicine