AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

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Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program [CMS-1693-P]

Dear Administrator Verma:

On behalf of the more than 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 for calendar year (CY) 2019 and modify other Part B policies. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for patients facing serious illness, as well as their families and caregivers.

Below we offer feedback on select proposed policies in this rule that affect our members and the vulnerable patients they serve. We would particularly like to highlight our feedback on CMS's proposals to reduce administrative burden related to the documentation of evaluation and management (E/M) visits and the accompanying proposed payment reforms, which we believe have the potential to have the greatest impact on our Academy members and their patients (either positive or negative, depending on which policies CMS finalizes), as demonstrated by the significant level of engagement AAHPM has witnessed from members, the physician community, and our non-physician hospice and palliative care partners.

We urge CMS to consider our comments as it finalizes policies for 2019, and we would be pleased to provide any additional input or assistance as needed.

Physician Fee Schedule

Evaluation and Management (E/M) Visits

Pursuant to CMS's efforts to reduce administrative burden for clinicians under its "Patients Over Paperwork" initiative, CMS proposes several far-reaching changes to both documentation requirements and coding and payment for office/outpatient evaluation and management (E/M) services. The medical community has long expressed concern and frustration over the burden associated with documenting E/M visits under the existing 1995 and 1997 E/M documentation guidelines which have gone unresolved for too long. In contrast, CMS's clear prioritization of this issue has marked a notable turning point, which AAHPM has welcomed. Our Academy also thanks CMS for its concerted effort to engage physicians and other stakeholders in developing solutions to the documentation burden and to ensure that they are aware of the significant changes that CMS has included in this year's proposed rule. The "one size fits all" requirements for history and physical documentation for all E/M services creates significant burden for our members, who often need to focus their time (and documentation) on accurately reflecting the meaningful services delivered. For Hospice and Palliative Medicine (HPM) practitioners, this may include detailed descriptions of symptoms, emotional distress, spiritual issues, and/or complex and difficult decision making and treatment planning. Under current guidelines, however, HPM clinicians are often required to include extraneous documentation detail regarding irrelevant history, review of unaffected systems, and unnecessary (and in some cases burdensome and difficult to the patient) physical exam elements, in order to justify an E/M code that can most adequately reflect the time and intensity of their work.

Given these challenges, AAHPM very much appreciates and supports several of the proposals CMS has included in the proposed rule that focus solely on reducing documentation burden for E/M visits – without affecting payment. ***Specifically, we request that CMS finalize the following proposals, which we believe can be implemented independently of any of the proposed payment changes:***

- ***Allowing physicians to document visits based solely on the level of medical decision making (MDM) or the face-to-face time of the visit as an alternative to the current guidelines.***
- ***If physicians choose to use the existing guidelines, limiting required documentation of the patient's history to the interval history gathered since the previous visit (for established patients);***
- ***Eliminating the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient; and***
- ***Removing the need to justify providing a home visit instead of an office visit.***

These four changes would provide greater discretion to clinicians to use their judgement to determine (1) the appropriate care to deliver to patients (e.g. home visit versus office visit) and (2) the extent of documentation required to support that care (e.g. MDM versus time), while also reducing the amount of unnecessary and duplicative documentation required in a medical record under current requirements that take time away from patients and contribute to "note bloat." In addition, removing the justification requirement for home visits will be particularly valuable for HPM clinicians who provide community-based palliative care services and routinely conduct home visits when caring for their seriously ill patients. Given all of the above, ***AAHPM urges CMS to finalize these four proposals without delay, to ensure that clinicians can benefit from the burden reduction they promise.***

However, AAHPM has concerns with CMS's proposal to apply a "minimum documentation standard" under which clinicians would only need to meet documentation requirements associated with a level 2 visit for history, exam, and/or MDM. While AAHPM supports burden reduction, we question whether the policy to document to level 2 will materially impact the amount of documentation HPM clinicians include in their records. This is because detailed documentation is necessary to support quality patient care, particularly to document clinical status, patient preferences, medical decision making, and treatment decisions – all of which capture the value-added work that HPM physicians provide. Fulsome documentation is also required to protect against liability, as well as to align with documentation requirements imposed by private payers. If CMS were to finalize this proposal, clinicians would face conflicting requirements based on insurer requirements that could contribute to greater burden. Combined with AAHPM's concerns about the accompanying payment changes that would collapse payment across levels 2-5, detailed below, ***these concerns lead AAHPM to the conclusion that the application of a level 2 minimum documentation standard is not appropriate at this time.***

We understand that implementing the proposed documentation changes independently of the proposed payment changes raises concerns for "upcoding" and thus program integrity. This is a real concern, and we would welcome the opportunity to work with CMS and the medical community to implement countermeasures, such as providing clear technical assistance for our members on documentation requirements, advising on streamlined audit processes, and working to refine the countermeasures over time. In the end, we believe the benefits to providers and beneficiaries of reducing documentation requirements well outweigh the risks to program integrity.

Turning to CMS's proposals to reform payment for office/outpatient E/M visits, ***AAHPM has significant concerns with the proposed changes to payment for E/M services,*** including CMS's proposals to:

- Collapse payment for outpatient/office E/M level 2 through 5 visits for new patients and for established patients;
- Allow for supplemental payment for E/M services through the following add-on codes:
    - GPC1X *(Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an established patient evaluation and management visit))*
    - GCG0X *(Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit))*
    - GPRO1 *(Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; 30 minutes (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service))*
- Require separate billing and payment for podiatric E/M visits; and
- Apply an E/M multiple procedure payment adjustment.

AAHPM members treat the most seriously ill Medicare beneficiaries – individuals who typically suffer from complex medical conditions and functional limitations, many of whom are near the end of life.

CMS's proposals would harm these vulnerable patients and the HPM specialists who care for them by moving away from a payment structure that compensates practitioners based on the complexity of patients (as currently supported under the existing five E/M levels and incorporated under current documentation guidelines) and instead collapsing payment for levels 2 through 5 and encouraging differential payment largely based on the specialty of the clinician providing the care.

The collapsed and blended payment for levels 2-5 seems to assume that the distribution of visit levels for each practice is such that increases in payment for lower complexity services (levels 2 and 3) will offset the reduction in payment for higher complexity services (levels 4 and 5). However, HPM specialists almost exclusively bill level 4 and level 5 visits. Providing payment based on weighted average billing of office/outpatient E/M visits across all specialists – many of whom routinely bill level 2 and level 3 visits – would result in payment rates that are insufficient to support the level 4 and 5 services HPM patients require. *Indeed, analysis conducted by the American Medical Association shows that HPM physicians would, on average, receive an alarming 20 percent reduction in E/M payment for office visits under CMS's proposal.* Practices that see a disproportionate share of high-complexity patients would likely see even larger reductions.

Additionally, these reductions would be particularly devastating for HPM clinicians and practices that regularly work as part of interdisciplinary care teams that include professionals whose care is not routinely compensated (e.g. registered nurses, social workers, chaplains) – practices that characteristically require supplemental financing to support those team members' services. The proposed reductions in E/M payment would mean that even physician services would not be adequately compensated, further limiting the ability of these teams to provide effective, high-quality care for patients with serious illness. *Should CMS finalize the payment policies as proposed, we anticipate that many palliative care practices, particularly those focused in outpatient settings, would close.*

While CMS has proposed add-on codes to address reductions in payment that many specialties would experience, *we believe that these add-on codes are both poorly justified and poorly specified.* For example, CMS provides little rationale for selecting the specialties that can bill the inherent visit complexity specialty add-on code (GCG0X) and little detail on when use of the code would be appropriate or what documentation would be required to support the use of the code. Further, CMS's proposals fail to recognize the intensive resources required for HPM specialists to provide care to seriously ill beneficiaries. Omitting HPM from the list of specialties eligible for the complexity add-on payment illustrates the clear opportunities for improvement and revision of CMS's proposals.

Even if that omission were corrected, we disagree that payments for E/M services should be tied to a practitioner's specialty. Instead, AAHPM believes that payment should be linked to the complexity of the patient, in order to ensure that payment is sufficient to support the services that complex patients need. Any practitioner in any given specialty on any given day can take care of high-complexity patients. Likewise, on any given day, specialists in one of the "high-complexity" specialties specified under GCG0X may see patients for a routine visit that requires less time and intensity. Tying payment to specialty does not recognize this variation in work performed within and across specialties. Moreover, we note that the specialty add-on code is also arguably in violation of statutory requirements that prohibit specialty specific payment rates – as are the separate G-codes for podiatric E/M services that CMS proposes. While we have heard CMS state in public forums that the availability of the specialty add-on is not limited based on a clinician's designated specialty under his/her Medicare enrollment but rather is tied

to the nature of the service being provided, it is difficult to interpret CMS's preamble language to be consistent with those statements, given multiple references to "specialties" in the application of this add-on code (rather than "visits" or "services") as well CMS's impact analyses, which only accounted for billing by the affected specialties.

We also note that the proposed primary care (GPC1X) and specialty (GCG0X) complexity add-on payments are too small to overcome the reduction in E/M revenue caused by the proposed collapse of levels 2 through 5 into a single blended payment. While we appreciate that the proposed new prolonged service code (GPRO1) is intended to further address the shortfall, as with the inherent complexity codes, there is insufficient detail to understand how this code would affect clinicians under the proposed changes, and we note that even CMS declined to include the code in its estimates of the E/M proposals (see Table 22 in the proposed rule). HPM clinicians are familiar with the existing Prolonged Services CPT codes, as the very complex, time-intense nature of palliative encounters leads many HPM clinicians to use these codes somewhat regularly. We believe that any application of prolonged service codes should adhere to the CPT convention of meeting the time requirements once the midpoint has passed, instead of requiring the "typical time" threshold to be reached. That said, *we disagree that the proposed prolonged service add-on sufficiently addresses the harmful impacts of the remaining E/M payment changes that CMS has proposed.*

The end result of CMS's package of E/M payment proposals – in addition to the significant payment cuts for HPM specialists noted above – is that patients with complex healthcare needs will likely experience reduced access to care. Many clinicians, as well as hospitals and health systems, will likely face strong incentives to avoid caring for the most complex patients, limit the length of visits, and/or bring patients in for multiple visits. This is particularly damaging to the beneficiaries cared for by AAHPM members, for whom frequent visits would cause significant added stress given their limited mobility, symptom burden (including pain, fatigue, nausea and shortness of breath), and strained family caregivers.

For all of the above reasons, AAHPM urges CMS not to finalize its E/M payment proposals. Further, we disagree that a simple delay of the proposals as written is appropriate, given our significant concerns about the impacts of the proposals on HPM specialists and the seriously ill patients they serve. Instead we urge CMS to take the time necessary to "get it right" for 2020, working with the medical community to develop new proposals that better address the underlying challenges that exist with the E/M codes.

In that important work, AAHPM urges CMS to adhere to the following principles:

- *Payments should align with practice and resource costs and should be sufficient to cover the costs of delivering care.*
- *Payments should be tied to patient complexity, to reflect the higher costs of delivering care to patients with complex care needs.*
- *Payments should incentivize the delivery of comprehensive, patient-centered, and coordinated care.*
- *Payments should be uniform across all specialties, without separate add-ons or codes for any given subset of specialties.*
- *Payments should support simplification of documentation requirements, as well as reduction of audit burden, while still ensuring sufficiently robust documentation is included in medical records.*

AAHPM recognizes that patient complexity may be difficult to determine and may vary across specialties and clinicians. When our members consider complexity, they take into account many considerations, for example, a patient's primary diagnosis and number of comorbidities, his/her prognosis and risk of death, functional status, and previous utilization of inpatient and emergency care. ***We believe these factors can serve as a starting point for contemplating how to link payments to patient complexity, and we would be happy to engage with CMS to address this question further.***

AAHPM would like to reiterate our thanks to CMS for recognizing the challenges that have long existed with E/M documentation, coding, and payment. ***We believe that the four proposals outlined on page 2 above specifically focus on E/M documentation improvements that can significantly alleviate burden, and we ask CMS to finalize those policies for CY 2019. However, we have serious concerns with the accompanying proposals to adjust office/outpatient E/M payment, and therefore urge CMS not to finalize the proposed changes to E/M payment, and to instead work with stakeholders to pursue necessary reforms to E/M coding and payment for CY 2020.*** AAHPM is fully committed to being an active and engaged partner in this process in order to achieve sound solutions for CY 2020 that adhere to the principles we outlined above.

Lastly, ***AAHPM encourages CMS to pursue innovative payment changes through alternative payment models that could address some of the conflicting incentives and limitations that have long challenged E/M coding, and fee-for-service payments more broadly.*** AAHPM developed the *Patient and Caregiver Support for Serious Illness (PACSSI)* model, which the Physician-Focused Payment Model Technical Advisory Committee (PTAC) has recommended for limited-scale testing and Secretary Azar has specifically commended and identified for potential refinement and implementation. This model replaces E/M payments with a per beneficiary per month payment intended to support comprehensive, coordinated and interdisciplinary palliative care services, while also including accountability for both quality and costs. AAHPM believes such an approach would ensure access to patient-centered care for high-need beneficiaries and limit documentation burden, while also reducing incentives to provide inappropriate and fragmented care. AAHPM stands ready to work with CMS to test, refine, and ultimately implement novel payment models like PACSSI to advance these shared goals.

Additional Policies to Reduce E/M Burden: Same-Day E/M Visits and Teaching Physician Documentation Requirements

In addition to the above proposals to reduce documentation burden, AAHPM would also like to thank CMS for its consideration of additional policies that could alleviate burden for clinician practices.

First, CMS requests comment on whether to remove the Medicare Claims Processing Manual language that prohibits payment for two E/M visits billed by a physician, or a physician of the same specialty from the same group practice, for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems that could not be provided during the same encounter. ***AAHPM supports the removal of this provision, as it would facilitate beneficiaries' access to unrelated but valuable E/M services on the same day, which is key for beneficiaries seeking care in multispecialty settings.*** This change acknowledges the modern reality of sub-specialization within practices, which has led to a much broader array of services being available "under one roof." This is particularly valuable for beneficiaries with serious illness, who often face limited mobility, caregiving and transportation challenges, and symptoms that make multiple visits on multiple days difficult and burdensome. Palliative care

subspecialists can train in any one of 10 primary specialties, and many of them continue to practice palliative care within their primary specialty group. Such "embedded" services can often be delivered on the same day as other care, which is of great value to beneficiaries. ***As a result, we urge that this provision be included in the final rule.***

Additionally, CMS proposes to revise documentation requirements for teaching physicians to eliminate the requirement that, for E/M services, the teaching physician must personally document his or her participation in the service (or in the review and direction of the service, as applicable in certain facilities) in the medical record and instead allow his/her presence to be documented by a physician, resident or nurse. Such documentation is already allowable for certain procedural services. ***AAHPM thus supports this proposal and agrees that the requirement for the teaching physician to personally document his or her participation in E/M services is burdensome and often duplicative, and does not meaningfully contribute to higher-quality patient care.*** We emphasize, however, that this proposed change in documentation by no means alters any of the requirements for supervision by teaching physicians, which are necessary for patient safety and high-quality education and training.

Communication Technology-Based Services

CMS proposes to establish separate payment for the following communication technology-based services:

- Brief Communication Technology-based Service (e.g. Virtual Check-in) (GVCI1)
- Remote Evaluation of Pre-Recorded Patient Information (GRAS1)
- Interprofessional Internet Consultation (99446, 99447, 99448, 99448, 994X0, 994X6)

Overall, AAHPM supports payment for these new communication technology-based services under the Medicare program, which we believe will help to improve access to physician services, particularly for underserved patients and those in rural areas. Indeed, the services proposed for payment recognize the type of work that is routinely done as part of the delivery of hospice and palliative care, but that under current policies has not been sufficiently reimbursed. For example, HPM clinicians may provide virtual check-in services to patients who experience rapid disease progression at the end of life, to ensure that patients receive the right care at the right level and in the right setting, consistent with their care plan and treatment preferences. HPM clinicians may also routinely provide consultative services consistent with the interprofessional internet consultation codes that CMS is proposing, as they facilitate coordination among patients' primary and specialty physicians. At the same time, ***we encourage CMS to take a cautious approach to implementation that considers appropriate valuation of such services and the re-distributional effects the addition of such services may produce given budget neutrality requirements under the Physician Fee Schedule (PFS).***

With respect to the virtual check-in, AAHPM profoundly appreciates CMS's recognition that proactive virtual care, done well, can decrease cost and burden for patients and the healthcare system. In response to CMS's broad request for comments around the creation of this code, AAHPM recommends:

- ***That the communication technology platforms through which virtual care can be provided for reimbursement should be construed as broadly as possible, including voice-only telephone calls and response to patient-initiated electronic mail or messages,*** to ensure that socioeconomically disadvantaged or elderly patients without access or ability to use video phone or computer-based technologies are not excluded from proactive care.

- *That CMS narrow the post-visit window during which payment for virtual check-ins would not be covered to 3 days.* While CMS notes that a virtual check-in provided within 7 days of an E/M service would be considered bundled with that E/M service, AAHPM would point out that our members regularly provide non-face-to-face check-in services for patients that exceed the post-service resources included in E/M codes. We believe this code could help to address this gap, but that a narrower window would be necessary to ensure appropriate care. Specifically, we are concerned that the 7-day window could create an incentive for clinicians to delay appropriate follow-up for patients, which could be particularly harmful for patients with serious illness.
- *That CMS allow for provider-initiated virtual check-ins for patients with two or more chronic conditions expected to last for 12 months or the life of the patient.* These check-ins could be used to enable periodic monitoring of weight or blood pressure for patients with unstable heart failure, blood sugar for those with uncontrolled diabetes, or discussion of recommendations from specialist visits.
- *That, similar to the approach used during the implementation of Advance Care Planning codes, CMS refrain from imposing a frequency limitation but rather perform close monitoring of usage trends to encourage proactive, patient-centered care.*
- *That documentation requirements should be minimal, requiring description of the medical topic discussed and the number of minutes spent in communication with the patient or caregiver*.
- Finally, the proposed work relative value unit (wRVU) valuation for GVCI1 of 0.25, $9.01 using 2019 proposed valuation, appears low when compared with the valuation of code 994X6, which values 5 or more minutes of interprofessional electronic assessment and management service by a consultative physician at 0.50 wRVUs, as the difference in documentation requirements is unlikely to contribute 100 percent more work effort. As a result, we request *that CMS refer the codes to the Relative Value Scale Update Committee (RUC) for evaluation and repricing that would apply beginning in 2020*.

For all of these communication technology-based codes, AAHPM recognizes that these services will impose additional cost-sharing on beneficiaries, which may be a barrier for widespread adoption of these codes. Given this cost-sharing, *we recommend that clinicians be required to obtain beneficiary consent prior to the completion of the service, and that consent be documented in the medical record. We also recommend that such consent requirements be consistent with requirements that currently apply for chronic care management services.* We also recognize that these codes could carry heightened program integrity risk – particularly the interprofessional internet consultation codes, as CMS highlights. AAHPM would be pleased to work with CMS to address these challenges in the delivery of care to patients with serious illness.

Chronic Care Remote Physiologic Monitoring (CPT code 990X0, 990X1, 994X9)

CMS proposes to provide payment for new remote physiologic monitoring CPT codes:

- 990X0 *(Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment)*
- 990X1 *(Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days)*
- 994X9 *(Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month)*

CMS also proposes to generally accept the RUC-recommended RVUs and direct practice expense (PE) inputs for all three codes, except that CMS proposes to refine the direct PE inputs for 990X1.

AAHPM supports the proposed updates to provide payment for the new chronic care remote physiologic monitoring, which better reflect the type of care that palliative care practices may provide to support their patients' treatment plan and care preferences. As such, ***AAHPM supports CMS's proposal to make separate payment for these codes, however we request that CMS accept all RVUs and direct PE inputs as recommended by the RUC.***

Chronic Care Management Services Provided by a Physician (CPT code 994X7)

CMS proposes to provide payment for chronic care management services provided by a physician (CPT code 994X7 (Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation /decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored)). However, rather than accept the work RVUs recommended by the RUC, CMS proposes work RVUs that rely on the amount of physician time required for the code, relative to the existing chronic care management code, CPT 99490.

AAHPM supports Medicare coverage of 994X7, but urges CMS to adopt the RUC-recommended work RVU for this code. While 994X7 does include double the amount of physician time, the work RVU should also consider the intensity of services provided. We expect that physicians will be directly providing chronic care management services for those patients who are more complex. Therefore, a straight extrapolation of time to determine the work RVU would not appropriately reflect the higher resources required for this code.

Malpractice RVUs

CMS continues to seek input on the next malpractice (MP) RVU update, due to occur in CY 2020 and, in particular, how CMS can improve how specialties in the state-level raw rate filings data are cross-walked for categorization into CMS specialty codes. In last year's proposed rule, CMS indicated that there was not sufficient data to develop specialty-level risk factors for the MP RVUs for the Hospice and Palliative Care specialty (Specialty Code 17) and instead proposed to cross-walk to Allergy/Immunology.

AAHPM believes that CMS should establish specialty-level risk factors that are specific to Hospice and Palliative Care, rather than relying on a crosswalk. AAHPM would be happy to work with CMS to improve data collection and fill in gaps, where applicable, in order to achieve this goal.

Comment Solicitation on Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders

CMS seeks comment on creating a bundled episode of care for management and counseling treatment for substance use disorders (SUD), including comment on the benefits of such a payment, coding and payment for the episode, and episode structure and services. CMS also seeks comments on regulatory

and subregulatory changes to help prevent opioid use disorder (OUD) – including through increased access to non-opioid alternatives for pain treatment and management – and to improve access to treatment for SUD under the Medicare program.

AAHPM thanks CMS for its consideration of these issues that are particularly important given rising rates of OUD and opioid-related overdose deaths. In general, AAHPM supports innovative payment approaches that improve access to care for SUD. However, we caution that there is a potential risk that a bundled payment may not adequately compensate comprehensive care, particularly for patients with complex needs, which could potentially result in reduced access to care for these patients.

As CMS continues to assess whether a bundled payment is appropriate, AAHPM urges CMS to consider protections that would ensure payments are sufficient to cover the cost of care for patients with complex care needs, such as concurrent serious illness management (e.g. for advanced cancer, heart failure, or dementia). Such protections could include:

- *Mechanisms to align payment with patient complexity, to ensure that payments for the most complex patients are sufficient to cover the costs of care. Such mechanisms would be important for protecting against patient-selection of low-risk patients and stinting of care.*
- *Mechanisms to link bundled payments to performance on appropriate quality measures, to provide accountability for delivery of appropriate, high-quality care within the bundle.*
- *Monitoring of practice patterns and patient experience and outcomes following implementation, to provide timely feedback on the performance of the bundle.*

We also ask CMS to ensure that the bundle does not limit access to other services, treatments, or providers, particularly for patients with serious illness who may also need treatment for SUD.

With respect to CMS's request for comments *regarding non-opioid alternatives for pain treatment, including barriers to access, AAHPM supports this focus in so far as it promotes comprehensive integrative pain management.* Last year, AAHPM was proud to be part of the inaugural Integrative Pain Care Policy Congress. This event brought together 70 leaders from more than 50 organizations representing the full scope of licensed and certified healthcare providers, public and private payers, policy advocates, research organizations, and the patient voice to identify strategies to achieve shared goals. These groups, which will meet again in November, agreed that "Comprehensive integrative pain management includes biomedical, psychosocial, complementary health, and spiritual care. It is person-centered and focuses on maximizing function and wellness. Care plans are developed through a shared decision-making model that reflects the available evidence regarding optimal clinical practice and the person's goals and values." AAHPM believes that the domains of palliative care naturally track with this vision.

Unfortunately, current reimbursement mechanisms do not support multidisciplinary pain management. There is an acute need for more research on safe and effective treatments for pain (which AAHPM has pointed to through a provision in the Palliative Care and Hospice Education and Training Act – see S. 693 / H.R. 1676), yet these treatments must be covered by payers if they are to become mainstream and accessible. When insurers typically cover medications but not non-pharmacologic approaches, or if complementary and alternative therapies that research has shown to be effective are not reimbursed under Medicare, this limits the availability of effective and safe non-opioid therapies. AAHPM therefore urges Medicare coverage of multi-modal and non-pharmacological pain treatment, such as therapeutic massage, acupuncture, and other proven modalities; otherwise prescribers will necessarily default to treatments, like opioids, that are reimbursed in order to ensure their patients' pain is managed. Further,

working through the Pain Management Best Practices Inter-Agency Task Force, CMS could urge the Food and Drug Administration to prioritize and accelerate approval of adjuvant analgesics to decrease the need for opioids as well as ease barriers to medical research on cannabinoids.

Finally, in this discussion of treatment for SUD, it is important to note that individuals with OUD may suffer with a serious or terminal illness and require palliative or hospice care – including opioid treatment. AAHPM would be deeply concerned if CMS policies served to restrict opioid prescribing to these patients or restrict coverage or reimbursement for appropriate opioid use for individuals suffering from OUD. Not providing appropriate pain management for a patient suffering from OUD who is seriously ill would have dire consequences, including the patient potentially seeking relief in illicitly obtained opioids and other narcotics.

For this reason, ***AAHPM urges CMS to be mindful of the need to balance the public health imperative to stem the tide of opioid abuse, misuse and diversion with the public health imperative to manage untreated pain and to ensure timely, safe, and appropriate access to opioid therapy for patients with serious illness who have opioid-responsive pain.*** Setting aside its financial costs, unrelieved pain causes inordinate human suffering resulting in longer hospital stays, increased readmissions and outpatient visits, and decreased ability to function or enjoy quality of life.

Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

CMS proposes to provide for separate payment, using a new Virtual Communications G code for use by RHCs and FQHCs only, for the cost of communication technology-based services or remote evaluation services that are not already captured in the RHC all-inclusive rate or the FQHC prospective payment system payment when the requirements for those services are met. CMS does not propose to allow payment for interprofessional internet consultation services for RHCs and FQHCs.

Consistent with our support for the proposed communication technology-based services under the PFS, ***AAHPM supports this proposal, which would extend the availability of important services to RHCs and FQHCs and increase access to care for Medicare beneficiaries in rural and underserved areas. However, AAHPM requests that CMS reconsider its decision not to provide RHCs and FQHCs the ability to separately bill for the interprofessional internet consultation services, which would be particularly important for the patients served by these clinics.***

Merit-Based Incentive Payment System

Proposals to Address Increasing Opioid Use Disorder and Overdose Deaths

Throughout its discussion of the MIPS program and its proposals for CY 2019, CMS offers several potential policies that it could pursue to leverage MIPS in the Administration's effort to prevent opioid use disorder (OUD) and address the surge in opioid overdose deaths that is currently impacting families and communities across the country. These include proposals to:

- Revise the definition of high-priority measures to include opioid-related quality measures;
- Add the following new measure to the Quality performance category:
    - Continuity of pharmacotherapy for opioid use disorder

- Add the following two new activities to the Improvement Activity inventory:
    - Patient medication risk education
    - Use of Centers for Disease Control and Prevention (CDC) Guideline for clinical decision support to prescribe opioids for chronic pain via clinical decisions support; and
- Add the following two new measures to the Promoting Interoperability performance category's e-prescribing objective, initially for bonus points only:
    - Query of prescription drug monitoring program (PDMP)
    - Verify opioid treatment agreement

In addition, CMS notes its intent to consider proposing in future rulemaking MIPS public health priority sets across the four performance categories, with an initial focus to develop a public health priority set around opioids.

The Academy recognizes that there is an indisputable public health imperative to curb opioid abuse, misuse, and diversion, and is deeply committed both to providing continuing education that results in optimal pain management and optimal care for all patients and to collaborating with professional, regulatory, and industry stakeholders to maximize individual and public safety. To that end, AAHPM advocates for the routine, evidence-based assessment of our patients, as well as shared decision-making in developing treatment plans, to ensure that clinicians identify the risks and benefits associated with care options – including opioid treatment – and that patients understand and consider such risks and benefits when making treatment decisions. Such assessment is critical for supporting and enabling responsible use of opioid medications, which is a priority for our members, who serve as stewards of their patients' care and well-being.

AAHPM also agrees that addressing OUD should be a high priority for the Administration and recognizes the potential for quality and value-based purchasing programs like MIPS to play a role in this effort. However, AAHPM is concerned with how best to balance the growing risks and consequences of OUD with the need for ready access to appropriate pain medications for patients with serious or complex chronic illness and those at the end of life – patients for whom high-dose opioids may pose more benefit than risk. For these patients, the timely and effective management of pain or other distressing symptoms is central to the delivery of high-quality palliative care, and opioid analgesics are a critical tool in alleviating that suffering. Therefore, public policies and accountability structures must recognize there is an equally important public health imperative to ensure that our sickest, most vulnerable patients have access to timely, effective treatment of their pain and suffering.

With respect to CMS's proposals, in particular, we question whether adopting such changes in a value-based purchasing program like MIPS is appropriate at this time, given the lack of evidence regarding the net impact of the proposed opioid-related measures and activities on patients' overall well-being, after accounting for factors such as patient safety, appropriate use, access to care, and pain management outcomes. Specifically, ***AAHPM is concerned that several of the above proposals could result in unintended consequences that would harm the seriously ill patients who turn to our members to alleviate pain and maximize quality of life through effective, high-quality palliative care.*** If finalized, the proposals would create incentives to reduce opioid prescriptions – even for patients with debilitating pain resulting from advanced disease progression who would respond to opioid treatment with more potential benefit than risk. ***As CMS contemplates final policies, AAHPM urges CMS to consider the unintended consequences that would likely befall these and other seriously ill patients who already encounter barrier after barrier to***

receiving appropriate treatment for pain management; to consider protections that could be incorporated, including exceptions for patients receiving hospice and palliative care and other patients with advanced stage serious illness; and to rely on clinical evidence regarding the reliability and validity of measures or activities to address public health and safety concerns with opioids, rather than finalize actions that are not supported by evidence but instead driven by a sense of urgency and may ultimately cause more harm than good.

Additional comments specific to individual proposals are provided below.

Revising the Definition of High Priority Measure and Establishing Public Health Priority Sets
AAHPM recommends that CMS not finalize its proposals to revise the definition of high priority measure and to establish an opioid public health priority set. In addition to the concerns noted above, we believe these actions would be premature given the current state of measurement science regarding the creation, testing, and implementation of opioid quality measures. We note that none of the existing MIPS measures that address opioids (408, 412, and 414) have been endorsed by the National Quality Forum. Likewise, for the proposed new opioid measure (Continuity of pharmacotherapy for opioid use disorder, discussed further below), the Measure Applications Partnership (MAP) recommended that the measure be refined and resubmitted prior to rulemaking.

Further, ***the Academy believes that the existing high priority designations – for example, patient safety or appropriate use – should be sufficient to determine whether an opioid measure should be considered a high-priority measure.*** If a measure cannot independently qualify for one of these designations, we do not believe that such measures should warrant being identified as a high-priority measure.

Proposed Addition of Continuity of Pharmacotherapy for Opioid Use Disorder Measure
While we agree with the importance of developing and utilizing measures that address OUD, AAHPM is concerned that CMS is proposing to finalize a measure that has not been determined to be valid and reliable for use under MIPS. As CMS notes in its rationale for this measure, this measure has not been tested or endorsed at the clinician or clinician group level. As such, the MAP recommended that the measure be refined and resubmitted prior to rulemaking.

As noted above, AAHPM believes that CMS should rely on clinical evidence when finalizing proposals for measures to include in the MIPS program. ***While we agree that consistent, ongoing treatment for OUD is critical, given the MAP's concerns, we do not support the addition of this measure at this time.***

Proposed Addition of Improvement Activities
CMS proposes to add two new improvement activities to the improvement activities inventory:

- Patient medication risk education; and
- Use of CDC Guideline for clinical decision support to prescribe opioids for chronic pain via clinical decisions support

While we again agree with the urgent need to address the surge in opioid use disorder and overdose deaths, AAHPM is concerned that both of these activities rely on the CDC Guideline for Prescribing Opioids for Chronic Pain, which does not apply to seriously ill patients followed by hospice and palliative care clinicians. The Guideline specifically notes that it provides "recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-

of-life care." However, for patients and clinicians who fall outside the intended target population, the Guideline is not strongly supported by available evidence. We are concerned, therefore, that including these measures in the MIPS program would exacerbate a tendency to extrapolate the Guideline to other specialists and patient populations for which it was not intended. Further, with regard to the proposed Patient Medication Risk Education improvement activity, which addresses risk education around concurrent opioid and benzodiazepine use, we note that there is a lack of evidence and literature on when the risks of concurrent prescribing outweigh the benefits, and likewise when the benefits outweigh the risks. Additionally, there is limited evidence to support the use of morphine milligram equivalent (MME)/day dosage limits included in the Guideline as a standard of care.

Proposed Addition of Promoting Interoperability Opioid Measures

CMS proposes to include two new opioid measures into the Promoting Interoperability performance category's e-prescribing objective, initially on an optional basis for 2019.

- Query of prescription drug monitoring program (PDMP)
- Verify opioid treatment agreement

AAHPM recognizes that CMS has finalized versions of both of the above measures for the Medicare and Medicaid Promoting Interoperability Programs in the FY 2019 Inpatient Prospective Payment System Final Rule. However, we believe that these measures would further discourage physicians from prescribing clinically appropriate opioids to patients who may legitimately require such treatment by creating access barriers and increasing burden for physicians who may be required to report on such measures. We are concerned, for example, that PDMPs may not be integrated into providers' electronic health records (EHRs), and that checking PDMPs would therefore create a barrier to prescribing that would disincentivize clinicians to electronically prescribe opioids. We also note that there is a lack of consensus regarding the value of opioid treatment agreements, and that there is little empirical evidence to support a causal effect of such agreements on improved patient outcomes. Even the CDC in its Guideline notes that its clinical evidence review did not find studies evaluating the effectiveness of written agreements or treatment plans.[1] Without an evidence base, we cannot agree that the benefits of implementing this measure would outweigh the costs.

We also believe that these measures do not include sufficient denominator exclusions to protect the most vulnerable of patients, including patients receiving hospice or palliative care, patients experiencing acute pain crises, patients with cognitive impairment, or other patients with advanced illness. Further, exclusions are also needed for prescribers in a state without a PDMP or in states where integration with a statewide PDMP is not feasible.

Given all of our concerns, ***AAHPM recommends that CMS not finalize these measures for the Promoting Interoperability performance category under MIPS. Should CMS finalize these measures, we recommend that CMS add further protections, including additional measure exclusions as described above, and that CMS monitor their impacts to ensure patients with serious illness continue to have ready access to medically-appropriate opioid treatments as needed to alleviate their pain and suffering. We also recommend that, if these measures are finalized, CMS continue to make these measures optional all future years, rather than requiring these measures to be scored starting with the 2020 performance period.***

[1] CDC Guideline for Prescribing Opioids for Chronic Pain (www.cdc.gov/drugoverdose/prescribing/guideline.html)

MIPS Eligible Clinicians

CMS proposes to modify the definition of a MIPS eligible clinician to include, beginning with the 2021 MIPS payment year, physical therapists, occupational therapists, clinical social workers, clinical psychologists, and groups that include such clinicians. AAHPM supports this proposal, which recognizes the important role that these clinicians play in caring for Medicare beneficiaries. AAHPM members work closely with social workers, psychologists, and therapists, who regularly serve as integral members of interdisciplinary palliative care teams. Expanding the definition of MIPS eligible clinicians to include these additional professionals and holding them accountable for performance under MIPS would place them on more equal ground with the current group of MIPS eligible clinicians (physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists) under the Medicare program.

At the same time, AAHPM recognizes that new participation in MIPS can place significant additional administrative burden on clinicians and groups. While current MIPS eligible clinicians benefitted from important transition policies in the first years of the MIPS program, such as Pick Your Pace, new MIPS eligible clinicians will face a much more challenging introduction to MIPS without a commitment from CMS to provide an on-ramp. As such, ***AAHPM urges CMS to allow for sufficient transition opportunities for these clinicians, to enable them to become accustomed to the program over time without significant risk of negative payment adjustments.*** In line with this recommendation, ***AAHPM thanks CMS for proposing to automatically reweight the Promoting Interoperability performance category score for these clinicians. AAHPM also recommends that CMS adopt additional protections, such as a separate point floor for quality measure scoring, or a new MIPS eligible clinician bonus added to the final score.***

Low-Volume Threshold

CMS proposes to update its low volume-threshold policies to add an additional criterion (furnishes 200 or fewer covered professional services to Medicare Part B-enrolled individuals) and to allow an eligible clinician or group to opt-in to MIPS if the clinician or group meets or exceeds at least one, but not all, of the low-volume threshold determinations.

AAHPM continues to support the availability of an opt-in for MIPS, and requests that CMS finalize this policy as proposed. Offering clinicians and groups the opportunity to opt-in to the program would allow for participation by clinicians who believe they are ready to engage in MIPS and would like to be recognized for their efforts. Further, it would support excellence in the care of people with serious illness – and of all Medicare beneficiaries – by creating additional incentives for practices of all sizes to maximize performance under MIPS.

Group Reporting

CMS seeks comment on whether and how a sub-group should be treated as a separate group from the primary group. Many HPM specialists practice in large multi-specialty care settings where they lack influence over comprehensive care decisions, and are often unable to select performance metrics that are relevant to the care that they deliver. Additionally, many palliative care clinicians find themselves contracting with multiple health systems, accountable care organizations, or provider organizations to care for patients across settings. Given this variation, ***AAHPM supports greater flexibility in allowing sub-***

groups to be treated as a separate group, but emphasizes that CMS should allow sub-groups to self-select how they would like to be assessed. Such self-selection could allow for subgroups to elect to participate in MIPS collectively, for example based on specialty or location. We believe this option will provide HPM specialists flexibility to report and be assessed on performance consistent with how they practice, based on measures that are meaningful to the care they provide. It would also encourage more meaningful engagement among specialists, who often question their role and influence over physician quality reporting mandates. *We reiterate, however, that flexibility to report at these levels should be voluntary.* Additionally, consistent with current policy, *CMS should continue to allow clinicians to participate via one or more arrangements (e.g. individual, TIN-based group, TIN subgroup), and to assign the highest final score for clinicians with multiple group/NPI final scores.* Finally, as detailed further below, we note that some sub-groups may not have the ability to utilize a different data collection type than their primary group, and that the primary group's data collection type may not include measures that are applicable to the sub-group. Thus, the ongoing availability of the Part B claims data collection type will be important for allowing for separate participation at the sub-group level.

Quality Performance Category: Part B Claims Collection Type

In addition to our comments above regarding potential changes to the quality performance category that pertain to opioid use, AAHPM would also like to address CMS's proposal to limit the Medicare Part B claims collection type to small practices beginning with the 2021 MIPS payment year and to allow clinicians in small practices to report claims as a group. While the Academy appreciates the added flexibility that CMS is proposing to offer small groups to report as a group via the Part B claims collection type, we have serious concerns with CMS's proposal to no longer allow data collection via Part B claims for individual eligible clinicians who are not part of a small practice. AAHPM believes that individual clinicians should continue to have the flexibility to utilize all available data collection types, regardless of their practice size. For example, this option allows clinicians who practice as part of large multi-specialty practices or health systems to report independently using measures that are more applicable to the care they deliver, without the need for their practices or health systems to invest in separate EHR systems or to participate in multiple different registries.

Additionally, for clinicians who have long relied on Part B claims for quality reporting, the proposed change, if finalized, will leave insufficient time for practices to procure, implement, and become accustomed to new reporting tools (e.g. EHRs, registries, or qualified clinical data registries) prior to the start of the 2019 performance period. This is particularly problematic given the full-year reporting period for the quality performance category that CMS proposes to maintain for 2019.

For all these reasons, *AAHPM requests that CMS not finalize its proposal to limit Part B claims data collection to small practices. Should CMS choose to finalize this policy, we recommend that CMS delay the effective date for at least two years, which would provide sufficient notice to practices to adopt and successfully transition to new reporting tools, procedures, and data collection types.*

Cost Performance Category

For the 2019 MIPS performance year, CMS proposes to increase the weight of the cost performance category from 10 percent to 15 percent. *AAHPM has serious concerns about this proposal and*

recommends that CMS maintain the cost performance category weight at 10 percent for 2019, particularly given the status of cost measurement for HPM specialists.

Specifically, there are not currently episode-based cost measures that meaningfully capture the work of HPM specialists, based on CMS's work to date. While it is possible that our members may be assessed on the Total Per Capita Cost and Medicare Spending Per Beneficiary Measures, we have long expressed our concerns with these measures, which are not meaningful to or actionable for our members, and we continue to believe that that CMS should discontinue their use in the MIPS program. Additionally, while our members currently serve on several clinical subcommittees focused on developing new episode-based cost measures (in Phase Two of the project), none of these measures are ready to be incorporated into the MIPS program.

Further, we are not aware that our concerns regarding initial field testing of episode-based cost measures have been addressed. These include concerns around strengthening risk adjustment methodologies to incorporate cost predictors around cognition and functional status, adjusting for regional variation, accounting for variation across different types of TINs (e.g. solo practitioner versus large multi-specialty health system), linking performance on cost measures to quality accountability, and monitoring to protect against patient selection or stinting. Particularly for the seriously ill patients that our members serve – many of whom are near the end of life – there is a great deal of concern that a focus on cost-savings alone is not appropriate nor consistent with the objectives of shared decision-making, effectuating patient preferences, and maximizing quality of life, which are central to the practice of palliative care.

Without better measures upon which to assess our members, paired with the necessary corrections to episode-based cost measurement identified above, we disagree that CMS should increase the weight of this cost category and thereby create conflicting incentives that would limit our members' ability to honor their patients' preferences and provide the care they need.

Promoting Interoperability Performance Category

For the 2019 MIPS performance period, clinicians are required to use EHR technology certified to the 2015 Edition certification criteria (2015 Edition CEHRT) for the Promoting Interoperability performance category. While we understand that the use of CEHRT is intended to encourage the robust use of health information technology and move towards interoperability, and ***we appreciate that CMS has proposed changes to significantly streamline the performance category and reduce burden*** (notwithstanding proposals to add two new opioid measures discussed in greater detail above), the fact remains that many HPM clinicians do not have access to CEHRT, for example because the Department of Health and Human Services does not certify technology for hospices or certain other settings or because individual or group practices do not have control over the availability of CEHRT in settings in which they practice. For instance, HPM specialists regularly provide services in inpatient settings, post-acute care settings, and home and domiciliary settings, where there is little availability of or control over CEHRT. While we recognize that CMS has established a hardship exception in cases where clinicians practice in settings where they do not have control over the availability of CEHRT, these hardship exceptions are burdensome for a number of reasons (e.g. annual application processes and late determinations). Additionally, for those HPM clinicians who do have access to CEHRT, such systems rarely have functionality that adequately supports the delivery and documentation of hospice and palliative care.

To address the above, ***AAHPM requests that CMS offer additional options for receiving automatic hardship exceptions under the Promoting Interoperability performance category, for example based on HPM specialty (specialty code 17) or less 25 percent of care provided in physician office settings.*** Under such an exception, these specialists would be assigned a 0 percent weighting for the Promoting Interoperability performance category in the MIPS final score. This approach would help to minimize burden for those HPM clinicians who continue to struggle with reporting requirements related to the use of CEHRT.

Additionally, as noted above, ***AAHPM supports CMS's proposal to automatically reweight the Promoting Interoperability performance category score for physical therapists, occupational therapists, clinical social workers, clinical psychologists, and groups that include such clinicians who are newly designated MIPS eligible clinicians for 2019.*** Further, the Academy requests that CMS maintain this policy for at least three years, to provide sufficient transition opportunities that enable these clinicians to succeed under MIPS.

Facility-Based Measurement

CMS proposes refinements to facility-based measurement policies for the 2019 MIPS performance period, including to update its determination of a facility-based individual and to automatically apply facility-based measurement to facility-based clinicians and groups who have higher performance under facility-based measurement for quality and cost than they do under standard MIPS participation. ***AAHPM supports these policies, which increase opportunities for participation under facility-based measurement and provide clinicians additional flexibility for how they are assessed under MIPS.***

CMS also seeks comment on how to attribute quality and cost for patients in post-acute care (PAC) settings, including hospice. AAHPM appreciates CMS's interest in expanding facility-based measurement to these additional settings, and we recognize the inherent challenges in doing so given the multiple settings and facilities in which clinicians may participate.

For HPM clinicians, we believe there may be a unique challenge – specifically that a large proportion of HPM clinicians may not bill for Part B services at the facility in which they predominantly practice, that is, the hospice. Many of our members serve as hospice medical directors or employed staff of hospice facilities. However, these same clinicians may also support the delivery of community-based palliative care – often as a subset of the work they do for their hospices – and the community-based palliative care may be provided across multiple settings, including domiciliary settings and skilled nursing facilities. ***For these clinicians, we believe their performance would most appropriately be tied to the performance of their hospice employers, and we request that CMS consider facility-based measurement policies that would prioritize this important relationship.***

AAHPM recognizes that CMS has emphasized the use of value-based purchasing programs for facility-based measurement in its current policies. However, we note that statute does not require the use of value-based purchasing programs, and we believe that relying on the Hospice Quality Reporting Program would still create similar incentives as those offered by pay-for-performance programs. ***We are therefore encouraged that CMS is considering the use of PAC quality reporting programs (QRPs), rather than only value-based purchasing programs, as it considers expansion of facility-based measurement into PAC settings. We are also encouraged that CMS is contemplating the use of individual measures, or a subset of measures, rather than requiring the application of performance across a QRP as a whole, which***

we believe provides greater flexibility to CMS and clinicians to develop appropriate facility-based measurement strategies for PAC settings.

Given the complexities inherent in expanding facility-based measurement to PAC settings, *AAHPM encourages CMS to establish a workgroup of physicians and other healthcare professionals who are experts in quality measurement for PAC settings to support the development of sound policies in this area. AAHPM would be pleased to participate in such a workgroup and support CMS's ongoing efforts to further reduce burden through facility-based measurement, while continuing to meaningfully link MIPS performance to the value of the care clinicians provide.*

Small-Practice Bonus

CMS proposes to add a small practice bonus of 3 points in the numerator of the quality performance category for MIPS eligible clinicians in small practices, rather than add a small practice bonus to the MIPS Final Score. While AAHPM agrees that a small practice bonus continues to be necessary for 2019, we disagree with the proposal to apply the bonus only to the quality performance category for several reasons, including:

- Adding the small practice bonus to the quality performance category rather than continuing to apply the bonus to the final score increases the complexity of an already difficult-to-understand scoring methodology;
- The small practice bonus would be applied inconsistently, based on the number of MIPS performance categories that are scored and the number of quality measures that are available and applicable for a MIPS eligible clinician. A clinician who is scored on all four performance categories would have a much lower bonus than a clinician who is only scored on quality and improvement activities and only has three available and applicable measures on which to be scored for the quality performance category.
- CMS assumes that a small practice that is scored on the cost performance category has no disadvantage relative to a large practice since there are no reporting requirements. However, small sample sizes may lead to much greater variation in performance, allowing for lower performance on cost measures that is due to chance.
- In general, it appears that small practices will receive a lower bonus this year than last year, even though CMS data – to our knowledge – does not demonstrate that small practices are performing better, relative to non-small practices, than they did when the small practice bonus was proposed.

Given the above, AAHPM urges CMS not to finalize its proposal. Rather, CMS should continue to apply a 5-point small practice bonus to the MIPS Final Score for the 2019 performance period, consistent with policies that apply for 2018.

Complex Patient Bonus

CMS proposes to maintain the complex patient bonus for the 2019 MIPS performance period while it continues to work with the Assistant Secretary for Planning and Evaluation, the public, and other key stakeholders on options for addressing patient complexity. *AAHPM thanks CMS for this policy, which protects access to care for complex patients and helps to level the playing field for clinicians such as AAHPM members who routinely care for complex and vulnerable populations.* We also appreciate CMS's

interest in more carefully accounting for risk factors in the calculation of MIPS final scores, and *we reiterate the need to ensure that risk adjustment methodologies appropriately account for the needs and costs of the sickest patients*. *We believe this is an area that requires careful consideration, and AAHPM would be happy to work with CMS as it continues to investigate options for incorporating risk factors in its MIPS scoring methodology.*

MIPS Performance Threshold

CMS proposes to adopt a performance threshold of 30 points for the 2019 MIPS performance period, up from 15 points for 2018. AAHPM believes that doubling the performance threshold for the third MIPS program year is overly aggressive and would disproportionately harm HPM clinicians who have few meaningful quality or cost measures upon which to be assessed, and who have struggled with the adoption of CEHRT, as noted above. While the Academy has been working on multiple fronts to correct these disadvantages (including seeking measure development funding in response to CMS's Funding Opportunity Announcement for measure development for the Quality Payment Program; serving as a convener for a multi-year collaboration to unify three existing palliative care registries; leading a data-driven project to define a global serious illness denominator that could be used for palliative care quality measures; and developing a serious illness payment model that was submitted to the Physician-Focused Payment Model Technical Advisory Committee for review and to CMS for further deliberation), additional time is needed for HPM clinicians to have the opportunity and ability to succeed under MIPS commensurate with other, more established specialties.

Furthermore, we would note that, given CMS's proposal to expand the definition of MIPS eligible clinician to physical therapists, occupational therapists, clinical social workers, clinical psychologists, and groups that include such clinicians, a performance threshold of 30 points in the first year of MIPS participation would create an un-level playing field that would automatically place these new MIPS eligible clinicians at a disadvantage.

Given the above, *we ask CMS not to finalize its proposed increase to the performance threshold to 30 points for 2019, and to maintain as low a performance threshold as possible for the third program year. As previously noted, we also ask that CMS include special protections for the new set of MIPS eligible clinicians to support successful transition to the MIPS program, such as a new MIPS eligible clinician bonus.*

MIPS Payment Adjustment: Waiver of the Adjustment for Certain Model Payments

CMS proposes to amend its regulations to specify that the MIPS payment adjustment factors would not apply to certain model-specific payments for the duration of a section 1115A model's testing, beginning in the 2019 MIPS payment year. This would apply to payments if they are:

- made in a specified payment amount (for example, $160 per-beneficiary, per-month); or
- paid according to a methodology for calculating a model-specific payment that is applied in a consistent manner to all model participants.

AAHPM supports this proposal, which we agree is necessary to test models that would involve such payments. We agree that absence of the waiver would complicate the evaluation of such models.

Advanced Alternative Payment Model (APM) Track of the QPP

Advanced APM and Other Payer Advanced APM Criteria

CMS proposes several updates to the Advanced APM criteria, which would, for the most part, similarly apply to the Other Payer Advanced APM criteria as well. These include:

- *Use of Certified Electronic Health Record Technology (CEHRT).* CMS proposes that beginning in CY 2019, in order to be an Advanced APM, the APM must require that at least 75 percent of eligible clinicians in each APM Entity use CEHRT to document and communicate clinical care with patients and other health care professionals.
- *Quality Measures.* CMS proposes to change the regulation so that it states that at least one of the quality measures upon which an Advanced APM bases payment must be finalized on the MIPS final list of measures; be endorsed by a consensus-based entity; or otherwise determined by CMS to be evidence-based, reliable, and valid. CMS also proposes to modify regulation to explicitly state that the outcome measure must be evidence-based, reliable, and valid unless there is no available or applicable outcome measure.
- *Risk.* CMS proposes to maintain the generally applicable revenue-based standard at 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities through QP Performance Period 2024.

AAHPM agrees with the proposed changes regarding quality measure requirements. We also appreciate CMS's proposal to maintain the generally applicable revenue-based standard at 8 percent for both Advanced APMs and Other Payer Advanced APMs, rather than increase risk requirements, in order to provide stability to APM participants seeking to achieve Qualifying APM Participant (QP) status. However, we disagree that CMS should increase the risk standards in future years and continue to urge CMS to require lower risk levels for small and rural practices not participating in medical home models.

As noted above with respect to the Promoting Interoperability performance category, AAHPM continues to have concerns regarding requirements to use CEHRT and how they apply to HPM specialists. As such, ***we cannot support CMS's proposal to raise the threshold for requiring use of CEHRT to achieve Advanced APM status for either Advanced APMs or Other Payer Advanced APMs.*** While we understand that CMS has estimated that the proposed change to the CEHRT requirement would not significantly affect current Advanced APMs, we believe it could potentially create challenges with respect to new APMs achieving Advanced APM status and with respect to new APM participants joining existing or future Advanced APMs.

Other Payer Polices Intended to Reduce Burden

CMS proposes additional policies associated with Other Payer Advanced APM determinations. Specifically, CMS proposes to:

- Allow for multi-year determinations for Other Payer Advanced APMs; and
- Allow Remaining Other Payers to utilize the Payer Initiated Process

AAHPM supports both of these proposals, which we believe will reduce burden and increase certainty for APM participants, including clinicians seeking to achieve QP status. As such, we urge CMS to finalize these policies as proposed.

Development of an Advanced APM Focused on Patients with Serious Illness

As noted above, AAHPM developed the *Patient and Caregiver Support for Serious Illness (PACSSI)* model, which the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended for limited-scale testing and Secretary Azar specifically commended and identified for potential refinement and implementation. AAHPM continues to believe that there is a critical need to expand access to community-based palliative care services for patients with serious illness and that – given existing statutory and regulatory barriers – such services could only effectively be provided in the context of an APM. As such, ***AAHPM urges CMS to prioritize the implementation of a serious illness payment model. In doing so, we recommend that CMS adhere to the following guiding principles, which shaped our Academy's work on the PACSSI model:***

- An APM for serious illness care should increase access to and ensure sustainability of high-quality palliative care and hospice services that improve quality of care and quality of life for patients with serious illness and their caregivers.
- To increase access to palliative care services:
    - An APM should allow participation by palliative care teams of many sizes and types, caring for patients throughout the course of serious illness, in many different markets and geographies, and at various levels of risk-readiness.
    - APM eligibility criteria should identify patients based on need, rather than arbitrary and inaccurate estimates of patient prognoses.
- The palliative care team structure and service requirements should be provided in accordance with the *National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care*.
- Quality measurement and accountability need to align with the state-of-the-field (to include measure concepts under *Measuring What Matters*, an expert consensus project convened by AAHPM and the Hospice and Palliative Nurses Association (HPNA)) and should help advance our understanding of high-quality palliative care.
- Payment should be sufficient to cover the cost of delivering care in diverse communities, including rural and underserved urban communities, without increasing net costs to the Medicare program. Payment benchmarks should also be accurately risk-adjusted, to avoid exaggerated losses or gains to providers.
- The APM development process should be transparent and inclusive, with engagement by a breadth of stakeholders from the serious illness provider community – including the National Coalition for Hospice and Palliative Care and representatives from other relevant medical specialty societies and provider organizations – to address cross-cutting high-priority concerns.

Finally, while we believe that a serious illness payment model could qualify as an Advanced APM, given our concerns noted above regarding the use of CEHRT among HPM specialists, ***we request that CMS waive the requirement for use of CEHRT for Advanced APM designation.*** Without such a waiver, eligible clinicians who specialize in HPM would continue to lack meaningful opportunities to participate in an Advanced APM, even if a serious illness payment model were implemented.

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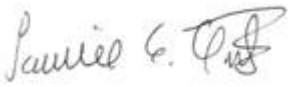
Thank you again for the opportunity to provide feedback on these policy proposals affecting payment under the Medicare Fee Schedule and other Part B programs. We are eager to collaborate with CMS to address the many challenges discussed here, as they have the potential to significantly impact our

Academy members and their seriously ill patients' access to high-quality palliative care. Please direct questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,



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President
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