



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
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies [CMS-1715-P]

Dear Administrator Verma:

On behalf of the more than 5,200 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to comment on the proposed rule to update payment rates for physicians and to modify other Part B policies for calendar year (CY) 2020 that was recently issued by the Centers for Medicare and Medicaid Services (CMS). AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine (HPM). 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.

Overall, AAHPM would like to thank CMS for its many proposals that more appropriately value and reimburse the time and resources required to provide care to patients with complex needs, including CMS's proposals for evaluation and management (E/M visits) and care management services. We also appreciate CMS's proposals to reduce documentation burden and better leverage the skills and capabilities of non-physician practitioners, who are critical to furnishing the comprehensive care hospice and palliative care patients need. On the pages that follows, we offer additional comments and further detail on these and other proposals in the rule that affect our members and the vulnerable patients they serve. We urge CMS to consider our comments as it finalizes policies for 2020, and we would be pleased to provide any additional input or assistance as needed.

Physician Fee Schedule

Payment for Evaluation and Management (E/M) Visits

AAHPM recognizes CMS's commitment to reducing burden for patients and providers and thanks CMS for its continued focus on alleviating unnecessary requirements and barriers to care in the delivery of E/M visits. AAHPM is particularly thankful for CMS's engagement with and responsiveness to the stakeholder community, as evidenced by the following proposals:

- To rescind policies finalized in the CY 2019 Physician Fee Schedule to collapse payment for office/outpatient E/M visit levels 2 through 4
- To adopt the new coding, prefatory language, and interpretive guidance framework provided by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel for office/outpatient E/M visits for new and established patients, including allowing levels to be selected by level of MDM or by time only
- To accept the RUC-recommended work values for all new and established patient office/outpatient E/M codes
- To adopt the CPT prolonged office/outpatient E/M code and values as submitted by the AMA and CPT and RUC: 99XXX (*Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)*)

AAHPM strongly supports the above CMS proposals to update coding, payment, and documentation requirements for office/outpatient E/M visits and urges CMS to finalize these policies as proposed.

AAHPM also supports CMS's proposal to adopt a simplified, single add-on code GPC1X for inherent complexity that would be billed with office/outpatient E/M visits. This code (*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*) would provide additional resources for certain types of office/outpatient E/M visits that focus on the non-procedural specialty care that our members provide to patients with serious illness, including those at the end of life. For new codes like this, however, ***we ask that CMS provide additional guidance clarifying when the code should be reported, to help ensure physicians are using the codes appropriately.***

With respect to prolonged services codes, AAHPM as noted above supports CMS's proposal to adopt the CPT and RUC recommendations for CPT 99XXX. We believe this policy is a significant improvement over existing codes for prolonged services provided on the date of the visit, and it will allow clinicians to more appropriately account for the extended time spent delivering E/M

services on that day. However, AAHPM has concerns that CMS's proposal to prohibit reporting of CPT 99358 (*Prolonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service*) and CPT 99359 (*Prolonged E/M service before and/or after direct patient care; each additional 30 minutes beyond the first hour of prolonged services*) would limit clinicians' ability to be reimbursed for prolonged non-face-to-face time spent in the management of patients' care on a different day from the visit.

The very complex, time-intensive nature of palliative care provided by our members leads many HPM physicians to use these codes somewhat regularly, so the loss of these codes in conjunction with an office/outpatient E/M visit would be highly problematic – especially for the most complex patients that our members serve. CMS states its belief that “CPT codes 99358 and 99359 may need to be redefined, resurveyed, and revalued.” While AAHPM would participate in any CPT Editorial Panel and/or RUC review of these services, we disagree that clinicians should be prohibited from billing these codes in the interim. ***AAHPM therefore urges CMS not to finalize policies that prohibit billing for valuable non-face-to-face services, and to continue making payment for 99358 and 99359 when reported for time spent before or after the date of the related E/M service.***

Finally, CMS asks for input on adjustments to related Physician Fee Schedule services that may be necessary to maintain relativity with the proposed changes to the office/outpatient E/M visits. AAHPM believes that the revisions to the office/outpatient E/M codes, including updates to the code values, is an important first step in more appropriately paying for the care our members provide. However, we believe that systematic undervaluation also exists with respect to E/M visits furnished in other sites of service, including skilled nursing facilities and patients' homes, which presents a barrier to many physicians and non-physician providers providing essential, high-value services in these settings. ***For these reasons, we recommend that CMS revisit and revalue E/M codes across all settings to maintain relativity and more appropriately value the work involved in providing evaluation and management services wherever a patient may need them. We also ask that CMS ensure that documentation guidelines are consistent between the office/outpatient E/M codes and codes describing E/M services in other settings.***

Care Management Services

Transitional Care Management Services

CMS proposes to increase payment for TCM services and to remove certain billing restrictions related to concurrent billing of TCM services. ***AAHPM supports CMS's proposed changes to TCM services***, which we agree should promote greater utilization of these high-value services. Additionally, with respect to the concurrent billing proposal, ***AAHPM agrees that the services described by the 14 codes for which CMS proposes to remove concurrent billing restrictions do not duplicate or overlap with TCM services.***

Chronic Care Management Services

CMS proposes several changes to coding and payment for CCM services that would allow physicians to bill incrementally to reflect additional time and resources required in certain cases, as well as to update certain billing requirements associated with CCM and complex CCM codes.

AAHPM thanks CMS for these changes, which we believe align with CMS's overall approach to more appropriately valuing the time involved in furnishing care to patients with complex health needs, and ***we support CMS adopting the chronic care management coding changes as proposed.***

With respect to valuation of the complex CCM codes, AAHPM notes that the value for proposed GCCC4, which accounts for 30 minutes of clinical staff time, is proposed at 0.50 work RVUs, while the value for proposed GCCC1, which accounts for 20 minutes of clinical staff time, is proposed at 0.61 work RVUs, consistent with the value for the original CCM code CPT 99490. AAHPM believes this discrepancy suggests that the complex CCM code is undervalued, and ***we encourage CMS to increase the value of GCCC4 appropriately to reflect the time, intensity and resources involved to delivering complex chronic care management services.***

Principal Care Management Services

CMS proposes separate coding and payment for Principal Care Management (PCM) services, which describe care management services for a single complex chronic condition, as follows:

- HCPCS code GPPP1 (*Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities*)
- HCPCS code GPPP2 (*Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities*).

According to CMS, a qualifying condition would typically be expected to last between three months and a year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. CMS is also proposing to add GPPP2 to the list of designated care management services for which CMS allows general supervision.

AAHPM thanks CMS for its proposals to cover PCM services, which we believe will provide additional flexibility to HPM physicians to provide care management services to many patients routinely under their care. While our members typically manage care for patients with multiple chronic conditions, including debility, frailty, and serious illnesses such as cancer, advanced

pulmonary disease, progressive neurologic disorders, and more, we also have members who care for patients who have a single serious illness driving significant care needs, such as a specific cancers, heart failure, end-stage renal disease and others. For these clinicians, the availability of a principal care management code will enable them to appropriately bill for the time and resources dedicated to managing their patients' single complex chronic condition.

However, we believe that CMS's proposal would benefit from the following improvements or clarifications:

- ***Alignment of the PCM codes with the Chronic Care Management (CCM) codes.*** It is not clear why CMS has proposed a separate payment structure for PCM codes relative to CCM codes. To the extent that clinical teams dedicate incrementally greater time to care management of patients, whether for one, two, or ten complex conditions, the coding and payment structure should allow for them to receive reimbursement that accounts for the resources expended. However, under the existing proposal, 30 minutes of physician time would be valued at 1.28 work RVUs, versus 1.45 work RVUs for physician time dedicated to CCM services under CPT 99491. Likewise, under CMS's proposal for GPPP2, CMS would value 30 minutes of clinical staff time the same as 20 minutes of clinical staff time under CPT 99490/GCCC1. Additionally, if a patient requires an hour of care management services provided by clinical staff in a month for a single, complex condition, much of that care would not be reimbursed without an add-on code. Given the above, ***AAHPM encourages CMS to align the coding and payment structure across CCM and PCM codes.***
- ***Increased flexibility to account for the non-face-to-face time spent.*** CMS asks whether both codes are necessary to appropriately describe and bill for PCM services, and whether an add-on code would be needed. AAHPM believes the answer to both question is "yes." Consistent with our comment above to align the PCM codes with the CCM codes, we believe that:
 - Separate coding is necessary to reflect time the time spent by a qualified health care professional versus clinical staff.
 - Flexibility should allow for clinicians to bill for both codes for the same patient in the same month, as necessary and applicable.
 - An add-on code would be appropriate to reflect incremental time spent above that addressed in the two codes.

AAHPM encourages CMS to finalize policies accordingly.

- ***Clarification on billing for concurrent services.*** AAHPM asks CMS to clarify whether the PCM codes could be billed along with remote physiologic monitoring codes and interprofessional internet consultation codes. AAHPM recognizes that time spent across these services could only be counted towards a single code.

AAHPM also appreciates CMS's concerns around potential unintended consequences of making separate payment for care management services, including potentially fragmented care, or duplicative services. As such, AAHPM believes that a requirement for a face-to-face service

within the 30 days prior to initiation of PCM services is reasonable, along with requirements for beneficiary consent – provided that consent requirements align with requirements that currently apply for CCM services. Moreover, AAHPM encourages CMS to take a cautious approach to implementation, given the re-distributional effects that the addition of these services may produce given budget neutrality requirements under the Physician Fee Schedule.

Finally, AAHPM would call into question CMS’s characterization that a qualifying condition would typically be expected to last between three months and a year, or until the death of the patient. Many patients experience serious illness that extends beyond a year. AAHPM is concerned that CMS may be placing arbitrary limits on the care that our members provide. While we recognize that CMS is not limiting the use of PCM codes to a year for any given patient, we caution against CMS adopting any type of framework that may impose such a restriction and discount the patients who may continue to be frail and have complex health care needs that would not be well-managed under a disruptive transition of care. As CMS continues to develop policies that enable clinicians and other providers to better manage the care of patients with complex and serious illness, ***AAHPM urges CMS to ensure that policies are patient-centered and do not impose harmful restrictions on medically necessary and appropriate services, including artificial limits on duration of care provided to high-need patients.***

Remote Physiologic Monitoring Services

CMS proposes to adopt a new add-on CPT code (CPT 994X0) to account for remote physiologic monitoring treatment management services provided for each additional 20 minutes of monitoring after the first 20 minutes. CMS proposes a work RVU of 0.50, rather than the RUC-recommended value of 0.61. ***AAHPM thanks CMS for its proposal to establish payment for 994X0, but recommends that CMS finalize the RUC-recommended value of 0.61, which aligns with the values for CPT 99457 (the base code for the initial 20 minutes of remote physiologic monitoring) and CPT 99490 for 20 minutes of CCM services.***

Additionally, CMS proposes to specify that remote physiologic monitoring services may be furnished under general supervision rather than the currently required direct supervision. ***AAHPM supports CMS’s proposal for general supervision and recommends that CMS finalize this policy as proposed.***

Comment Solicitation on Consent for Communication Technology-Based Services

CMS seeks comment on whether a single advance beneficiary consent could be obtained for a number of communication technology-based services, including virtual check-ins, remote evaluation of recorded image/video, and interprofessional internet consultation services. ***AAHPM supports a single advance beneficiary consent that would cover all of the communication technology-based services. We also encourage CMS to consider options to allow for verbal consent, similar to policies CMS has implemented for CCM and TCM services.*** We note that patients are acutely aware of cost-sharing requirements for which they are billed, and that practices routinely educate patients on their cost-sharing obligations as a result. As such, we believe that practices will naturally identify solutions that best balance their needs for burden reduction against beneficiaries’ needs for informed consent.

Online Digital Evaluation Service

CMS is proposing separate payment for codes for online digital evaluation services, including CPT codes that may be furnished by practitioners who can independently bill E/M services (CPT 9X0X1, 9X0X2, and 9X0X3) and G codes that may be performed by practitioners who cannot independently E/M services (GNPP1, GNPP2, and GNPP3). (Note that CMS proposes to use the G codes in place of 98X00, 98X01, and 98X02 in order to refer to the performance of an “assessment” rather than the CPT-recommended term “evaluation.”) **AAHPM supports separate payment for these services, but recommends that CMS adopt the RUC recommended work RVUs for 98X01, 98X02, and 98X03 when valuing codes GNPP1, GNPP2, and GPPP3, respectively.**

Physician Supervision of Physician Assistant (PA) Services

CMS proposes to update its regulations regarding physician supervision of PA services, such that CMS would consider the statutory physician supervision requirement to be met if a PA performs services in accordance with State law and State scope of practice rules for PAs in the State in which his or her services are furnished, with medical direction and appropriate supervision as provided by State law in which the services are performed. In the absence of State law governing physician supervision of PA services, CMS proposes that the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA’s approach to working with physicians in furnishing their professional services.

AAHPM generally supports this proposal, which we believe would allow PAs to practice to the full extent of their license consistent with state law and is largely aligned with CMS’s regulations regarding collaboration for nurse practitioners (NPs) and clinical nurse specialists (CNSs). PAs serve as critical members of interdisciplinary care teams that provide palliative care services in both hospice and non-hospice settings. The availability of PAs on these teams allows for greater and more timely access to high-quality hospice and palliative care, and the need for PAs to practice at the top of their license in close collaboration with physicians will only become more important to ensuring access in the face of a growing workforce shortage of palliative care clinicians.¹ However, AAHPM asks that CMS provide greater clarification on what it means to document the PA’s approach to working with physicians in states without laws governing physician supervision of PA services, including to specify that PAs must document their scope of practice and indicate their relationships that they have with physicians to deal with issues outside of their scope of practice. This added clarification will better align with CMS’s regulations regarding NPs and CNSs and also help to protect patient safety.

Furthermore, AAHPM asks CMS to similarly update requirements for physician supervision of PA services provided under the hospice benefit, as specified at 42 CFR 418.304(f)(2)(iii).

Review and Verification of Medical Record Documentation

CMS proposes to “establish a general principle to allow the physician, the PA, or the [advanced practice registered nurse; APRN] who furnishes and bills for their professional services to review

¹ Kamal AH, Wolf SP, Troy J, et al. Policy Changes Key to Promoting Sustainability and Growth of the Palliative Care Specialty Workforce. *Health Affairs* 2019;38(6):910-918

and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students or other members of the medical team,” noting that this would apply to all Medicare-covered services paid under the Medicare Physician Fee Schedule. ***AAHPM thanks CMS for this proposal, which would not only mitigate burden for the PAs and APRNs who were not able to benefit from the burden reduction policies finalized for teaching physician documentation last year, but would also significantly reduce burden across all billing professionals.***

However, AAHPM would appreciate clarification from CMS as to whether this policy applies to documentation made by students across all disciplines, including non-APRNs, social workers, and spiritual care providers, and whether the term “members of the medical team” would also include all such disciplines. In the delivery of hospice and palliative care, our members necessarily work in interdisciplinary teams to address the full range of patients’ physical, emotional, social, and spiritual well-being. To the extent that this proposal would cover documentation made across the full range of disciplines, this proposal would provide significant relief for our members. ***AAHPM requests that CMS provide clarification clearly articulating that representatives from these disciplines – both students and fully practicing professionals – would be covered under this policy.*** AAHPM believes this would be consistent with CMS’s proposals to update physician certification statement requirements for non-emergency ambulance transport, under which CMS adds licensed practical nurses, social workers, and case managers to the list of staff who may sign certification statements.

Revisions and Additions to Medicare Program Denial of Enrollment and Revocation of Enrollment Reasons

AAHPM opposes CMS’s proposals to update its regulations regarding denial and revocation of enrollment in the Medicare program and urges CMS not to finalize these misguided and likely harmful policies.

First, CMS proposes to add that improper prescribing of Part B drugs could serve as a basis for enrollment revocation, in addition to CMS’s existing authority to base revocation on improper prescribing of Part D drugs that has already been codified in regulation text. AAHPM has serious concerns with this proposal, as well as with the underlying improper prescribing revocation authority for Part D. While we recognize that this policy is intended to address cases where prescribers may engage in fraudulent and abusive behavior, particularly around prescription of controlled substances, we are concerned that the revocation authority may inappropriately target certain specialists, like HPM physicians, who prescribe opioids and other pain management drugs at significantly greater rates than clinicians in other specialties. We are also concerned that this proposal may lead clinicians to limit their prescribing practices based on potential revocation concerns, limiting patients’ access to necessary pain treatment that would be most appropriate for their individualized needs. We believe that existing mechanisms are already in place to address cases of fraud and abuse, and that the proposed expansion of the revocation authority based on improper prescribing is unnecessary and could lead to unintended consequences.

Additionally, CMS proposes to add both a denial and revocation reason that allows for denial or revocation of Medicare enrollment if an eligible professional has been subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. CMS identifies several factors that it would consider when making a determination to deny or revoke enrollment on these grounds, including:

- The nature of the patient harm
- The nature of the conduct
- The number or type of sanctions or disciplinary actions that have been imposed (e.g. license restrictions, required compliance appears, participation in rehabilitation or mental/behavioral health programs; required abstinence from drugs or alcohol and random drug testing; license restrictions regarding the ability to treat certain types of patients; administrative/monetary penalties; or formal reprimands)
- The number of patients impacted
- “Any other information that CMS deems relevant to the determination”

AAHPM has significant concerns with this proposal, which we believe would:

- give CMS overly broad authority to deny or revoke enrollment;
- provide insufficient clarity regarding the standards that CMS would apply to determine whether denial or revocation is warranted;
- heighten already significant barriers to health professionals seeking and receiving necessary – and at times life-saving – treatment for mental/behavioral health needs, including substance use disorder;
- rely on actions that are not indicative of patient harm and may result in unintended consequences;
- potentially reduce access to clinicians, including in rural and underserved areas and in care locations such as nursing facilities, depending on the extent to which CMS relies on this authority.

Many actions taken by oversight entities may be based on a complaint by a single individual patient who, for example, may disagree with a physician’s medically appropriate decision not to prescribe a certain medication or who did not understand the relative risks and benefits of a treatment as they were communicated by the physician. Under CMS’s proposal, which does not outline clear criteria for how patient harm is determined or what extent of harm would be required to pass CMS’s threshold for triggering a negative determination, such oversight actions could serve as the basis for the physician’s enrollment revocation. We do not believe this is an appropriate outcome, and we believe the stakes involved in denying or revoking Medicare enrollment are too high for CMS to finalize this this proposal – particularly for HPM clinicians for whom Medicare beneficiaries serve as the overwhelming majority of their patient population. The vague standards and overly broad authority, paired with the devastating impact of enrollment denial or revocation on a clinician’s ability to practice his or her hard-earned profession, persuade us to oppose this proposal.

Furthermore, with respect to CMS's intent to consider participation in rehabilitation or mental/behavioral health programs when making an enrollment or revocation determination, we are concerned that this policy will create a barrier for clinicians to seek mental or behavioral health treatment services. Research shows that health professionals experience behavioral and mental health conditions at rates equal to or greater than the population overall, and also that they may not seek treatment for fear of professional consequences. This proposed rule, if finalized, will most certainly worsen this problem. AAHPM objects in the strongest terms to any regulation that would further distance our colleagues from necessary and at times life-saving medical treatment.

Physician Assistant Prescribing for Beneficiaries in Hospice and Comment Solicitation on Advanced Practice Providers/Practitioners (APPs) in Hospice Care

AAHPM appreciates that CMS has included a proposal to permit a hospice to accept drug orders from a physician, NP, or PA. CMS proposes that the PA must be an individual acting within his or her state scope of practice requirements and hospice policy, and must also be the patient's attending physician. However, CMS also specifies that the PA providing these orders may not have an employment or contractual arrangement with the hospice. AAHPM does not believe that such restrictions are appropriate or in the best interest of hospice patients.

Currently across the nation, PAs are employed or contracted by inpatient palliative care teams, palliative care clinics, and facility- and home-based palliative care programs – just as they practice in other areas of medicine, such as critical care, hospital medicine, or emergency medicine – where their prescriptive authority is not limited as proposed. To restrict prescribing privileges only for patients enrolled in the hospice benefit is inconsistent with routine PA practice and only creates an obstacle to delivering timely, high-quality hospice care – particularly at a time when the need for a skilled palliative and end-of-life care workforce is expected to increase. We also note that CMS's proposed restrictions are not consistent with other proposals in this rule to reduce burden by allowing clinicians, including PAs, to practice within their state's scope of license. AAHPM recognizes that PAs are not currently included in hospice COPs, which appears to be the origin of the proposal only to allow drug orders from a PA who is neither employed nor contracted by a hospice. However, as we believe that this serves as a barrier to appropriate hospice patient care, ***AAHPM requests that CMS take action to allow PAs to fulfill their patient responsibilities as attending physicians, including by amending the hospice conditions of participation (COPs) in order to specify that PAs may prescribe medication to Medicare hospice patients, regardless of whether the PA has an employment or contractual relationship with the hospice.***

We offer the comments below in response to CMS's solicitation on the current and future role of non-physician practitioners, or advanced practice providers (APPs), which is the more commonly accepted term in hospice care. We include both Advanced Practice Registered Nurses (Nurse Practitioners, Clinical Nurse Specialists and others) and also Physician Assistants (PAs) to be APPs.

- *What is the role of an NPP/APP in delivering safe and effective hospice care to patients? What duties should they perform? What is their role within the hospice interdisciplinary group and how is it distinct from the role of the physician, nurse, social work, and counseling members of the group?*

APPs allow for greater and more timely access to high-quality hospice care, often in some of the most vulnerable communities. APPs hired by the facility and supervised by the medical director would be able to practice independently and to the top of their license. This includes, but not limited to, performing history and physical exams; delineate goals of care with patients and families; diagnosing, treating and prescribing appropriate pharmacologic and non-pharmacologic interventions for the patient; evaluating patients' response to therapies; refining the patient's care plan as the patients' disease trajectory evolves; participating in interdisciplinary teams (IDTs); and conducting family meetings. Within IDTs, APPs generally take on roles that are equivalent to each other and should be on equal footing across disciplines.

In many instances, APPs function in a manner similar to physicians. Indeed, AAHPM supports expanding the range of services that are available to APPs, including allowing PAs to conduct the face-to-face encounter with a hospice patient for recertification determinations. This expansion of authority (which would be effectuated through statute) would significantly increase access to hospice care and reduce burden for hospices and physicians providing hospice care, particularly in rural areas where recertification visits may require significant driving time (hours) to reach a patient. NPs are already allowed to fill this critical role, but expanded authority for PAs would help to further increase access. However, we support the continued requirement for a hospice medical director to provide supervision and conduct physician certification consistent with Medicare statute and regulations.

- *Nursing services are a required core service within the Hospice benefit, as provided in section 1861(dd)(B)(i) of the Act, which resulted in the defined role for NPs in the Hospice COPs. Should other NPPs/APPs also be considered core services on par with NP services? If not, how should other NPP/APP services be classified?*

AAHPM supports all APPs to be defined as equals of the current defined role for NPs in the hospice CoPs and, subsequently, for APP involvement (regardless of discipline) to be considered a core service to the extent allowed by state scope of practice requirements. In clinical practice, all APPs generally share the same job descriptions and work expectations for patient care.

- *In light of diverse existing state supervision requirements, how should NPP/APP services be supervised? Should this responsibility be part of the role of the hospice medical director or other physicians employed by or under contract with the hospice? What constitutes adequate supervision, particularly when the NPP/APP and supervising physician are located in different offices, such as hospice multiple locations?*

Given current workforce considerations, we believe that supervision requirements should defer to state law and that APPs should be allowed to practice to the top of their license. Additionally, when there is no state law governing physician supervision of or collaboration with APPs, we support requiring APPs to document their scope of practice and indicate their relationships with hospice medical directors to deal with issues outside

of their scope of practice. This position is consistent with our stance on CMS's proposal to update physician supervision requirements for PAs detailed above. In any situation, however, the actions of APPs must be in accordance with documented plans of care, which are created and monitored by the IDT.

- *What requirements and time frames currently exist at the state level for physician co-signature of NPP/NPP orders? Are these existing requirements appropriate for the hospice clinical record? If not, what requirements are appropriate for the hospice clinical record?*

Requirements for co-signature vary by state and type of NPP. Some require co-signature at 3 days, though most are within the 7-14 day range, and some are also open-ended. In states where there is independent NPP practice, no co-signatures are required. We do not have any concerns with these requirements, if any apply, with respect to documentation included in the hospice medical record.

- *What are the essential personnel requirements for PAs and other NPPs/APPs?*

AAHPM believes the essential personnel requirements include completed training at an accredited advanced practice registered nurse (APRN) or PA program, state licensure in good standing, and maintenance of continuing education requirements. For APP disciplines that offer certification in hospice and palliative care, we note that such certification is preferred. However, we recognize that such a requirement may contribute to limited access and availability of APPs for hospice care, which would be problematic given the workforce shortage facing the field.

Quality Payment Program

Transforming the Merit-based Incentive Payment System (MIPS): MIPS Value Pathways Request for Information

CMS proposes to apply a new MIPS Value Pathways (MVP) framework beginning with the 2021 MIPS performance period. CMS notes that the MVP framework would create a more cohesive participation experience and reduce burden by connecting measures and activities from across the four MIPS performance categories that are relevant to a specialty or medical condition.

AAHPM appreciates CMS's recognition that the MIPS program is exceedingly complex and its interest in making the program more meaningful, more streamlined, and less burdensome for clinicians. While we agree that CMS's overarching goal is vital, however, we have concerns that the fundamental approach required under MIPS undermines the ultimate goal of providing high-quality, high-value care to Medicare beneficiaries. Rather than being patient-centered and focusing on the overall patient experience of care, the MIPS program pits clinicians and groups against one another and requires that there be winners and losers based on each's ability to maneuver across the complicated MIPS participation and scoring landscape.

Hospice and palliative care clinicians have long endured a dearth of relevant cost and quality metrics that could apply in the MIPS program and, therefore, the idea of developing MVPs specifically for palliative care is appealing. However, when we begin to contemplate what such an MVP might entail, we bump up against the limitations of the MIPS program. ***We believe an MVP should be patient-centered, not provider-centered, and it should focus on the experience of the patient across the care continuum:*** while hospice and palliative care clinicians play an important role in managing patients' care experience, there are numerous other primary and specialty care providers who will contribute to a given patient's journey with serious illness and who will determine whether the patient ultimately meets or exceeds his or her goals of care. For a patient with cancer, for example, assessing a clinician on management of a patient's neutropenia without also understanding the patient's experience of pain would do a great disservice to the patient. We understand that multi-specialty groups that address the full spectrum of a patient's care may be able to be assessed in a patient-centered fashion at the group level; however, we are concerned that – under the current limitations of the MIPS program – there are too many small practices that will be subject to siloed measures or pathways that inadequately assess the outcomes of greatest interest for patients with serious illness.

AAHPM recognizes that movement of clinicians into alternative payment models (APMs) is a long-term goal under HHS's value-based transformation agenda. AAHPM supports this goal and believes it may be a solution to enabling patients with serious illness to receive the multidisciplinary, patient-centered care they require. Indeed, AAHPM developed our own APM, which we submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and collaborated with CMS in ongoing model development efforts that culminated in CMS's announcement of the serious illness population (SIP) option of the Primary Care First model. However, we also recognize that APMs will not be available broadly for wide-scale participation and that many practices will not have the resources or expertise to succeed under APMs. As such, ***streamlined and meaningful MVPs that break down silos and focus on care across the continuum will be critical for those who remain in the MIPS program.***

Additionally, as CMS contemplates a strategy for MVP implementation, AAHPM offers the following targeted recommendations:

- ***Ensure clinician choice in MVP participation and selection.*** AAHPM disagrees that clinicians should be assigned on a mandatory basis to MVPs, as CMS suggests. CMS's MVP framework represents a significant shift in how clinicians would participate in MIPS, when they have already invested time and resources in succeeding under the current approach. As significant a change as that envisioned under MVPs would result in confusion, disruption, and burden – especially in the short term. Furthermore, MVPs have not been tested or validated to determine whether they indeed achieve CMS's goals of making MIPS participation more meaningful and streamlined, and CMS's previous experiences with attributing clinicians to certain measures (e.g. total per capita cost or Medicare spending per beneficiary) have resulted in application of measures that are not meaningful or actionable for clinicians. ***Ensuring that clinicians can choose whether or not to participate in an MVP, and which MVP is most appropriate, will be critical for the success of this effort.***

- ***Forego claims-based population health measures.*** AAHPM has serious concerns with CMS's proposal to increase reliance on population health measures through MVPs. As noted above, existing population health measures have been plagued with challenges, including inappropriate attribution, concern regarding case mix adjustment, and limited actionability. In addition, the potential for unintended consequences has not been adequately studied, such as the risk that the all-cause readmission measure could drive stinting of care and excess mortality. Evidence of such harm has been reported in other Medicare quality programs; for example, a recent report of an association between the Hospital Readmission Reduction Program and increased mortality warrants further study and highlights the importance of vigilance for unintended outcomes.² For these reasons, we believe the risks outweigh the benefits for using these measures at this stage in our understanding of the results they may drive.
- ***Apply a staged approach to implementation of MVPs.*** AAHPM is concerned that CMS's proposed timeline for implementation of MVPs is too aggressive, particularly given the lack of existing MVPs, the lack of information on how clinicians would respond to and perform on MVPs, and the amount of disruption that would arise as CMS undertakes a significant revision to its approach towards performance measurement. To address these challenges, we recommend that CMS adopt a staged approach that begins with small-scale piloting of MVPs, developed in coordination with applicable stakeholders, in order to provide better information on the benefits and challenges of performance assessment using MVPs and to limit the burden that will inevitably ensue with full implementation.
- ***Ensure appropriate risk adjustment.*** AAHPM continues to encourage CMS to expand its approach to risk adjustment, including to incorporate information about functional and cognitive status, adjust for regional variation, and account for variation across different types of Tax Identification Numbers (e.g. solo practitioners versus large multi-specialty groups). Particularly for the seriously ill patients that our members serve, appropriate risk adjustment will be critical for ensuring apples-to-apples comparisons across clinicians and groups.
- ***Develop MVPs focused on seriously ill patients.*** AAHPM appreciates CMS's efforts to better identify patients with serious illness. For example, under the Primary Care First serious illness population option, CMS is identifying a seriously ill population based on claims data. While we believe this work continues to require refinement, we are encouraged that CMS is engaged in this effort, and we urge CMS to continue exploring mechanisms to better identify this population. We believe this is a necessary first step towards developing metrics that assess care for this high-need population, including for incorporation into MVPs. Furthermore, we encourage CMS to work closely with the hospice and palliative care provider community to ensure that MVPs are appropriately

² Wadhwa RK, Maddox KEJ, Wasfy JH, Haneuse S, Shen C, Yeh RW. Association of the Hospital Readmissions Reduction Program With Mortality Among Medicare Beneficiaries Hospitalized for Heart Failure, Acute Myocardial Infarction, and Pneumonia. *JAMA*. 2018;320(24):2542. doi:10.1001/jama.2018.19232.

targeted and designed to measure performance on the outcomes that matter most for patients with serious illness, including to ensure that MVPs focused on this population measure appropriate access to palliative care services.

- ***Reduce reliance on the Promoting Interoperability (PI) measures for certain clinicians.*** CMS proposes to rely on PI measures as a key structural component of any MVP. While AAHPM recognizes the importance of certified electronic health record technology (CEHRT) and interoperability as a quality mechanism, few electronic health record (EHR) vendors have developed CEHRT that is applicable to hospice and palliative care in the absence of specific payment incentives³, leaving many HPM clinicians to struggle with the PI performance category. AAHPM has raised this ongoing challenge with CMS numerous times, including asking for automatic hardship exceptions from the PI (former Advancing Care Information) category for HPM clinicians. AAHPM continues to be concerned that HPM clinicians will be at a disadvantage under MIPS, including under MVPs, and we ask CMS to work with us to reach a viable solution for this ongoing challenge.
- ***Maintain flexibility for small and rural practices.*** AAHPM encourages CMS to maintain flexibility for small and rural practices that already struggle to keep pace with larger practices and may be disproportionately harmed when CMS up-ends its approach to performance assessment and value-based purchasing. While the above recommendations apply broadly, we believe choice, staged implementation, accurate risk adjustment, and relief from population health and PI measures are even more important when considering impacts of a transition to MVPs for small and rural practices. Additionally, AAHPM would also support scaled-back reporting requirements, targeted technical assistance, ongoing availability of small practice bonuses, and continued flexibilities such as hardship exceptions.
- ***Ensure meaningful public reporting.*** CMS solicits input on updating public reporting for MVPs, including potentially reporting a “value indicator” to help patients and caregivers make decisions about their health care. While AAHPM appreciates this goal, we urge CMS to take a cautious approach when implementing new public reporting strategies, given the challenges with developing and testing indicators of value that convey their intended messages. For example, we are concerned that patients may not share the same understanding of “value” as CMS, and that a “value indicator” may be misunderstood. We also worry that apples-to-apples comparisons across clinicians or groups will still remain a challenge – for example when comparing small practices against large practices, or comparing performance across different geographic regions. And we question how CMS will report on performance when measures may not have “optimal” rates, and higher measure percentages may not necessarily align with quality. These and numerous other challenges will need to be addressed as CMS undertakes changes to public reporting for clinician performance that rely on the use of MVPs in order to ensure that

³ For example, hospices were not eligible for payment incentives to adopt CEHRT under the Medicare Electronic Health Record Incentive Program.

patients and their families are accurately interpreting the reported data and its implications for the care they will receive.

AAHPM looks forward to ongoing engagement with CMS on the evolution of the MIPS program, including through development of applicable MVPs, to ensure that it can serve as a meaningful and effective way of assessing HPM clinicians as they deliver patient-centered care for individuals with serious illness.

Proposals and Solicitations Regarding Measures to Address Opioid Use Disorder (OUD)

CMS includes several proposals and solicitations on measures intended to address OUD through the MIPS program, including:

- A request for information on the use of the Potential Opioid Overuse electronic Clinical Quality Measure (eCQM) for the Quality performance category
- A request for information on potential new measures for OUD that could be incorporated into the PI category in future years
- A request for comment on the development of measures for the PI category that are based on existing measures, including the National Quality Forum (NQF) and Centers for Disease Control and Prevention (CDC) Quality Improvement opioid measures
- A proposal to make the Query of PDMP measure optional and eligible for bonus points under the PI performance category for performance year 2020
- A proposal to remove the Verify Opioid Treatment Agreement measure from the PI performance category for performance year 2020

As we have previously commented, 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 opioid use disorder (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, as we have noted previously, ***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: 1) opioid analgesics may be critical to alleviating their pain and other distressing symptoms, 2) high-dose opioids may pose more benefit than risk, and 3) evidence-based guidelines support their use. Therefore, public policies and accountability structures must recognize there is an equally important public health imperative to ensure that

our sickest, highest need patients have access to timely, effective treatment for their pain and suffering.

With respect to CMS's solicitations, in particular, ***we question whether adopting new measures as contemplated 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 options for new measures that CMS contemplates for the Quality and PI performance categories could result in unintended consequences that could 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.

To the extent that CMS continues to pursue measures to address OUD, AAHPM offers the following general comments for consideration:

- **Need for appropriate exclusions.** For any new measure focused on measuring inappropriate use of or access to opioid treatments, ***AAHPM urges CMS to ensure that the measure includes sufficient denominator exclusions for patients with serious or complex chronic illness and those at the end of life to protect access to treatments for patients with the highest needs.*** To begin, the denominator exclusions should include patients who are in a hospice election or who are discharged to hospice, as well as those who are receiving palliative care. These patients are more likely to require concurrent prescribing of multiple opioids to address pain associated with their terminal illnesses or concurrent prescribing of a benzodiazepine with an opioid to manage complex symptoms. Additionally, we believe other patients with serious illness – for example patients with advanced stages of diseases including cancer, AIDS, dementia and other incurable neurodegenerative diseases, chronic lung disease, end stage renal disease, cirrhosis, heart failure, hemophilia, or sickle cell disease – should also be excluded. Many such patients may lack access to hospice or formal, specialized palliative care, for example due to barriers such as culturally-linked patient preferences, residence in rural or underserved communities, or physician failure to refer. Yet, these patients may require multiple opioid prescriptions to manage pain and provide symptom relief, for example as a result of palliative care services provided by primary care clinicians. Other patient groups that should also be excluded from the denominator include patients who are receiving opioids for the treatment of addiction. We are concerned that the failure to incorporate appropriate denominator exclusions under new measures could raise access barriers to appropriate medications for these high-need populations.
- **Need for evidence-based approach and concern with CDC Guideline.** ***AAHPM urges CMS to rely on clinical evidence regarding the reliability and validity of measures to address public health and safety concerns with opioids.*** In particular, AAHPM is concerned about the use

of measures that rely on the *CDC Guideline for Prescribing Opioids for Chronic Pain*, which does not apply to seriously ill patients managed 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, and even the authors of the Guideline have gone on record about the risk of patient harm when the Guideline is misinterpreted and misapplied.⁴ We are concerned, therefore, that including measures in MIPS that rely on the Guideline would exacerbate a tendency to extrapolate the Guideline to other specialists and patient populations for which it was not intended. 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, even for patients managed in primary care settings. Further, with respect to measures focused on 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.

- **Lack of benchmarks.** *AAHPM is concerned that many of the measures do not have clear benchmarks or target levels of performance.* Given differences in patients’ clinical status and pain management needs, it is not clear how medical necessity and physician judgement of patients’ conditions will be taken into account in performance assessments. As such, it is not clear how performance on such measures will or will not reflect appropriate delivery of care.
- **Need for appropriate risk adjustment.** *AAHPM encourages CMS to apply appropriate risk adjustment to quality measures that focus on opioid usage to account for variation in patients across practices.* We are concerned that, as clinicians will have different case mixes, this will necessarily result in differential outcomes on these opioid measures. For example, clinicians that disproportionately treat patients with sickle cell disease may have higher rates of concurrent prescribing. Without appropriate risk adjustment, practices may face incentives to either limit prescriptions for medically necessary opioids, or potentially to turn away patients who may be more likely to require them. We believe that an appropriate risk adjustment methodology would incorporate factors such as cognition, functional status, and socioeconomic status, as well as standard demographic and claims-based health factors, to allow for apples-to-apples comparison across practices.

Until CMS can accommodate all of the above, AAHPM cannot support the inclusion of new measures related to opioid use in the MIPS program.

AAHPM also offers the following recommendations on CMS’s proposals regarding the two existing opioid-related PI measures:

⁴ See <https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html>

- Query of prescription drug monitoring program (PDMP). AAHPM continues to have concerns with this measure and believes that, *if CMS continues to retain this measure in the PI performance category, CMS should add further protections, including additional measure exclusions as described above. Likewise, we support CMS's proposal to make this measure optional, with a yes/no response, and to offer bonus points.*
- Verify opioid treatment agreement. AAHPM supports CMS's proposal to remove this measure from the PI performance category, as proposed.

Performance Category Weights

CMS proposes to establish revised category weights for the cost and quality performance categories under MIPS such that the weight of the cost performance category would be set at 20 percent for the 2020 performance year (up from 15 percent for 2019) and would incrementally rise to 30 percent by 2022, while the quality performance category weight would drop to 40 percent for 2020 (down from 45 percent for 2019) and would continue to decrease each year until it reaches 30 percent by 2022.

While we recognize that statute requires the cost and quality category weights to be set at 30 percent for the 2022 performance year, we continue to have concerns with increasing the weight of the cost performance category, and *we recommend that CMS not finalize its proposal to incrementally adjustment performance category weights between now and 2022.* As we have noted in previous comments, 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. Given concerns about the applicability of the cost performance category to HPM clinicians, *we disagree that CMS should raise the weight of this category at this time. We also believe that CMS should retain flexibility regarding this performance category's weight for future years.*

Performance Threshold

CMS proposes to increase the performance threshold from 30 points for performance year 2019 to 45 points for performance year 2020 and to 60 points for performance year 2021. *AAHPM encourages CMS to carefully consider how this proposed increase would affect small practices, and whether additional accommodations may be needed to ensure that small practices have equal opportunity to succeed under the MIPS program as their larger counterparts.*

Quality Performance Category: Data Completeness Criteria

CMS proposes to increase the data completeness threshold from 60 percent to 70 percent for performance year 2020. *AAHPM objects to this proposal, which would disproportionately burden small practices and practices – like those of many HPM clinicians – that rely on manual extraction and reporting of quality information to participate in MIPS.* As noted above, many HPM practices have not been able to adopt CEHRT, due to the lack of CEHRT that is applicable to the practice of

hospice and palliative medicine. These clinicians are often forced to rely on manual processes to meet their quality reporting obligations under MIPS, and meeting the existing 60 percent data completeness threshold already proves to be a challenge. Increasing the data completeness threshold will only serve to increase burden and divert more time and financial resources away from patient care and towards burdensome administrative tasks.

AAHPM recognizes CMS's concern regarding representativeness of the reported data and concern about practices cherry picking data to result in higher performance. To address this issue, *AAHPM believes that a low-burden approach to identifying an assured random sample could provide an alternative that would allow for reporting on a smaller but representative set of cases to determine quality performance, and we encourage CMS to pursue implementation of such an approach.*

Quality Performance Category: Measure Updates

CMS proposes to remove several measures from the quality category that apply to care provided to patients with serious illness. We disagree with the removal of these measures, given the current gap that exists in quality measurement for this vulnerable population. We offer specific feedback on these measures below.

- **#131 Pain Assessment and Follow-up (NQF 0420).** AAHPM disagrees that this measure should be removed due to the potential for excessive prescribing of pharmacologic therapies to address pain. This measure addresses pain assessment, which is a core element of palliative care on which clinicians should be assessed. It does not address the extent to which patients report improvement in pain management, which more directly speaks to treatment and prescribing patterns. CMS's proposal represents a clear example of how quality measurement decisions may have the impact of reducing access to pain management – if pain is not assessed in the absence of this measure, then clinicians may have less opportunity to offer appropriate therapies.
- **#403 Adult Kidney Disease: Referral to Hospice.** AAHPM disagrees that this measure should be removed due to limited adoption. Just because a measure is not widely used does not mean that it is of little clinical importance. Timely and appropriate referral to hospice results in significant benefits for patients, their caregivers, and the Medicare program, and encouraging such action – even for targeted populations – should be prioritized. Existing data demonstrate an ongoing gap in this measure, with only 23 percent of patients with end-stage renal disease enrolled in hospice at the time of death.⁵ Additionally, there are many reasons for slow measure adoption, including CMS's own policies regarding capping the scores of measures without benchmarks, that have little to do with clinical importance, and we do not believe CMS should cripple efforts to improve quality based on the standard of limited adoption alone.

⁵ United States Renal Data System. 2018 USRDS annual data report: Epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2018.

- **#456 Percentage of Patients who Died from Cancer Not Admitted to Hospice (NQF 0215).** AAHPM objects to the removal of this measure. CMS notes that this measure concept is already captured in measure #457 Percentage of Patients who Died from Cancer Admitted to Hospice for Less than 3 Days. We disagree with that conclusion. The denominator for #457 is defined as “patients who died from cancer and *were admitted to hospice.*” Patients who were never admitted to hospice are not counted. Therefore, clinicians could avoid accountability for short hospice stays by simply not referring to hospice at all whenever death appears imminent. However, hospice care, even when for just a few days, can have a tremendous positive impact on patients’ and caregivers’ experience during the patients’ last days of life. We believe both measures should be used in conjunction with one another to balance incentives to provide both overall access to hospice care and its timely utilization.

In addition, CMS proposes to include a new All-Cause Unplanned Admission for Patients with Multiple Chronic Condition (MCC) claims-based measure in the MIPS program beginning with performance year 2021. ***AAHPM objects to the addition of the MCC measure, which we believe could result in unintended consequences, including increasing the risk that providers avoid admitting patients with multiple chronic conditions to the hospital for medically necessary care.*** We also reiterate concerns about claims-based measures, which suffer from attribution challenges and lack of actionable information. ***If CMS chooses to pursue a measure focused on admissions, we believe it would be more appropriate for CMS to pursue more targeted measures that focus on ambulatory-sensitive admissions, in order to home in on variation in care that can be tied to clinician performance.***

Finally, CMS proposes to remove MIPS quality measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for two consecutive performance periods. ***AAHPM disagrees with this new criterion for measure removal, which we believe particularly disadvantages specialty providers like HPM physicians for whom there is a current dearth of applicable measures.*** Removing measures without benchmarks after only two years creates a great deal of uncertainty for measure developers who invest significant time and resources to develop and test measures that they believe are clinically meaningful and address gaps in care that currently exist, thereby disincentivizing new measure development. Indeed, the Academy is leading measure development efforts for two new MIPS measures with the support of measure development funding appropriated under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). However, we have limited ability to predict the extent of adoption and use of our measures, and over what timeframe, after they are finalized. And because our field is only just starting to be represented in quality measurement and reporting, it would be a huge blow to learn that our measures would be removed from MIPS after only two years, before they had the time and opportunity to gain traction within the HPM provider community. Furthermore, we note that CMS’s proposal does not acknowledge the structural disadvantages new measures face under MIPS. Under current policy, for example, clinicians who report new measures may be subject to a cap of three points if there are not a sufficient number of reporters of the measure to establish benchmarks. Additionally, there is a lack of reporting options for sub-groups within multi-specialty practices, who therefore do not have incentives or

opportunity to report separately on measures that are meaningful for their specialty practice. ***For all these reasons, we urge CMS not to finalize this proposal.***

Cost Performance Category

CMS proposes several changes to the cost performance category, including revising the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures, as well as adding 10 new episode-based cost measures to the cost performance category for the 2020 performance period. ***AAHPM appreciates CMSs' interest in refining the TPCC and MSPB measures to address concerns raised by stakeholders, including around attribution. We also appreciate CMS's decision to exclude hospice services from the MSPB measure, which we believe will mitigate inappropriate incentives to forego referral to hospice.***

At the same time, we continue to have significant concerns about the cost category. As mentioned above, we have long objected to the use of the TPCC and MSPB measures for evaluating clinician performance and, even with the refinements as proposed, we are concerned that CMS is rushing implementation without ensuring that measures are tested and validated – and especially that they are attributing clinicians properly. We also highlight concerns raised by the MAP Coordinating Committee on both measures, as well as the Committee's final recommendation not to support the TPCC measure for rulemaking at this time. Further, we note that the existing and proposed episode-based cost measures, while they may include palliative care, would likely not and should not apply to our members, meaning that there continues to be a gap in meaningful, well-structured cost measures for HPM clinicians. For these reasons, as noted above, ***we cannot support CMS's proposal to increase the weight of the cost category for 2020 or future performance years.***

Additionally, we would note an overarching concern about episode-based cost measures and their implications for access to palliative care services. Historically, access to community-based palliative care services has been low, and patients have not received palliative care consistent with their needs. We are concerned that episode-based cost measures “bake in” a lack of palliative care services (which are often billed using E/M codes), and that accountability for episode-based costs measures may discourage appropriate integration of palliative care. For this reason, AAHPM has repeatedly called for CMS to include an accountability framework that includes quality measures that create incentives for high-value, patient-centered care, including through the delivery of palliative care for patients with serious illness. While we appreciate that CMS's proposal for MVPs seeks to move closer toward this goal, ***we reiterate the need for MVPs to ensure that access to palliative care is promoted under MVPs, once they are implemented, and the need for CMS to mitigate disincentives to provide high-quality palliative care under the current cost performance category and overall MIPS framework.***

Improvement Activities Performance Category

CMS proposes to increase the minimum number of clinicians in a group or virtual group who are required to perform an improvement activity to 50 percent beginning with the 2020 performance year and future years. CMS also proposes that at least 50 percent of a group's National Provider Identifiers (NPIs) must perform the same activity for the same continuous 90 days in the performance period beginning with the 2020 performance year. AAHPM has significant concerns

with this proposal, which would drastically escalate requirements for participation in improvement activities from CMS's current requirement for only one NPI to participate in an improvement activity for the full group to receive credit – again moving the goal post when clinicians are still adapting to MIPS program requirements. We also note that this proposal does not address the variation in roles and responsibilities undertaken by different clinicians in group practices, particularly large multi-specialty practices. Such variation may require individual clinicians to participate in improvement activities that are tailored towards their specific roles in order to best promote high-quality care, rather than all or most clinicians participating in a single improvement activity. CMS's proposal, however, would take away practices' autonomy and flexibility to direct their quality improvement resources in a manner that is most appropriate for each of the clinicians involved. Furthermore, participation of a single clinician in a single improvement activity may have broad benefits across a practice's patient population, which this policy fails to recognize. ***Given these concerns, we urge CMS not to finalize this policy as proposed.***

Promoting Interoperability: Hospital-based Group Designation

CMS proposes to revise the definition of a hospital-based group to specify that a group would be determined to be a hospital-based group if more than 75 percent of the NPIs billing under the group's TIN are determined to be hospital-based. ***AAHPM supports this change, which would align group determination criteria for hospital-based groups with that applied for non-patient facing groups and facility-based groups, and recommends that CMS finalize this proposal.*** AAHPM believes this change will increase flexibility to clinicians practicing in hospital settings and reduce burden for groups who have limited control over the availability of CEHRT in the workplace.

Promoting Interoperability: Requests for Information

CMS includes several requests for information related to the Promoting Interoperability performance category. While the Academy appreciates CMS's interest in improving how data from EHRs may be accessed and used, we note that these RFIs presume a threshold level of utilization of CEHRT that may not apply for HPM providers. As noted above, however, few EHR vendors have developed CEHRT that is applicable to hospice and palliative care in the absence of specific payment incentives. HPM clinicians will continually be disadvantaged until EHR vendors are motivated to develop compliant and affordable CEHRT products for the hospice and palliative care field. To address this challenge, ***we urge CMS to engage with EHR vendors to encourage development of CEHRT focused on hospice and palliative care services and settings and to engage with Congress to enact necessary incentives to remedy this longstanding disadvantage that HPM clinicians – as well as the hospices in which many of them work – have experienced.***

Complex Patient Bonus

CMS proposes to maintain the complex patient bonus for the 2020 MIPS performance period while it continues to review data to work on a long-term solution to account for patient risk factors in MIPS. ***AAHPM thanks CMS for this policy, which continues to protect 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 high-need 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

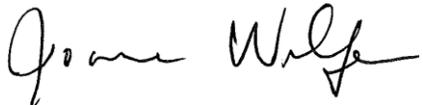
need to ensure that risk adjustment methodologies appropriately account for the needs and costs of the sickest patients.

Physician Compare

CMS solicits input on updating public reporting on Physician Compare to including information from narrative questions and other patient-reported outcome measures, as well as to publish a single “value indicator” reflective of cost, quality, and patient experience and satisfaction. Consistent with our comments on MVPs, ***we urge CMS to take a cautious approach when implementing new public reporting strategies, given the challenges with developing and testing indicators of value that convey their intended messages. We believe extensive user testing as well as a robust, transparent, and iterative rulemaking process will be critical for ensuring that meaningful, valid, reliable, usable, and patient- and family-friendly information is conveyed to patients and caregivers.***

Thank you again for the opportunity to provide feedback on these policy proposals affecting payment under the Medicare Physician 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,



Joanne Wolfe, MD MPH FAAHPM
President

American Academy of Hospice and Palliative Medicine