AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

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September 13, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Calendar Year (CY) 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulations Updates; Provider and Supplier Prepayment and Post-payment Medicare Review Requirements [CMS-1751-P]

Dear Administrator Brooks-LaSure:

On behalf of the 5,300 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the calendar year (CY) 2022 Medicare Physician Fee Schedule (MPFS) proposed rule. 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.

Summary of Key Recommendations

In the detailed comments that follow, we make the following recommendations:

- To work with Congress to ensure that projected payment reductions to MPFS services are averted.
- To include our specialty in CMS impact tables for the CY 2022 MPFS final rule, and for all future MPFS proposed and final rules going forward.
- To work with Congress to eliminate permanently the geographic and originating site restrictions on Medicare telehealth services.
- To finalize CMS' proposal to extend the availability of Category 3 services through 2023.
- To add several services to the Medicare telehealth services list on a Category 3 basis, including home services for new patients, domiciliary or rest home services for new patients, and initial nursing facility services.
- To expand the applicability of CMS' proposal regarding the use of audio-only communications technology for telehealth services to include office and outpatient evaluation and management (E/M) services as well as advance care planning codes.

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- To allow additional time to study the impact of direct supervision via virtual presence and to consider the potential benefits of extending this flexibility permanently to a small subset of services for which virtual supervision may be of high value and low risk of patient harm.
- To finalize CMS' proposals regarding valuation of codes in the chronic care management/complex chronic care management/principal care management code family, and to work with Congress to eliminate copayments for these care management services.
- To issue an interim final rule to implement and pay separately for Current Procedural Terminology (CPT) code 99072 with no patient cost-sharing and without application of budget neutrality adjustments and to work with Congress to pursue payment for pandemic-related costs incurred by physicians outside of budget neutrality.
- To support patient-centered management of pain by clarifying, modifying and/or expanding existing care management codes as needed to include patients with chronic pain and significant acute pain; to reframe CMS' discussion around chronic pain to emphasize the importance of an individualized approach to pain management, and to address administrative and financial barriers that impede patient access to comprehensive multimodal, multidisciplinary pain care.
- To finalize CMS' proposals regarding split (or shared) services in facility settings – particularly those that allow split (or shared) billing policies to be applied to both new and established patients, as well as to the billing of prolonged services – but not require reporting of a separate modifier.
- To finalize CMS' proposals for critical care services that allow non-physician practitioners (NPPs) to report critical care services and that allow critical care services to be furnished as split (or shared) visits.
- To update CMS' proposed regulation text to confirm that hospice attending physician services furnished by rural health clinics (RHC) and federally qualified health centers (FQHC) will continued to be covered in the scope of benefits if patients change their attending physician at any time during the course of their hospice election.
- To undertake a revision to the Enteral and Parenteral Nutrition Therapy national coverage determination (NCD) to ensure that it reflects current evidence and the standard of care and allows for uniform coverage policy nationwide, rather the removing the NCD altogether.
- To finalize CMS' proposals to revise the compliance date for electronic prescribing of controlled substances (EPCS) for Part D to January 2023; to establish a compliance threshold of 70 percent; and to establish certain conditions under which the ECPS requirement could be waived by CMS, including in cases of recognized emergencies and extraordinary circumstances.
- To not finalize CMS' proposal to extend the compliance deadline for EPCS for beneficiaries in long-term care facilities, and rather to coordinate the timing of this requirement with implementation of a new named version of the NCPDP SCRIPT standard.
- To focus CMS' efforts on improving collection of self-reported race and ethnicity data – in a manner that is respectful of and responsive to patients' needs and concerns – rather than relying on algorithms to impute racial and ethnicity identification of patient populations for the purposes of stratifying performance feedback by race and ethnicity.
- To pursue options for collection of data on social risk factors and incorporate such data into performance feedback.

- To consider our comments regarding implementation of MIPS Value Pathways (MVPs), including with respect to the clinical focus of MVPs, voluntary MVP participation, and voluntary subgroup reporting.
- To remedy the historic under-investment in quality measure development, particularly for measures appliable to patients with serious illness, and to allow for such measures that can be broadly adopted across care settings.
- To not finalize CMS' proposal to increase the data completeness requirements for quality measure submission under MIPS for 2023.
- To retain quality measures focused on patients with serious illness in the MIPS quality measure inventory until improved replacement measures are available.
- To add palliative care exclusions or exceptions to certain MIPS quality measures, as proposed.
- To maintain the Query of Prescription Drug Monitor Program (PDMP) measure as an optional measure worth 10 bonus points for CY 2022 and on an ongoing basis, and to take specified steps regarding testing and measure refinement prior to mandating reporting of the measure in the Promoting Interoperability (PI) performance category.
- To finalize CMS' proposal to provide automatic reweighting of the PI performance category for small practices and to pursue changes to encourage small practices' reporting under this category.
- To not finalize CMS' proposal to update the IA_PSPA_6 measure regarding consultation of the PDMP to increase the percentage of applicable patients for whom clinicians must review prescription history within the PDMP.
- To finalize CMS' proposal to continue doubling the complex patient bonus with a cap of 10 bonus points for CY 2021 performance.
- To proceed cautiously and make further refinements with respect to CMS' proposal to update the methodology for determining a complex patient bonus.
- To not finalize CMS' proposal to add facility affiliations on clinicians' individual profile pages for a range of facilities, including hospices.

Physician Fee Schedule and Other Part B Payment Policies

Conversion Factor and Payment Impacts

CMS estimates a CY 2022 conversion factor of $33.5848, which reflects a 3.75 percent reduction relative to the CY 2021 conversion factor. While AAHPM recognizes that the reduction is primarily driven by the expiration of the 3.75 percent increase provided for CY 2021 under the *Consolidated Appropriations Act, 2021* (CAA) and is not a result of CMS actions, we are nonetheless dismayed to find MPFS payments once again facing steep cuts that will have significant financial implications for physician practices. Such cuts are currently expected to occur in addition to mandatory sequestration reductions of 2 percent that are specified in statute and as well as further reductions of 4 percent under the Statutory Pay-as-You-Go Act (expected to be triggered in January as a result of spending under the *American Rescue Plan Act of 2021*). These reductions would likely take place while the nation continues to struggle with high rates of COVID-19 illness and with the longer-term ramifications of the pandemic on physician practices – many of which have seen reduced revenues and higher costs as a result of the public health emergency (PHE). These multiple, overlapping payment reductions would place significant added financial pressures on practices, as well as reduce access to care for beneficiaries who rely on those practices to receive medically necessary care. As

such, ***we urge CMS to work with Congress to ensure that the projected payment reductions are averted and that MPFS payments remain steady during this time of uncertainty and financial stress for physician practices.***

Additionally, AAHPM was disappointed to see that our specialty of Hospice and Palliative Care (specialty code 17) continues not to appear on the specialty impact table in the Regulatory Impact Analysis (Table 123). As we have noted in previous years, the absence of this information hampers our ability to make fully informed comments in response to CMS' proposals, and we believe it is an oversight that must be remedied. ***We therefore urge CMS to include Hospice and Palliative Care in its impact tables for the CY 2022 MPFS final rule, and for all future MPFS proposed and final rules going forward.***

Telehealth and Other Services Involving Communications Technology

Permanent Expansion of Medicare Telehealth Services

As we have previously noted, AAHPM members and their patients have experienced tremendous benefits with the use of telehealth and virtual services during the PHE for COVID-19. Particularly for the seriously ill patients our members serve, who may experience mobility and/or cognitive limitations, the use of communications technology has facilitated access to timely and high-quality medically necessary care. However, while the need for technology-enabled access has been paramount during the PHE, we believe that such need exists for seriously ill patients even outside of a pandemic. Patients with serious illness face challenges in accessing care on a routine basis. Leaving their homes for a 30-minute office visit can be a huge burden if, for example, they contend with pain, frailty, or medical instability and/or rely on caregivers to assist with transportation. As a result, we believe ongoing access to telehealth services outside the PHE will be critical for ensuring that patients with serious illness continue to have meaningful access to medically necessary and clinically appropriate palliative care.

In particular, we believe the statutory geographic location and originating site restrictions that limit the availability of Medicare telehealth services are outdated and do not reflect the current needs and technological capabilities to safely, effectively, and efficiently deliver care – not to mention patients' and providers' preferences for receiving and delivering care with minimal burden. ***AAHPM therefore continues to urge CMS to work with Congress to eliminate permanently the geographic and originating site restrictions on Medicare telehealth services such that patients can continue to receive such services beyond the end of the PHE, regardless of their location across the country.***

Addition of Services to the Medicare Telehealth Services List

CMS proposes to revise the timeframe for inclusion of the services added to the Medicare telehealth services list on a Category 3 basis, specifically proposing to retain all Category 3 services until the end of CY 2023. CMS also solicits comment on whether any additional services should now be added to the Medicare telehealth services list on a Category 3 basis.

AAHPM supports CMS' proposal to extend the availability of Category 3 services through 2023 and agrees that the additional time will be important for both compiling and submitting evidence to support the permanent addition of Category 3 services to the Medicare telehealth services list, as well as for engaging in full notice and comment rulemaking.

We also recommend that CMS add the following additional services on a Category 3 basis:

- *Home services for new patients (CPT codes 99341-99345)*
- *Domiciliary or rest home services for new patients (CPT codes 99324-99328)*
- *Initial nursing facility services (CPT codes 99304-99306)*

The Academy believes that these services are ideal candidates for addition to the Medicare services on a Category 3 basis. Not only are they similar to services already included on the Medicare telehealth services list (specifically, the office and outpatient E/M codes for new patients), but they can also be performed effectively via two-way, real-time audio-video telecommunications technology to offer clinical benefit to patients, particularly when the services are used to support the delivery of community-based palliative care. Allowing these services to continue to be furnished via telehealth on a Category 3 basis following the end of the PHE will enable the collection of evidence that we believe will clearly support their permanent addition to the Medicare telehealth services. We note that physical examination comprises a relatively small proportion of the E/M service for a palliative care visit, and many of the components of the physical exam can be done via telecommunications technology. For example, clinicians can count respirations, conduct a visual examination for edema, and assess patients' comfort and distress levels based on visual and verbal assessments. Additionally, whether in the home, in domiciliary settings or – especially – in nursing facility settings, more often than not a family member, caregiver, or healthcare provider is available to assist in completing comprehensive assessments, as needed. For patients with serious illness who may experience difficulties accessing care and must rely on these services, home, domiciliary, and nursing facility visits furnished via telehealth can provide a vital connection to medically necessary care that also efficiently utilizes health resources, particularly in rural areas where clinicians may otherwise need to travel long distances to assess patients in these settings.

While we recognize that the ability to utilize the home and domiciliary codes outside of the PHE is limited to care in certain cases specified in statute, we believe that the Medicare telehealth list should reflect those services that can be furnished via telehealth in a clinically appropriate and beneficial way, and that evidence collected during the Category 3 period will demonstrate that the codes recommended above meet these criteria. We are also hopeful that, should Congress act to eliminate geographic and originating site restrictions, the codes will be readily available for broader utilization.

Additionally, with respect to frequency limitations on telehealth visits furnished in nursing facilities, we reiterate our request to eliminate all unnecessary frequency limitations and instead rely on physician determinations of medical necessity – as well as CMS' oversight and auditing policies – to guide frequency of telehealth services.

Lastly, while the Academy urges CMS to allow office and outpatient E/M telehealth services to be furnished using audio-only telecommunications technology, as noted below, should CMS opt not to finalize this recommendation, the Academy recommends that CMS add telephone E/M services (CPT codes 99441-99443) to the Medicare telehealth services list on a Category 3 basis. Absent permanent coverage of audio-only office and outpatient E/M telehealth services, we believe that audio-only services should be allowed to be furnished on a temporary, Category 3 basis, to demonstrate the ongoing clinical benefit of such services outside of the PHE.

Payment for Medicare Telehealth Services Furnished Using Audio-Only Telecommunications Technology

For the purposes of furnishing Medicare telehealth services, CMS proposes to define "interactive telecommunications system" to include audio-only communications technology, but only when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients under specified conditions outlined in the proposed rule. AAHPM appreciates CMS' recognition that it has the authority to allow the use of audio-only telecommunications technology for telehealth services and believes that application of the technology to mental health services is necessary and appropriate given the demonstrated benefits of audio-only mental health services during the PHE.

AAHPM strongly supports ongoing coverage of audio-only services when two-way audio-visual technology is not available due to a patient's characteristics or situation. As such, ***we urge CMS to use its authority to expand the applicability of audio-only communications technology for telehealth services to include office and outpatient E/M services as well as advance care planning services.*** In the wake of the COVID-19 outbreak, audio-only services have offered a lifeline to patients requiring care who were not able or willing to utilize two-way audio/visual telecommunications technology to receive telehealth services – patients that our members have treated all too frequently. Use of audio-only E/M services have enabled such patients to maintain access to medically necessary care that could be furnished in a clinically appropriate manner via audio-only telecommunications technology, as determined by treating physicians, rather than resulting in patients foregoing care that could result in further complications or exacerbations. For seriously ill patients, this could include assessment of disease progression and symptoms, including with respect to functional, nutritional, and cognitive status, as well as prescription of medications and counseling services. While AAHPM appreciates that visual inspection could assist in completing such a visit, audio-only E/M services – as needed and available to accommodate lack of video communications – have nonetheless enabled patients to receive more timely and efficient care.

Likewise, ongoing availability of audio-only advance care planning services is vital, particularly for patients with serious illness or at the end of life. These services enable critical discussions about goals of care, treatment options, values, and preferences that can help to ensure that patients receive appropriate care – that is, the care they want where they want it. The PHE has demonstrated that advance care planning services can effectively be furnished via audio-only communications technology, when necessary, as they essentially allow for conversations between the provider, the patient, and the patient's family members or surrogates. Indeed, in many cases audio-only communication has been a necessity as patients have been in separate locations from their family and caregivers, yet both parties have had to be involved in advance care planning discussions with their providers. AAHPM therefore believes that patients should be able to continue to access this service through audio-only technologies even after the PHE to facilitate their receipt of informed and comprehensive care that is consistent with their goals and treatment preferences.

We also note that, in many cases, patients' inability to access traditional telehealth has stemmed from structural disadvantages that have long harmed low-income, rural, and aged – often chronically and/or seriously ill – populations, and such disadvantages will continue to persist after the PHE. Absent our recommended changes, the expected discontinuation of medically necessary and clinically appropriate audio-only office and outpatient E/M services and advance care planning

services following the PHE will further exacerbate disparities in both access to healthcare services and health outcomes for these disadvantaged populations.

Finally, we recognize that CMS must weigh increased access to services against program integrity considerations. As such, we believe that CMS' conditions requiring the patient to be located in his or her home, the distant site physician to have the technical capability at the time of service to use an interactive telecommunications system that includes video, and the patient to not be capable of or to not consent to the use of video technology are reasonable for Medicare payment of audio-only telehealth services.

Direct Supervision via Virtual Presence

CMS seeks information on whether the flexibility CMS afforded during the PHE to allow direct supervision via virtual presence should be continued beyond the end of the year in which the PHE for COVID-19 ends, as currently scheduled. As we noted in our comments last year, ***AAHPM agrees that additional time to study this flexibility outside the context of a PHE would be beneficial and allow for collection of data about the benefits and risks of direct supervision via virtual supervision. Following such a testing period, we encourage CMS to consider the potential benefits of extending this flexibility permanently to a small subset of services for which virtual supervision may be of high value and low risk of patient harm.*** For example, use of virtual presence for direct supervision may be particularly valuable in cases where patients are homebound and require home visits by palliative care practitioners – for example to manage transitions of care – that may be safely furnished by clinical staff via virtual presence. In this case, continuation of the virtual presence flexibility could expand the availability of community-based palliative care services and increase the efficiency of delivering safe, high-quality care. Such an outcome may be particularly important given the significant shortage of trained hospice and palliative medicine practitioners facing our nation.[1]

Principal Care Management and Chronic Care Management Services

CMS is proposing to accept the recommended work values for the 10 Current Procedural Terminology (CPT) codes in the chronic care management (CCM)/complex chronic care management (CCCM)/principal care management (PCM) code family, as shown in Table 12 of the proposed rule. AAHPM thanks CMS for recognizing the work required to furnish the above services. ***AAHPM supports CMS' proposal and recommends that CMS finalize the values as proposed.***

Additionally, while CMS does not address this in the proposed rule, we note that a key barrier to the provision of the codes in this family is the requirement that copayments be applied and collected. While AAHPM, CMS, and other stakeholders recognize and value the work and resources required to furnish these care management services – as well as the benefit that accrues to patients suffering from chronic or other high-risk diseases – Medicare beneficiaries often have difficulty understanding why copayments would be required for services in which they are not directly engaged. As a result, beneficiaries may decline to provide consent, leading to underutilization of these important services.

[1] Kamal, A., Wolf, S.P., Troy, J.D., et al (2019). Policy Changes Key to Promoting Sustainability and Growth of the Specialty Palliative Care Workforce. *Health Affairs, 38 6*, 910-918. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00018. Accessed September 9, 2021.

This is even more troubling given the potential savings that care management services could accrue to the Medicare program, as early evaluation results showed net savings to the Medicare program following delivery of CCM services.[2] Given the above, ***AAHPM urges CMS to work with Congress to eliminate copayments for these care management services, in order to promote their adoption and ultimately improve the care of Medicare beneficiaries with chronic or serious illness.***

Comment Solicitation on the Impact of Infectious Disease on Codes and Ratesetting

CMS seeks input from stakeholders about strategies to account for PHE-related costs. AAHPM believes that this is an important topic that appropriately acknowledges the financial burden associated with investments required to protect patients and staff against transmission of deadly diseases like COVID-19, including investments in supplies, physician and staff time, and even physical infrastructure, and we support CMS' intentions to more appropriately incorporate payment for such costs into the MPFS through future rulemaking. However, we are concerned that physician practices are already bearing these significant costs – as they have been for the past year and a half. As such, they require immediate relief. ***We therefore urge CMS to issue an interim final rule to implement and pay separately for CPT code 99072 (Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious diseases). CMS should use all available authorities to make payment with no patient cost-sharing during the PHE and without application of budget neutrality adjustments.***

Furthermore, we believe a baseline position should be to protect practitioners against harmful payment reductions during a PHE for infectious disease. As noted above, however, MPFS payments are expected to see a reduction of 3.75 percent for 2022 – not to mention additional substantial reductions due to sequestration. Even if CMS were to incorporate costs related to infectious diseases into MPFS payments in future rulemaking separate from our immediate request, statutory budget neutrality requirements would lead to offsetting reductions, potentially leaving physician practices no better off – or potentially even worse off – than they would be absent inclusion of such costs. Clearly, a more sustainable approach is needed to allow physician practices to recoup the high costs they must bear in response to pandemic conditions, as well as to protect them from egregious payment reductions that would directly harm their financial sustainability in the middle of a PHE. ***AAHPM again urges CMS to work with Congress to prevent MPFS reductions that will result in serious financial consequences for physician practices. Congressional action to support payment for pandemic-related costs incurred by physicians outside of budget neutrality should also be pursued.***

Comment Solicitation on Separate MPFS Coding and Payment for Chronic Pain Management

CMS solicits comment on whether to consider creating separate coding and payment for medically necessary activities involved with chronic pain management and achieving safe and effective dose reduction of opioid medications when appropriate, or whether the resources involved in furnishing these services are appropriately recognized in current coding and payment.

[2] Schurrer J, O'Malley A, Wilson C, et al. Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report. Mathematica Policy Research. November 2, 2017. https://mathematica.org/download-media?MediaItemId={97B69DA4-1A9D-474E-BA9F-D827D86774F5}. Accessed August 31, 2021.

Timely and effective management of pain and other distressing symptoms is central to providing seriously ill patients with high-quality palliative care, and opioid analgesics are a critical tool in alleviating that suffering. We therefore appreciate CMS' interest in payment policies that might better support comprehensive management of patients' pain and appropriate use of opioid medications. However, ***we do not believe that separate coding and payment is necessary to support access to appropriate pain care. We find that the services CMS lists for effective patient-centered management of pain are already represented in existing coding, including E/M codes, CCM/CCCM/PCM codes, and more.*** Some physicians and other health professionals may simply be unaware that existing codes can be applicable to pain care services, so this information should be provided through CMS, the American Medical Association, medical societies, and other communications. Moreover, we believe that any new payment policies developed by CMS should not be limited to management of chronic pain but should also focus on improving support for the treatment of acute pain, sickle cell disease, and pain related to serious illness, such as experienced by palliative care and hospice patients. At the same time, management of pain is only one aspect of comprehensive palliative care, and many of our patients with serious illness have unique issues that could not be adequately addressed using the type of code that CMS appears to be envisioning. ***We therefore recommend that CMS work with stakeholders to clarify, communicate, modify, and/or expand existing care management codes focused on patients with chronic diseases to include patients with chronic and significant acute pain.***

We also take this opportunity to caution CMS against conflating chronic pain management with treatment of opioid use disorder (OUD). We are concerned that CMS' framing of the issue places opioid dose reduction and transition from opioid dependence at its center. While these are important goals for patients who have developed OUD in the course of chronic pain treatment, they are not appropriate for all patients with chronic pain, including many whose chronic pain may be a result of serious illness. Patients with pain are not all the same, so managing pain effectively and safely requires an individualized approach based on many factors, including pain syndrome, patient risk factors, underlying illnesses, life expectancy, clinical expertise, degree of control and monitoring available to the treatment team, and appropriate goals of treatment. Defaulting to a dose reduction position fails to take these considerations into account.

Further, to date there is no scientific basis to support calls to restrict the dosage and duration of opioid treatment for pain, and an overemphasis on such goals would unduly burden patients with serious and life-threatening illness who, as a population, typically require higher doses of opioids, often for long periods. As such, ***we recommend that CMS reframe its discussion around chronic pain management, including to emphasize the importance of an individualized approach to pain management that relies on clinician judgement to determine the type, dose, and duration of opioid treatment, if any; to clearly articulate the conditions under which dose reduction may or may not be appropriate; and to remove administrative and financial barriers (e.g. prior authorization, prohibitive cost sharing) to accessing comprehensive multimodal, multidisciplinary pain care.***

Split (or Shared) Visits

CMS makes several proposals for billing split (or shared) services in facility settings that are performed by physicians and other non-physician practitioners (NPPs). ***AAHPM generally supports CMS' proposals, which provide greater clarity and flexibility in the delivery of split (or shared) services***

in facility settings. We particularly appreciate CMS' proposal to allow split (or shared) billing policies to be applied to both new and established patients, as well as to the billing of prolonged services, and we recommend that CMS finalize these policies as proposed. These policies appropriately recognize movement to team-based care, which is a hallmark of comprehensive palliative care. However, ***we recommend that CMS not require a modifier to be reported for split (or shared) visits, which would add additional reporting burden related to billing of E/M services.***

Critical Care Services

CMS includes several proposals to update its critical care E/M visit policies to improve transparency and clarity, as well as to account for recent revisions to E/M visit coding and payment. ***AAHPM supports CMS' proposals for critical care services that allow NPPs to report critical care services and that allow critical care visits to be furnished as split (or shared) visits by a physician and NPP in the same group on a given calendar date.*** Inpatient palliative care teams regularly use these codes as they relate to life sustaining treatment discussions with patients and their families, and the proposals identified above would support such teams to more efficiently and effectively furnish these services using a team-based approach.

Payment for Attending Physician Services Furnished by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to Hospice Patients

CMS proposes to codify the new statutory provisions from the CAA in FQHC and RHC regulation text to reflect that hospice attending physician services are covered in the scope of benefits when furnished during a patient's hospice election "only when provided by an RHC/FQHC physician, [nurse practitioner], or [physician assistant] designated by the patient at the time of hospice election as his or her attending physician and employed or under contract with the RHC or FQHC at the time the services are furnished" (emphasis added). While AAHPM believes that these provisions will help to improve access to hospice care for patients and families in rural and underserved areas, we are concerned that CMS' language would inadvertently prevent payment for hospice attending services furnished by RHC and FQHC physicians if beneficiaries change their attending physicians during the course of their hospice election. Under CMS regulations at 42 CFR 418.24(g), hospice patients are allowed to change their designated attending physician by filling a signed statement with their hospice. Beneficiaries should be able to retain this flexibility when they are receiving hospice attending physician services from RHCs and FQHCs. ***AAHPM therefore encourages CMS to update its proposed regulation text to confirm that RHC and FQHC hospice attending physician services will continue to be covered in the scope of benefits if RHC and FHQC patients change their attending physician at any time during the course of their hospice election.*** This change will help ensure that RHC and FQHC beneficiaries have the provider of their choice throughout their hospice care.

National Coverage Determination (NCD) for Enteral and Parenteral Nutritional Therapy

CMS proposes to remove NCD 180.2 for Enteral and Parenteral Nutritional Therapy, noting outdated portions of the NCD that, for example, do not provide for routine coverage of pharmacy-prepared parenteral solutions. Given its outdated coverage policies, and the fact that contractors have already proposed local coverage determinations (LCDs), CMS states its belief that removing this NCD would better serve the needs of the Medicare program and its beneficiaries.

AAHPM has concerns with this approach, and we request that CMS not finalize this proposal. Patients with serious illness affecting their gastrointestinal tract may require enteral or parenteral nutritional therapy to ensure digestion and absorption of sufficient nutrition to maintain necessary weight and strength. We believe that coverage of enteral and parenteral nutrition would benefit from national coverage policies that are consistently applied across the country. While we agree that policies in the NCD require updating – for example, to allow for coverage of more than one monthly supply at a time or to clearly allow for coverage of pharmacy-prepared solutions – we do not believe that the NCD should be completely removed, nor that coverage determinations should be delegated to local contractors. Rather, ***we recommend that CMS undertake a revision to the NCD to ensure that it reflects current evidence and the standard of care for Medicare beneficiaries requiring enteral or parenteral nutritional therapy and that coverage policy remains uniform nationwide.***

Electronic Prescribing for Controlled Substances

CMS makes several proposals related to electronic prescribing for controlled substances (EPCS) for Part D drugs, including to revise the compliance date from January 1, 2022, to January 1, 2023; to establish a compliance threshold of 70 percent of electronically prescribed Part D prescriptions for controlled substances; and to establish certain conditions under which the EPCS requirement could be waived by CMS, including in cases of recognized emergencies and extraordinary circumstances. ***AAHPM supports these proposals and recommends that CMS finalize them as proposed.***

AAHPM members recognize the value of electronic prescribing to support individual and public safety as well as appropriate prescribing of controlled substances. Indeed, our members report widespread adoption of electronic prescribing as a routine part of their hospice and palliative care practice. At the same time, we recognize that some physician practices may require additional time to fully implement EPCS, particularly given the challenges that the PHE has imposed, and we therefore appreciate CMS' proposal to revise the compliance date for the EPCS requirement.

We also appreciate that CMS' policies recognize that electronic prescribing for 100 percent of Part D prescriptions for controlled substances may not be achievable. Both the proposed 70 percent compliance threshold and the proposed waivers for cases of recognized emergencies and extraordinary circumstances would provide assurance to practitioners that they will not be in violation of EPCS requirements if they fail to use EPCS in limited circumstances. Waivers for recognized emergencies and extraordinary circumstances, in particular, would allow prescribers to be exempt from EPCS requirements under cases that are not reasonably within the control of the prescriber – a policy that we believe appropriately balances the benefits of electronic prescribing against the potential burdens practitioners might face.

CMS also proposes to extend the compliance deadline for Part D controlled substance prescriptions written for beneficiaries in long-term care facilities, from January 1, 2022, to January 1, 2025. While AAHPM shares the goal of implementing electronic prescribing for long-term care facilities, we are concerned that such implementation may be premature, particularly given pending changes to the NCPDP SCRIPT standard that will address three-way communication needs across prescribers, long-term care facilities, and pharmacies. ***We suggest that CMS coordinate the timing of its long-term care electronic prescribing compliance deadline with implementation of a new named version of the SCRIPT Standard.***

Quality Payment Program

Closing the Health Equity Gap in CMS Clinician Quality Programs

AAHPM is dedicated to improving quality of life and quality of care for all people living with serious illness, as well as their families and caregivers, regardless of race, gender, gender identity, sexual orientation, age, religion, ethnicity, socioeconomic status, or disability. This includes a commitment to promoting equitable care and tackling systemic discrimination and implicit bias, along with the many other social and physical determinants of health linked to health disparities and adverse outcomes. We therefore applaud and support CMS in its goal to identify and advance efforts to achieve health equity across the Medicare program.

However, ***AAHPM has significant concerns about CMS' consideration of the use of algorithms to impute racial and ethnic identification of patient populations to stratify data under the CMS Disparity Methods by race and ethnicity.*** In too many cases, across a range of sectors – including health care – algorithms and other artificial intelligence tools have been found to contribute to further harm to disadvantaged populations.[3,4,5] Such outcomes result from the perpetuation of human biases that – consciously or unconsciously – shape people's decisions every day, including around the development and coding of algorithms. AAHPM is concerned that CMS' contemplated imputation algorithms could similarly incorporate biases that result in incorrect classification of patient populations, which might then be used to inappropriately guide quality improvement efforts. Indeed, even as CMS points to a high rate of concordance between indirectly estimated and self-reported racial and ethnic identification for many racial and ethnic groups under imputation models currently under consideration, CMS also notes that the algorithms are considerably less accurate for individuals who self-identify as American Indian/Alaskan Native or multiracial. Such findings are particularly problematic given recent Census results showing that the multiracial population experienced a 276 percent increase between 2010 and 2020.[6] The Census findings also highlight the fact that the nation's demographics are changing, raising questions about the validity of imputation models that may rely on outdated data.

Given the mistrust that many racial and ethnic minorities already hold towards the healthcare and public health systems, the Academy is concerned that the use of faulty imputation algorithms could further weaken confidence among these populations. ***Rather than rely on imputation algorithms to stratify quality performance data by race and ethnicity, we urge CMS to focus efforts on improving collection of self-reported race and ethnicity data – in a manner that is respectful of and responsive to patients' needs and concerns – in order to meaningfully incorporate such data into performance feedback.***

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[3] Obermeyer Z, Powers B, Vogeli C, and Mullainathan S. Dissecting racial bias in an algorithm used to manage the health of populations. *Science*, 2019. 366(6464):447-453.

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Additionally, as CMS is well aware, other social risk factors contribute to health disparities besides race, ethnicity, and dual eligibility status. ***We encourage CMS to pursue options for collection and incorporation of data on such factors into its performance feedback, including social isolation, transportation, use of interpreter services, health literacy, availability of caregiving, housing scarcity, food scarcity, marital status, and socioeconomic status – to name a few.***

MIPS Value Pathways (MVPs)

For the Merit-based Incentive Payment System (MIPS), CMS includes several proposals related to MIPS Value Pathways (MVPs), including around initial voluntary implementation starting in 2023 and inclusion of subgroup reporting, which would become mandatory starting with the 2025 performance period. While AAHPM continues to appreciate CMS' interest in making MIPS more meaningful, more streamlined, and less burdensome for clinicians, ***we have concerns that the movement to MVPs fails to address shortcomings in the MIPS program that limit its effectiveness in promoting high-quality, high-value care to Medicare beneficiaries. Furthermore, we have significant concerns that CMS' proposals for mandatory subgroup reporting through MVPs starting with CY 2025 performance may further increase burden and promote more disjointed care, rather than support holistic, patient-centered care.*** This is particularly true for patients with serious illness, whose care needs span across specialties and provider types.

As we have repeatedly noted, ***AAHPM believes that MVPs should be patient-centered, not provider-centered, and 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 that patient ultimately meets or exceeds their goals of care.

Rather than promoting such team-based care, however, CMS' proposals for mandatory subgroup reporting risk further siloing care furnished to such patients, while also significantly increasing burden for physician practices. As proposed, multispecialty group practices seeking to report via MVPs would likely have to report multiple sets of measures and improvement activities for each different specialty type included in the practice. This may be true even for small practices, which may – for example – include a single clinician representing each of five specialties. In this case, a practice administrator could be required to manage reporting for up to twenty different quality measures and 10 improvement activities for the practice, in addition to Promoting Interoperability (PI) measures that would have to be identically reported five times for each MVP submission. This would require significant investments in staff time and practice infrastructure to successfully report, taking resources away from patient care. It also deviates from the initial intent of the group reporting option, which was to ease the reporting burden on practices by not requiring separate data submission for each individual clinician. In many cases, this level of burden likely would lead practices to forgo MVP reporting, but such an option might not be available if CMS moves to mandatory MVP reporting as contemplated before the end of the decade, a policy that our Academy does not support. Additionally, as CMS notes, some clinicians may practice across multiple specialties – an occurrence that is frequent among AAHPM members. For example, a physician may serve as both an oncologist and a palliative care specialist for two different patients, or even for the same patient. While we appreciate that CMS recognizes and anticipates a variety of different potential participation

options for these scenarios, such as allowing participation in multiple MVPs across multiple subgroups or participation in a single subgroup that is most applicable to a clinician's scope of practice, we believe further clarity is required, and we request that CMS continue to keep these scenarios in mind as it works out future details.

These challenges illustrate the drawbacks of mandatory subgroup reporting, and we therefore urge CMS to keep subgroup reporting voluntary. We also recommend providing group practices flexibility to determine the most appropriate way to organize their clinicians into subgroups for the purposes of subgroup reporting. At the same time, the above discussion also highlights the benefits of MVPs focused on specific patient populations – for example, seriously ill patients. ***Population-focused MVPs would enable group practices with aligned viewpoints and perspectives regarding care delivery to be held accountable for outcomes across their patient population, ideally using measures that are meaningful to patients and reflective of high-quality care, while minimizing duplicative reporting and unnecessary burden.***

With respect to measures, our Academy is also concerned about the availability of measures in the MIPS program that are relevant to palliative care. Given that MVPs rely on the MIPS measure inventory, it is difficult to imagine MVPs that would meaningfully assess the care provided to seriously ill patients. ***We believe this stems from a historic under-investment in measure development, which we urge CMS to remedy – particularly given that many stakeholders would otherwise not have the resources to develop appropriate measures.*** AAHPM, in collaboration with our partners, was fortunate to receive funding authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to support the development of two patient-reported outcome measures. However, without such funding, these measures would not have been possible. At the same time, even with the expected adoption of these measures into MIPS, gaps in quality measurement for patients with serious illness persist, and additional investment is required.

We also urge CMS to reconsider its approach to quality measurement to allow for measures that can be broadly adopted across care settings. In our experience with our two quality measures, the demands of the MIPS program – which is focused on outpatient care – required the measure specifications to be narrowly tailored. This limits their ability to be incorporated into quality measurement efforts across other settings like inpatient or home-based care, despite the glaring absence of measures focused on palliative care across-the-board. Additionally, we also note the challenges of incorporating patient-reported outcome measures into the MIPS program, given the lack of mechanisms available in MIPS to gather and report on such measures.

To the extent that MVPs continue to focus on specific specialties rather than populations, we urge CMS to incorporate palliative care measures into MVPs that focus on patients with serious illness, for example MVPs related to heart disease, stroke, and oncology. Addressing topics such as advance care planning or timely hospice care would reflect prioritization of high-quality care for patients with serious illness and could be incorporated into the foundational population health measures for these MVPs to create strong incentives for appropriate serious illness care.

Finally, given the concerns we have noted above regarding MVPs, ***AAHPM strongly opposes mandatory MVP reporting starting in 2028, as CMS contemplates.***

MIPS Quality Performance Category

Data Completeness

CMS proposes to maintain the data completeness criteria threshold of at least 70 percent for the 2022 MIPS performance period, but also to increase the data completeness criteria threshold to at least 80 percent starting with the 2023 MIPS performance period. ***While AAHPM appreciates CMS' proposal for 2022, we disagree with the proposed increase to the data completeness requirements for 2023, which we believe will create significant burden, particularly for small practices that may continue to rely on manual abstraction of medical records for quality performance reporting.***

We note that small practices have been disadvantaged under the MIPS program relative to non-small practices since the beginning of the program, and the PHE for COVID-19 has created additional challenges as practices contend with reduced visit volume; higher costs associated with personal protective equipment (PPE), social distancing requirements, and cleaning supplies; and significant uncertainty regarding the trajectory of the PHE. Without the resources available to larger practices and health systems, such demands can place small practices' financial sustainability at risk. CMS' proposal to increase the data completeness criteria threshold, if implemented, could place further burden on these practices at a time when they are already struggling. As such, ***we recommend that CMS maintain the data completeness criteria threshold at 70 percent over the next several years. Furthermore, any increase in the threshold in the future should be accompanied by additional resources and/or accommodations for small practices.***

Quality Measure Inventory

AAHPM disagrees with CMS' proposals to remove the following two measures from the MIPS quality measure inventory:

- ***Q 144 (NQF 0383): Medical and Radiation – Plan of Care for Pain***
- ***Q 342 (NQF 0209): Pain Brought Under Control within 48 Hours***

Assessing and managing pain are important components of treatment for patients with serious illness. By eliminating key measures in this domain (as opposed to management of acute pain associated with specific procedures) without concurrently offering replacement measures, CMS' proposals effectively de-prioritize quality measurement for pain care for such patients. This is particularly true given the proposed elimination of Q 342, a high-priority measure that assesses an important outcome in the care of patients receiving palliative care. We are also concerned about CMS' proposal to remove Q 144 while retaining Q 143: *Medical and Radiation – Pain Intensity Quantified*, which appears to favor a more targeted action (i.e., quantification of pain) over a broader, more holistic, and more impactful action (i.e., development of a plan of care for pain). And while both measures proposed for removal may be imperfect, they nonetheless create important opportunities for treating practitioners to engage in discussions with seriously ill patients to address their pain treatment needs.

As noted above, AAHPM is in the process of finalizing new patient-reported outcome measures for palliative care that we anticipate will be incorporated into the MIPS quality measure inventory in the next few years. This includes a measure assessing whether patients received the help they wanted for pain. We believe this measure would offer an improved alternative to Q 342 when it is adopted. Until such time, however, removal of the proposed measures would create a vacuum in quality

assessment related to pain management for patients with serious illness. As such, ***AAHPM urges CMS to retain both measures in the MIPS inventory until improved replacement measures are available.***

CMS also proposes to exclude or except patients receiving palliative care from the measure denominators for the following measures:

- Q 001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- Q 112: Breast Cancer Screening
- Q 113: Colorectal Cancer Screening
- Q 117: Diabetes: Eye Exam
- Q 119: Diabetes: Medical Attention for Nephropathy
- Q 128: Body Mass Index (BMI) Screening and Follow-Up Plan
- Q 236: Controlling High Blood Pressure
- Q 238: Use of High-Risk Medications in Older Adults
- Q 309: Cervical Cancer Screening
- Q 418: Osteoporosis Management in Women Who Had a Fracture
- Q 438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

AAHPM agrees that patients receiving palliative care are not appropriate for the clinical quality actions being assessed in these measures and supports CMS' proposal to add palliative care exclusions or exceptions.

MIPS Promoting Interoperability (PI) Performance Category

Query of PDMP Measure

CMS proposes to maintain the Electronic Prescribing Objective's Query of Prescription Drug Monitor Program (PDMP) measure as optional and worth 10 bonus points for the CY 2022 performance period, but also seeks comment on plans for requiring the Query of PDMP measure in the near future. ***AAHPM supports CMS' proposal to maintain the measure as optional for the CY 2022 performance period, but we also strongly recommend that CMS retain the measure's optional status on an ongoing basis.*** We have concerns that requiring mandatory reporting of this measure – particularly as CMS moves away from yes or no attestation to assessment based on performance – could pose significant challenges for MIPS eligible clinicians who may routinely prescribe controlled substances. This includes AAHPM members who – as palliative care practitioners – rely upon opioids and other treatment options to alleviate pain for patients with serious illness as part of a comprehensive, patient-centered plan of care. And while we understand the interest in preventing misuse and abuse of controlled substances, there is also an imperative to ensure safe and appropriate access to controlled medications for patients with serious illness to mitigate pain.

We are also concerned that many states' PDMPs may not be ready to effectively exchange data with electronic medical records, which may place MIPS eligible clinicians in some states at a relative disadvantage over others. ***Before mandating the reporting of this measure, we therefore recommend that CMS engage in more targeted review and testing to determine states' readiness to support providers in successfully reporting this measure.***

Finally, ***AAHPM also recommends that, prior to establishing a mandatory reporting requirement for this measure, CMS incorporate appropriate denominator exclusions for patients with serious or***

complex chronic illness and those at the end of life. Additional exclusions are necessary to protect access to treatments for patients with the highest needs.

Small Practice Hardship Exception

CMS proposes to no longer require an application for clinicians and practices seeking to qualify for the small practice hardship exception under the PI performance category starting with CY 2022 performance. Instead, CMS would assign a weight of 0 percent to the PI performance category and redistribute its weight to another performance category or categories if no data are submitted for any PI measures. If data are submitted for a MIPS eligible clinician in a small practice, they would be scored and weighted on the PI performance category like all other MIPS eligible clinicians. CMS also seeks comment on low participation of small practices in the PI performance category and potential options to increase their participation in the future.

AAHPM thanks CMS for its proposal to provide automatic reweighting of the PI performance category for small practices, which often face resource constraints in implementing certified electronic health record technology (CERHT) or taking full advantage of CERHT capabilities, and we recommend that CMS finalize this policy as proposed. Automatic reweighting would reduce burden and the likelihood that small practices could avoid a negative payment adjustment under MIPS.

At the same time, we believe there are concrete steps that could be taken to increase small practices' investment in and use of CEHRT, in order to support interoperable exchange of data, improved care coordination, and patient safety. To begin, many small practices focused on community-based palliative care are often hospice-based and therefore rely on the EHR technology adopted by their hospice organizations. However, hospice adoption of CEHRT has been limited due to hospices' historic exclusion from participation in the Medicare and Medicaid EHR Incentive Program. As a result, few EHR vendors have developed CEHRT that is applicable to hospice settings, and hospices have not been able to make the investments in core health information technology (HIT) necessary to meet objectives for meaningful use of CEHRT. ***Financial incentives for hospices would therefore help to remedy the historic disadvantage that hospice programs have experienced and promote more widespread adoption of CEHRT by hospices, while also assisting any affiliated community-based palliative care practices that must rely on hospice HIT to participate in MIPS.*** Notably, these investments would also facilitate care coordination and transitions of care for patients who elect the hospice benefit as hospices' CEHRT capabilities come online.

We also recommend that CMS provide opportunities for small practices to gain experience reporting under the PI category without risk of penalties. While CMS proposes that small practices that submit data for the PI performance category would be scored and weighted like all other MIPS eligible clinicians – and presumably their PI data would also be publicly reported – such a policy would create a disincentive for small practices to report at all. If small practices were instead given the option of reporting on a trial basis, they could familiarize themselves with PI reporting requirements and protocols and gain confidence in their ability to successfully report under this performance category. Trial reporting by small practices could also increase data collection by CMS to enhance CMS' understanding of small practices' performance on PI objectives and identify further opportunities for improvement.

Finally, ***we encourage CMS to consider alternative measures and objectives under the PI performance category that may be more readily accommodated by small practices.*** Our members report that the PI performance category measures in their current form are more suited to large practices and health systems that can invest in significant infrastructure. Implementing alternative reporting requirements for small practices that, for example, allow for selection of a subset of measures among a larger inventory of measures that reflect different, but still meaningful, ways of interacting with CEHRT could lower barriers for small practices to participate in this performance category.

Improvement Activity (IA) Performance Category – IA Inventory

CMS proposes to add the following IAs to the IA inventory for performance year 2022:

- Create and implement an Anti-Racism Plan
- Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols

Additionally, CMS proposes to update several IAs in order to incorporate changes designed to promote health equity, including but not limited to:

- Expanding IA_AHE_1 (Engagement of New Medicaid Patients and Follow-up) to include other underserved populations in addition to Medicaid patients;
- Updating IA_AHE_5 (MIPS Eligible Clinician Leadership in Clinical Trials or Community-Based Participatory Research) to add as an explicit option that the research could focus on addressing health-related social needs as drivers of health; and
- Updating IA_CC_14 (Practice improvements that engage community resources to support patient health goals) to require screening for a range of health-related social needs using evidence-based tools before and in addition to supporting connections to community resources.

AAHPM greatly appreciates CMS' efforts to incorporate interventions and incentives to address social risk and promote health equity through the MIPS program.

CMS also proposes to update IA_PSPA_6 (Consultation of the Prescription Drug Monitoring Program [PDMP]) to increase the percentage of applicable patients being prescribed Schedule II opioid prescriptions for whom clinicians must review prescription history within the PDMP from 75 percent to 100 percent; CMS also proposes to include an exception for patients receiving palliative and hospice care. ***AAHPM appreciates the proposed exception, which we believe is important for reducing barriers to medically necessary pain care for patients with serious illness and at the end of life. However, we believe that the proposed 100 percent threshold is unreasonable and untenable, does not include sufficient exceptions for patients with serious illness, and could serve to severely restrict access to opioid medications necessary to alleviate patients' pain and suffering.*** Further, we believe this change could create disincentives for practices to select and report on this PDMP IA, which would undermine CMS' goals for proposing the increased threshold.

Complex Patient Bonus

For CY 2021 performance, CMS proposes to continue doubling the complex patient bonus as previously finalized, with a cap of 10 bonus points added to the final score. ***AAHPM supports this proposal, which supports practices that have been continuing to furnish care to vulnerable patients while navigating the challenges of the PHE for COVID-19 in 2021.***

CMS also proposes to revise the complex patient bonus formula beginning with the CY 2022 MIPS performance period to better target clinicians who treat a higher caseload of more complex and high-risk patients, including establishing a cap of 10 points. AAHPM appreciates CMS' goal of protecting access to care for medically and socially complex patients whose providers – like AAHPM members – routinely care for complex and vulnerable populations. At the same time, we reiterate the need to ensure that the methodology for determining the bonus appropriately accounts for the needs and costs of the sickest patients*. We encourage CMS to consider further refinements to the complex bonus methodology to better account for both medical acuity and social risk beyond its current emphasis on hierarchical condition coding and dual-eligibility data.* Such efforts may begin with improved data collection, including through expanded collection of self-reported race and ethnicity data and through use of Z codes for collection of data on social risks. For the latter, CMS could consider provider education and either provider or patient incentives for reporting of Z-codes to promote data collection and reporting. *We also caution against potential unintended consequences of reducing access to care for vulnerable populations by creating arbitrary cut-offs that may discourage practices just below the cut-off from treating complex patients, which could further exacerbate health disparities. Additionally, we recommend that CMS increase the total points that can be applied under the complex patient bonus up to 20 points and implement scaling that would ensure that those clinicians in the upper quartile of risk scores receive at least 15 points.*

We also recommend that CMS make clear in any public reporting of MIPS scores those clinicians that serve a high proportion of complex patients. Such clinicians are likely to have lower MIPS scores, on average, than clinicians who do not routinely care for such patients. Public reporting of final scores without clear explanation could prompt clinicians to limit access to care for vulnerable patients.

Public Reporting of Facility Affiliations

CMS proposes to add facility affiliations on clinicians' individual profile pages for a range of facilities including inpatient rehabilitation facilities; long-term care hospitals; skilled nursing facilities; inpatient psychiatric facilities; home health agencies; hospices; and dialysis facilities. *AAHPM opposes this proposal, which raises significant concerns.* These concerns include:

- Misrepresentation of clinicians' relationship with facilities. AAHPM is concerned that adding affiliations to profile pages will send the wrong message to patients. The term "affiliation" implies a formal relationship with a facility, while CMS' proposed approach of building facility affiliation data (based on services furnished for only three Medicare patients within a 6-month period) could clearly capture facilities with which clinicians have fairly minimal, and likely informal, engagement. Implications about such relationships could unnecessarily and inappropriately raise questions from consumers about potential conflicts of interest and self-dealing as physicians refer patients to any of the facilities included under this proposal.
- Potential linkage to facilities with poor quality ratings that do not reflect the clinicians' services. While AAHPM recognizes that patients may view facility affiliation data as being helpful to their care decisions, there is a real risk that the affiliated facilities may have poor quality ratings that would reflect poorly on clinicians. In cases where clinicians have minimal interaction with facilities – which again may be common given CMS' proposal to apply a threshold of only three Medicare patients to establish affiliations – such poor ratings would be wholly independent of the quality of care furnished by the clinicians' themselves. Indeed, absent CMS' proposed policy, clinicians may choose to follow patients into facilities with poor

ratings to maximize the quality of care patients receive. CMS' proposal, however, would subject clinicians to perceptions of poor care based on the affiliated facilities posted to their profile pages, which may decrease their willingness to treat patients at facilities with poor quality performance.

- Potential for confusion with multiple facility affiliations listed. Given the low threshold to establish an affiliation, and the number of different facility types that are included under the policy, it is highly likely that many clinicians could have multiple facilities determined to be affiliated, and that many consumers would have difficulty understanding how to interpret such data if all facilities were listed. CMS has not provided any clarity regarding how such cases would be handled — for example, whether only a single facility would be listed, and if so, how CMS would determine which to list; if multiple facilities are listed, whether CMS would prioritize the facilities in any manner, and if so, how; or how CMS would explain what multiple affiliations represent and why clinicians may have multiple affiliations.

We are concerned such unintended consequences could create disincentives for clinicians to continue caring for patients at facilities with which they do not have formal relationships. This would reduce patients' access to care, disrupt continuity of care, and damage patients' relationships with their care providers. For all these reasons, ***we urge CMS not to finalize this policy.***

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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,

Nathan E. Goldstein, MD FAAHPM
AAHPM President