



AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

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September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: Medicare and Medicaid Programs: CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts [CMS-1770-P]

Dear Administrator Brooks-LaSure:

On behalf of the more than 5,500 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) 2023 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:

- Work with medical societies and Congress to avert steep payment reductions for 2023 in the short term and to achieve broader Medicare physician payment reforms for the long term that ensure financial stability and predictability, promote value-based care, and safeguard access to high-quality care.
- Include “Hospice and Palliative Care” (specialty code 17) in CMS impact tables for the CY 2023 MPFS final rule, and for all future MPFS proposed and final rules going forward.
- Work with Congress to permanently eliminate the geographic and originating site restrictions on Medicare telehealth services.
- Continue coverage and payment of audio-only evaluation and management (E/M) services and advance care planning services outside the context of the public health emergency (PHE) for COVID-19.
- Ensure continued flexibility regarding the location of the physician or other professional when furnishing services via telehealth.

- Finalize CMS' proposals to extend certain telehealth flexibilities for the 151-day period following the end of the PHE for COVID-19.
- Retain initial nursing facility care visits, home or residence visits for new patients, and telephone evaluation and management (E/M) services on the Medicare Telehealth Services List after the 151-day post-PHE period.
- Continue to allow coverage and payment for telephone E/M services and advance care planning services furnished via telehealth using audio-only communications technology.
- Finalize a single telehealth place of service (POS) indicator to be reported after the 151-day post-PHE period, rather than two separate POS indicators, to minimize reporting burden.
- 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.
- Finalize updates to coding, valuation, and guidance for Other E/M Visits consistent with the recommendations of the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel and the Relative Value Scale (RVS) Update Committee, including for prolonged services codes, nursing facility code valuations, and home or residence services practice expense (PE) inputs.
- Provide clarification regarding the "practitioner who is personally responsible" for discharge management services.
- Provide ongoing flexibility in the determination of the substantive portion of split (or shared) visits and allow the substantive portion to be determined based on either medical decision making or furnishing more than half the total time spent on the visit on a permanent basis.
- Move ahead with full implementation in 2024 of HCPCS G2211 for office/outpatient E/M visit complexity.
- Pursue specialty enrollment designation for non-physician practitioners (NPP), but not require proof of certification for an NPP to specify a specialty.
- Update the proposed definition of chronic pain for the purposes of CMS' proposals to establish separate coding and payment for chronic pain management and treatment (CPM) services to reflect "persistent or recurrent pain lasting longer – or expected to last longer – than three months."
- Provide clarification on numerous aspects of how the CPM codes may be used.
- Ensure that CPM codes will not be used to limit patients' access to necessary medical or pharmaceutical benefits.
- Take a balanced approach with respect to the administrative requirements that apply to CPM codes to minimize administrative burden while mitigating program integrity risk.
- Pursue strategies to improve utilization of chronic care management, complex chronic care management, principal care management, and advance care planning codes, including reduced administrative burden and engagement with Congress to eliminate cost-sharing requirements.
- Develop or update alternative payment models (APMs) through the Center for Medicare and Medicaid Innovation to support the delivery of interdisciplinary palliative care services for patients with serious illness who are not eligible for or have not elected the hospice benefit.
- Finalize CMS' proposal to extend its existing compliance action of sending letters of non-compliance for prescribers who do not meet requirements for electronic prescribing of controlled substances under Part D. In the future, do not implement policies that penalize practitioners acting in good faith to prescribe medically necessary controlled substances to patients with serious illness when they are unable to transmit such prescriptions electronically.

- Pursue population-focused Merit-Based Incentive Payment System (MIPS) Value Pathways (MVPs) that would put the patient at the center of care, including by introducing better quality and cost measures into the MIPS program, offering incentives to encourage the development and testing of measures, and aligning incentives across care teams to maximize patient outcomes. Among other considerations, quality measures should support patient-centered communication.
- Incorporate newly National Quality Forum-endorsed patient-reported measures that assess patients' experience of feeling heard and understood and patients' experience of receiving desired help for pain in MVPs focused on patients with serious illness, once the measures are approved for use in the MIPS program.
- Finalize CMS' proposal to classify health equity measures as "high priority" for purposes of MIPS; provide clarification on which measures would meet the definition of a health equity measure; and consider less traditional health equity measures, such as clinical process or outcome measures for which there might be disparities in performance between different patient populations.
- Do not finalize CMS' proposal to increase the data completeness criteria for the reporting of measures in the quality performance category under MIPS for CY 2024 and CY 2025 and instead maintain the data completeness criteria at 70 percent over the next several years.
- Finalize the adoption of the "Screening for Social Drivers of Health" measure into the MIPS quality measure inventory but ensure that the measure remains optional and add exclusions to the denominator for patients who opt-out of screening or who may be unable to complete the screening. CMS should also clarify that clinicians would have the flexibility to choose the screening tools that are most appropriate for their practices and patient populations.
- Finalize updates to measure #453, Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life, as proposed.
- Continue to prioritize efforts to increase health equity and improve care for disadvantaged populations, including through the addition of new improvement activities (IAs) to the IA inventory.
- Do not finalize CMS' proposal to require mandatory reporting of the Query for Prescription Drug Monitoring Programs (PDMP) measure under the Promoting Interoperability performance category, nor the addition of Schedule V drugs to the measure. Further, CMS should incorporate appropriate denominator exclusions for patients with serious or complex chronic illness and for those at the end of life.
- Continue to pursue the adoption of a more granular approach to assessing patient risk for purposes of the complex patient bonus formula, including the use of the Area Deprivation Index (ADI).
- Consider a range of additional social drivers of health in CMS' efforts to address health equity; respect patients' preferences to decline to share personal information and do not penalize practitioners for doing so; prioritize the development of patient-reported outcome measures that assess the extent to which patients' language needs are readily and proficiently met; and include patient stakeholders in CMS decision-making around measures of health equity.
- Pursue an alternate, shortened Consumer Assessment of Health Providers and Systems (CAHPS) for MIPS survey with questions tailored to reflect specialty care, but pause consideration of questions on price transparency given limited familiarity with and ongoing implementation of new *No Surprises Act* requirements as well as the need for additional clarity regarding expected activities practices should undertake.

Physician Fee Schedule and Other Part B Payment Policies

Conversion Factor and Payment Impacts

CMS estimates the CY 2023 MPFS conversion factor to be \$33.0775, which reflects a reduction of almost 4.5 percent relative to the CY 2022 conversion factor — a decrease largely driven by the expiration of the 3 percent increase provided for CY 2022 under the *Protecting Medicare and American Farmers from Sequester Cuts Act* (PMAFSCA), along with statutory budget neutrality requirements. We are troubled to once again be facing steep cuts to Medicare physician payments that will harm our members' ability to sustain their practices and provide high-quality care to patients with serious illness. Notably, this estimated payment reduction would be layered on top of 2 percent Medicare sequestration reductions that fully resumed in July of this year, and an additional 4 percent sequestration reduction to Medicare payments that is slated to take effect under the *Statutory Pay-as-You-Go Act* in January 2023, following a one-year delay as mandated by the PMAFSCA. Further, the 2023 reduction would reflect the third year in a row that MPFS payments have faced significant cuts absent Congressional action, despite the relative stability that was presumably assured following the passage of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA). Given the record rates of inflation, staffing shortages, physician burnout, and other lingering effects of the COVID-19 public health emergency (PHE), such payment reductions are appallingly unsustainable and will create real challenges with respect to the sustainability of physician practices and the ongoing availability and quality of services for Medicare beneficiaries.

AAHPM, along with the AMA and more than a hundred other specialty societies and state medical associations, endorsed a set of [characteristics of a rational Medicare payment system](#), which provides a framework for future payment reform that should ensure financial stability and predictability, promote value-based care, and safeguard access to high-quality care. ***AAHPM urges CMS to work with medical societies and Congress to avert the estimated payment reductions for 2023 in the short term and to achieve broader reforms consistent with the above goals for the long term.***

Additionally, AAHPM was disappointed to see that our specialty of Hospice and Palliative Care (specialty code 17) is still not included in the specialty impact table in the Regulatory Impact Analysis (e.g., Table 138). 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 again urge CMS to include Hospice and Palliative Care in its impact tables for the final rule, and for all future MPFS proposed and final rules going forward.***

Payment for Medicare Telehealth Services under Section 1834(m) of the Social Security Act

Implementation of Temporary Telehealth Provisions of the Consolidated Appropriations Act, 2021 and 2022 and Need for Permanent Expansion of Telehealth Flexibilities

CMS discusses the temporary telehealth flexibilities that Congress and CMS have afforded in response to the public health emergency (PHE) for COVID-19, along with flexibilities that Congress extended for 151 days after the end of PHE for services that are on the Medicare Telehealth Services List under the *Consolidated Appropriations Act, 2022* (CAA 2022), and provides notice that it intends to implement the post-PHE flexibilities through program instruction or other subregulatory guidance. Among other telehealth flexibilities extended during this period under the CAA 2022 are an expansion in the scope of telehealth originating sites to include any site in the country where the beneficiary is located at the time of the telehealth service, including the beneficiary's home, as well as extension of coverage and payment of telehealth services included on the Medicare Telehealth Services List as of March 15, 2022, that are furnished via an audio-only telecommunications system.

AAHPM appreciates that Congress provided the 151-day extension for specified telehealth flexibilities, but we continue to believe that permanent expansion of telehealth flexibilities is needed to support care for patients with serious illness. Such patients may experience mobility and/or cognitive limitations, and they are particularly susceptible to morbidity and mortality associated with infectious diseases such as COVID-19. They also often contend with pain, frailty, or medical instability and/or rely on caregivers to assist with transportation, increasing the need for and benefits of accessing health care via telecommunications technology. Furthermore, these patients have benefitted from use of audio-only communications, which Congress has recognized as a crucial tool in the delivery of telehealth services, to maintain access to medically necessary care when they have been unwilling or unable to access telehealth services using audiovisual telecommunications technology. This includes audio-only evaluation and management (E/M services) as well as audio-only advance care planning services. As a result, we believe that ongoing access to telehealth services – including audio-only services – outside the PHE will be critical for ensuring that patients with serious illness, particularly those in rural and under-resourced areas, 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 these services beyond the 151-day post-PHE period, regardless of their location across the country. We also urge CMS to align with Congress and recognize the need for and benefits of audio-only E/M services and advance care planning services outside the context of a PHE.*

Additionally, *we recommend that CMS also ensure continued flexibility regarding the location of the physician or other professional when furnishing services via telehealth.* Such flexibility during the PHE has maximized the availability of professionals to furnish services, helped ensure access to care for patients regardless of their location, and provided accommodations to physicians that reduce risk of infection, support flexible work arrangements, and decrease risk of burnout.

Treatment of Services on the Medicare Telehealth Services List During the 151 Days Following the End of the PHE and In the Period Thereafter

CMS proposes that, following the end of the PHE, it will continue to include on the Medicare Telehealth Services List for an additional 151 days the services that are otherwise set to be removed from the list when the PHE ends. CMS notes that these services will no longer be on the Medicare Telehealth Services List on the 152nd day after the end of the PHE and claims for these codes will then be denied.

AAHPM supports CMS’ proposal to extend the availability of services on the Medicare Telehealth Services List for the 151-day period following the end of the PHE for COVID-19, in order to align with the extension of telehealth flexibilities Congress enacted in the CAA 2022. We believe this proposed change will minimize confusion regarding telehealth flexibilities during the transitional period following the end of the PHE.

At the same time, *AAHPM continues to have concerns regarding CMS’ treatment of the following services, which we believe should remain on the Medicare Telehealth Services List after the 151-day post-PHE period, rather than removed as CMS has previously finalized:*

- *Initial Nursing Facility Care Visits (CPT codes 99304-99306)*
- *Home or Residence Visits for New Patients (CPT codes 99341-99342; 99344-99345) (as proposed to be updated for CY 2023)*
- *Telephone E/M Services (CPT Codes 99441-99443)*

To begin, *we believe the services furnished to new or initial patients in their homes, domiciliary or rest home settings, or in nursing facilities should be added to the Medicare Telehealth Services List on a Category 3 basis.* These services are similar to services already included on the Medicare Telehealth Services List, and they can 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. We note that physical examination comprises a relatively small proportion of the E/M service for a palliative care visit, and many – if not all – of the components of the physical exam can be done via telecommunications technology. Further, ongoing availability of these services via telehealth will maximize access to care for patients with serious illness who require them and who are often among the most medically frail and in need of high-quality palliative care.

Additionally, as we have noted above and in previous comment letters, AAHPM strongly supports ongoing coverage of audio-only services when two-way audio-visual technology is not available. In the wake of the COVID-19 outbreak, use of audio-only E/M services has enabled patients with serious illness 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 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 with serious illness to receive more timely and efficient care – particularly those in rural and under-resourced areas. We are, therefore, vexed by CMS' position that the telephone E/M services will be removed from the Medicare Telehealth Services List and not separately payable under the Medicare program following the 151st day after the PHE ends. This is particularly troubling given that reliance on audio-only telehealth is associated with structural disadvantages that have harmed low-income, rural, and aged populations. While the Administration has emphasized its commitment to achieving health equity, it has dismissed a key tool for addressing disparities in access to care via its position to curtail use of audio-only telehealth after the PHE. *We therefore urge CMS to reconsider its policy and instead continue coverage and payment for telephone E/M services at their current valuations.* We recognize that such a position would also require CMS to expand the applicability of audio-only telecommunications technology for telehealth services to include telephone E/M services.

Furthermore, we consider the ongoing availability of audio-only advance care planning services after the 151-day post-PHE period to be vital, particularly for patients with serious illness or at the end of life. As we have previously commented, 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. Therefore, *AAHPM believes that patients and their families/surrogates should be able to continue to access advance care planning services through audio-only communications technologies even after the PHE, so as to facilitate their receipt of informed and comprehensive care that is consistent with*

their goals and treatment preferences, and we urge CMS to use its authority to expand the applicability of audio-only communications technology for telehealth services to include advance care planning services on a permanent basis.

Use of Modifiers for Telehealth Services Following the End of the PHE

CMS proposes that Medicare telehealth services furnished on or before the 151st day after the end of the PHE will continue to be processed for payment as Medicare telehealth claims when accompanied with the modifier “95.” CMS further proposes that, during the 151-day period after the end of the PHE, physicians and practitioners can continue to report the place of service (POS) code that would have been reported had the service been provided in-person, as finalized on an interim basis for services furnished during the PHE. **AAHPM thanks CMS for this policy and recommends that CMS finalize it as proposed.** As with the previous policy to retain services on the Medicare telehealth services for the 151-day post-PHE period, we believe this proposed change will limit confusion regarding telehealth flexibilities during the transitional period following the end of the PHE.

CMS also proposes that Medicare telehealth services furnished on or after the 152nd day following the end of the PHE will need to be reported with a telehealth POS indicator and proposes to require reporting of a new POS indicator, POS “10”, for telehealth services provided in patients’ homes. **AAHPM has concerns with this proposal, which we believe could increase administrative burden. Instead, we recommend that CMS finalize a single telehealth POS indicator that reports on the delivery of a telehealth service without specifying an originating site.** As we noted above, AAHPM believes permanent expansion of PHE telehealth flexibilities is needed, including to allow patients to receive telehealth services from wherever they are located in the country. If Congress finalizes ongoing availability of this flexibility, the proposed POS indicators will not be sufficient to report telehealth furnished to a beneficiary who, for example, may be receiving a telehealth service from her car outside her workplace. In order to prevent unnecessary administrative burden and streamline reporting of telehealth, we believe a single telehealth POS indicator is sufficient to support appropriate telehealth reporting and payment.

Expiration of PHE Flexibilities for Direct Supervision Requirements

CMS seeks information on whether to allow immediate availability for direct supervision through virtual presence to continue beyond the end of the year in which the PHE for COVID-19 ends, as currently scheduled. As we previously commented, **AAHPM believes 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 supervision 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.

Other E/M Visits

CMS proposes to adopt the revised E/M framework and guidelines for Other E/M code sets – that is, for inpatient and observation services; discharge management services; emergency department visits; nursing facility visits; home and residence visits; and cognitive assessment and care planning services –

advanced by the AMA CPT Editorial Panel with some modifications. The proposed adoptions include:

- The list of qualifying activities that count toward “time” for visit level selection
- The recommendation to no longer require history and physical exam (H/P) for use in level selection (and just allow clinicians to perform H/P when medically necessary)
- The new CPT codes and descriptors, with the exception of the prolonged services code
- The new medical decision making (MDM) guidelines for Other E/M code sets
- Most relative value unit (RVU) recommendations from the AMA RVS Update Committee (RUC) for the codes.

CMS proposes to not adopt the following CPT policies:

- Allowing for attainment of “time” by using the CPT rule of passing the time “midpoint.” The full time for the CPT code descriptor must be met for purposes of Medicare billing.
- Adopting the new CPT prolonged services code. Instead, CMS proposes implementation of three G-codes for prolonged services.

CMS also proposes to delay the effective date of the “substantive portion” policy for split (or shared) visits until January 1, 2024. In the meantime, for visits other than critical care visits, the CY 2022 policy that defines substantive portion as “one of the three key components (history, exam, or MDM) or more than half of the total time” spent by the physician and NPP remains in effect.

CMS also offers additional discussion and raises considerations around related topics, including specialty enrollment designations for NPPs and CMS’ previously finalized code G2211 to address the inherent complexity in furnishing certain office and outpatient E/M visits.

AAHPM offers the following comments in response to CMS’ proposals and discussion for Other E/M Visits:

- Support for overall CMS approach. Subject to the comments provided below, *AAHPM appreciates CMS’ overall approach to generally adopt CPT and RUC recommendations for Other E/M Visits.* AAHPM agrees that refinement of these codes was necessary, and our specialty society offered input to the CPT/RUC Workgroup on E/M which reviewed these codes.
- Need to align with CPT and RUC recommendations. While CMS generally accepted most of the CPT and RUC recommendations regarding coding and valuation, there were certain instances where CMS’ proposals either diverged, or where CMS raised questions or concerns with the recommendations. Given the robustness of the CPT and RUC processes for developing their recommendations, including CMS involvement throughout this process, *we recommend that CMS align with the CPT and RUC recommendations on the following:*
 - **Treatment of prolonged services codes.** CMS’ most notable divergence from the CPT recommendations occurs with respect to the Other E/M prolonged services codes, including the proposed development of replacement G-codes and the proposed designation of prolonged services codes CPT 99358 and 99359 as invalid for the purposes of Medicare payment. AAHPM disagrees with these proposals. To begin, we are concerned that the use of G-codes does not treat these time-based codes in a manner consistent with other time-based codes in the CPT code set and also creates problems with relativity – problems that do not result under the recommended CPT prolonged services codes. Furthermore, invalidation of CPT 99358 and 99359 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 time-intense nature of palliative care

services leads many HPM physicians to use these codes somewhat regularly, so the loss of these codes in conjunction with Other E/M visits would be highly problematic – especially in treating the most complex patients that our members serve.

- **Nursing facility code valuations.** CMS raises questions regarding the appropriateness of the RUC recommendations for nursing facility codes. However, AAHPM supports the RUC recommendations, which we believe properly account for the time and intensity of services furnished during these visits.
- **Home or residence services PE inputs.** CMS proposes to refine PE inputs for CPT codes 99341, 99342, and 99344. AAHPM disagrees with these proposals and supports adhering to the RUC recommendation.
- Need for clarification regarding the “practitioner who is personally responsible” for discharge management services. CMS proposes to revise its billing guidelines to reflect that CPT 99238 and 99239 should be “billed by the practitioner who is personally responsible for discharge service (or, in the case of the death of the patient, the physician who personally performs the death pronouncement).” *AAHPM requests clarification regarding how to define the practitioner who is personally responsible for the discharge service.* We note that care is increasingly provided in care teams, with physicians working collaboratively with NPPs; physicians are largely responsible for the medical decision making associated with discharge management and NPPs complete discharge paperwork and provide instructions to patients. This may result in some uncertainty regarding who maintains personal responsibility for the discharge. This is equally true for care delivered in the context of teaching team structures. As such, we believe clarification is necessary to ensure that physicians or other practitioners engaging in medical decision making can appropriately bill for discharge day management services.
- Need for ongoing flexibility in the determination of substantive portion of split (or shared) visits. *AAHPM thanks CMS for its proposal to delay the effective date of the “substantive portion” policy that it finalized in last year’s Physician Fee Schedule final rule, and instead allow the substantive portion to be determined based on “one of the three key components (history, exam, or MDM)” or more than half of the total time spent by the physician and NPP for CY 2023.* We note that this ongoing flexibility is necessary to support team-based care, with physicians often engaging in medical decision making and NPPs completing remaining core elements of patient visits. We therefore encourage CMS to provide ongoing flexibility in the determination of the professional furnishing the substantive portion of split (or shared) visits. Specifically, *we encourage CMS to allow the determination of the substantive portion to be based on either medical decision making or furnishing more than half the total time spent on the visit, on a permanent basis.* This approach would align with E/M level selection guidelines and would also appropriately recognize the important role of medical decision making in the delivery of care – particularly for seriously ill patients requiring palliative care – furnished through split (or shared) visits.
- Support for full implementation of G2211 in CY 2024. *AAHPM appreciates CMS’ discussion of add-on code G2211 for office/outpatient E/M visit complexity, and we reiterate our support for full implementation of this code in 2024.* We agree that implementation of the code at that time will allow for more appropriate payment for the complexity of and resources required for furnishing office or outpatient care for patients with serious or complex conditions.
- Support for specialty enrollment designations for NPPs. *AAHPM appreciates CMS’ consideration of whether specialty enrollment designations should be pursued and agrees that such designations would be beneficial.* Lack of such information limits stakeholders’ ability to understand the way NPPs practice and the care they deliver. Further, better information about NPPs’ participation in

particular specialty areas could help to identify where resources are further needed to address workforce needs. However, *we recommend that, should CMS pursue specialty enrollment designations for NPPs, it should not require proof of any type of certification for an NPP to specify a specialty; this would be consistent with rules CMS applies for physician specialty enrollment designations and would limit burden for NPPs as they update their enrollment in CMS systems.*

Chronic Pain Management and Treatment (CPM) Bundles

CMS proposes to create separate coding and payment for CPM services beginning January 1, 2023. Specifically, CMS proposes to create two HCPCS G-codes to describe monthly CPM services:

- **HCPCS code GYYY1:** Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care (e.g. physical therapy and occupational therapy, and community-based care), as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using GYYY1, 30 minutes must be met or exceeded.)
- **HCPCS code GYYY2:** Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month (List separately in addition to code for GYYY1). (When using GYYY2, 15 minutes must be met or exceeded.)

Valuation for these codes is based on a crosswalk to principal care management (PCM) services.

AAHPM recognizes that the codes, as proposed, could potentially be used to support pain management aspects of team-based palliative care. Specifically, we believe these codes could be useful for furnishing CPM services under a comprehensive, physician-led team-based approach, where clinical staff could engage in many of the elements required to bill the code (e.g., assessment, counseling, care coordination) while the physician or other qualified health professional would engage in activities including medical decision making; care plan development, revision, and maintenance; and crisis care. Using the codes this way, physicians would provide face-to-face service in an initial visit and potentially for a month or two thereafter but, on an ongoing basis, much of the care would be managed by clinical staff, with face-to-face physician visits likely to take place roughly every 90 days, or as needed based on significant changes in patients' clinical profiles. Such use of these codes would support appropriate pain management and treatment needs, while leveraging the skills and experience of the range of care team members responsible for patients' overall care. However, we believe additional clarification and updates are required to ensure that the codes can be utilized in a way that maximizes physicians' and other practitioners' ability to manage chronic pain while minimizing burden and ensuring that payments reflect the cost of providing care.

We offer comments to address our questions and concerns as follows:

- Definition of chronic pain. *AAHPM recommends that CMS update the definition of chronic pain to reflect "persistent or recurrent pain lasting longer – or expected to last longer – than three months."* In many cases (for example, with cancer), the trajectory for patients' experience of pain is well

understood to extend beyond three months. Availability of CPM codes to manage these patients' pain would be valuable from the outset, to support timely and appropriate pain management and treatment, even when patients have not experienced pain for the full three months.

- Clarification of the time required by the physician. *AAHPM requests clarification regarding the requirement for a "required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health care professional, per calendar month."* This language suggests that the physician must perform the face-to-face visit *each month* before the code may be billed. *We disagree that mandatory monthly face-to-face time with the physician is necessary or appropriate for ongoing chronic pain management and treatment services* and may even exacerbate chronic pain issues as it takes away patient time from seeking other valuable services, such as a psychologist or therapist or other members of the care team. We also note that such a requirement would go against trends towards use of total time, rather than face-to-face time, for evaluation and/or management services, which would thereby create confusion regarding the use of these codes. Based on language in the preamble, we believe that CMS may intend only for the very first use of the CPM code for a given physician and patient to require 30 minutes of face-to-face time, and that subsequent visits over the following months would not require the same face-to-face time by a physician or other qualified health professional. However, as written, the code description does not align with such an interpretation. *We therefore suggest that CMS could consider three separate codes: one for the initial visit in the first month that requires face-to-face time with the physician, one for subsequent visits in following months that does not require face-to-face physician time, and the add-on code.* We also note that many elements of the service do not require face-to-face time at all, consistent with other care management services.
- Availability of concurrent billing with E/M services for established patients. *AAHPM requests clarification from CMS that the CPM codes may be billed on the same day or in the same month as E/M codes for established patients.* The preamble language states that the CPM codes "could not be billed on the same date of service as CPT codes 99202– 99215 (Office/outpatient visits new)" (emphasis added); however, we understand that this reflects an error, and the prohibited codes should only reference 99202 – 99205 for new patients. We note that, in caring for patients with serious illness, our members routinely provide pain management services, but such services do not reflect the full range of care involved in the delivery of comprehensive palliative care. For example, in treating cancer patients, our members may be managing a wide range of symptoms in addition to pain. As such, the proposed CPM codes would largely fail to describe the care furnished by our members, and they would instead rely on other codes, including E/M codes, to bill for the services rendered. As noted above, we would expect that the CPM codes most likely would be used by our members when furnished by physicians working in systems that enable comprehensive, team-based care that have the clinical staff, resources, and flexibility to provide high-value care.
- Clarification of the role of clinical staff in furnishing elements of the CPM codes under general supervision. *AAHPM requests that CMS finalize that the services described by the CPM codes may be furnished by clinical staff working incident to physician services under general supervision, in order to enable the organization and delivery of CPM services as illustrated above.* Failure to allow clinical staff to perform elements of the code and/or requirements for direct supervision would undermine practices' ability to furnish team-based care and render the payments insufficient to account for the costs of delivering care. CMS could also consider creating separate codes that reflect physician time versus clinical staff time, as it has done with chronic care management (CCM) codes.

- Ability to furnish services via telehealth. *AAHPM recommends that CMS clarify that face-to-face portions of the CPM codes may be furnished via telecommunications technology, and that CMS add the finalized CPM codes to the Medicare Telehealth Services List.* AAHPM envisions that the CPM codes may be used to furnish one aspect of care under a holistic care plan for patients with serious illness and, as noted above, the delivery of services via telehealth is critical for supporting access to care for such patients. Additionally, patients with chronic pain are likely to have mobility challenges, so availability of telehealth would also improve patients' access to and experience of care.
- Risk of unintended uses of the code. *AAHPM urges CMS to ensure that the CPM codes will not be used to limit patients' access to necessary medical or pharmaceutical benefits.* In particular, we are concerned that the codes could be used to restrict patients' access to opioid medications, as they are intended for use in caring for patients with chronic pain for whom opioid medications are often not advised. While AAHPM recognizes that there is an indisputable public health imperative to curb opioid use disorder, misuse, and diversion, we also believe there is an equally important imperative to ensure that our sickest, most vulnerable patients have access to timely, effective treatment of their pain and suffering, including through the use of opioid medications when clinically appropriate. AAHPM would therefore strongly object to any efforts that curtail providers' ability to furnish individualized treatment for patients with pain, including to limit access to opioid medications for patients receiving CPM services.
- Concerns regarding documentation requirements and overall administrative burden. AAHPM is concerned that the codes, as proposed, could be accompanied by significant administrative burden, including through excessive documentation requirements. At the same time, we recognize that there is a potential program integrity risk that unscrupulous actors might leverage these codes to inappropriately prescribe or dispense opioid medications. *We therefore request that CMS take a balanced approach with respect to administrative requirements that best minimizes administrative burden while mitigating program integrity risk.*

Potentially Underutilized Services

CMS seeks comments on ways to identify specific services and address possible barriers to improve access to high-value, potentially underutilized services by Medicare beneficiaries. CMS also seeks to understand which existing services may represent high-value, potentially underutilized services.

AAHPM urges CMS to pursue strategies to improve the delivery of comprehensive palliative care services to patients who are not yet eligible for or have not elected the hospice benefit. For patients with serious illness, palliative care delivered through interdisciplinary care teams not only can help to relieve pain and other distressing symptoms but also can address patients' psychosocial and spiritual needs which, together, improve their capacity to contend with the stresses of serious illness. Palliative care can also [improve patient and caregiver outcomes](#), including through better care coordination and reduced utilization of high-cost interventions that are inconsistent with patients' goals and preferences. Besides billing of E/M codes, some palliative care services may be furnished via CCM, complex CCM, principal care management, and advance care planning codes, and therefore increased utilization of these services would support delivery of high-value care – particularly for patients with serious illness who would benefit from community-based palliative care services.

AAHPM urges CMS to pursue strategies to improve utilization of CCM, complex CCM, principal care management, and advance care planning services to support the delivery of palliative care, including to review billing requirements and reduce administrative burden associated with furnishing these services.

We also encourage CMS to work with Congress to eliminate beneficiary cost-sharing requirements, which serve as a major deterrent for patients to receive these services.

Additionally, *we continue to call on CMS, through the Center for Medicare and Medicaid Innovation, to develop or update alternative payment models (APMs) to support the delivery of interdisciplinary palliative care services for patients with serious illness who are not yet eligible for or have not elected the hospice benefit.* While AAHPM engaged with the Innovation Center to inform the development of a community-based palliative care model – an effort that contributed to the announcement of the Primary Care First model and its Serious Illness Population (SIP) component – we were disappointed to learn of CMS’ decision not to move forward with the SIP component of the model last fall. We continue to believe that such a model is necessary to support the testing and expansion of community-based palliative care services for Medicare beneficiaries with serious illness, and that such efforts will meaningfully improve the quality and value of care provided to these patients, along with their families and caregivers.

Enforcement of Electronic Prescribing of Controlled Substances (ECPS)

CMS proposes to extend its existing compliance action of sending letters to non-compliant prescribers from the CY 2023 ECPS program implementation year to the CY 2024 year. CMS also seeks comment on potential penalties that it may implement for non-compliant prescribers starting in CY 2025.

AAHPM supports CMS’ proposal to extend its existing compliance action of sending letters of non-compliance through 2024. While we appreciate the value of ECPS to support individual and public safety as well as appropriate prescribing of controlled substances, we also recognize that some physician practices will have difficulty fully implementing the requirements, and the additional year of limited compliance action will provide needed time to come into compliance with ECPS requirements.

For compliance actions starting with 2025, AAHPM appreciates CMS’ inclination to impose enforcement actions on non-compliant providers, particularly given the exceptions that CMS finalized in rulemaking last year and the additional year of limited compliance action CMS proposes this year. At the same time, we are concerned that some prescribers may nonetheless fall through the cracks and that many of the proposed penalties CMS is contemplating – including referrals to the U.S. Drug Enforcement Administration or state authorities – may be excessive and overly punitive. *AAHPM would oppose policies that penalize practitioners acting in good faith to prescribe medically necessary controlled substances to patients with serious illness when they are unable to transmit such prescriptions electronically.*

Merit-Based Incentive Payment System (MIPS)

CMS MIPS Value Pathways (MVP) Strategy and Request for Information

CMS reiterates its intent to move to MVPs to improve value, reduce burden, inform patient choice, and reduce barriers to participation in APMs. CMS also reiterates its intent for MVPs to become the only method to participate in MIPS in future years.

AAHPM has significant concerns with this proposed MVP strategy, particularly given little indication on CMS’ part that it has considered or been responsive to comments we have previously raised regarding the need for MVPs to be patient-centered and to promote team-based care. Further, we highlight the limited availability of measures in the MIPS program that are relevant to palliative care, and we question how such measures could be translated into MVPs that meaningfully assess the care provided to patients

with serious illness. As such, we find it difficult to understand how CMS intends to fully transition away from traditional MIPS, and we would object to such a policy if meaningful MVP alternatives for performance assessment and accountability for palliative care practitioners have yet to be developed.

While we believe MVPs – if structured correctly – could potentially achieve the goals CMS envisions, we believe a different approach is needed. For example, *MVPs focused on specific patient populations – for example, patients with serious illness – could lead to higher quality, higher-value care.* Such 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, particularly if they use measures that are meaningful to patients and reflective of high-quality care across coordinated care teams, while also minimizing duplicative reporting and unnecessary burden. *We encourage CMS to pursue such population-focused MVPs that would put the patient at the center of care. This would require the introduction of better quality and cost measures than what are available through the current MIPS measure inventory, as well as incentives to encourage the development and testing of such measures. It would also require changes to the program to align incentives across care teams to maximize patient outcomes.*

Proposed New MVPs

CMS proposes to adopt five new MVPs, including Advancing Cancer Care, Optimal Care for Kidney Health, Optimal Care for Neurological Conditions, Supportive Care for Cognitive-Based Neurological Conditions, and Promoting Wellness. *AAHPM appreciates that CMS provides sufficient flexibility and breadth in its quality measures and improvement activities – particularly for the proposed Cancer Care MVP – to support high-quality care while minimizing provider reporting burden.* We also appreciate that CMS has included a quality measure and improvement activity focused on advance care planning in the proposed Cancer Care and the two proposed Neurological Conditions MVPs, as well as an advance care planning quality measure in the proposed Kidney Health MVP, though CMS should consider adding the advance care planning improvement activity to the Kidney Health MVP as well.

In general, *AAHPM strongly supports the inclusion of measures that support patient-centered communication, like those focused on advance care planning.* To that end, we highlight that AAHPM serves as the measure steward for two measures that were recently endorsed by the National Quality Forum (NQF):

- NQF# 3665 Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood
- NQF# 3666 Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain

Measures such as these collect information directly from patients to better understand their experience of care and focus on what matters most. AAHPM has submitted these measures for consideration to be used in MIPS, and we believe that, once approved for such use, they would be ideal candidates to be added to MVPs focused on patients with serious illness.

We also appreciate the inclusion of Q457 Percentage of Patients who Died from Cancer Admitted to Hospice for Less than 3 Days in the proposed Cancer Care MVP. As we previously suggested, addressing topics such as advance care planning or timely admission to hospice care through MVPs 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.

Quality Performance Category: Health Equity Measures as High Priority Measures

CMS proposes to amend the definition of the term “high priority” measure to include health equity measures starting with the CY 2023 performance period. *AAHPM shares CMS’ commitment to advancing health equity and applauds CMS for its proposal to classify health equity measures as “high priority” for purposes of MIPS.* This proposal not only emphasizes the importance of health equity but will help to better incentivize the use of health equity-focused measures and to close the health equity gap. We do have concerns, however, that CMS does not identify which current or newly proposed quality measures would qualify as a high priority health equity measure. *We assume that the newly proposed “Screening for Social Drivers of Health” measure would meet this definition, but request clarification from CMS on this and any other measures that would meet the definition of health equity. When determining which measures meet this definition, we also request that CMS look beyond more traditional health equity-focused measures and consider other clinical process and outcome measures for which there might be disparities in performance between different patient populations.*

Quality Performance Category: Data Completeness Requirements

CMS proposes to raise the data completeness criteria from 70 percent to 75 percent for the CY 2024 and CY 2025 performance periods/2026 and 2027 MIPS payment years. *AAHPM disagrees with this proposed increase to the data completeness requirements, which we believe will create significant burden for practices reporting under MIPS.*

In particular, small practices that may continue to rely on manual abstraction of medical records for quality performance reporting will face challenges in meeting more stringent data completeness requirements. Since the beginning of the program, small practices overall have been disadvantaged under MIPS relative to non-small practices, and this proposal would further exacerbate disparities as small practices seek to regain footing after the challenges they have experienced over the past few years as a result of the COVID-19 PHE. At the same time, even larger practices are likely to be burdened by the higher data completeness criteria CMS is proposing. For example, practices that rely on electronic medical records may lose data as a result of non-interoperable data exchange, which may result in lower data completeness levels than required under the proposed criteria.

Given these challenges, *AAHPM recommends that CMS maintain the data completeness criteria at 70 percent over the next several years.* In the rule, CMS provides data to suggest that it is feasible for eligible clinicians and groups to achieve a higher data completeness threshold without jeopardizing their ability to participate and perform well under MIPS. However, this analysis was based on 2017 performance year data when clinicians were only required to submit a single quality measure, for a single patient, for a single day, which we do not believe is an accurate representation of reporting trends.

Quality Performance Category: Proposed New Measure – Screening for Social Drivers of Health

As a first step towards addressing determinants of health (DOH) to close health equity gaps among patients served by MIPS-eligible clinicians, CMS proposes the adoption of an evidence-based DOH measure, starting in 2023, that would support identification of specific DOH associated with inadequate healthcare access and adverse health outcomes among patients. The measure, titled “Screening for Social Drivers of Health,” assesses the percentage at which providers screen their adult patients for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. *AAHPM appreciates CMS’ effort to prioritize capturing drivers of health data, especially since the COVID-19 PHE magnified the disproportionate*

burden of these drivers of health on historically under-resourced communities. We believe that capturing this data is an important first step to taking more actionable steps towards closing the health equity gap. As CMS looks to the future, we encourage the agency to continue to evaluate how it can further encourage follow-up on health-related social needs identified through this measure, but to also keep in mind that clinicians cannot do this alone and require a team-based approach to addressing patients' social needs.

At the same time, ***AAHPM requests that this measure remain optional in MIPS since not all clinicians have the resources or time to easily access and apply these screening tools and not every patient is comfortable reporting this data.*** Collecting this data, while important, is operationally complex for some practices and requires the adoption of new data collection protocols, as well as revised workflows and staff training.

Similarly, ***we request that CMS add exclusions to this measure to reflect patients who opt-out of screening and patients who are themselves unable to complete a screening and have no legal guardian or caregiver able to do so on the patient's behalf.*** These exclusions would ensure that clinicians are not penalized for patient choices or circumstances that are outside of the control of the clinician and would also ensure alignment of this measure with the version CMS recently adopted for use in the Inpatient Quality Reporting (IQR) program.

AAHPM also encourages CMS to work with stakeholders to develop standardized screening tools for use across settings and the public and private sector in order to minimize provider burden. However, until such standardization has been achieved, ***we request that CMS clarify in the specifications that clinicians would have the flexibility to choose the screening tools that are most appropriate for their practice and patient populations, which further aligns with the IQR program.***

Quality Performance Category: Proposed Changes to Measure #453

CMS proposes to update measure #453 Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life. Specifically, CMS states:

"We propose to revise multiple components of the measure to reflect the measure intent to only include systemic cancer-directed therapy for the purposes of this measure. We propose to clarify the terminology and revise the numerator note to include a definition for systemic cancer-directed therapy to allow for precise implementation of the measure. This ensures that the denominator eligible patient population aligns with the treatments that have been shown to not only negatively impact the patient's experience at the end of life, but also have not been shown to improve outcomes (<https://ascopubs.org/doi/full/10.1200/JCO.2016.70.1474>). ASCO advocates that 'curtailing unnecessary treatments at the end of life will help drive down end-of-life resource utilization costs' and for 'early integration of palliative care/hospice services for patients with late stage cancer in order to avoid aggressive measures at the end-of-life.'"

AAHPM supports these changes which, importantly, improve the measure's ability to incentivize appropriate care at the end of life. We agree that early integration of palliative care/hospice services for patients with late-stage cancer can avoid aggressive measures that are not consistent with patients' goals and preferences at the end-of-life. ***We therefore recommend that CMS finalize the updates to measure #453 as proposed.***

Improvement Activities Performance Category: Proposed New Improvement Activities

CMS proposes to add three new improvement activities (IAs) focused on health equity, including:

- Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data
- Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients
- Create and Implement a Language Access Plan

AAHPM applauds CMS for continuing to prioritize efforts to increase health equity and improve care for disadvantaged populations through the MIPS program, including through the addition of these IAs to the IA inventory.

Promoting Interoperability Performance Category: Changes to the Query of Prescription Drug Monitoring Programs (PDMPs)

Beginning with the performance period in CY 2023, CMS proposes to require MIPS eligible clinicians to report the Query of PDMP measure for the Promoting Interoperability performance category. CMS also proposes to expand the Query of PDMP measure to include Schedule III and IV drugs in addition to Schedule II opioids, and seeks comments on whether to expand this measure to include Schedule V or other drugs with potential for abuse.

AAHPM has serious 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 utilizing electronic health record technology to prevent misuse and abuse of controlled substances, we disagree that mandating queries of PDMPs using CEHRT advances this goal. [Recent data](#) show that use of prescription opioid medications has decreased nationwide over the past decade while overdose deaths have skyrocketed, with synthetic opioids, excluding methadone, accounting for the vast majority of overdose deaths in recent years. These data suggest that opioid prescriptions are not a major contributor to the overdose epidemic which the nation is currently experiencing. As such, it is not clear that increasing emphasis on the Query of PDMP measure is clinically relevant. ***Rather than making this measure mandatory, we encourage CMS to consult with medical societies focused on addiction medicine to better understand the causes of overdose morbidity and mortality and to advance alternative measures that better address the relationship between substance use disorders and illness.***

AAHPM also strongly opposes the addition of Schedule V drugs to the Query of PDMP measure. By definition, such drugs have low potential for abuse and consist primarily of preparations containing limited quantities of certain narcotics. Requiring clinicians to query PDMPs each time a Schedule V drug is prescribed would result in excessive administrative burden with little to no clinical benefit and could even increase harm as clinicians forego prescription of medically necessary drugs to avoid the burden of PDMP consultation.

Finally, ***AAHPM again 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.*** As we have previously commented, additional exclusions are necessary to protect access to treatments for patients with the highest needs.

Complex Patient Bonus: RFI on Risk Indicators for the Complex Patient Bonus Formula

For purposes of the complex patient bonus formula, CMS currently pairs average Hierarchical Condition Category (HCC) risk scores, which CMS believes is a valid proxy for medical complexity, with the proportion of dually eligible patients to create a more complete complex patient indicator. In this request for information (RFI), CMS seeks feedback on additional risk indicators it may want to consider in the

future when calculating the complex patient bonus formula, including adjustments for beneficiaries in areas with a high Area Deprivation Index (ADI).

AAHPM supports CMS' interest in adopting a more granular approach to assessing patient risk for purposes of the complex patient bonus formula, including the use of the ADI. We believe the ADI is more accurate than the HCC and other common approaches since it looks beyond zip codes and takes into account census blocks, which more precisely reflect the actual neighborhoods where patients live and disparities that exist depending on which block the patient resides. More accurately identifying these disparities is a critical first step to supporting practices that require increased interdisciplinary care and collaboration to take care of patients who face barriers from a social determinants of health perspective. For example, some practices need to hire care coordinators to most effectively help patients with activities like finding a grocery store in a food desert, and CMS payment policies should support practices in making these critical investments.

RFI on MIPS Quality Performance Category Health Equity

To facilitate efforts to reduce health inequities, CMS seeks feedback on different approaches to measuring health equity within MIPS.

AAHPM is dedicated to improving quality of care and quality of life 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 through its quality performance and improvement programs.

AAHPM appreciates that many efforts to address health equity begin with self-reported data from patients, including for demographic characteristics and social drivers of health. In addition to the characteristics CMS identified, ***AAHPM encourages CMS to also consider factors such as social isolation, health literacy, availability of caregiving, housing scarcity, marital status, and socioeconomic status – to name a few.*** However, we also caution that many patients express concerns about sharing data on such factors with health systems and public programs. While we believe that efforts to improve collection of self-reported data are important, we also note that data collection efforts should be respectful of and responsive to patients' needs and concerns. ***To the extent that patients decline to share information, practitioners should not be penalized for respecting patients' preferences.***

Additionally, while AAHPM supports the need for improvements regarding a broad array of social drivers of health, ***AAHPM specifically highlights the need for development of a patient-reported outcome measure that assesses the receipt of appropriate language services and/or the extent of clinician-patient communication and believes that CMS should make this a priority.*** Our members, particularly in urban settings, often witness situations where clinicians do not have access to medical interpreters and, instead, must rely on a family member or their own, often limited, language skills. For example, one AAHPM member reports that his hospital has 3 iPads to support translation for roughly 300 beds. Lack of access to language services is a real and serious problem that has a major implications for overall quality and outcomes, not just within the specialties of hospice and palliative care – where communication is paramount – but in medicine across the board. Without access to appropriate language services, clinicians cannot obtain a clear understanding of a patient's history or preferences, which sets the stage

for inequitable care. *AAHPM urges CMS to prioritize the development of metrics that assess the extent to which patients' language needs are readily and proficiently met.*

Finally, *as CMS continues to consider additional measures of healthy equity, in general, it is critical that patient stakeholders are part of the conversation and have an influential voice.* Community member input, in particular, is necessary to ensure that health equity measures are reflective of and acceptable to the community being served and accurately capture the needs of the community.

Addition of New Consumer Assessment of Health Providers and Systems (CAHPS) for MIPS Survey Questions – RFI

CMS seeks input on potential modifications to the CAHPS for MIPS survey, including to include questions on health disparities and price transparency and to make the survey more broadly applicable to specialty providers. *AAHPM supports the creation of alternate shortened surveys with questions tailored to reflect specialty care, separate from a version that would be utilized for primary care, to ensure that the survey meaningfully captures patients' care experience – including aspects relevant to primary care, when applicable. However, we believe it is premature to include a question on price transparency and conversations about the cost of healthcare services and equipment.* We note that the *No Surprises Act* requirements have only recently been established and effectuated, with many of the requirements not applicable to large segments of the physician community and/or the patients they serve. Furthermore, additional provisions are still being implemented, for example, regarding transmission of good faith estimates to insurance companies to support preparation of explanations of benefits. Against this backdrop, many clinicians and practices are not well versed in different pricing levels of the various insurance companies with which they are contracted, nor have they established workflows for readily identifying pricing information. They would therefore not be able to easily communicate information on prices to patients or caregivers. Additionally, greater clarity is required regarding what conversations about the cost of healthcare services and equipment might entail; for example, would a conversation referring a patient to an insurance provider to determine out-of-pocket costs be sufficient? Therefore, *AAHPM recommends that CMS delay implementation of CAHPS questions on price transparency until practices and health plans have developed, tested, and fully adopted streamlined processes and protocols for obtaining accurate pricing information to share with patients and caregivers and until stakeholders have received appropriate guidance on what is expected and how to succeed for such questions.*

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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@aaahpm.org or 847-375-4841.

Sincerely,



Tara C. Friedman, MD FAAHPM
AAHPM President