AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

June 27, 2016

Andrew M. Slavitt
Acting Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-5517-P: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Mr. Slavitt,

On behalf of the nearly 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank CMS for the opportunity to comment on proposed policies related to the implementation of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses and other health and spiritual care providers deeply committed to improving quality of life for patients facing serious or life-threatening conditions, as well as their families.

As we noted in our earlier feedback to CMS, given the breadth and depth of issues that need to be addressed to ensure successful implementation of MACRA, we strongly urge CMS to approach this transition in a thoughtful and deliberate manner that includes ongoing consultation with the clinical stakeholders that will be most directly impacted by these changes. As CMS embarks on implementing this new quality reporting and payment update system, it is also absolutely critical that it use this opportunity to refocus incentives on more meaningful activities that make sense to the clinician and ultimately improve the care of the patient. This system must not become a series of meaningless steps that place administrative burdens on clinicians without providing true improvements in the quality and value of care provided to patients.

We remind CMS that Hospice and Palliative Medicine (HPM) is a unique specialty with a paucity of truly relevant measures. Our patients are all seriously ill and death is not always a negative outcome. In fact, it could be a neutral or positive outcome. Our standard of care also involves a cross-cutting interdisciplinary team of physicians, nurses, social workers and chaplains, working in a variety of settings (inpatient hospitals, outpatient care, hospice, nursing homes, and individual patient homes). As such, **the approach to measure development for our field cannot be cookie cutter and will warrant special consideration under MACRA programs and policies**. In some instances, this will require excluding seriously ill patients from measures and activities. In other cases, raising the bar on quality for seriously ill patients will require taking a more

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population-based approach, such as ensuring that measures and standards are consistent regardless of whether a patient is cared for by a cardiac specialist, an oncologist, or palliative care provider.

It is important to recognize that seriously ill patients with palliative care needs are not always referred to palliative care specialists. Sometimes clinicians who are not specialists in palliative care manage the more basic palliative care needs, and sometimes these needs are not addressed at all. The few quality measures currently available that are relevant to palliative care focus predominantly on patients who are receiving specialty-level palliative care or enrolled in hospice and these measures thus miss a large proportion of suffering patients who, for any number of reasons, have not accessed those specialty-level services. It is critically important to invest in developing and testing measures appropriate for all providers who care for seriously ill patients with palliative care needs, since they have very few meaningful and broad-based measures to work with at this time. Regardless of the approach, **CMS must keep in mind that quality care for patients with serious illness and at the end-of-life is extremely important, but often costly and incredibly challenging to measure. We urge CMS to be mindful of this as it finalizes the proposals in this rule and especially as it prioritizes MACRA-authorized funding for measure development and technical assistance.**

I. MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) PROVISIONS

A. Identifying MIPS Eligible Clinicians

Eligible Professional Identifiers

The current system places too much emphasis on compliance and reporting simply to avoid penalties. To incentivize more meaningful engagement, CMS must organize the data collection and reporting mechanisms in a way that recognizes quality improvement efforts at multiple levels and allows for calculating performance congruent with the multiple ways that providers practice and are organized. **Reporting and analysis should be allowed at several different levels in a 'building block' manner, with individual physicians having direct control over selecting the mechanism that works best for their practices.**

In the rule, CMS proposes to use multiple identifiers that would allow MIPS eligible clinicians to be measured as an individual or collectively through a group's performance. However, the same identifier would have to be used for all four MIPS performance categories (i.e., a clinician cannot report as an individual for some aspects of MIPS and as a group for others). Although CMS proposes to use multiple identifiers for participation and performance, it would use a single identifier (Taxpayer Identification Number [TIN] / National Provider Identifier [NPI]) for applying the payment adjustment, regardless of how the clinician is assessed. More specifically, if a clinician is identified by TIN only for purposes of performance, CMS would still use the TIN/NPI when applying the payment adjustment.

AAHPM supports the strategy of relying on the TIN/NPI combination when applying the payment adjustment since it allows CMS to calculate performance for multiple unique TIN/NPI combinations (i.e., those who practice under more than one TIN), which enables greater accountability for individual clinicians beyond what might be achieved when using the TIN, alone. This strategy also provides a safeguard for clinicians who might try to change their identifier simply to avoid payment penalties. Furthermore, it allows CMS to more accurately identify which TIN/NPIs are still MIPS eligible clinicians after exclusion criteria have been applied (e.g., clinicians who are excluded due to the proposed low volume threshold or are determined to be an Alternative Payment Model Qualifying Participant after the performance period).

Individual vs. Group Reporting

AAHPM appreciates that CMS proposes to preserve the individual and group reporting mechanisms and to expand reporting options available to group practices by allowing them to report as such across all four MIPS performance categories. The group practice reporting option is important to many clinicians since it provides an opportunity to reduce the participation burden that could be experienced by larger groups that would otherwise have to report data for each individual.

However, the rule is not exactly clear in regards to how CMS plans to evaluate groups versus individuals across the four MIPS performance categories of Quality, Resource Use, Advancing Care Information (ACI, formerly Meaningful Use), and Clinical Practice Improvement Activities (CPIAs). These details are critical since this will be the first time that group practices could demonstrate meaningful use of electronic health records (EHRs) and report on CPIAs. **We request that CMS provide a more detailed explanation of how it intends to evaluate group performance and determine payment adjustments based on group performance under each of the four MIPS performance categories.** Will CMS evaluate each individual within the group and combine those scores into a composite group score or will it look at group performance, as a whole, as it currently does under the Physician Quality Reporting System (PQRS) (e.g., in accordance with the proposed quality reporting threshold, did the group, as a whole, report on six measures for 90% *of the group's* applicable patients)? While it might be feasible to evaluate group level performance for quality and resource use and then apply that score to everyone in the TIN regardless of whether all individuals in the group contributed to the score, that strategy does not translate as easily to the new ACI and CPIA categories.

Despite our support for maintaining group practice reporting as one option under MIPS, we do not necessarily believe that it always results in genuine team-based approaches to care that are foundational to raising the bar on quality, especially in our field. It is not uncommon for individual specialists within a larger group to not even know that their group is participating in the PQRS on their behalf. Palliative care clinicians often represent small clinical service lines in a large health system, add value primarily through improving quality and lowering costs rather than driving billing revenues, and function as consultants without a primary service of their own. All these factors often cause individual HPM providers to go unrecognized in a larger group and to have little to no control over measure selection, reporting mechanisms, and overall participation decisions. While this might allow some individual members of the group to avoid penalties without having to actively report on any measures, this concept seems to contradict CMS's goal of incentivizing meaningful participation across specialties and does little to promote care-coordination.

Since MIPS represents an unprecedented shift from pay-for-reporting to pay-for-performance, it is more important than ever to ensure that individual clinicians have direct control over that for which they are being held accountable. As such, **we recommend that CMS adopt a policy that would give individuals the option to be evaluated as an individual even if their group elects to use group reporting.** This would provide individual clinicians with the flexibility to demonstrate their unique contributions to quality improvement in situations where they might otherwise be held accountable for cases attributed to the group over which they have no direct control.

Similarly, individuals also should have the flexibility to determine if they want to be evaluated as part of a unique group of clinicians that might not necessarily align with their billing TIN, and to determine which other individuals best represent their "care team." As such, we continue to recommend that CMS use its authority under MACRA to give clinicians the option to participate in MIPS as a "virtual group." As we noted in our RFI comments, virtual groups account for multiple aspects of modern day medical practice that the current approach to quality improvement often fails to account for, including:

- The fact that physicians often work for multiple organizations or in multiple settings at the same time;
- The fact that those in smaller or independent practices do not have the same level of resources, negotiating power, or overall influence over more comprehensive care decisions that larger group practices and systems do;
- The fact that healthcare system consolidation is increasingly common, which makes it challenging to assess the performance of individual practitioners practicing in larger multi-specialty groups and minimizes the control that these individual practitioners have over selecting performance metrics that most accurately reflect the quality of their care.

Virtual group reporting is especially important for HPM given the cross-cutting nature of our specialty and the current lack of opportunities among our members to demonstrate their distinct contributions to quality. As CMS works to develop more formal policies related to virtual groups, **we request that it not limit the number or size of virtual groups, adopt prescriptive geographic standards, or limit the reporting mechanisms available to these groups.** Such limitations would be arbitrary, would ignore the diverse needs of virtual groups, and could impede collaborations that might benefit from this option.

CMS also proposes that clinicians and groups may elect to submit information via multiple mechanisms; however, they must use the same identifier for all performance categories and they may only use one submission mechanism per category (i.e., a clinician cannot report as an individual for some aspects of MIPS and as a group for others). AAHPM reiterates earlier comments that, in some instances, a physician might want to align with a group practice for one category (e.g., resource use measurement), but be evaluated as an individual when it comes to quality measures or clinical practice improvement activities (CPIAs). We recognize the technical complexity of permitting this flexibility, but support providing clinicians with this option and request that CMS evaluate the feasibility of doing this in the future.

Place of Service Codes

Since members of our specialty practice in a variety of settings, it is also important that MIPS capture place of service (POS) codes for services delivered when assessing quality or cost performance. The system must recognize that a service delivered in a hospital might not be comparable to services delivered at home, in an emergency room or in a psychiatric center. Incorporating the POS identifier into MIPS reporting will be critical to ensuring that feedback reports and opportunities for improvement are meaningful. **CMS should review the current list of POS codes to ensure that the list is adequate given today's current practice settings and to provide for appropriate comparisons.**

B. Exclusions

Low Volume Threshold

CMS proposes a low-volume threshold under which clinicians would be excluded from MIPS. CMS defines this exclusion as an individual clinician *or* group who, during the performance period, has Medicare billing charges less than or equal to $10,000 *and* provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. CMS's intent here is to retain as MIPS eligible clinicians those who are treating relatively few beneficiaries, but engage in resource intensive specialties, as well as those treating many beneficiaries with relatively low-priced services.

We disagree with CMS's proposed low-volume threshold. We do not believe $10,000 is an adequate threshold, as we believe eligible clinicians who provide expensive procedures and services to patients may easily meet the $10,000 low-volume threshold on one or two procedures or services alone. Therefore, we request that CMS increase the dollar amount for the low-volume threshold to $30,000.

Specifically, we recommend that CMS amend the low-volume threshold to exclude an individual clinician who, during the performance period, has Medicare billing charges less than or equal to $30,000 and provides care for 100 or fewer Part B-enrolled Medicare beneficiaries.

Newly Medicare-Enrolled Eligible Clinicians

In the case of a professional who first becomes a Medicare-enrolled eligible clinician during the performance period for a year, CMS will not treat that professional as a MIPS eligible clinician until the subsequent year. CMS proposes to define a new Medicare-enrolled eligible clinician as a professional who first becomes a Medicare-enrolled eligible clinician within the PECOS during the performance period for a year and who has not previously submitted claims as a Medicare-enrolled eligible clinician either as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier.

We oppose this proposal since it would impose an undue burden on newly practicing professionals who enter practice late in a year. For example, a clinician who newly enrolls in Medicare in November 2017, would be required to begin participation in MIPS beginning January 1, 2018, just two months following their enrollment. Clinicians new to practice are already overwhelmed by other federal mandates and administrative duties and should not be expected to comply with yet another set of complex requirements that further diverts attention away from direct patient care. **We request that CMS modify this proposal such that a physician would have at least a full year before being considered a MIPS eligible clinician** (e.g., a clinician who enrolls in Medicare in 2017 would not be expected to begin participation in the program until January 1, 2019).

C. MIPS Performance Period

CMS proposes January 1 through December 31, 2017, as the initial performance period for the first MIPS payment adjustment in 2019. Given the number of new reporting components under MIPS, the complexity of scoring mechanisms, and the ongoing lack of relevant measures and sufficient risk and attribution methodologies for specialties, such as ours, AAHPM strongly recommends that CMS delay the start date of MIPS.

Successful implementation of this new program will require a phased approach that provides adequate time for practicing clinicians and their supportive staff to familiarize themselves with these new requirements and for CMS and third-party vendors to conduct supportive outreach and education and to build a sufficient foundation of data on which to set meaningful and fair benchmarks. A phased approach would also provide CMS with the opportunity to learn from mistakes along the way and to adapt policies accordingly.

During the initial transition period, it is critical that CMS use MACRA-authorized funding to invest more heavily in user-friendly and easily accessible educational tools, well-formed and responsive technical assistance, and other interactive resources to assist clinicians with understanding their participation options and what, exactly, they need to maximize their performance score. The task of distilling all of this information is enormous and one that professional societies cannot do without some federal assistance.

While we agree with a calendar year performance period, we request that CMS delay the start of the performance period of the 2019 MIPS payment adjustment to start in January 1, 2018. As we expect the final rule setting forth the requirements for the MIPS to be published in November 2016, we do not believe two months (mainly during the holiday season) gives us enough time to adequately educate our members on how to successfully participate in the MIPS prior to the start of the performance period. It is our hope that, within this year, the community is able to develop measures that are more meaningful to eligible clinicians in palliative care.

We note that this request is in keeping with the intent of the MACRA legislation. Specifically, the MACRA legislation states the following:

*''(4) PERFORMANCE PERIOD.—The Secretary shall establish a performance period (or periods) for a year (beginning with 2019). **Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year**. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year."*

When the legislation was written, in quality programs such as the PQRS, CMS established reporting periods that occurred two years prior to the implementation of payment adjustments. We believe it was Congress' intent under MACRA to urge CMS to establish a performance period for the MIPS that occurred closer than two years from the time an eligible clinician is assessed a payment adjustment. While we understand the operational limitations associated with implementing a later performance period, we urge CMS to strongly consider the feasibility of delaying both the performance period and, if necessary, the payment adjustment start date in order to give clinicians more time to understand their participation options and adapt their practices to these new requirements.

Going forward, **we also urge CMS to continue to work to close the gap between the performance period and the payment year so that data is more meaningful and actionable for both clinicians and patients.** Closing this gap would also allow CMS to make more timely modifications to the program as necessary.

D. MIPS Composite Performance Score (CPS)

General Comments

The proposed scoring system for the CPS uses a combination of points, percentages, and averages to calculate the overall CPS. No two MIPS performance categories are scored the same and benchmarking and baseline approaches vary throughout. The lack of one consistent approach makes it difficult for clinicians to understand how to maximize their scoring potential. While we recognize that a standardized approach is not always appropriate, we encourage CMS to streamline CPS methodologies as much as possible so that they are easier to understand among those being held accountable.

AAHPM also opposes stop-gap policies that attempt to accelerate the roll-out of this program by inappropriately creating data when such data does not yet exist. For example, to establish the overall performance threshold against which clinicians' 2017 CPS will be compared for purposes of determining 2019 MIPS payment adjustment, CMS proposes to model 2014 and 2015 Part B allowed charges, PQRS data submissions, Quality and Resource Use Reports (QRUR) feedback data, and Medicare and Medicaid EHR Incentive Program data to inform where the performance threshold should be since it will not yet have historical MIPS data. Since CMS lacks historical data for the CPIA performance category, it would apply some sensitivity analyses to help inform where the performance threshold should be. **AAHPM strongly opposes CMS's proposal to use non-MIPS historical data to set the performance threshold for the first year of MIPS for both the CPS and the individual performance categories.** Going forward, it is inappropriate to evaluate clinician performance and adjust payments based on benchmarks derived from programs that existed prior to MIPS since these programs have evolved over the years and relied on different measures, reporting mechanisms, and participation incentives than are being proposed for MIPS. This is yet another reason to delay the start date of MIPS and to adopt policies that minimize payment adjustments or hold clinicians harmless from downward adjustments until a sufficient foundation of MIPS data has been collected.

Redistribution of Performance Category Weights

CMS proposes to reweight the performance categories for MIPS eligible clinicians when there are not sufficient measures and activities applicable and available to them. Specifically:

- If the MIPS eligible clinician does not receive a resource use or ACI performance category score, and has at least three scored quality measures (either submitted measures or those calculated from administrative claims), CMS proposes to reassign the weights of the performance categories without a score to the quality performance category. Alternative Proposal: CMS also proposes an alternative that would reassign the weight proportionately to each of the other performance categories for which the clinician has received a performance category score.
- If the MIPS eligible clinicians have fewer than three scored measures in the quality performance category score, then CMS proposes to reassign the weights for the performance categories without scores proportionately to the other performance categories for which the clinician has received a performance category score.

AAHPM supports CMS using its authority to re-weight certain categories to zero if there are an insufficient number of available measures or activities. However, we request that any excess weight from the resource use and ACI performance categories be applied to the CPIA category rather than the quality performance category since the CPIA category is the only one over which clinicians have true flexibility to demonstrate their commitment to higher value care in a manner that is most meaningful and relevant to their practice and patient population. While the quality performance category also provides eligible clinicians with some choice over which measures to report, we do not think that the quality performance category should be over-weighted by being assigned more than 50% of the weight of an eligible clinicians' overall CPS given the ongoing lack of suitable measures for some specialties. With respect to MIPS eligible clinicians who have fewer than three scored measures in the quality performance category, we also urge CMS to distribute the weight to the CPIA performance category.

E. MIPS Performance Categories: Quality

Reporting Requirements

While MIPS presents an important opportunity to fix things that are not working in current quality reporting programs, we also believe that the initial transition to this new system needs to be as simple and seamless as possible so that it does not disrupt clinical practice or minimize the time that physicians have to spend with their patients. As such, we appreciate that CMS proposed to maintain all of the current PQRS reporting mechanisms (i.e., claims reporting, qualified clinical data registry [QCDR], qualified registry, EHR, and Web Interface) to ensure flexibility for clinicians with different needs. We also appreciate CMS's proposal to lower the number of measures that must be reported under MIPS from nine to six and to no longer require that reported measures span three National Quality Strategy domains.

Nevertheless, we have serious concerns about CMS's proposal to require the reporting of six measures for 80% of all applicable Medicare patients through claims and 90% of all patients (both Medicare and non-Medicare) through QCDRs, qualified registries and EHRs. While we prefer that CMS maintain the current 50% reporting threshold, our bigger concern is with the six measure requirement given the ongoing paucity of measures available to directly address the palliative and other care needs of seriously ill patients. **We strongly urge CMS to further reduce the number of required quality measures, especially in the initial years of MIPS, to only require the reporting of three measures.** As proposed, the bar for the quality category is still too high of a burden given ongoing measure gaps in our field, which are discussed in more detail below, and will simply lead to reporting for the sake of reporting, rather than more meaningful engagement in higher value healthcare. While we support a gradual shift towards more robust measures, we also oppose CMS's requirement that all clinicians report on at least one outcome

and one cross-cutting measure, especially given CMS's simultaneous proposal to reduce the number of measure designated as cross-cutting. We instead encourage CMS to only use bonus points to encourage the reporting of these types of measures.

Over time, we request that CMS evaluate the feasibility of allowing QCDRs to determine the most appropriate reporting sample (whether a discrete number or percentage) on a measure-by-measure basis, which would be submitted for approval during the self-nomination process. Not all registries are created equally and there is precedent for allowing QCDRs to determine an appropriate sampling methodology for patient experience measures.

Measures

Ongoing Lack of Palliative Care-Focused Measures

AAHPM reminds CMS that there are currently no measures in the PQRS or in the proposed MIPS measure set that specifically address the broad category of palliative care for patients of any age, without being disease-specific. CMS proposes various specialty and sub-specialty specific measure sets to assist clinicians with navigating what is now a set of over 300 quality measures. In proposing these sets, CMS recognizes that very specialized clinicians may only have a handful of applicable measures and makes special accommodations so that specialties with less than six measures in a set would only have to report those measures. Unfortunately, neither CMS nor AAHPM has been able to identify a meaningful specialty measure set that focuses specifically on HPM, which further emphasizes the challenge our members will face in trying to find six meaningful measures to report.

Among the limited number of measures available to HPM providers in the proposed MIPS measure set, many do not apply to all patients due to a limited denominator (e.g., cancer, dementia) or limitations related to certain settings (e.g., ICU, hospice). For example, current PQRS oncology-related measures do not allow for home based visits. PQRS #342: *Pain Brought Under Control within 48 Hours* is not always possible to do or measure in outpatient palliative care. Other measures cannot be used by our members who bill for inpatient palliative care services since their codes are often not included in the measure, and/or they are excluded by the definition of the measure (e.g., one must be the treating oncologist to use the PQRS pain assessment measures #143 and #144). The existing set of PQRS measures also fails to focus on the emotional, social, and spiritual needs of patients and their caretakers—an aspect of care that is integral to quality in our field. Furthermore, while some eligible clinicians may report on measures that address specific conditions, these condition-specific measures do not apply to all our eligible clinicians. Finally, we note that while our eligible clinicians may be able to report on certain measures, it may be difficult for these clinicians to meet the proposed 20 case minimum. For example, while Parkinson's and Alzheimer's are conditions that are commonly treated by palliative care specialists, some eligible clinicians may work in a facility primarily focused on patients with Parkinson's and not Alzheimer's. Therefore, these clinicians may not necessarily be able to meet the 20 case minimum for Alzheimer's. Overall, these ongoing challenges highlight the ongoing lack of adequate quality measures addressing palliative medicine and the need to focus investments on closing this critical gap.

The Institute of Medicine (IOM), the National Quality Forum (NQF), the Measures Application Partnership, and CMS have all acknowledged that palliative and end-of-life care represents a major gap in quality measurement. **We strongly urge CMS to recognize this consensus and to prioritize investments in the development and testing of patient- and family-centered palliative care measures.** In general, these measures should aim to better align treatments to patient goals, such as measures that assess the quality of advance care planning conversations and shared decision making; measures that more comprehensively evaluate symptom reduction (e.g., not simply assessing and treating pain, but also side effects and trade-offs of managing pain, and non-pain symptoms such as dyspnea, constipation and

fatigue and anorexia); and measures that evaluate concordance of care with patient wishes. Ideally, these palliative care measures would be broadly applicable across multiple settings, not just ambulatory settings. Most importantly, we highlight the need for a common denominator that comprehensively captures the patient population appropriate for palliative care. No measure currently used under federal quality reporting programs focuses on this population exclusively. Instead, CMS tends to rely on disease-oriented quality measures that are not appropriate for all patients, especially those with multiple chronic conditions and significant debility near the end of life.

MACRA funding is an incredible opportunity for CMS to partner with our field's experts to develop measures that are cross cutting, flexible, and patient-centered, and emphasize care coordination, shared decision-making, family meetings, and establishing goals of care. In order to increase our measure repertoire and the usability of measures we already have, we need funding for measure development, measure modification, and testing in new populations and settings. The palliative care community has already started some of this work, but needs technical assistance to take it to the next level. In 2014, AAHPM and the Hospice and Palliative Nurses Association – in consultation with the Center to Advance Palliative Care, the National Hospice and Palliative Care Organization, The Joint Commission, the U.S. Department of Veterans Affairs and numerous other stakeholders – launched Measuring What Matters (MWM), a project which produced a consensus recommendation for a portfolio of performance measures that all hospice and palliative care programs could use for program improvement. The goal of MWM was to sort through all relevant published measures and select a concise set that would matter most for patients with palliative care needs across all settings. We are now prioritizing what will constitute Phase 2 of the project, which we hope will include creating e-specifications and patient-reported outcome measures; field-testing altered, expanded and untested measures; and developing a common palliative care denominator.

Only existing measures without modifications were considered during the project, so the MWM "Top 10 Measures that Matter" is not a unified set with a common set of definitions. For many years, experts have tried to develop a common denominator that would enable the field to target patients who are most likely to benefit from palliative care. However, doing so involves striking the right balance between number and/or type of chronic conditions, extent of functional and cognitive impairments, and overarching quality of life. With some guidance, collaboration, and funded technical assistance, we believe the MWM Top 10 Measures that Matter could evolve into more meaningful and useful measures and help to close the gap in measures that target the palliative care patient population specifically.

AAHPM stands ready to assist CMS with developing measures that focus specifically on a patient's palliative care needs. We have been considering how best to measure these realms of care for many years through the aforementioned efforts, and we look forward to working with CMS to overcome some of the obstacles that have prevented us from developing more implementable measures in this space.

While not an AAHPM-sponsored effort, we support our colleagues' efforts to develop more palliative care-centric measures through the CMS-approved ICLOPS QCDR. The ICLOPS QCDR has come a long way in developing measures that are meaningful to eligible clinicians in palliative care, as several of the measures approved for reporting in 2016 specifically address palliative care, including:

- Screening for Clinical Depression
- Pain Brought Under Control within 2 Encounters
- Patients Treated With an Opioid Who Are Given a Bowel Regimen
- Patients Admitted to the ICU Who Have Care Preferences Documented
- Patients With Advanced Cancer Screened For Pain at Outpatient Visits
- Palliative Care: Pain Screening

- Palliative Care: Pain Assessment
- Palliative Care: Dyspnea Treatment
- Palliative Care: Dyspnea Screening
- Palliative Care: Treatment Preferences
- Palliative Care: Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns

While we appreciate that the QCDR mechanism provides some of our members with the opportunity to test these more innovative and meaningful measures, we note that this QCDR specific to palliative care is in an early, pilot phase, and most HPM clinicians will be reporting quality measures through another mechanism. Therefore, while we applaud the introduction of palliative measures in the QCDR space to address our concerns, our members also need additional options to report meaningful and applicable measures within the traditional MIPS measure set.

There are a couple of actions that CMS could take in the immediate future to temporarily close these gaps and to provide our members with better reporting choices as we continue to work with stakeholders to develop more meaningful measures. One option would be to re-instate the measures groups reporting option. We were disappointed with CMS's proposal to remove all measures groups from MIPS since this would pose yet another reporting challenge to our members. **While more applicable measures are developed, we request that CMS retain measures groups, particularly the Multiple Chronic Condition measures group.** Specifically, we request that CMS retain the Multiple Chronic Condition measures group established for the 2016 PQRS, which contains the following measures:

- 47: Care Plan
- 110: Preventative Care and Screening: Influenza Immunization
- 128: Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- 130: Documentation of Current Medications in the Medical Record
- 131: Pain Assessment and Follow-Up
- 134: Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- 154: Falls: Risk Assessment
- 155: Falls: Plan of Care
- 238: Use of High-Risk Medications in the Elderly

We believe that it is important to provide a measures group option for our eligible clinicians to voluntarily report, particularly since no specialty measure set was proposed by CMS for palliative care eligible clinicians. In addition, we believe that CMS should retain the measures group reporting criterion established for the 2018 PQRS payment adjustment. Specifically, we request that CMS establish the following criterion for reporting measures groups: For the performance period for the 2019 MIPS payment adjustment, report at least 1 measures group and report each measures group for at least 20 patients.

To help to fill critical measure gaps in our specialty, AAHPM also continues to urge CMS to consider the following measures for inclusions in MIPS as soon as possible:

- *Palliative Care: Advance Care Planning:* This measure from the NCQA/PCPI was adopted from PQRS Measure #47, and it extends the denominator population to capture people under the age of 65 who are at the end of life.
- *Palliative Care: Dyspnea Screening and Management:* This measure is from the NCQA/PCPI. Dyspnea is a symptom frequently seen in patients with serious illness and/or near the end of life.

Assessment and treatment of symptoms such as dyspnea are critical for optimal palliative care. Identification and treatment (if necessary) of dyspnea improves quality of life.

- *Patients Treated with an Opioid who are Given a Bowel Regimen*: NQF Measure #1617 is another important measure since opioids are commonly used in the management of moderate to severe pain, and constipation is a common adverse effect. Additionally, this measure is included in the hospice quality reporting program, as part of the Hospice Item Set (HIS).

In addition to these, we urge CMS to consider adding to MIPS the following recently reviewed measures from the NQF's Palliative and End-of-Life Care Measure Maintenance Project that are specifically relevant to palliative care (although not specified or tested for all care settings):

- NQF #1634 Hospice and Palliative Care -- Pain Screening
- NQF #1637 Hospice and Palliative Care -- Pain Assessment
- NQF #1638 Hospice and Palliative Care -- Dyspnea Treatment
- NQF #1639 Hospice and Palliative Care -- Dyspnea Screening
- NQF #1641 Hospice and Palliative Care – Treatment Preferences

Facility-Based Measures

MACRA provides CMS with the authority to adopt measures used for non-physician payment systems, such as inpatient hospital measures, for purposes of the quality and resource use performance categories. Although CMS recognized RFI comments received related to this proposal, it is not proposing this as an option for year one of MIPS because there are several operational considerations that must be addressed before it can be implemented.

We remind CMS that an additional way to help fill the gap in palliative care-focused measures would be to give physicians the option to elect to be measured based on hospital or other facility-level performance (e.g., measures used under the Hospice Quality Reporting Program) as a surrogate for clinician-level performance. However, this decision must remain in the control of the clinician given the implications for payment and public reporting. Over the longer term, we would be happy to work with CMS to try to re-specify and test some of these measures so that they can be used for clinician-level accountability, particularly by those who practice within these larger facilities.

CAHPS Survey Measures

AAHPM has long voiced concerns about CMS mandating the use of the CG-CAHPS since this instrument does not sufficiently capture experience of care, especially care that is most relevant to hospice and palliative care patients. As such, we support CMS's proposal to no longer require that larger group practices report this survey.

While we wholeheartedly support efforts to improve the patient's care experience, we do not believe that patient satisfaction measures should be lumped with other metrics of clinical care evaluated under the quality measurement component of MIPS. Patient experience measures are often subjective and might not always target things that are in the direct control of the individual physician (e.g., patient wait times in a hospital setting). They also do not always correlate with clinical standards (e.g., overprescribing pain medications to keep the patient satisfied). As such, **we recommend that CMS limit the use of patient satisfaction surveys to the CPIA category and give physicians the freedom to select a patient experience survey that is most appropriate for their patient population, rather than limiting the choice to the CAHPS for PQRS survey only.**

Global/Population Health Measures

CMS also proposes to automatically calculate the following population/global measures into a clinician or group's total quality performance score, as applicable:

- All-cause readmissions
- AHRQ acute preventive quality indicator composite (bacterial pneumonia, UTI, dehydration)
- AHRQ chronic preventive quality indicator composite (COPD, HF, DM)

These administrative claims-based measures, which are currently used under the Value Modifier (VM) and do not require the clinician to submit any data to CMS, would contribute to a clinician or group's overall quality performance category score in addition to the six measures discussed above. CMS has determined these measures to be reliable with a minimum case size of 20 (200 for the all-cause readmission measure).

Although AAHPM appreciates CMS's effort to identify areas where good outpatient care can potentially prevent the need for hospitalizations, we recommend that CMS not maintain these measures since they are claims-based, not risk-adjusted and calculated with little transparency. As a result, the data they produce it confusing and of little value to clinicians. Under MIPS, clinicians should have control over the selection of all measures used for accountability. Also, while we very much support the incorporation of population health measures, we believe there are more appropriate ways to target this domain, such as through proposed activities under the CPIA category.

Scoring Quality Measures

Case Minimums

To ensure that MIPS eligible clinicians are measured reliably, CMS proposes to use for the quality performance category measures the case minimum requirements for the quality measures used in the 2018 VM: 20 cases for all quality measures, with the exception of the all-cause hospital readmissions measure, which has a minimum of 200 cases. We do not believe in a one-size-fits-all approach to establishing case minimums. Rather, we request that CMS develop case minimums tailored to each measure, as appropriate.

Bonus Points for High Value Measures

CMS proposes scoring adjustments to create incentives for clinicians to submit certain high priority measures (i.e., outcome, appropriate use, patient safety, efficiency, patient experience and care coordination measures) and to allow these measures to have more impact on the total quality performance category score. Specifically, CMS proposes to provide two bonus points for each outcome and patient experience measure and one bonus point for other high priority measures reported in addition to the one outcome/high priority measure that would already be required under the proposed quality reporting criteria. Bonus points also would be available for measures that are not scored (i.e., not included in the top six measures for the quality performance category score). However, bonus points for high priority measures would be capped at 5% (or, alternatively, 10%) of the denominator of the quality performance category score. These policies would apply to MIPS quality measures, as well as non-MIPS measures reported through QCDRs. CMS proposes to determine which measures are high priority during the QCDR measure review process.

AAHPM supports CMS's proposal to assign bonus points for each outcome, patient experience, and high-priority measure a MIPS eligible clinician reports. However, to encourage the reporting of these measures, we do not believe there should be a cap on the amount of bonus points an eligible clinician may earn within the quality performance category.

AAHPM has reservations about CMS's proposal to increase the requirements for outcome and other high-priority measures in the future. While we share the goal of moving toward more "high value" measures, there is no single standard across specialties in regards to which types of measures have the greatest value in driving results. Measures considered "high value" may differ by specialty, patient, and setting. For example, process measures that are evidence-based can be integral to improving outcomes, especially in our field where so few measures exist, and should be preserved as an option for specialties that are still working towards the evaluation of outcomes. Requiring clinicians to report on specific types of measures also mistakenly assumes that individual physicians have influence over which measures are developed and available to meet their needs. Clinicians should not be penalized for infrastructural barriers that they cannot control.

In general it is critical that, in the initial years of MIPS, CMS give clinicians as much flexibility as possible in regards to measure selection and that it not adopt incentives that will adversely disadvantage one specialty over another—particularly specialties that are truly trying to do the right thing. Over the longer term, **we strongly recommend that CMS closely track whether clinicians across all specialties have a relatively equal opportunity to select high priority measures and that CMS make adjustments if it identifies any imbalances.**

Bonus Points for Using CEHRT/QCDRs

CMS also proposes to allow one bonus point under the quality performance category score for each reported measure up to the cap described, if a clinician meets the requirements for "end-to-end electronic reporting." This would be accomplished when:

- The clinician uses certified electronic health record technology (CEHRT) to record the measure's demographic and clinical data elements in conformance to the standards relevant for the measure and submission pathway, including but not necessarily limited to the standards included in the CEHRT definition;
- The clinician exports and transmits measure data electronically to a third party using relevant standards or directly to CMS using a submission method as defined by federal standards; and
- The third party intermediary (for example, a QCDR) uses automated software to aggregate measure data, calculate measures, perform any filtering of measurement data, and submit the data electronically to CMS using a submission method.

AAHPM is concerned about linking this bonus structure to CEHRT since some QCDRs do not yet have the ability to obtain data from CEHRT in the manner specified by the federal government. HPM clinicians also often lack control over EHR selection and data standards are still lacking (as discussed below), which restricts the amount and the quality of data that can be seamlessly pulled into a registry from CEHRT. **We request that CMS instead provide bonus points simply for the use of QCDRs, to further incentivize registry adoption and to recognize the investment of time and resources needed to participate in a registry.**

F. MIPS Performance Category: Resource Use

Under MIPS, CMS proposes to maintain the following two problematic cost measures used under the VM for purposes of calculating the MIPS Resource Use performance score: the Medicare Spending Per Beneficiary (MSPB) measure and the Total Per Capita Cost measure. In addition, CMS also proposes 41 new episode-based cost measures.

AAHPM strongly opposes CMS's decision to maintain the flawed Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost measures under MIPS. These measures inappropriately assume that physicians have control over other physicians' care plans and treatment decisions and produce data that are

confusing and of little value to both clinicians and the public. The MSPB measure is further weakened by CMS's proposal to remove the specialty adjustment. AAHPM supports specialty adjustments, especially in regards to resource use measurement. If anything, we request that CMS adopt even more granular subspecialty adjustments since, within our specialty alone, hospice providers will have different utilization and resource use patterns than palliative care providers. We are also concerned about CMS's proposal to reduce the case minimum threshold from 125 to 20 patients, as well as by CMS's proposal to expand the primary-care services definition used to attribute patients to the Total Per Capita Cost measure so that it also includes the new Medicare care coordination codes (i.e., transitional care management codes (CPT 99495 and 99496) and the chronic care management code (CPT 99490). As a result of these proposals, even more HPM clinicians will be held accountable for these majorly flawed measures, which were intended for hospital-level accountability.

While we favor more granular episode-based cost measures and appreciate the hard work that has gone into developing these to date, we believe that a lot of important work is still needed, such as fine-tuning episode definitions and risk-adjustment and attribution methodologies, to ensure these measures accurately and comprehensively account for the multiple factors that contribute to the overall cost of caring for a patient. We appreciate that CMS is in the process of developing patient condition groups that better describe the patient's clinical history, as well as patient relationship categories and codes that better distinguish the relationship and responsibility of a physician with a patient at the time of furnishing an item or service. We believe these classification codes will help to paint a clearer picture of who is responsible for what during a care episode. However, MACRA does not require CMS to begin collecting these codes on claims until 2018, and CMS is still in the process of collecting initial public feedback on this policy.

CMS also has not yet figured out how to better account for less quantifiable things that contribute to the overall value of care, such as upfront investments that might result in system-wide savings over the long-term or avoid costs elsewhere in the health system. Part of mastering this process will be bridging the ongoing gap between quality and resource use measurement. Currently, there is very little connection between the two. In the end, CMS needs to focus on appropriateness of care, including the alignment of care with patient goals, rather than measuring raw spending data in isolation.

Due to these ongoing concerns, **AAHPM respectfully requests that CMS use its authority under MACRA to re-weight the Resource Use category to zero given the range of deficiencies related to the proposed set of measures**. Ideally, we would like to see CMS shift to more focused episode-based cost measures, and we look forward to working with CMS on this front. However, until CMS has had the opportunity to develop and implement more granular attribution mechanisms, clinicians should not be held accountable for these defective measures. Specifically, we believe that the weight given to the resource use performance category should be redistributed to the CPIA performance category.

G. MIPS Performance Category: Advancing Care Information

Objectives and Measures

AAHPM is disappointed that CMS's proposed strategy for reinventing Meaningful Use still largely relies on an all-or-nothing scoring approach since it maintains practically all of the current modified Stage 2 and Stage 3 objectives and measures and would require clinicians to report on all of those measures in order to be eligible for a base and performance score under this category. This strategy continues to erroneously assume that every objective and measure is equally relevant, appropriate and feasible for every clinician. It also ignores the fact that many physicians have encountered substantial difficulty trying to comply with Stage 2, and the vast majority are not expected to achieve full compliance with Stage 3 either.

While we appreciate CMS's attempt to abandon existing thresholds for each measure, this accommodation is insufficient and does not offer clinicians the flexibility to select measures that are most relevant to their practice, available resources and experience with HIT. AAHPM urges CMS to take more concrete steps to move beyond what is still largely a one-size-fits-all, all-or-nothing approach to meaningful use. **To realize the full potential of EHRs, requirements of the program need to be less prescriptive to allow clinicians to creatively incorporate technology into their unique clinical workflows and to respond to their patient needs.**

Hardship Exemptions

In our RFI comments, we requested that CMS preserve and expand exemptions for clinicians that lack control over EHR adoption decisions. Many challenges that our members currently face related to EHRs have to do with their lack of control over the systems used in their practice. Even when they do have some control over these systems, they often face the larger challenge of convincing EHR vendors to adopt necessary functionalities without charging exorbitant fees.

Under the EHR Incentive Program, hospital-based clinicians and those facing a significant hardship were exempted from being a meaningful EHR user. Under MIPS, these hardship exemptions would not apply to the ACI performance category. However, CMS instead proposes to assign a weight of zero to the ACI performance category for the following clinicians:

- *Hospital-Based MIPS Eligible Clinicians.* Similar to the definition of a hospital-based EP CMS established for the EHR Incentive Program, CMS proposes to define a "hospital-based MIPS eligible clinician" as a MIPS eligible clinician who furnishes 90% or more of his or her covered professional services in inpatient hospital or emergency room settings in the year preceding the performance period.
- *MIPS Eligible Clinicians Facing a Significant Hardship,* defined as:
    - A clinician who is classified as a non-patient facing MIPS eligible clinician (based on the number of patient-facing encounters billed during a performance period)
    - Insufficient Internet Connectivity
    - Lack of Control over the Availability of certified EHR technology
    - Lack of Face-to-Face Patient Interaction
- *Clinicians Previously Not Eligible to Participate in the Medicare/Medicaid EHR Incentive Programs:* Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and CRNAs

As noted earlier, AAHPM supports CMS using its authority to reweight a performance category to zero when hardships exist. We also appreciate CMS's proposal to not hold newly eligible clinicians accountable under this performance category and to maintain the carve-out for hospital-based clinicians. However, we encourage CMS to reduce the threshold for hospital-based services from 90% to 75% under MIPS. We also request that CMS clarify how it intends to apply the hospital-based definition to group practices.

Interoperability and HIT Standards

We remind CMS that the regulatory framework currently guiding meaningful use of EHRs must be revised to eliminate obstacles to technological innovation, enable interoperability, and improve usability to meet the needs of patient care and reduce the burden of excessive data collection requirements.

One particularly significant barrier to the development of more appropriate measures for our field has been the ongoing lack of a standard lexicon to define aspects of palliative medicine for purposes of quality improvement. **AAHPM urges CMS to invest in the development of a dictionary of data elements needed to ensure accurate and coordinated palliative care quality measurement.** The 2014 IOM report

"*Dying in America"* recognized that, in order to better understand and improve the care received by those at the end of life, we need better information about dying—not just about the demographic characteristics and health conditions of those who die, but also about their quality of life as they cope with declining health, the quality of the health care provided to them during this time, and the quality of their death. The ability to better capture this data would serve many other specialties, beyond HPM, and could drive patient-centered and family-oriented quality care. As we have expressed numerous times in the past, most EHRs still do not capture much of what is needed to measure palliative care quality. Incentive programs to develop standardized data elements and corresponding quality measures in partnership with large electronic medical record vendors (EPIC, Cerner) and other government agencies would spur this development.

MIPS Performance Category: Clinical Practice Improvement Activities

Attestation and Scoring

In order to achieve the highest potential score in this category, CMS proposes that individual clinicians and groups must achieve a total of 60 points. CPIAs are categorized as high-weighted CPIAs (20 points each) and medium-weighted CPIAs (10 points each), and clinicians can choose any combination to achieve the maximum score. Those who select less than the designated number of CPIAs will receive partial credit based on the weighting of the CPIA selected. For clinicians and groups that are small or located in rural areas or geographic Health Professional Shortage Areas, CMS proposes that only two CPIAs would be required (either medium or high) to achieve the highest score of 100% in this category, and that only one CPIA would be required to achieve a 50% score.

AAHPM continues to view this supplemental component of MIPS as an invaluable opportunity to demonstrate our specialty's commitment to higher quality and higher value care in a way that is not possible under the current system. We very much appreciate that CMS is proposing an annual attestation process for the first year of MIPS and that clinicians would only be expected to engage in CPIAs for a minimum of 90 non-consecutive days. We also are glad to see that CMS has proposed an inventory of over 90 varied activities from which a clinician could choose and that CMS has not imposed any minimum requirements in regards to selecting activities from specific CPIA subcategories. These policies will ensure greater flexibility and permit clinicians to choose activities that are most relevant to their practice. Finally, we appreciate CMS making accommodations to ease the reporting burden for small and rural clinicians. We strongly urge CMS to maintain all of these policies beyond the first year of MIPS.

One aspect of CMS's proposal that we do not favor is the decision to assign different weights to different activities. We continue to believe that all CPIAs, regardless of subcategories, should be weighted equally while experience with this category is gained.

Specific Activities

As noted earlier, we very much value patient experience, but do not necessarily believe it is appropriate to include in the quality performance category of MIPS. As such, we were pleased to see that CMS's proposed CPIA inventory includes multiple options to recognize efforts to improve patient experience, including:

- Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.
- Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.
- Collection and follow-up on patient experience and satisfaction data on beneficiary engagement.

We also appreciate that multiple CPIAs would recognize clinician participation in a QCDR, including:

- Participation in a QCDR, demonstrating performance of activities for promoting use of patient-reported outcome (PRO) tools and corresponding collection of PRO data (e.g., use of PQH-2 or PHQ-9 and PROMIS instruments).
- Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.
- Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.

We urge CMS to maintain the QCDR-related activities, but to more broadly define them so that they recognize participation in a local or institution-based clinical data registry, even if it is not considered a QCDR (currently, only one CPIA is worded that way).

We also appreciate that CMS's proposed inventory of activities includes:

- Participation in designated private payer clinical practice improvement activities.
- Proactively manage chronic and preventive care for empaneled patients that could include advance care planning.

Other CPIAs that we would still like to see incorporated into CMS's list include:

- Adherence to one or multiple Measuring What Matters metrics (for more information, see: http://aahpm.org/quality/measuring-what-matters)
- Documented adherence or reliance on *Choosing Wisely* recommendations
- More specifically improving advance care planning documentation
- Pain/dyspnea management
- Coordinating or participating in interdisciplinary education efforts to disseminate basic palliative care skills, such as communication, symptom management and inter-professional collaboration
- Physician attendance and participation in ACGME-accredited events (such as AAHPM's annual conference). In conjunction with the Patient Quality of Life Coalition, we request that this activity be weighted as high in the CPIA performance category.
- Fellowship or other advanced clinical training completed during a performance year
- Physician practice accreditation, such as accreditation achieved by the National Committee for Quality Assurance (NCQA) or other recognized accreditation organizations (beyond the Patient-Centered Medical Home).
- Implementation of palliative care training, focusing on what palliative care is and the specific patient needs that could trigger a palliative care referral.

H. Public Reporting

Despite comments opposing CMS's current strategy for public reporting, MACRA facilitates the continuation of the phased approach to public reporting by requiring the Secretary to make available on the Physician Compare website, in an easily understandable format, individual and groups performance information, including:

- The MIPS eligible clinician's CPS;
- The MIPS eligible clinician's performance under each MIPS performance category (quality, resource use, CPIA and advancing care information);
- Names of eligible clinician's in Advanced APMs and, to the extent feasible, the names of such Advanced APMs and the performance of such models; and

- Periodically post aggregate information on the MIPS, including the range of composite scores for all MIPS eligible clinician's and the range of the performance of all MIPS eligible clinician's with respect to each performance category.

AAHPM supports efforts to assist patients and consumers with healthcare decision-making, but **we reiterate our concern about releasing too much data too rapidly since it could have the unintended effect of confusing and even misleading the public.** We request that CMS approach public reporting carefully and deliberately by continuing its strategy of first evaluating which measures are most appropriate for public reporting and then testing the release of those measures to determine which reporting formats are most meaningful to both physicians and the public. CMS also should evaluate to what extent the public is using the data for decision-making. AAHPM supports CMS's decision to maintain its current policy of only making available to the public measures that prove to be valid, reliable, and accurate upon analysis; that are deemed to be statistically comparable; that meet a minimum sample size of 20 patients; and that are not first-year measures.

It is absolutely critical that CMS work closely with professional societies and their clinical experts throughout this process and to be as transparent as possible regarding the outcomes of these analyses. AAHPM also requests that, in instances where insufficient performance data exists, CMS provide clear disclaimers explaining why certain physicians lack relevant measure data and why this should not be interpreted as an indicator for poor performance.

I. Feedback Reports

Under MACRA, CMS is required, at a minimum, to provide clinicians with timely (e.g., quarterly) confidential feedback on their performance under the quality and resource use performance categories beginning July 1, 2017. CMS has discretion to provide such feedback regarding the CPIA and ACI performance categories. With this authority, CMS proposes to initially include in the feedback reports information on quality and resource use only. CMS will distribute the first performance feedback reports by July 1, 2017. As this is prior to CMS having received any MIPS data, CMS proposes to initially provide feedback using historical data set (e.g., CY2015 or CY2016 data) as a baseline, as available and applicable. Within these performance categories, CMS proposes to use fields similar to those currently available in the QRURs. As technically feasible, CMS plans to provide data fields such as the CPS and each of the four performance categories in future performance feedback once MIPS data becomes available. In addition, it plans to explore the possibility of including the MIPS adjustment factor in future feedback reports.

Since CMS's feedback reports are confidential and intended to assist clinicians with tracking their performance and managing deficiencies throughout the reporting period, AAHPM recommends that CMS be as transparent as possible by providing data on as many performance categories as is feasible. While we recognize that too much information can confuse and overwhelm a clinician and strongly urge CMS to continue to work with clinical stakeholders to make reports more user-friendly, clinicians should at least have the opportunity to access a complete snapshot of their ongoing performance data if they so choose. To minimize confusion, we recommend that CMS make certain those portions of data (e.g., data about Advancing Care Information performance to date) available as supplemental materials or appendices so that it does not detract from the main report. CMS also should include clear disclaimers about the limitations of these data, how it might not yet accurately represent final performance in a category, and how CMS is working with stakeholders to address how best to present these data.

CMS proposes to initially make performance feedback available using a CMS designated system, such as a web-based portal and, if technically feasible, perhaps an interactive dashboard. Given CMS's decision to

rely on historic data, CMS proposes to provide feedback on an annual basis, at a minimum for the first year. As the program evolves, and CMS can operationally assess/analyze the MIPS data, it may in future years consider providing performance feedback on a more frequent basis, such as quarterly. AAHPM supports efforts to provide clinicians with data in as real a time as possible but, at the very least, on a quarterly basis since feedback can meaningfully guide improvements in practice.

We would also like to remind CMS of ongoing challenges that our members face when trying to access these reports. Individual physicians practicing in larger group practices, institutions, or health systems are typically not even aware of these reports and, even when they are, it is often difficult to secure access to the reports from administrators. While we appreciate CMS's efforts to keep these reports secure and confidential, this process should not result in the diversion of valuable time away from the patient nor should it preclude the very physicians who are being evaluated from accessing the reports.

Overall, feedback reports must balance comprehensibility with usability and should provide clear guidance on where/how a physician could intervene to decrease costs or improve quality. Simply sharing large amounts of data with clinicians who do not have database personnel to parse the information into a useful format is of limited efficacy. We appreciate ongoing efforts to improve the readability of these reports, but remind the agency that all the fixes in the world will not make inherently flawed measures more comprehensible or meaningful. A large part of improving these reports will be improving the underlying measures and performance calculation methodologies.

II. ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)

Below we address the specific proposals CMS makes regarding the Advanced APM incentive payment. However, we would generally like to state that while we recognize the strategy of a short-term focus on 'shared savings' models that ties physician risk to anticipated savings to the program, we also firmly believe that a sustainable physician payment model cannot rest solely on expectations of specific cost reduction tied to individual practice performance. As a result, we urge CMS to begin planning a transition to payment models that adequately support services that deliver high-value care to individual beneficiaries and populations. The Hospice and Palliative Medicine (HPM) community has significant experience in evidence-based delivery models that achieve these goals, and AAHPM would welcome the opportunity to work closely with CMS to help inform APM development relevant to our field.

A. Advanced APM Criteria

MIPS-Comparable Quality Measures Criterion

CMS proposes that the quality measures on which the Advanced APM bases payment must include at least one (1) of the following types of measures:

- Any of the quality measures included on the proposed annual list of MIPS quality measures;
- Quality measures that are endorsed by a consensus-based entity;
- Quality measures developed under section 1848(s) of the Act (i.e. quality measures as part of the Secretary's Quality Measure Development Plan)
- Quality measures submitted in response to the MIPS Call for Quality Measures; or
- Any other quality measures that CMS determines to have an evidence-based focus and be reliable and valid.

CMS notes that it believes that quality measures that are endorsed by the NQF would meet these criteria. CMS also proposes to establish an Innovation Center quality measure review process for those measures that are not NQF-endorsed or included on the final MIPS measure list.

AAHPM supports the CMS proposal related to the quality measure criterion for Advanced APMs as we believe it provides the flexibility needed in APM design to select the most appropriate measures needed to measure quality of the care delivered to patients in the context of that APM. We would like to add that AAHPM and the Hospice and Palliative Nurses Association have convened several multi-disciplinary consensus panels dedicated to choosing measures for our field that are meaningful to patients and families, actionable, and have potential impact for internal quality improvement. (For more information, see Measuring What Matters at http://aahpm.org/quality/measuring-what-matters.) We have asked Hospice and Palliative Medicine programs to select measures from our list on a voluntary basis, so that there are some common core issues being measured across programs. We will subsequently work towards helping programs recommend the measures for broader measurement project opportunities within their health systems. We believe that these activities will begin to provide the basis for hospice- and palliative-based measures that can be used in the context of APMs, and we believe that the criteria CMS sets forth for quality measurement in Advanced APMs allows for the inclusion of such measures.

Additionally, **AAHPM requests that CMS include measures reported through a Qualified Clinical Data Registry (QCDR) among the criteria for payment through an advanced APM.** QCDRs represent a viable opportunity for the provider community to establish measures that drive quality and value for the patients they serve, and will be among the portfolio of activities we engage with interdisciplinary leaders in our field to provide CMS with meaningful metrics.

Financial Risk Criterion

CMS proposes to define financial risk so that APMs meeting the Advanced APM criteria must include downside risk. CMS declined to adopt a standard whereby the criterion is met using a measurement of the time and money commitments required to implement an APM. **AAHPM requests that CMS reconsider its decision to not include time and start-up costs as part of the financial risk assessment**. There are many financial risks that can be more than nominal but not accounted for in the proposed rule, including:

- Start-up costs to get the APM off the ground, such as data collection and analysis, and establishing procedures for coordinating care and sharing information;
- Ongoing costs for new employees such as care managers, social workers and other licensed and non-licensed professional caregivers;
- Foregone revenue from billable services that are reduced under an APM due to use of appropriateness guidelines and efforts to reduce exacerbations of patients' conditions requiring emergency department visits and hospitalizations.

A practice may incur these costs with the goal of recovering them through savings on other services, but if the savings are not achieved elsewhere, the practice will suffer losses that may threaten not only its ability to transform sufficiently to participate in an APM, but its very viability. That can be a significant financial risk to the practice even if the practice is not required to make a payment to CMS.

As a result, practices will risk significant losses if payments through the APM are not enough to cover both practice investments necessary to deliver value, as well as reduced fee-for-service revenues. CMS requests comments on how it could potentially create an objective and meaningful financial risk criterion that would define financial risk for monetary losses based on performance under the APM differently. The practice could be saving money for Medicare by reducing hospital admissions and expensive tests and procedures, but still be losing money for the practice. We believe that the definition of more than nominal

financial risk should be must include the expenditure of resources required to implement an APM that is going to generate savings to the Medicare program overall. Physicians will be much more willing to take accountability for costs that they can affect through their own performance, such as the costs of preventable complications, than they are to take on risk for the total cost of care for a large patient population. Financial risk should be defined in a way that allows physicians to take accountability for the services they can truly influence instead of requiring physicians to take responsibility for total Medicare spending on every health problem and service their patients receive. Also, it is important that CMS allow sufficient time to achieve savings goals and not expect them to be reached in year one.

In addition, CMS's proposed financial risk criterion would apply to the design of the APM financial risk arrangement between CMS and the participating APM Entity (i.e., if the structure of the arrangement meets the proposed financial risk requirement, then the criterion has been met). The proposal does not impose any additional performance criteria related to bearing financial risk (i.e., Eligible Clinicians under an Advanced APM Entity do not need to bear any risk under the APM so long as the APM Entity bears that risk). **AAHPM strongly supports the evaluation of the financial risk criterion at the level of the APM Entity, not the individual practitioner, and urges that performance (for purposes of payment) be measured over multiple years.** Given the variation we are likely to see in designs of APMs and physician participation options going forward, we believe evaluating the model design overall and over time is the best way to ensure that CMS policies encourage flexibility in model design as we collectively seek to expand APM participation options in the future.

B. Qualifying Participant (QP) Determinations

Unit of Assessment

In determining whether Eligible Clinicians qualify for QP status in order to receive the Advanced APM Incentive Payment, CMS proposes that an Eligible Clinician's QP status for a given payment year would be based on a collective evaluation of a group consisting of all Eligible Clinicians participating in an Advanced APM Entity. **AAHPM is extremely supportive of the CMS proposal to assess QP status collectively for the Eligible Clinicians participating in an Advanced APM.** Hospice and Palliative Medicine physicians have a long tradition of providing interdisciplinary team-based care. The team-based approach is reflected not only in the direct patient care that is provided to patients with serious illness, but also in the large investment in infrastructure that must be made to provide high-quality care to beneficiaries with serious illness. In much the way that primary care medical homes invest in information technology, training, and accreditation, HPM practices must ensure that the infrastructure exists to efficiently provide team-based care to patients with significant care needs. This also requires a strong commitment to interdisciplinary community-anchored care, which includes coordination with a patient's primary care or treating physicians, hospital and facility teams, and home care providers. We have long believed that for hospice and palliative medicine episodes of care, responsibility for care quality and resource use should not be assigned to individual physicians, but rather to appropriate teams that work to meet patient and caregiver needs. We believe that the CMS decision to collectively assess the QP status of all participating Eligible Clinicians supports this concept.

Revenue and Patient Count Methodologies

Proposal to Include Patient Count Methodology

CMS proposes that CMS would calculate Threshold Scores for Eligible Clinicians in an Advanced APM Entity under both the payment amount and patient count methods for each QP Performance Period. CMS proposes that CMS would assign QP status using the more advantageous of the Advanced APM Entity's two scores. In response to the RFI, we stated that we believe eligible physicians should retain the option to use the patient approach to calculating the share of their Medicare "business" that is attributable to

one or more APMs, instead of the revenue approach. Therefore, **AAHPM supports CMS' proposal to include and calculate both the revenue and patient count methodologies for QP determination, and use the most advantageous calculation.** Reporting the proportion of patients who are being managed within an APM may be a more patient-centered approach than summing up revenues from the services physicians provide. In some cases, it may be simpler to determine what proportion of a physician's patient population has conditions or episodes covered by APMs than to calculate revenues attributable to APMs. However, if specific APMs are designed around higher-cost conditions—such as those experienced by many patients through end-of-life—some physicians may be more likely to meet the MACRA thresholds using the revenue approach. For these reasons, we applaud CMS' decision to include both QP threshold options. Given that two of the main objectives of MACRA were to create an incentive to participate in APMs and to move payments toward more value-driven methodologies, we believe including the patient count methodology is an important proposal.

All Payer Advanced APM Combination Option

Under the QP revenue and patient count threshold proposals related to All Payer Advanced APM Combination Option, CMS proposes that APM Entities and/or Eligible Clinicians must submit certain information for CMS to assess whether other payer arrangements meet the Other Payer Advanced APM criteria and to calculate Threshold Scores and QP determination under the All-Payer Combination Option. In addition, CMS will ask each payer to attest to the accuracy of all submitted information including the reported payment and patient data. CMS proposes that if a payer does not attest to the accuracy of the reported payment and patient data, these data will not be assessed under the All-Payer Combination Option. Because this requirement leaves Eligible Clinicians dependent on payer behavior well outside their control, CMS seeks comment on alternatives to requiring payer attestation, such as addressing the scope and intensity of audits to verify the submitted data.

As we stated in our response to the RFI, **AAHPM believes physicians should be able to attest to their non-Medicare payer revenue and patient counts associated with participation in an Advanced APM, and the process for submitting this information should not add administrative burdens to APM participants**. Given the safeguards that CMS has in place with audits and other enforcement mechanisms that monitor the validity of data submitted, we believe that CMS should make the Other Payer revenue and patient count attestation process the least burdensome as possible.

C. Advanced APM Incentive Payments

CMS proposes to make APM Incentive Payments to the TIN that is affiliated with the Advanced APM Entity through which Eligible Clinicians meet thresholds during the QP performance period. From an operational standpoint, we understand the rationale behind this proposal. However, **AAHPM remains concerned by CMS's decision to not include any requirements that such APM entities demonstrate meaningful participation in governance by physicians, regardless of whether the APM Entity is a physician-owned organization**. APM Entities could include physician practices, independent practice associations, physician-hospital organizations and other organizations. This will be particularly true as physician-focused payment models (PFPMs) approved by the PFPM Technical Advisory Committee (PTAC) come online. However, if the organization is a hospital or other entity that is not physician-owned, then AAHPM believes it should be required to provide a means for physicians to influence the governing policies of the organization, such as through CMS-mandated requirements for significant practicing physician representation on the governing board, particularly given that CMS proposes to make the incentive payment directly to the TIN rather than to the Eligible Clinicians whose performance generates the payment.

We also believe that the methods that an APM Entity uses to distribute APM incentive payments to the physicians and other health professionals participating in the APM should foster collaboration among the team, not competition or conflict. While we appreciate that, in the proposals to establish criteria for Advanced APMs and QP status determinations, CMS tries to avoid micromanaging the APM development process, we strongly believe APM incentive payments must be paid in large part to the clinicians and practices who are fundamentally transforming their practices to value-based care delivery. If the payment does not make its way to the participants, it will not serve as an incentive to the Eligible Clinicians at all. Therefore, **AAHPM requests that, at the very least, CMS should direct existing models that CMS has proposed to qualify as Advanced APMs to articulate how they would distribute potential Advanced APM incentive payments so that Eligible Clinicians can make informed participation decisions.**

III. PHYSICIAN-FOCUSED PAYMENT MODELS (PFPMS)

PTAC and CMMI Interaction

In the proposed rule, CMS states that MACRA does not require PFPMs to meet the criteria to be an Advanced APM for purposes of the incentives for participation in Advanced APMs. Therefore, CMS does not propose to define PFPMs solely as Advanced APMs. CMS states that stakeholders may propose either Advanced APMs or other PFPMs that might lead to better care for patients, better health for communities, and lower health care spending. CMS received many responses recommending that all proposed PFPMs selected for testing by CMS should not be subject to the additional criteria for Advanced APMs. CMS replied that MACRA makes a clear distinction between APMs and Advanced APMs; as a result, CMS does not believe the statutory requirements for Advanced APMs can or should be waived for proposed PFPMs. **AAHPM continues to disagree with this extremely narrow perspective.** For MACRA to succeed in reforming the delivery of care and improving value for patients and the Medicare Trust Funds, CMS must be willing to give serious consideration to proposed PFPMs that are supported by PTAC. Further, we continue to believe that **CMS should establish an easy pathway for PFPM proposals to be adopted as Advanced APMs. The regulations should also make it clear that PFPMs that are recommended by the PTAC will be accepted by CMS.**

While we appreciate that CMS recognizes that both stakeholders and the PTAC may want to discuss in their proposals, comments, and recommendations, respectively, whether a proposed PFPM would be an Advanced APM, **we believe that CMS must make a more concerted effort to ensure that the resources stakeholders put into the development of PFPMs have a fair chance of being evaluated as an Advanced APM for purposes of potential access to the APM incentive payment.**

PTAC Submission Review Criteria

We have encouraged CMS to be flexible as it considers requirements for model design and delivery reform. Hospice and Palliative Medicine providers deliver high-value services to many of the sickest Medicare beneficiaries in a wide variety of settings and practice models. AAHPM is generally supportive of the proposed PTAC review criteria. However, we continue to strongly urge CMS to include HPM providers in any and all APMs related to serious, life-limiting conditions or episodes and to adequately pay for the services necessary to provide beneficiaries the best care possible. **We encourage CMS to add questions related to whether a model submitted to PTAC considers the inclusion of Hospice and Palliative Medicine providers or, at a minimum, how it will deliver care to patients with serious, life-limiting illness.** We believe it is important to include this because the PFPM review criteria should explicitly support coordinated systems of care and remove siloes of care that have been built up over the years and which have become obstacles to quality improvement and resources use management.

AAHPM also requests CMS consideration of the following comments related to the PTAC submission review criteria proposals:

- CMS proposes to include criterion that the PFPM must either aim to solve an issue in payment policy not addressed in the CMS APM portfolio at the time it is proposed, or include in its design APM Entities who have had limited opportunities to participate in (e.g. because one has not been designed that would include physicians and practitioners of their specialty). Additionally, CMS proposes that a proposed PFPM that includes multiple specialties may meet the PFPM criteria where a minimum of one of the specialties in the proposed PFPM is not currently being addressed by another APM. CMS states that it believes this reflects the intent of MACRA where it specifically directs the Secretary to establish PFPM criteria, including models for specialist physicians. **AAHPM supports this criterion as well as the flexibility that CMS allows in proposing that the model need not be solely focused on the area in which a gap has been identified.** We believe that APM participation options for HPM providers have been limited to date. We are encouraged by the focus on PFPMs and the opportunity it provides to increase APM participation in Hospice and Palliative Medicine. We believe this criterion encourages submission of models that would address the APM participation gap facing providers in our field.

- CMS proposes a category of criteria that promote payment incentives for higher-value care, including paying for value over volume and providing resources and flexibility necessary for practitioners to deliver high-quality health care. CMS proposes a criterion that PFPMs should provide incentives to practitioners to deliver high-quality health care. CMS also proposes a criterion that the PFPM proposal must pay APM Entities under a payment methodology that furthers the PFPM Criteria. **AAHPM generally supports these criteria**.

  Much of the focus on physician payment reform to date has been on three kinds of models: accountable care organizations, bundled payments for hospital-based episodes, and patient-centered primary care medical homes. Regarding what PFPMs might look like in the context of Hospice and Palliative Medicine, we believe it is likely that episode-based payments that include HPM might have more logical inclusion in episode-based payment models related to complex and chronic disease management. However, **AAHPM would ask the PTAC and CMS to be cautious in its approach to procedural episode-based payments.** We understand the inclination to think of these episodes in the context of particular medical conditions. Because of the nature of Hospice and Palliative Medicine, it would likely not make sense to include these services in procedural bundles, even in the context of certain conditions, because of the variation in when those services are actually utilized and appropriate. Instead, we believe it is better to structure episodes involving HPM as a separate bundle that commences once those services are necessary, rather than including them in a more general condition-specific bundle. We can envision a subset of "Hospice and Palliative Medicine" episodes of care that focus on particular conditions. For example, a chronic obstructive pulmonary disease Hospice and Palliative Medicine-focused episode, congestive heart failure Hospice and Palliative Medicine-focused episode, or advanced cancer Hospice and Palliative Medicine episode could make strong candidates for this type of initiative. In addition, community-dwelling patients with dementia show higher rates of unmet needs and hospitalizations and thus could make good candidates for an episode-based payment.

- CMS proposes a category of criteria that address care delivery improvements that promote better care. Specifically, CMS proposes criteria to address integration and care coordination, patient choice, and patient safety. **AAHPM supports these criteria and, because these components are so critical, we believe that PFPM adherence to these criteria should be assessed in the context of the model's proposed quality measures**. AAHPM believes that quality measures must be

patient-centered and account not only for a patient's diagnosis but their prognosis as well. We are particularly concerned that certain disease-oriented quality measures are not appropriate for all patients, especially those with significant debility near the end of life, and we request that the PTAC consider this in its review of PFPMs. We believe that episode-based payment systems should include quality measures in the following areas:

- Measures that ensure the proper use of advance directives;
- Measures related to identifying and achieving patient goals of care;
- Measures for assessing patient symptom control; and
- Measures that assess patient satisfaction.

In addition, we believe that efforts to incorporate quality measures into episode-based payment models must also involve the work already being done in the development of registries. Promoting registries should be considered a national investment critical to improving health care quality and learning systems. We believe the inclusion of these efforts in the review by PTAC (and subsequently CMS) will help to ensure that the PFPM criteria-related integration and care coordination, patient choice, and patient safety are being met.

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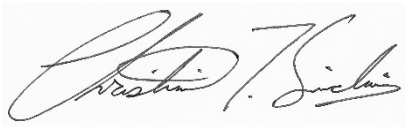
Thank you again for the opportunity to provide feedback on the important issues addressed in this proposed rule. MACRA offers new opportunities for AAHPM to advance its core mission of expanding access of patients and families to high-quality palliative care and advancing the discipline of Hospice and Palliative Medicine. We are eager to collaborate with CMS to address the many challenges discussed here in order to ensure the impact on patients and providers is positive. Please address questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,



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