AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

Submitted electronically via regulations.gov

July 12, 2024

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Alternative Payment Model Updates and the Increasing Organ Transplant Access (IOTA) Model [CMS-5535-P]

Dear Administrator Brooks-LaSure:

On behalf of the more than 5,200 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the Increasing Organ Transplant Access (IOTA) proposed rule referenced above. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, pharmacists, and other health professionals deeply committed to improving quality of life for the expanding and diverse population of patients facing serious illness, as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality, equitable palliative and hospice care.

Summary of Key Messages and Recommendations

- AAHPM supports several aspects of the proposed IOTA model, including CMS' proposal to apply a health equity performance adjustment for the achievement domain of the accountability framework, CMS' proposed transparency requirements, and CMS' proposal to include the CollaboRATE Shared Decision-Making Score in the quality accountability framework.

- AAHPM remains concerned with the use of mandatory models and urges CMS to implement mandatory alternative payment models with caution, as further detailed below.
- To protect against harmful outcomes, CMS should increase the weight of the quality domain such that its weight exceeds the weight of the achievement and efficiency domains, respectively. CMS should also consider stronger quality protections in the first two years, rather than applying pay-for-reporting only.
- CMS should implement clear safeguards to protect against coercion of potential donors and transplant recipients, as well as targeted monitoring to assess the extent to which patients feel pressured to donate or receive kidney transplants.
- CMS should risk adjust quality measures to account for the fitness of donors and recipients, for example to take into account frailty and co-morbidities.
- CMS should monitor the end-of-life experience of deceased donors and their families, as well as those approached for donation who decline, including paying careful attention to those hospitals whose performance scores are bolstered by deceased donor organs.

IOTA Proposals

CMS proposes to implement the IOTA model, a new mandatory organ transplant model specifically focused on kidney transplants. The proposed model would hold kidney transplant hospital participants accountable on three performance domains: achievement (60 points), efficiency (20 points, and quality (20 points). Additionally, the proposed quality domain would be comprised of a post-transplant outcome measure and three quality measures – the CollaboRATE Shared Decision-Making Score, Colorectal Cancer Screening, and the 3-Item Care Transition Measure.

To begin, we agree with the need to improve the organ transplant system, and ***we note our support for specific aspects of the model that we believe will help to promote equity, transparency, and patient-centered care. These include:***

- ***CMS' proposal to apply a health equity performance adjustment for the achievement domain under the accountability framework.*** We agree with the need to provide incentives to reduce disparities in organ transplant rates.
- ***CMS' proposed transparency requirements,*** under which participant hospitals would be required to publicly post, on a website, their patient selection criteria for evaluating patients for addition to their kidney transplant waitlist, as well as to inform Medicare beneficiaries, on a monthly basis, of the number of times an organ is declined on their behalf and the reasons for the decline. These requirements will help to reduce distrust around organ transplant decisions, so we urge CMS to ensure that participant hospitals are compliant with these requirements.
- ***CMS' proposal to include the CollaboRATE Shared Decision-Making Score in the quality accountability framework.*** We believe this tool will generally capture how well care teams engage in understanding what matters most to patients and families.

However, AAHPM is concerned with the mandatory nature of the proposed model, which we believe places participants at significant financial risk regardless of their readiness for participation or their opportunities for success. Additionally, while we recognize that IOTA participants would be hospitals, we take this opportunity to reiterate concerns about mandatory models and the challenges they may pose for physician practices. Successful participation in alternative payment models often requires new infrastructure investments and technical capabilities – for example, sophisticated data management and

analysis capabilities, dedicated resources to continually assess and refine performance, and updates to electronic medical records – along with the development and implementation of new care management practices. Such demands would be challenging, if not impossible, to meet for many practices, especially smaller practices, thereby setting such practices up for failure. ***To the extent that CMS should require future participation in new models for physician practices, AAHPM recommends that CMS apply exemptions or special accommodations for small practices and practices that are inexperienced with value-based payment arrangements, for example only applying upside risk.***

We are also concerned with the incentives that the proposed model may create, particularly given what we see as shortcomings in the model's accountability framework. First, we are concerned that the framework places too much emphasis on the number of transplants without sufficient protections to guard against harmful patient outcomes. Given our members' experience with palliative and end-of-life care, including for patients and families on the donor and recipient sides, we are all too familiar with the potential difficulties that may arise – for example, disagreement about determinations of brain death or inability of donor patients to receive desired end-of-life care. Additionally, we note that, under the current proposal, patients could have very poor outcomes for the first two years, but hospitals would still be eligible to receive bonus payments given the pay-for-reporting structure. ***To protect against harmful outcomes, we recommend that CMS increase the weight of the quality domain such that its weight exceeds the weight of the achievement and efficiency domains, respectively. In conjunction with this approach, we recommend that CMS consider stronger quality protections in the first two years – for example, by assessing performance on additional process measures that would reflect appropriate care delivery, rather than applying pay-for-reporting only.***

We also highlight that the model incentives create significant risk for coercion, including for potential transplant recipients as well as potential donors and their families. ***AAHPM recommends that CMS implement clear safeguards to protect against coercion of patients to donate or receive kidney transplants.*** As one mechanism, ***CMS should administer the CollaboRATE Shared Decision-Making Score measure to patients and families that were offered but did not opt to receive transplants. CMS should also monitor and evaluate the extent to which patients feel pressured under the model to either donate or receive kidneys, including on the part of those who are approached to be living donors but who decline.***

Additionally, we raise concerns related to the fragile state of patients involved in the model – again on both the donor and recipient sides. To begin, ***we believe that quality measures should be risk adjusted to account for the fitness of the donor and the recipient.*** Outcomes may vary widely, for example, based on frailty levels or co-morbidities. Additionally, we note that the experience for families of donors on the verge of death can be particularly challenging, as well as for individuals approached for donation who do not choose to participate. In our members' experience, there is often pressure for families of patients who may be potential donors to choose donation, and such a decision may result in death in the operating room rather than in a palliative care unit. Such an experience for end-of-life care may be distressing for some families, particularly when the impact of a donation decision on end-of-life care experiences is not clearly explained to families. ***CMS should therefore monitor the experience of deceased donors and their families, as well as those approached for donation but who do not donate, including to pay careful attention to those hospitals whose performance scores are bolstered by deceased donor organs.***

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Thank you again for the opportunity to provide feedback on the IOTA Model proposed rule. Please direct questions or requests for additional information to Wendy Chill, Director of Health Policy and Government Relations, at wchill@aahpm.org.

Sincerely,

Vicki Jackson, MD, FAAHPM
President