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Submitted electronically via regulations.gov

June 10, 2024

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

RE: Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Program Requirements; and Other Policy Changes [CMS-1808-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 fiscal year (FY) 2025 Hospital Inpatient Prospective Payment System 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 offers the following key messages and recommendations, which are further detailed in our comments below.

- CMS should add to its distribution framework a method for prioritizing specialties that offer high value and/or demonstrate significant shortage, like HPM.
- AAHPM supports CMS' proposal to include HPM as a psychiatry subspecialty that may qualify for receipt of the reserved psychiatry graduate medical education (GME) positions under the Consolidated Appropriations Act, 2023 (CAA 2023).
- AAHPM raises concerns with the Transforming Episode Accountability Model (TEAM) and urges CMS to implement mandatory alternative payment models with caution, as further detailed below. CMS should also incorporate additional recommended cross-cutting quality measures that assess quality of care for patients with serious illness and evaluate performance on measures well beyond the end of the episode, to identify potential delay of care outside the episode window.

Payment for Indirect and Direct Graduate Medical Education Costs

CMS includes several proposals regarding the distribution of additional Medicare-funded graduate medical education (GME) positions that were authorized under the Consolidated Appropriations Act, 2023 (CAA 2023). AAHPM recognizes that the CAA 2023 includes a number of requirements and limitations to which CMS must adhere. However, we are concerned that CMS' approach will not allow for distribution of the positions in a way that aligns with the nation's evolving healthcare landscape and priorities. Therefore, ***AAHPM urges CMS to consider the need for targeted policies that address both historic disparities in the availability of GME slots and a growing shortage of trained professionals in the field of HPM,*** as we detail further below.

The Value of an HPM Workforce

HPM specialists represent a small but increasingly important segment of the physician workforce who are specially trained to provide high-quality palliative care to a diverse population of patients across a range of healthcare settings. Palliative care focuses on matching treatments to achievable patient goals in order to maximize quality of life from diagnosis to death. In practice, this involves detailed and skilled communication with patients and families to elicit goals and preferences, as well as expert assessment and management of physical, psychological and other sources of suffering across the multiple settings (hospital, post-acute care, ambulatory clinics, home) that patients traverse through the course of a serious illness.

Demand for these skills is expected to increase as the number of people living with serious and complex chronic illness is projected to skyrocket over the coming decades. Such demand is driven by a growing body of medical research that has documented the numerous benefits of high-quality palliative and hospice care for patients and families, for hospitals and payers, and for the healthcare system as a whole. Palliative care is associated with enhanced quality of life for patients, higher rates of patient and family satisfaction with medical care, reduced hospital expenditures and lengths of stay, and other positive outcomes — including longer patient survival time. Hospice care has also been associated with lower costs of care, better outcomes (such as relief of pain), and even longer life, despite its focus on comfort rather than treatment aimed at cure.

The Need to Invest in an HPM Workforce

Delivery of high-quality palliative care cannot take place without sufficient numbers of healthcare professionals with appropriate knowledge and skills. Despite the growing need for palliative care, however, the field has been unable to expand to meet patient and health system demand because of a significant shortage of trained providers.

Looking only at physician specialists, the George Washington University Health Workforce Institute found that current training capacity for HPM specialists is insufficient to provide hospital-based care and keep pace with growth in the population of adults over 65 years old. As of May 2024, there were a total of 185 HPM fellowship training programs accredited by the Accreditation Council for Graduate Medical Education. For the 2024-2025 academic year, these programs have 375 positions filled. This number is far too low, particularly considering the rapid expansion of community-based palliative care, such as in outpatient and home-based settings.

The current HPM physician shortage can be attributed in large part to faulty Medicare policy. Despite the fact that the majority of patients receiving palliative care and hospice services are Medicare beneficiaries, and that HPM has been repeatedly shown to increase value in health care by improving quality while reducing costs compared to usual care, Medicare does not sufficiently invest in the training of HPM physicians. Largely because the Balanced Budget Act of 1997 placed a limit on the number of Medicare-supported residency slots before HPM was formally recognized as a medical subspecialty by the American Board of Medical Specialties, specialty training in HPM has been overly dependent on private-sector philanthropy or institutional support. Given the instability of such funding, this is not a sustainable or rational way to train our nation's HPM physicians.

The addition of new GME positions under the CAA 2023 presents a small but meaningful opportunity to remedy the historic misalignment between Medicare-supported residency positions and the physician workforce needed to support the expanding population of Medicare beneficiaries with serious illness or multiple chronic conditions. To that end, ***AAHPM supports CMS' proposal to include HPM as a psychiatry subspecialty that may qualify for receipt of the reserved psychiatry GME positions under CAA 2023.*** HPM is an important component of psychiatric care, and the prioritization of GME slots for an HPM program accredited with psychiatry as a core specialty will help to build a workforce capable of addressing the needs of patients with serious illness through a psychiatric lens.

As CMS contemplates final policies for allocating the remaining, non-psychiatry GME positions, ***AAHPM also urges CMS to add to its framework a method for prioritizing specialties that offer high value and/or demonstrate significant shortage, like HPM.*** Programs that maintain partnerships at the residency level with HPM fellowship programs – e.g., a surgery residency that includes a paired HPM fellowship track – should also be prioritized in order to support development of much needed skill sets. Such changes would help to build a physician workforce more closely aligned with the nation's evolving healthcare needs and improve care and quality of life for millions of Americans facing serious illness, along with their families and caregivers.

Transforming Episode Accountability Model (TEAM)

CMS proposes to implement the Transforming Episode Accountability Model (TEAM), a new mandatory episode-based payment model that would focus on 5 types of episodes that would cover an initial inpatient admission or outpatient procedure through thirty days after discharge. Hospice services would be included among the costs that participating hospitals would be accountable for during the episode period. Hospitals would also be accountable for performance on up to three quality measures, including measures focused on all-cause readmission, patient safety and adverse events, and – as applicable – total hip and/or total knee

arthroplasty patient-reported outcome-based performance.

AAHPM is concerned with the mandatory nature of the model, which we believe places participants at significant financial risk for factors they cannot control. Particularly under the Medicare fee-for-service program, where beneficiaries may seek out the services of any willing provider without limit, holding participants accountable for managing utilization and spending seems problematic. Additionally, while we recognize that TEAM participants would be hospitals, we take this opportunity to reiterate concerns about mandatory models and the challenges that 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 development and implementation of new care management practices. Such demands would be challenging if not impossible to meet for many practices, especially small practices, thereby setting such practices up for failure. ***To the extent that should CMS 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 episode-based payment models may create – particularly models that are focused on procedures. Such models place undue emphasis on managing the procedures, rather than better managing patients' underlying conditions. Additionally, the short-term nature of episode models creates incentives to push services outside of the episode window. Since hospice services are included in the costs that TEAM participants would be accountable for, we are concerned about the risk of hospitals delaying appropriate hospice care.

Unfortunately, the quality accountability framework included in the TEAM does not provide any lever to protect against inappropriate care for patients with serious illness, including delay of hospice – an issue that we specifically raised in our comments in response to CMS' Request for Information on Episode-Based Payment Models [CMS-5540-NC]. There we recommended that CMS include in any new episode-based payment model cross-cutting quality measures centered on outcomes that matter most to patients with serious illness. These include measures that focus on:

- Patient-reported experience of serious illness care
- Prevention and treatment of symptoms
- Timely and appropriate use of hospice care, and
- Avoidance of potentially preventable hospital stays.

These measure recommendations reflect the work of AAHPM in partnership with the National Coalition for Hospice and Palliative Care, as discussed in more detailed recommendations previously submitted to CMS.

We continue to believe inclusion of these measures is necessary to promote high-quality care and protect patients with serious illness from unintended consequences of incentives created by episode-based payment models. ***We therefore urge CMS to incorporate these measures into TEAM.***

Furthermore, ***we strongly recommend that CMS evaluate performance on these measures well beyond the end of the episode, and at least 90 days after hospital discharge.*** Such an evaluation approach is needed to identify potential delay of care outside the episode window.

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Thank you again for the opportunity to provide feedback on the FY 2025 Inpatient Prospective Payment System 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 MPH FAAHPM