AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1807-P
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments [CMS-1807-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 Calendar Year (FY) 2025 Medicare Physician Fee Schedule (MPFS) proposed rule referenced above. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine (HPM). 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.

Physician Fee Schedule Provisions

- CMS should work with medical societies and Congress to avert the estimated 2.8 percent payment reductions for CY 2025 in the short term and to achieve broader Medicare physician payment reforms that address the structural problems affecting the MPFS for the long term.
- CMS should include specialty code 17, Hospice and Palliative Care, in its specialty impact tables in the MPFS final rule and all future proposed rules going forward. CMS should also update the specialty code description to read "Hospice and Palliative Medicine" rather than "Hospice and Palliative Care."
- CMS should work with Congress to permanently eliminate the geographic and originating site restrictions on Medicare telehealth services, such that patients can continue to receive telehealth services on an ongoing basis, regardless of where they are located in the country, including in their homes.
- We support CMS' proposals to extend the following telehealth and virtual care flexibilities through 2025:
    - To remove frequency limitations for the provision of subsequent care inpatient services, subsequent care skilled nursing facility services, and critical care consultations furnished via telehealth;
    - To continue to permit practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their homes;
    - To continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications; and
    - To continue to allow teaching physicians to have a virtual presence for purposes of billing for services furnished in all teaching settings when the service is furnished virtually.
- We also support CMS' proposals to allow for virtual direct supervision in specified cases, and to allow audio-only communication technology to meet the definition of "interactive telecommunications system" for the purposes of furnishing Medicare telehealth services to patients in their homes.
- CMS should accept for Medicare payment the CPT and RUC recommendations for the telemedicine E/M codes and recognize their status as inherently non-face-to-face services that would not be subject to telehealth restrictions.
- AAHPM supports CMS' proposals regarding caregiver training services (CTS). However, we ask that CMS clarify that CTS services may be furnished by auxiliary personnel incident to the services of a billing practitioner.
- CMS should devise policies that would allow for services comparable to the community health integration (CHI), principal illness navigation (PIN), and social determinants of health (SDOH) assessment services to be furnished by clinical staff under physician supervision in institutional settings. CMS should also explore options to waive patient cost-sharing for such services, including by working with States and with Congress.

- AAHPM supports CMS' proposals to establish advanced primary care management (ACPM) services. However, we recommend that CMS consider expanding the highest-level code to include patients who are homebound. We also encourage CMS to minimize confusion and support appropriate use of care management services through steps further detailed in our comments below.

Merit-Based Incentive Payment System (MIPS) Provisions

- AAHPM strongly disagrees with CMS' plans to sunset traditional MIPS and to fully transition to MIPS Value Pathways (MVPs) on a mandatory basis starting with performance year 2029. We also have concerns with CMS' requirement for mandatory subgroup reporting starting with performance year 2026. If CMS maintains its policy of requiring subgroup reporting, CMS should uphold its precedent of not establishing any restrictions on subgroup formation. CMS should also finalize an exception to mandatory subgroup reporting for small practice TINs.
- AAHPM supports CMS' proposals to add the measure "Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood" (Heard and Understood; Quality ID #495) to several MVPs, including Advancing Cancer Care, Advancing Care for Heart Disease, Coordinating Stroke Care, Optimal Care for Kidney Health, and Neurological Conditions. We also recommend that CMS add Heard and Understood to the Value in Primary Care MVP.
- AAHPM supports the addition of Heard and Understood to the cardiology, geriatrics, and nephrology measure sets. AAHPM further requests that CMS add Heard and Understood to the following additional specialty sets: Clinical social work, Neurology, Pulmonology, and Skilled nursing facility.
- AAHPM recommends that CMS separately add the measure "Receiving Desired Help for Pain" (Help Wanted for Pain; CBE ID #3666) to the MIPS measure inventory.
- AAHPM supports CMS' efforts to prioritize patient-reported outcome measures (PROMs) and patient-reported outcome performance measures (PRO-PMs) in CMS quality reporting and payment programs and CMS Innovation Center Models. However, we emphasize the importance of including patient-reported experience measures (PREMs) under this umbrella of work. We also underscore the need to ensure that CMS does not limit the use of PROMs, PROM-PMs, and PREMs to just those included in the PROMIS repository; rather CMS should support the development and implementation of measures that are more targeted to specific populations, conditions, or specialties, including measures like Heard and Understood and Help Wanted for Pain.
- CMS should finalize its proposals to eliminate the weighting of improvement activities and to reduce the number of activities that must be reported in order to achieve full credit for the Improvement Activities performance category.
- In lieu of CMS' proposal to revise scoring for topped out measures in specialty measure sets with limited measure choice, CMS should consider alternative approaches for identifying specialties and subspecialties with limited measure choice and addressing the struggles they may experience in reaching high performance levels as a result of scoring caps and other related policies.
- In addition to CMS' proposal to apply a complex organization adjustment for virtual groups and alternative payment model (APM) entities that submit electronic clinical quality measures (eCQMs), CMS should expand the availability of bonus points to all eCQM reporters, and in particular to small practices. CMS should further consider broadening the availability of bonus points to include reporting via other reporting mechanisms when data are abstracted from an electronic health record.

- AAHPM appreciates CMS' proposal to modify the scoring methodology for the cost performance category.
- CMS should finalize its proposal to maintain the MIPS performance threshold at 75 points for performance year 2025/payment year 2027.

Request for Information on Building on the MVP Framework to Improve Ambulatory Specialty Care

- CMS should not increase its reliance on MVPs beyond the MIPS program, including in a specialty APM based on MVPs. Instead, CMS should focus on establishing tailored models to drive specialist engagement in value-based arrangements, and in particular should pursue a specific model allowing for increased coverage of and access to community-based, team-based palliative care services to support patients with serious illness. Additionally, CMS should take caution in expanding the use of mandatory models to physician practices, and in particular apply exemptions or special accommodations for small practices and practices inexperienced with value-based payment arrangements.

Medicare Physician Fee Schedule Provisions

CY 2025 Conversion Factor

CMS estimates that the CY 2025 conversion factor (CF) will be $32.3562. This reflects a reduction of 2.8 percent relative to the CY 2043 CF – a decrease driven by the elimination of Congressional assistance provided for 2024 under the *Consolidated Appropriations Act, 2024*. Notably, assuming no Congressional intervention, 2025 will be the fifth year in a row that physician payment rates will decrease under the MPFS.

AAHPM continues to be deeply troubled by this ongoing erosion of payment for Medicare physician services – a trend that devalues the role that physicians play in promoting the health and well-being of Medicare beneficiaries year over year. It also fails to adequate compensate physicians for the costs that they incur, as annual payment updates do not account for inflation in practice expense costs. To illustrate, between 2020 and 2025, the conversion factor will have ***decreased*** by 10.3 percent under CMS' current estimate, while the Medicare Economic Index (MEI) – which reflects physician practice cost inflation – will have ***increased*** by 21 percent, a rate that accounts for the historically high levels of inflation seen in recent years. This disparity between changes in physician costs versus changes in payment is inexcusable and unsustainable. Indeed, the Medicare Trustees highlight this same dynamic, where payment updates are not expected to keep pace with physician cost increases; absent a change, the Trustees note that they "expect access to Medicare-participating physicians to become a significant issue in the long term."

AAHPM recognizes that the limitations on conversion factor growth stem from structural problems with the statutory formulas for updating payments under the MPFS, including the fact that payment updates are not tied to any indicators of inflation – unlike updates received for almost every other Medicare payment system – and that changes in relative value units (RVUs) are subject to budget neutrality adjustments. Especially as CMS has sought to balance out PFS payments to place greater emphasis on cognitive services in recent years – a change that AAHPM has supported – the outsized budget neutrality adjustments have been particularly damaging to physician payment rates and have furthermore undercut much of the gains for cognitive specialties that the RVU changes have been intended to produce.

Troublingly, physicians are still paying the price for budget neutrality adjustments that were required as a result of changes in coding, valuation, and payment for office and outpatient (O/O) evaluation and management (E/M) services finalized for CY 2021.

Consistent with the American Medical Association and numerous other specialty societies and state medical associations, AAHPM continues to believe that fundamental reforms are needed in how Medicare physician payment updates are made. In particular, AAHPM believes annual PFS conversion factor increases tied to changes in the MEI – as included in H.R. 2474, the Strengthening Medicare for Patients and Providers Act – are critical for ensuring that payments keep pace with costs. ***AAHPM therefore urges CMS to work with medical societies and Congress to avert the estimated payment reductions for CY 2025 in the short term and to achieve broader reforms that address the structural problems affecting the MPFS for the long term.***

Additionally, AAHPM was again disappointed to see that our specialty of Hospice and Palliative Medicine (as designated by specialty code 17 for Hospice and Palliative Care) is still not included in the specialty impact table in the Regulatory Impact Analysis (e.g., Tables 128 and 129), despite repeated requests over the past several years. The absence of this information hampers our ability to develop fully informed comments in response to CMS' proposals, and we believe it is an oversight that must be remedied. ***We therefore again urge CMS to include specialty code 17, Hospice and Palliative Care, in its impact tables for the final rule, and for all future MPFS proposed and final rules going forward. We also request that CMS update the specialty code description to read "Hospice and Palliative Medicine" rather than "Hospice and Palliative Care;"*** such a change would align the physician specialty code description with the physician subspecialty recognized by the American Board of Medical Specialties.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

As we have previously noted, AAHPM members and their patients have experienced tremendous benefits with the use of telehealth and virtual services, both during the public health emergency for COVID-19 and after. Particularly for the seriously ill patients our members serve, who may experience mobility and/or cognitive limitations, the use of telecommunications technology has facilitated access to timely and high-quality medically necessary care. These patients regularly face challenges in accessing care, including as a result of pain, frailty, or medical instability and reliance on caregivers to assist with transportation. The waiver of Medicare telehealth geographic restrictions and originating site requirements over this time has helped to address these barriers, resulting in substantial benefits for patients, including greater patient access to care teams, more timely assessment and management of pain and other symptoms, and increased ability for care teams to engage in follow-up as medically necessary.

We are therefore troubled by the ongoing uncertainty that our nation faces as Congress continues to deliberate on whether to extend such flexibilities beyond the end of the calendar year. We note that the statutory geographic and originating site restrictions are outdated; do not reflect the current needs and technological capabilities to safely, effectively, and efficiently deliver care; and are not responsive to patient's and providers' preferences for receiving and delivering care with minimal burden. ***AAHPM therefore again urges CMS to work with Congress to permanently eliminate the geographic and originating site restrictions on Medicare telehealth services, such that patients can continue to receive***

telehealth services on an ongoing basis, regardless of where they are located in the country, including in their homes.

We also note that the current lack of clarity about the availability of telehealth on widespread basis complicates providers' ability to engage in long-term planning and investment, and likewise creates hurdles for CMS to implement long-term and forward-thinking policies based on a clear understanding of the future telehealth landscape. Given this landscape, ***we appreciate that CMS has proposed to extend the following telehealth and virtual care flexibilities through 2025***, despite uncertainty regarding Congressional action for the same period:

- *To remove frequency limitations for the provision of subsequent care inpatient services, subsequent care skilled nursing facility services, and critical care consultations furnished via telehealth;*
- *To continue to permit practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their homes;*
- *To continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications; and*
- *To continue to allow teaching physicians to have a virtual presence for purposes of billing for services furnished in all teaching settings when the service is furnished virtually.*

We also appreciate that CMS is proposing to exercise its authority to implement additional flexibilities on a permanent basis, including to allow for virtual direct supervision in the specified cases CMS proposed, where patient safety risks are low, and to allow audio-only communication technology to meet the definition of "interactive telecommunications system" for the purposes of furnishing Medicare telehealth services to patients in their homes. We particularly appreciate ongoing availability of audio-only E/M and advance care planning services, which – when needed to accommodate beneficiaries' inability or unwillingness to utilize video communications – have enabled patients with serious illness to receive timely and efficient care, rather than forego or delay care. For example, these services have enabled physicians and patients to hold discussions about goals of care, treatment options, values, and preferences; allowed for assessment of disease progression and symptoms; and facilitated prescribing of medications and counseling services. We also highlight that reliance on audio-only telehealth services is associated with structural disadvantages that have harmed low-income, rural, and aged populations, such that maintaining availability of audio-only telehealth would serve to advance health equity goals.

We recognize that the audio-only policy would only apply to patients receiving telehealth services in their homes, and that – absent Congressional action that extends the waiver of originating site or geographic restrictions – the ability for patients to receive telehealth services in their homes will be severely restricted. However, we are hopeful that Congress will extend these flexibilities and therefore believe the proposed change regarding the use of audio-only technology is important to establish in advance.

Valuation of Specific Codes

Telemedicine Evaluation and Management (E/M) Services

CMS proposes to not accept recommendations submitted by the CPT Editorial Panel and the Relative Value Scale (RVS) Update Committee (RUC) new coding and valuation for telemedicine E/M services,

identified by CPT codes 9X075, 9X076, 9X077, 9X078, 9X079, 9X080, 9X081, 9X082, 9X083, 9X084, 9X085, 9X086, 9X087, 9X088, 9X089, and 9X090.

AAHPM disagrees with CMS' proposal and believes that the new telemedicine E/M services should be separately valued and paid under the MPFS consistent with the CPT and RUC recommendations. These services are not intended to be furnished as face-to-face services; rather, they are intended to be furnished via communications technology. As a result, we believe they should be treated in a manner consistent with brief virtual check-ins and remote physiologic monitoring services, which are not included on the Medicare Telehealth Services List and not subject to telehealth originating site or geographic restrictions. Such treatment would maintain patient access to virtual E/M services in a manner consistent with flexibilities that have been in place for telehealth E/M services in response to the PHE for COVID-19 – a high priority for the Academy. For these reasons, ***AAHPM urges CMS to accept for Medicare payment the CPT and RUC recommendations for the telemedicine E/M codes and recognize their status as inherently non-face-to-face services that would not be subject to telehealth restrictions.*** We note that such an approach would not eliminate the need for Congress to extend telehealth flexibilities, including, for example, to allow patients to receive advance care planning services via telehealth wherever they are located in the country.

Caregiver Training Services (CTS)

CMS includes numerous proposals related to caregiver training services, including to:

- Establish new coding and payment for caregiver training for direct care services and supports;
- Establish new coding and payment for caregiver behavior management and modification training that could be furnished to the caregiver(s) of an individual patient;
- Allow consent for CTS services to be provided verbally by the patient or representative; and
- Add CTS to the Medicare Telehealth Services list on a provisional basis.

AAHPM agrees that caregiver training is important to patients and families and generally support these proposals. However, we ask that CMS clarify that CTS services may be furnished by auxiliary personnel incident to the services of a billing practitioner, in order to ensure that practice resources can be used most effectively.

Request for Information for Services Addressing Health-Related Social Needs

CMS requests information on the services it previously created to address health-related social needs – specifically the community health integration services, principal illness navigation services, and social determinants of health risk assessments. Among other topics, CMS is interested in feedback regarding any barriers to furnishing the services and if the services allow practitioners to better address unmet social needs that interfere with practitioners' ability to diagnose and treat the patient.

In response to this request, AAHPM raises concerns regarding the ability of academic medical centers and other facility-based provider types to furnish these services, given that regulations specify that services and supplies "must be furnished in a noninstitutional setting to noninstitutional patients" for Medicare to cover the incident to services (42 CFR 410.26(b)). Academic medical centers regularly house palliative

care programs that could otherwise benefit from the availability of these codes; in some areas, palliative care is almost exclusively available out of academic centers. As a result, palliative care practices are unable to utilize these codes to better address the health-related social of the seriously ill patients they serve. *AAHPM therefore recommends that CMS devise policies that would allow for comparable services to be furnished by clinical staff under physician supervision in institutional settings.*

We also highlight the challenges that patients with health-related social needs are likely to experience in paying required cost-sharing amounts. We believe cost-sharing requirements create barriers to care for the patients who would most benefit from these services, leading to their underutilization. *We therefore recommend that CMS explore options to waive patient cost-sharing for these services, including by working with States and with Congress.*

Advanced Primary Care Management Services

CMS proposes to establish and pay for three new advanced primary care management (APCM) G-codes that describe a set of care management services and communications-technology based services (CTBS) furnished under a broader application of advanced primary care. These codes aim to simplify billing and documentation requirements, as compared to existing care management and CTBS codes.

AAHPM thanks CMS for this proposal, which we believe has the potential to significantly reduce complexity and administrative burden associated with billing existing care management codes. Given the number and scope of care management services that are currently available, we welcome efforts to minimize complexity. We also highlight that a small but growing number of palliative care practices are taking on primary care responsibilities for the seriously ill patients they serve, and that we expect this trend to continue, particularly for practices furnishing care in rural areas where access to health care services is limited. As a result, we believe that these codes could increase practices' incentives to develop advanced primary care capabilities, which we believe are aligned with delivering comprehensive, high-quality palliative care to patients with serious illness, and provide a lower-burden way to be reimbursed for establishing such capabilities. To the extent that the primary care needs of our patients with serious illness are managed by advanced primary care practices, we believe these codes would also help those practices reduce gaps in care, thereby supporting better outcomes for our patients.

At the same time, *we recommend that CMS consider expanding the highest-level code to include patients who are homebound.* Homebound patients require significantly more resources to manage given the severity of their conditions and the extent of their functional limitations, as well as the added resources to furnish in-person care as needed in their homes. Including homebound patients in the highest code would recognize these resources and further increase practices' ability to provide comprehensive advanced primary care services to this high-need population.

Additionally, as CMS finalizes its policies for APCM services, *we encourage CMS to minimize confusion and support appropriate use of care management services, including by taking the following steps:*

- *Clarifying that existing care management codes and CTBS can continue to be furnished and paid, including (but not limited to) chronic care management, principal care management, and transitional care management services when APCM services are not billed for a patient.*

- *Clarifying the extent to which APCM codes may be furnished by facility-based practices, which are prohibited from furnishing services on an "incident to" basis.*
- *Providing additional education and training to help organizations understand when and how best to select among the array of care management service options available for managing their patients' care.*

Merit-Based Incentive Payment System (MIPS) Provisions

Request for Information (RFI): Transforming the Quality Payment Program (QPP)

CMS discusses its belief that it could fully transition to MIPS Value Pathways (MVPs) and sunset the traditional MIPS program by performance year 2029. CMS seeks feedback on clinician readiness for MVP reporting, and on policies needed to sunset traditional MIPS and transition to MVPs.

CMS also notes that it previously established that, for 2026 performance onward, a multispecialty group reporting MVPs must form subgroups to report an MVP. CMS seeks input on whether it should specify any parameters for subgroup reporting and whether it should establish an exception for mandatory subgroup reporting for small practices.

AAHPM strongly disagrees with CMS' plans to sunset traditional MIPS and to fully transition to MVPs on a mandatory basis starting with performance year 2029. As we have stated in previous comments, the movement to MVPs fails to address shortcomings in the MIPS program that limit its effectiveness in promoting high-quality, high-value care for Medicare beneficiaries. For example, performance across the performance categories remains siloed, leading to disjointed efforts to meet individual performance category requirements rather than enabling a comprehensive approach to delivering well-coordinated, patient-centered, accountable care. Additionally, too often, there is little to no linkage between the quality and cost measures included in the MVPs – a linkage that is critical for determining value as well as avoiding inappropriate stinting of care. We also believe that MVPs should be more patient-centered, not provider-centered, and that they should place greater focus on the experience of the patient across the care continuum.

Even if MVPs did not suffer from these limitations, however, we also highlight the limited availability of quality and cost measures in the MIPS program that are relevant to palliative care. While we appreciate that CMS is proposing to add the only palliative care measure in the MIPS program – "Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood" (Quality ID #495) – into several MVPs (as we discuss later in this letter), we remain concerned that MVPs do not provide sufficient opportunity for our members to meaningfully engage in and be assessed on MVPs. Without such opportunities, we find it difficult to understand how CMS intends to fully transition away from traditional MIPS and require MVP reporting.

We also continue to have concerns with CMS' requirement for mandatory subgroup reporting, which we worry will increase burden and promote more disjointed care, rather than support holistic, patient-centered care. This is particularly true for patients with serious illness, whose care needs span across specialties and provider types. While hospice and palliative care clinicians play an important role in managing patients' care experience, there are numerous other primary and specialty care providers who will contribute to a given patient's journey with serious illness and who will determine whether that patient ultimately meets or exceeds their goals of care. *If CMS maintains its policy of requiring subgroup*

reporting starting in 2026, AAHPM encourages CMS to uphold its precedent of not establishing any restrictions on subgroup formation. We believe this approach will maximize subgroups' ability to furnish and be held accountable for team-based care. *We would also support an exception to mandatory subgroup reporting for small practice TINs, as CMS contemplates*, as subgroup reporting would require unnecessary investments in staff time and practice infrastructure for small practices to successfully report, taking resources away from patient care.

MVP Proposals

AAHPM supports CMS' proposals to add the measure "Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood" (Heard and Understood; Quality ID #495) to several MVPs, including:

- *Advancing Cancer Care*
- *Advancing Care for Heart Disease*
- *Coordinating Stroke Care*
- *Optimal Care for Kidney Health*
- *Neurological Conditions*

Heard and Understood is the result of a coordinated effort by AAHPM, the National Coalition for Hospice and Palliative Care (Coalition) and RAND Health, under a CMS-awarded cooperative grant, to develop a measure that offers patients living with serious illness, their families, and caregivers a way to share feedback about the desired care they receive, as well as one that enables physicians, health systems, and payers to better understand how well the care they provide meets patients' needs and preferences. While other patient-report experience measures exist, Heard and Understood represents the first measure to focus on palliative care in physicians' offices and clinics.

AAHPM believes that the above MVPs address the needs of patients with serious illness who would benefit from the patient-centered care and complex shared decision-making conversations that this measure supports, leading us to previously recommend the addition of the Heard and Understood measure to these MVPs. As we have stated, embedding this measure within existing MVPs focused on serious illness would give MVP participants the option to measure whether their patients' needs and preferences are being met. By including the measure in the MVPs as proposed, we also believe that more clinicians would be willing to participate in an MVP since the measures would more accurately reflect their practices and patient populations. We are therefore pleased to see CMS include its proposals to add Heard and Understood to the above MVPs in this year's proposed rule, and we thank CMS for this action.

At the same time, we were disappointed that CMS did not propose to add Heard and Understood to the Value in Primary Care MVP, which we also previously requested. We believe that responsiveness to seriously ill patients' needs and preferences is important in supporting effective team-based care, and that expanding the understanding of primary care to include primary palliative care would help to increase access to palliative care, support more comprehensive primary care, and facilitate delivery of care consistent with what matters to patients. For these reasons, *we again recommend that CMS add Heard and Understood to the Value in Primary Care MVP.*

Quality Performance Category

Quality Measures and Specialty Measure Sets

Consistent with previous requests by AAHPM, CMS proposes to add Heard and Understood to the following specialty measure sets:

- Cardiology
- Geriatrics
- Nephrology

AAHPM supports the addition of the measure to these specialty measure sets and believes that CMS should finalize these changes as proposed.

AAHPM further requests that CMS add Heard and Understood to the following additional specialty sets:

- ***Clinical social work***
- ***Neurology***
- ***Pulmonology***
- ***Skilled nursing facility***

As with cardiology, geriatrics, and nephrology, these specialties provide care to patients with serious illness who would benefit from improved responsiveness to their needs and preferences, and the addition of the measure would offer additional options for physicians in those specialties to meet MIPS reporting requirements.

Finally, ***AAHPM again recommends that CMS separately add the measure "Receiving Desired Help for Pain" (Help Wanted for Pain; CBE ID #3666) to the MIPS measure inventory.*** This patient-reported measure was developed by AAHPM, the Coalition, and RAND Health under the same CMS cooperative grant as Heard and Understood, and it assesses the percentage of patients aged 18 years and older who had an ambulatory palliative care visit and report getting the help they wanted for their pain from their palliative care provider and team. This is a key element of patient and family-centered palliative care, separate and distinct from the concepts captured by Heard and Understood. Including both Help Wanted for Pain and Heard and Understood to the MIPS inventory would allow providers caring for patients with serious illness to be assessed on multiple measures that reflect the quality of medical care that they provide, rather than on cross-cutting measures that are less closely related to the quality of their clinical practice.

RFI on Principles for Patient-Reported Outcome Measures in Federal Models/Quality Programs

CMS discusses its commitment to elevating the patient voice in health care by incorporating more patient-reported outcome measures (PROMs) and patient-reported outcome performance measures (PRO-PMs) in CMS quality reporting and payment programs and CMS Innovation Center Models. CMS also provides an illustrative set of guiding principles that it could consider to advance its goals around the incorporation of PROMs and PRO-PMs, and it seeks feedback on those principles and on approaches for accelerating the development and availability of such measures. In this discussion, CMS elevates the need for a data infrastructure to minimize administrative burden and highlights the availability of the Patient-

Reported Outcomes Measurement Information System® (PROMIS®) as a currently existing, unified, non-proprietary PROM repository.

AAHPM has long advocated for the incorporation of outcome measures into CMS quality programs and alternative payment models, and prioritized patient input in developing care plans, furnishing health care services, and assessing quality of care. Indeed, palliative care is predicated on the notion that services and supports are provided in a manner that aligns with patients' and caregivers' needs and preferences. ***We therefore applaud CMS in its effort to prioritize PROMs and PRO-PMs in CMS programs and models.***

As CMS considers opportunities for elevating the patient voice, we emphasize the importance of including patient-reported experience measures (PREMs) under this umbrella of work. As we note above, AAHPM has developed two PREMs focused on the delivery of palliative care in physicians' offices and clinics: Heard and Understood (Quality ID #495) and Help Wanted for Pain (CBE ID#3666). These measures were developed under a CMS-awarded cooperative grant (Cooperative Agreement #1V1CMS331639-01-00) following CMS identification of significant measure gaps for palliative care. PREMs like Heard and Understood and Help Wanted for Pain assess patients' perspectives of the quality of care they received – information that can be valuable in identifying gaps in care delivery and opportunities to improve care processes.

We also underscore the need to ensure that CMS does not limit the use of PROMs, PROM-PMs, and PREMs to just those included in the PROMIS repository. While the PROMIS measures help to establish a baseline level of quality, we do not believe it provides sufficient insight into the spectrum of care delivered by Medicare physicians. ***CMS should therefore support the development and use of PROMs, PROM-PMs, and PREMs that may be more targeted to specific populations, conditions, or specialties, including measures like Heard and Understood and Help Wanted for Pain.***

Improvement Activities (IA) Performance Category – IA Weights and Attestation Requirements

CMS proposes to eliminate the weighting of IAs, as well as to reduce the number of activities to which MIPS eligible clinicians must attest in order to achieve full credit for the IA performance category. ***AAHPM thanks CMS for these proposals and recommends that CMS finalize the policies as proposed.*** We agree that these changes will simplify scoring and reduce administrative burden for MIPS eligible clinicians and groups.

MIPS Final Score Methodology

Scoring for Topped Out Measures in Specialty Measure Sets with Limited Measure Choice

CMS proposes to revise its methodology for scoring certain topped out quality measures that would otherwise be subject to a 7-point scoring cap. The measures would be selected from specialty measure sets that CMS has identified as having limited measure choice, and measures would be proposed and finalized through rulemaking. For performance year 2025, CMS proposes that 16 measures would be subject to this revised scoring methodology.

For selected measures, the 7-point scoring cap for topped out measures would not apply, and instead CMS would apply separate benchmarks that would be set in a such a manner that a performance rate for a measure at the 97th percentile would correspond to 7.5 measure achieve points. CMS expects that this approach would generally result in higher scores for the selected topped-out measures.

Overall, AAHPM appreciates that CMS recognizes challenges when MIPS eligible clinicians and groups have limited measure choices where measures are subject to topped-out scoring caps, and that CMS has proposed to address such challenges through its revised scoring methodology. However, we believe this proposal suffers from a critical flaw that limits the impact of the proposal and leaves too many MIPS eligible clinicians and groups with little to no relief.

In particular, we are concerned with CMS' approach that would focus on specialty measure sets with limited measure choice. Particularly for a specialty like HPM, which does not have its own specialty measure set, it is not clear how our members could benefit from this policy at all, despite already being at a disadvantage due to lack of a specialty measure set. Even understanding the extent to which HPM physicians struggle with limited scoring due to topped out measures is a challenge given the lack of a specialty measure set. ***We therefore urge CMS to consider alternative approaches for identifying specialties and subspecialties with limited measure choice and addressing the struggles they may experience in reaching high performance levels as a result of scoring caps and other policies that limit the total points they can receive as a result of factors outside of their control.*** In the absence of more granular data, CMS could consider – for example – applying its revised scoring methodology to all topped-out measures subject to the cap, rather than the small subset identified in the proposed rule.

Complex Organization Adjustment for Virtual Groups and APM Entities

CMS proposes to establish a Complex Organization Adjustment under which virtual groups and APM entities would receive one measure achievement point for each submitted electronic clinical quality measure (eCQM) that meets data completeness and case minimum requirements. While AAHPM does not have concerns with this proposal on its face, we question why CMS would not apply this policy more broadly, for example to encourage eCQM adoption across all reporters, and in particular small practices. Given the well-established pattern of poorer performance by small practices relative to large and complex organizations, we believe that this policy unfairly places small practices at a disadvantage – a state that is particularly problematic given the zero-sum nature of the MIPS program. ***We therefore recommend that CMS expand the availability of bonus points to all eCQM reporters, and in particular to small practices.***

We also encourage CMS to further consider broadening the availability of bonus points to include reporting via other reporting mechanisms, including circumstances where data submitted to a registry (e.g., using CQM or QCDR measures) are abstracted from an EHR. As we have previously noted, HPM physicians have experienced challenges with adoption of certified electronic health record technology (CEHRT) due to the limited availability of CEHRT that is tailored towards the delivery of palliative care. We note that incentives to adopt CEHRT were not provided to hospice programs, where many AAHPM members practice. Even where CEHRT is used, our members face challenges related to direct electronic extractions of data to registries for purposes of MIPS reporting.

Modification to Scoring Methodology for the Cost Performance Category

CMS proposes to modify the methodology for scoring the cost performance category beginning with the calendar year 2024 performance period/2026 MIPS payment year. Under the new methodology, CMS would determine 10 benchmark ranges based on the median cost of all MIPS eligible clinicians attributed the measure, plus or minus standard deviations. Performance consistent with the median cost for all MIPS eligible clinicians attributed a given measure would be equivalent to 10 percent of the performance threshold. CMS anticipates that this revised methodology would raise cost category scores across the board.

AAHPM appreciates that CMS has identified that scoring under the cost performance category is subject to systematic biases that consistently result in lower average performance in the performance category compared to the quality performance category, and that CMS is proposing changes that would prevent the cost performance category from disproportionately reducing the scores of MIPS eligible clinicians and groups that receive cost performance category scores.

MIPS Performance Threshold

AAHPM supports CMS' proposal to maintain the MIPS performance threshold at 75 points for performance year 2025/payment year 2027, and we encourage CMS To finalize the policy as proposed. Maintaining the performance threshold at 75 points will provide stability and avoid any additional burden that a higher performance threshold would impose.

RFI: Building on the MVP Framework to Improve Ambulatory Specialty Care

CMS seeks input on a potential future CMS Innovation Center model intended to increase engagement of specialists in value-based payment and to encourage specialty engagement with primary care providers. The model would apply to specialists in ambulatory settings and leverage the MVP framework. Under the envisioned model, participants would not receive MIPS payment adjustments, but rather adjustments based on their performance on a set of clinically relevant MVP measures that they are required to report. Participants' final scores would only be compared against other model participants of the same specialty type/clinical profile who are also required to report on those same clinically relevant MVP measures. CMS notes that it is considering mandatory participation of relevant specialty care providers, which it would implement through notice and comment rulemaking.

While AAHPM appreciates that CMS recognizes the need to support specialty engagement in value-based models, we have significant concerns with a model such as that envisioned and detailed by CMS. To begin, as detailed above in our response to the RFI for transforming the QPP, we believe MVPs suffer from significant shortcomings that limit their ability to promote high-quality, high-value care. Likewise, we are not aware of any evidence that suggests that MVPs – either in their current form or in way envisioned by CMS – can lead to changes that improve the quality or value of care furnished by specialty providers. *We therefore do not believe that CMS should increase its reliance on or use of MVPs beyond the MIPS program.*

Moreover, we disagree with the proposed "catchall" approach for improving ambulatory specialty care that CMS is considering, particularly given the myriad ways in which specialists and health care teams engage with patients and patient care. ***We believe that tailored models would be most effective in promoting specialist participation and engagement, addressing identified gaps in care, and requiring accountability on quality and cost dimensions that are most meaningful and appropriate for the care being delivered.***

For example, AAHPM has been highlighting gaps in care for patients with serious illness due to barriers that limit palliative care teams' ability to receive adequate reimbursement for comprehensive palliative care services – and therefore limit patients' ability to receive high-quality palliative care. AAHPM has sought to address this gap through the pursuit of and advocacy for a robust Medicare alternative payment model that would offer payment for palliative care services and enable palliative care teams to take on cost and quality accountability for patients with serious illness, including through the development of a model that we submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) called Patient and Caregiver Support for Serious Illness (PACSSI). This model included targeted beneficiary eligibility criteria, specific care delivery requirements, meaningful payment incentives, and accountability for quality performance on measures that we believed mattered the most to patients and caregivers. With these and other parameters specifically designed to address the gaps in care we identified, we were optimistic that our model would have generated meaningful engagement by the palliative care provider community and positive quality outcomes for patients with serious illness. While our efforts have not yet resulted in an APM that allows for broad participation by palliative care clinicians to date, ***we believe that targeted models like PACSSI are necessary to drive specialist engagement in value-based arrangements, and that a specific model allowing for increased coverage of and access to community-based, team-based palliative care services is needed to support patients with serious illness.***

Furthermore, as we have repeatedly emphasized, ***AAHPM has significant concerns about mandatory models, and we believe that CMS should take caution in expanding the use of such models to physician practices,*** which we believe would place physicians 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. Furthermore, we highlight that mandatory participation in a model like the one CMS envisions would be particularly challenging for certain practices, like small and rural practices, which have historically demonstrated poorer performance under the MIPS program. This is likely due to limited resources, which would prevent small and rural practices from making the making the investments needed to excel under MIPS – or under the model CMS contemplates. ***To the extent that should CMS require future participation in its envisioned APM for specialty practitioners, 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.***

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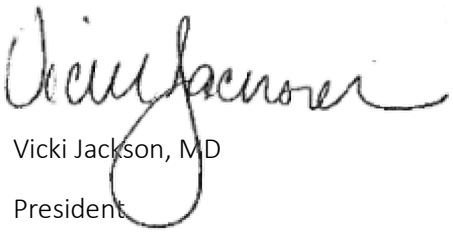
Thank you, again, for the opportunity to provide feedback in response to the CY 2025 Medicare Physician Fee Schedule proposed rule. AAHPM would be pleased to work with CMS to address our feedback and recommendations above. Please direct questions or requests for additional information to Wendy Chill, Director of Health Policy and Government Relations, at wchill@aahpm.org.

Sincerely,



Vicki Jackson, MD

President