AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

Submitted electronically to macra.rfi@mail.house.gov

October 31, 2022

The Honorable Ami Bera, M.D.
172 Cannon House Office Building
Washington, D.C. 20515

The Honorable Larry Bucshon, M.D.
2313 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Kim Schrier, M.D.
1123 Longworth House Office Building
Washington, D.C. 20515

The Honorable Michael C. Burgess, M.D.
2161 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Earl Blumenauer
1111 Longworth House Office Building
Washington, D.C. 20515

The Honorable Brad R. Wenstrup, D.P.M.
2419 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Bradley Scott Schneider
300 Cannon House Office Building
Washington, D.C. 20515

The Honorable Mariannette Miller-Meeks, M.D.
1716 Longworth House Office Building
Washington, D.C. 20515

RE: Request for Information on stabilizing the Medicare physician payment system

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks:

On behalf of the more than 5,500 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank you for the opportunity to provide feedback on the effectiveness of the *Medicare Access and CHIP Reauthorization Act (MACRA) of 2015* (Public Law No: 114-10), and on actions Congress can take to stabilize the Medicare physician payment system going forward. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for patients facing serious illness, as well as their families and caregivers.

Summary of Key Recommendations

The following provides a summary of AAHPM's key recommendations, which are further detailed below:

- Work with medical societies and other stakeholders to achieve broad reforms to the Medicare physician payment system to ensure financial stability and predictability, promote value-based care, and safeguard access to high-quality care.
- Ensure sufficient and meaningful opportunities for specialists to participate in alternative payment models (APMs) and Advanced APMs and support investment in and coverage of palliative care services for patients with serious illness through new models and updates to existing models.

- Extend the 5 percent Advanced APM incentive payment established under MACRA.
- Retain the current thresholds for substantial participation in Advanced APMs to qualify for the Advanced APM incentive payment.
- Prioritize the availability of upfront payments to model participants to support investments in infrastructure and practice transformation.
- Require public reporting of data on specialty-level participation for each model operated by the Centers for Medicare & Medicaid Services (CMS), including for hospice and palliative medicine.
- Allow the CMS Innovation Center to support and, as determined appropriate, expand models that make investments in high-value services like palliative care.
- Provide additional flexibility to CMS to align performance across the performance categories under the Merit-based Incentive Payment System (MIPS) to minimize silo effects and encourage more holistic, patient-centered care.
- Implement changes to MIPS to make the program more patient-centered and focused on the experience of patients across the care continuum.
- Provide funding for measure development and adopt policies that incentivize the development and use of more meaningful specialty-focused measures within the MIPS program.
- Offer financial incentives to hospices to adopt certified electronic health record technology to assist affiliated palliative care practices that rely on hospice health information technology to participate in MIPS.
- Incorporate further accommodations for small practices under MIPS assessment and scoring rules to ensure that they are not disproportionately harmed.

Need for Predictable and Sustainable Payments

AAHPM believes that fundamental problems with the Medicare Physician Fee Schedule (MPFS) – including those codified via statutory changes specified in MACRA – have resulted in a payment system that is unpredictable and unsustainable for the nation's physician workforce. While MACRA promised stability relative to the requirements of the Sustainable Growth Rate (SGR) formula that it replaced, it failed to eliminate budget neutrality requirements, which have led to significant scheduled payment reductions under the MPFS for three consecutive years. While Congress mitigated most – but not all – of the scheduled reductions for 2021 and 2022, associated reductions of nearly 4.5 percent are still slated to take effect for 2023. Budget neutrality requirements are particularly problematic under the MPFS, where payment increases for one or more specialties can result in across-the-board payment cuts for all others. Furthermore, MACRA failed to adequately account for increases in physicians' practice costs when establishing payment updates for each year. Such a failure has been problematic since the passage of MACRA, but it has been particularly troubling most recently given record rates of inflation and marked healthcare staffing shortages. The continued lack of stability and predictability in Medicare physician payments will create real challenges with respect to the sustainability of physician practices and the ongoing availability and quality of services for Medicare beneficiaries.

AAHPM, along with the American Medical Association and more than a hundred other specialty societies and state medical associations, endorsed a set of characteristics of a rational Medicare payment system, which provides a framework for future payment reform that should ensure financial stability and predictability, promote value-based care, and safeguard access to high-quality care.

AAHPM believes that it will be imperative for Congress to work with medical societies and other stakeholders to achieve broad reforms to the Medicare physician payment system consistent with this framework.

Limited Success in Promoting Health System Transformation

AAHPM is also concerned that MACRA has not been effective in promoting widespread innovation and health system transformation, particularly for specialty providers like our members who have few opportunities to participate in APMs or Advanced APMs that would qualify them for the 5-percent incentive payment established under MACRA. AAHPM viewed the passage of MACRA and the establishment of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) as a valuable opportunity to implement models that could increase coverage and availability of high-value palliative care services for Medicare patients with serious illness. This was – and continues to be – particularly urgent given the well-documented benefits of comprehensive palliative care, contrasted against the numerous barriers that exist under current Medicare payment systems to adequate reimbursement for the delivery of such care.

AAHPM has sought to address this gap through the pursuit of and advocacy for a robust Medicare APM that would offer payment for palliative care services and enable interdisciplinary palliative care teams to take on cost and quality accountability for patients with serious illness. In the fall of 2017, AAHPM submitted a model proposal to the PTAC called *Patient and Caregiver Support for Serious Illness* (PACSSI). Following PTAC's recommendation of limited-scale testing of the PACSSI model to the U.S. Department of Health & Human Services (HHS) Secretary, AAHPM – along with additional stakeholders – worked to inform CMS on critical elements of a community-based palliative care model that should be tested by the CMS Innovation Center. The subsequent announcement of the Serious Illness Population (SIP) component under the Innovation Center's Primary Care First (PCF) model in April 2019 appeared to be a first step for making community-based palliative care services available to Medicare patients with serious illness on a pilot basis, including in conjunction with the delivery of advanced primary care services for certain qualifying practices. However, in November 2021, CMS announced it would not move forward with the SIP component of the PCF model, unraveling years of investment and preparation by stakeholders seeking to participate in this aspect of the model and putting the brakes on the most advanced effort to date to test community-based palliative care services in the traditional Medicare program.

As we approach the close of another calendar year without a model that tests increased access to palliative care services for patients with serious illness, it is alarming and disappointing to see that the 5-percent Advanced APM incentive payment established under MACRA is expiring for performance years starting in 2023. Without this incentive, physician groups and health systems will face significant difficulty making the investments needed to effectively participate in Advanced APMs – including any potential future community-based palliative care APM, should one ultimately be implemented. We also raise concerns about the increasing participation thresholds that will need to be met to qualify for that incentive payment starting with participation in 2023. Under current law, participation thresholds next year will be virtually impossible to meet, particularly for physicians and other clinicians who are newly participating in Advanced APMs, thereby minimizing practitioners' incentive or ability to qualify under the Advanced APM pathway.

AAHPM is further confounded by the lack of easily accessible data on the rates of specialty participation across Medicare APMs and Advanced APMs, including separate reporting for physicians practicing Hospice and Palliative Medicine. Without clear information on participation rates by specialty, it is difficult to understand the extent to which the incentives available under MACRA are attainable across specialties or where greater efforts must be made to move specialists more effectively along the value-based care continuum.

We also highlight the need for APMs to provide upfront payments to model participants to support the development of infrastructure that can enable care transformation and increase likelihood of successful quality and cost performance. Limited availability of such upfront investments creates barriers for APM participation, particularly for small practices and institutions newly engaging in care transformation efforts.

Finally, we underscore a fundamental barrier to the promotion and utilization of certain high-value services like palliative care, based on language in the CMS Innovation Center authorizing statute that requires APMs to either reduce or maintain costs to be expanded beyond a testing phase. This requirement places an overemphasis on the cost component of value and diminishes the contribution of quality. It is possible that certain services like palliative care may require new investments that modestly increase costs in the short term yet drive substantial benefits to patient experience and quality of life – and thus deliver more value. AAHPM believes that there must be a willingness to make investments in services like palliative care that achieve desired outcomes, even if they may not result in short-term net savings.

In response to the challenges discussed above, AAHPM believes Congress should take the following actions to ensure more widespread adoption of effective APMs and Advanced APMs that transform the delivery of health care:

- *Ensure that there are sufficient and meaningful opportunities for specialists to participate in APMs and Advanced APMs, including through new models and modifications to existing models that create greater incentives for specialty participation. Models should be implemented or updated to support patients with serious illness through investments in and coverage of palliative care services, as well as through quality measures that hold model participants accountable for delivering high-quality palliative care to patients with serious illness. A model that specifically tests the delivery of community-based palliative care should be included in CMS' APM portfolio.*
- *Support new and ongoing participation in APMs and Advanced APMs by:*
    - *Extending the 5 percent Advanced APM incentive payment established under MACRA;*
    - *Retaining the current thresholds for substantial participation in Advanced APMs to qualify for the incentive payment; and*
    - *Prioritizing the availability of upfront payments to APM participants to support investments in infrastructure and practice transformation.*
- *Require public reporting of data on specialty-level participation for each model operated by CMS, including participation by hospice and palliative medicine specialists.*
- *Allow the CMS Innovation Center to support and, as determined appropriate, expand models that make investments in high-value services like palliative care, even if such models may result in modestly higher costs.*

Shortcomings of an Overly Complex, Burdensome, and Siloed MIPS

AAHPM also emphasizes the limitations of the Merit-based Incentive Payment System (MIPS), the value-based purchasing program established by MACRA that applies to those practitioners who are not able to qualify for MACRA's Advanced APM pathway. Unfortunately, this program – which assesses practitioners across four performance categories of Quality, Cost, Promoting Interoperability, and Improvement Activities – suffers from fundamental problems that limit its ability to promote high-value care.

To begin, rather than being patient-centered and focusing on the overall patient experience of care, the MIPS program pits clinicians and groups against one another and requires that there be winners and losers based on the ability of each to maneuver across the complicated MIPS participation and scoring landscape. The complex scoring and payment adjustment policies focus on individual clinician performance rather than collaborative, team-based patient care tailored to individual patients' treatment goals and preferences. Furthermore, performance assessment across the four performance categories is siloed, further increasing burden and limiting practitioners' ability to focus on the holistic delivery of care. While AAHPM appreciates that CMS has attempted to address some of these concerns through the implementation of MIPS Value Pathways (MVPs), we believe that the MVP framework does not directly address underlying programmatic flaws.

We also note that there is a dearth of relevant cost and quality metrics that apply to different specialties, including hospice and palliative care, resulting in practitioners being assessed on measures not directly related to the care they provide. Additionally, in many cases, practitioners may be assessed on measures over which they may have little to no control. We believe this stems from a historic under-investment in measure development, which we believe must be remedied if the MIPS program is to be successful in incentivizing practitioners to provide high-quality, high-value care. We also note that, where applicable cost and quality measures do exist, there is no direct link between what is being measured on the quality versus cost dimension – limiting the program's ability to truly assess whether high-value care is being delivered.

With respect to the Promoting Interoperability performance category, we note that this category focuses more on the functionalities of certified electronic health record technology (CEHRT), rather than on the comprehensive use and exchange of digital data. This is particularly detrimental for hospice and palliative care practitioners due to the limited availability of CEHRT that is tailored towards the delivery of palliative care. We note that incentives to adopt certified health information technology systems were not provided to hospice programs, where many AAHPM members practice.

Finally, we highlight the challenges that small practices experience in meeting the demands of the MIPS program. As demonstrated by CMS data, small practices are less likely to succeed under MIPS than other practices: on average, small practices earned a final score of almost 70 points, compared to an average score of nearly 90 points for all participant types. While CMS has included many accommodations in MIPS participation and scoring rules for small practices, they remain at a disadvantage and experience disproportionate harm under the program.

In response to the shortcomings discussed above, AAHPM believes Congress should take the following actions to improve the ability of MIPS to produce high-quality, high-value care:

- *Provide additional flexibility to CMS to align performance across performance categories and minimize silo effects to encourage a more holistic, patient-centered approach to care improvement.*
- *Implement changes to MIPS that make the program more patient-centered and focus on the experience of the patient across the care continuum.*
- *Provide funding for measure development and adopt policies that better incentivize the development and use of more meaningful specialty-focused measures within the MIPS program.*
- *Offer financial incentives for hospices to adopt CEHRT to remedy the historic disadvantage that hospice programs have experienced while also assisting any affiliated palliative care practices that rely on hospice health information technology to participate in MIPS.*
- *Incorporate further accommodations for small practices to ensure that they are not at a disadvantage under MIPS.*

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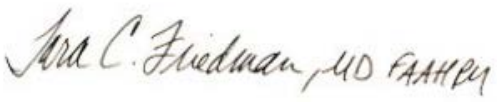
Thank you again for the opportunity to provide feedback on MACRA's effectiveness in stabilizing Medicare physician payments and promoting value-based care. If you have any questions or need additional information, please reach out to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,



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