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June 27, 2016

Mr. Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-5517-P
US Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave. SW
Washington, D.C. 20201

Via Electronic Submission: www.regulations.gov

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; Proposed Rule
81 Fed. Reg. 89 (May 9, 2016)

Dear Administrator Slavitt:

Thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule, "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" (CMS-5517-P).

The Center to Advance Palliative Care (CAPC) is a national organization dedicated to ensuring that all persons with serious illness have access to quality palliative care, regardless of diagnosis, setting of treatment, or state of the disease. Palliative care is an interdisciplinary, team-based model of care that emphasizes care coordination, pain and symptom management, shared decision making, and patient-centered goal-setting. The provision of palliative care has consistently been shown to improve patient experience and satisfaction,[1] [2] reduce caregiver burden,[3] [4] and increase survival[5]; it has also been shown to reduce needless hospital admissions and readmissions through effective care coordination and symptom management[6] [7] [8]; and through these gains in quality, it reduces costs.[9] [10] [11] While there is no narrowly defined target population for palliative care, a recent paper

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[1] Delgado-Guay MO, et al. *Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team*, 115(2) Cancer 437-45 (2009)

[2] Casarett D, et al., *Do palliative consultations improve patient outcomes*? 56 J Am Geriatric Soc'y 593, 597-98 (2008)

[3] Gelfman LP, et al., *Does palliative care improve quality? A survey of bereaved family members*, 36 J Pain Symptom Manag 22, 25 (2008)

[4] Hudson P, et al. *Reducing the psychological distress of family caregivers of home-based palliative care patients: short-term effects from a randomized controlled trial*, Psycho-Oncology (2013)(Advance online publication. doi: 10.1002/pon.3242)

[5] Temel JS, et al., *Early palliative care for patients with metastatic non- small-cell lung cancer*, 363 New Eng J Med 733, 739 (2010)

[6] Nelson C, et al., *Inpatient palliative care consults and the probability of hospital readmission*, 15(2) Perm J 48-51 (2011)

[7] Enguidanos S, et al., *30-day readmissions among seriously ill older adults*. 15(12) J Palliat Med 1356-61 (2012)

[8] Lukas L, et al., *Hospital outcomes for a home-based palliative medicine consulting service*, 16(2) J Palliat Med 179-84 (2013)

[9] RS Morrison et al., *Cost savings associated with US hospital palliative care consultation programs*, 168 Arch Intern Med 1783, 1785 (2008)

[10] Penrod JD et al., *Hospital-based palliative care consultation: Effects on hospital cost*, 13 J Palliat Med 973, 976 (2010)

in Health Services Research identified patients with serious medical conditions (such as advanced cancer, heart failure, COPD, ESRD and dementia), functional impairment (dependency in one or more activities of daily living) and one or more hospitalizations or skilled nursing facility admission in the last year as among the most appropriate candidates.[12] Patients with all three characteristics had a 50 percent likelihood of hospitalization and a 22 percent likelihood of death in the subsequent 12 months, a group clearly appropriate for palliative care.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) marks a watershed in how health care will be paid for in the United States from this point forward. It gives effect to HHS's ambitious goals of tying payment to value, and creates incentives to accelerate clinicians' adoption of APMs. The field of palliative care views the new Quality Payment Programs (QPP) created under this law as the single best opportunity to ensure that patients with serious illness receive the care they need, in the right place, at the right time. We applaud CMS for its work in operationalizing the MACRA directives, as it has clearly incorporated feedback collected from previous comment opportunities on the MIPS, APMs, and Episode Groups. Despite these efforts, we continue to have concerns about some of the proposals for the QPP – particularly those related to MIPS, which will impact a majority of palliative care clinicians starting in 2017.

Palliative care is a small, relatively new specialty that has faced many challenges under Medicare Fee-for-Service (FFS). Greatest among these challenges is the fact that physician and nurse practitioner reimbursement for many palliative care-relevant cognitive services codes is insufficient, and FFS billing fails to account for the critical contributions of other interdisciplinary team (IDT) members such as social workers, nurses, and chaplains. Unlike better remunerated and procedural specialties, the field has not been well-positioned to develop meaningful quality and cost measures for itself. Yet without these relevant quality measures, early adopters of the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program have struggled to participate. While palliative care can improve patient outcomes and help achieve overall cost savings, these early adopters have encountered the following barriers:

1. Existing quality measures are not refined enough to capture the care we provide, particularly given the multi-morbid, multi-setting nature of our patient population; and
2. Palliative care clinicians often serve in a consultative or supplementary role in a patient's care, and typically have little direct control over our colleagues' spending for Medicare beneficiaries.

Despite CMS's steps to mitigate the potential damage to palliative care clinicians, we foresee potential unintended consequences resulting from the proposed rule. And if palliative care clinicians struggle and/or lose their practices due to negative payment adjustments under MIPS, it will ultimately be the highest-risk and highest-cost patients who suffer. To help frame our comments for this payment track, we will use the following case study to highlight potential concerns with the proposed rule:

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[11] Agency for Healthcare Research and Quality, *System-integrated program coordinates care for people with advanced illness, leading to greater use of hospice services, lower utilization and costs, and high satisfaction.* Retrieved from https://innovations.ahrq.gov/profiles/system-integrated-program-coordinates-care-people-advanced-illness-leading-greater-use

[12] Kelley AS et al. *Identifying older adults with serious illness: A critical step toward improving the value of health care.* Health Serv Res. doi: 10.1111/1475-6773 (2016)

Mrs. Jessup, a 72-year-old female with metastatic cancer, was admitted to a community hospital with significant pain, shortness of breath, weakness, anxiety, edema, and fatigue resulting from acute heart failure. After an initial assessment, her attending physician decided to bring in a palliative care consult to help manage her complex symptoms and underlying condition. The palliative care consultation-based practice operates under the corporate umbrella of a local hospice and is equipped to follow patients from the hospital into the home and/or outpatient setting. Over the course of Mrs. Jessup's six-day inpatient stay and 90-day follow-up, the palliative care team provided:

1. Symptom management of her dyspnea and pain;

2. Education on her illness and disease trajectory and possible prognosis;

3. Coordination of care between the other involved services throughout the duration of her inpatient stay;

4. Goals of care conversation and addressing advance directives;

5. Assessment of needs at home on discharge and preparing needed services for discharge; and

6. Ongoing pain and symptom management, coordination of care and social support once she returned home.

To address the potential threat MACRA poses to palliative care clinicians (and by extension, patients like Mrs. Jessup), we make the following recommendations to CMS as it finalizes the proposed rule:

1. CMS must invest MACRA funding in developing patient-centered quality measures that address known gaps in care, and are diagnosis-agnostic. We strongly encourage the agency to collaborate with organizations such as the American Academy of Hospice and Palliative Medicine (AAHPM) and the Hospice and Palliative Nurses Association (HPNA), which can provide appropriate clinical expertise to guide such work.
2. CMS must review proposed measures for MIPS and extend denominator exclusions in measures that could pose a potential risk to palliative care patients.
3. CMS must acknowledge that palliative care clinicians care for the highest-risk, highest-cost patient populations and yet are almost never the primary decisionmakers/cost drivers for these patients. Given this, CMS must: a) develop a mechanism for differentiating providers by patient case-mix when calculating performance on both cost and quality measures; b) reconsider the use of the transitional care management and chronic care management for beneficiary attribution; and c) clarify details of the appeals process that clinicians can use if they are unfavorably scored through no fault of their own.
4. CMS must make a new round funding available to poorly-resourced specialties and practices to support the adoption of CEHRT.
5. CMS must continue to develop criteria for APMs that consider the needs of seriously ill patients with multi-morbidity, frailty, functional and cognitive impairments, etc., and design the models in such a way that risk-bearing entities are more inclined to accept these patients.

In the following sections, we propose additional recommendations and provide more detail on ways in which the agency can both support the field's transition and honor the original intent of the law.

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Merit-based Incentive Payment System (MIPS)

A. MIPS Performance Period

We support CMS's proposal to use a full calendar year performance period as the basis from which to calculate payment adjustments; however, we are concerned that the final rule may be released as late as November 2016 and contain substantial changes. This would give our clinicians two months or less to understand everything that is required of them and adjust their systems as necessary before CMS begins holding them accountable. **Therefore, we propose that CMS delay the initial performance period so that it begins on January 1, 2018.** We believe this request respects the intent of the MACRA legislation for the performance year to be as close to the payment adjustment year as possible. This grace period should allow smaller practices and those unable to participate in the original quality reporting programs to develop the necessary reporting structures and processes, and will set the stage for greater success in the QPP.

B. Quality Performance Category

We appreciate CMS proposals in this section to lower the quality measure submission threshold to six measures, remove the requirement to submit across a minimum number of domains, and build in opportunities for eligible clinicians and groups to earn bonus points if they report on additional quality measures. This extra flexibility should remove some of the reporting burden on clinicians and result in more meaningful data collected.

Key Concerns and Recommendations

As CAPC and our partners have shared in previous rulemaking and other comment opportunities, the discussion of quality measures is a difficult one for palliative care. The field is still relatively new and small as compared to other specialties, and does not have the resources necessary to bear the cost of measure development. Given this, we are left with a dearth of patient- and family-centered measures that can capture the benefit of palliative care. To rectify this situation, we need investment in the following:

1. Evidence-based process measures in MIPS that address the broad category of palliative care for patients of any age and stage of illness, without being disease-specific. The majority of current MIPS measures are specified for patients with a particular diagnosis. Without broadly applicable measures, palliative care providers find themselves in the position of either having to report on measures that are not clinically relevant or contrary to the interests of the patients, or being subject to CMS review and possible negative payment adjustments despite the high quality of care they provide;
2. A common denominator that comprehensively captures the seriously ill, frail, and multi-morbid patient population with frequent transitions across settings appropriate for palliative care. No measure currently used under federal quality reporting programs, or recommended for future years, focuses on this population exclusively (for example, the newly proposed ASCO measures are excellent and address critical aspects of care, but are only relevant for cancer patients); and
3. Evidence-based patient-centered outcomes measures that address critical gaps, including but not limited to: reduction in symptoms other than pain; occurrence and documentation of shared decisionmaking; concordance of care with patient goals; impact of episode on the family/caregiver; and rate of burdensome transitions in the last six months of life.

We urge CMS to begin investing in activities to fill critical measure gaps and to collaborate with organizations such as the American Academy of Hospice and Palliative Medicine (AAHPM) and the Hospice and Palliative Nurses Association (HPNA) that can provide appropriate clinical expertise to guide such work.[13] In the meantime, **we suggest that CMS incorporate existing NQF -endorsed palliative care measures into MIPS**. While the inclusion of the ASCO measures is appreciated, these measures alone are not sufficient. In 2014, cancer accounted for 22 percent of all deaths in the United States,[14] indicating the need for similar measures that address the needs of the remaining 78 percent who suffer from frailty, cognitive impairments and multiple chronic conditions. Furthermore, there is a need for more measures that can address care provided to these patients earlier in the disease course. To reduce this gap for the coming reporting year, **we suggest that CMS inspect the palliative care measures currently under review by the NQF Palliative and End-of-Life Standing Committee for possible inclusion in MIPS.**

Additional Concerns and Recommendations

Emphasis on Outcomes Measures. Both Congress and CMS have alluded to an increased emphasis on outcomes measures as more become available in future years. While we support this decision in theory, it is important to note that the science of quality measurement is well-behind the ambitions of Congress and CMS. This is particularly true in our field, where despite substantial research evidence on the benefits of palliative care in multiple patient populations and care settings, we have no NQF-endorsed measures that can be employed to demonstrate the link of palliative care to improved patient-centered outcomes. **CMS must recognize that clinical outcomes measures similar to reducing HbA1c in diabetes patients do not currently exist for people with serious illness, and therefore be willing to accept NQF-endorsed process measures until such time as appropriate outcomes measures become available.**

Denominator Adjustment in Existing MIPS Measures. While reviewing the GPRO Web Interface manual, we noted that some measures have important exclusions; for instance, GPRO PREV-9 (BMI Screening and Follow-Up Plan) excludes from its denominator patients in which there is "any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate". We support this language as it does not exclude clinicians from providing necessary care, but allows them to exercise their clinical judgment if they deem a measure inappropriate or harmful. Therefore, we request that **CMS extend this exclusion to the following CMS Web Interface measures**:

1. GPRO DM-2: Composite (All or Nothing Scoring): Diabetes: Hemoglobin A1c Poor Control
2. GPRO HTN-2: Controlling High Blood Pressure
3. GPRO IVD-2: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
4. GRPO PREV-5: Breast Cancer Screening
5. GPRO PREV-6: Colorectal Cancer Screening
6. GPRO PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Removal of Cross-Cutting Designation. We are concerned with CMS's proposal to remove the cross-cutting designation from the following six measures: 1) PQRS #046 – Medication Reconciliation

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[13] We encourage CMS to review the Measuring What Matters project to learn more about the field's progress so far, and where critical gaps remain. This project was led by AAHPM and HPNA, for more information, please visit http://aahpm.org/quality/measuring-what-matters.

[14] National Center for Health Statistics. Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities. Hyattsville, MD. 2016. Retrieved from http://www.cdc.gov/nchs/data/hus/hus15.pdf#019

Post Discharge; 2) PQRS #131 – Pain Assessment and Follow-Up; 3) PQRS #134 – Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan; 4) PQRS #154 – Falls: Risk Assessment; 5) PQRS #155 – Falls: Plan of Care; and 6) PQRS #318 – Falls: Screening for Fall Risk. While several of these measures need tweaks in order to be applicable across patient populations, they remain some of the most appropriate measures the field currently has. Removing the cross-cutting designation limits the available options palliative care providers have to meet CMS's requirements. **We request that CMS restore cross-cutting designation to these six measures.**

Removal of Measures Groups Reporting Option. We note the removal of measures groups as a reporting option under MIPS and suspect that the list of proposed specialty measures sets is an attempt to replace these groups. We would like more information on the rationale behind this decision, as we thought the Multiple Chronic Conditions measure group had potential as workable solution for palliative care reporting. On a related note, **we suggest that CMS explore the possibility of using the NQF's newly formed Palliative and End-of-Life Care Standing Committee to help develop a Palliative Care Specialty Measure Set under MIPS.**

Feedback Loop on Reporting Mechanisms. We appreciate that CMS has proposed retaining all the current PQRS reporting mechanisms, which will help ensure flexibility for clinicians with different needs. However, **CMS must continue to solicit feedback on individual clinician and group experience reporting under MIPS** to ensure that reporting is simple and does not disrupt the patient-provider interaction.

Increased Reporting Thresholds. We are very concerned with the proposed increase in quality reporting thresholds to 90 percent for those reporting via QCDR, qualified registry, or EHR, and 80 percent for those reporting using Part B claims. Palliative care providers embedded in large groups using these options typically serve a small percentage (5-10 percent) of the total patient population, and are often not given much consideration when the group selects its quality measures. Under the PQRS, our providers were insulated from having to report on irrelevant or potentially harmful measures that did not have reasonable exclusions because the 50 percent threshold made it less likely that "noncompliance" for these patients would be included in the sample. However, the increased thresholds make it far more likely that a quality manager could insist that all clinicians report on the selected measures, whether or not they are appropriate. If that is to occur, palliative care providers risk either subjecting their patients to needless services for the purposes of quality reporting, or exposing themselves and their larger group to possible negative payment adjustments. The increased reporting threshold increases the threat of harm to our most vulnerable patients, which we find an unacceptable tradeoff. Therefore, **we recommend that CMS maintain the existing threshold of 50 percent.**

Redistribution of Performance Category Weights. We support 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 Advancing Care Information performance categories be applied to the Clinical Practice Improvement Activity (CPIA) category rather than the Quality performance category.** The CPIA category is the only one over which clinicians have 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 category also provides eligible clinicians with some choice over which measures to report, we do not think this category should be assigned more than 50 percent of the weight of an eligible clinician's overall Composite Performance Score (CPS) given the ongoing lack of suitable measures for some specialties.

Appeals Process. We are concerned that CMS will find implementation of its plan to prepare and disseminate mid-year performance reports difficult. Everyone agrees that clinicians must have enough information about their progress to properly benchmark, predict performance, and make course corrections for a given year. Yet under the PQRS and VM, the feedback reports were so delayed that some of our clinicians were not only unable to course-correct within a given year, but they went an entire subsequent year without having the information necessary to make adjustments. We do not have any specific recommendations on this issue, but thought it important to highlight.

On a related note, we see that CMS has generally outlined a targeted review process in the event that an eligible clinician or group wishes to appeal the calculation of the CPS or the adjustment factor. As CMS finalizes the rule, we ask that it **make more specific information on the targeted review process available to clinicians including: the point of contact; the rubric for reviewing performance; the suggested supporting documentation to facilitate the review; and the estimated timeframe**.

C. Resource Use Performance Category

Given the number and complexity of the methodologies CMS is proposing to appropriately determine patient attribution, we respect how seriously the agency is taking the responsibility of ensuring that costs are linked to the appropriate provider. We also appreciate CMS and Congress's decision to lower the weighting of the Resource Use performance category for the first two years while stakeholders gain a better understanding of the impact on clinicians.

While Mrs. Jessup was in the hospital, members of the palliative care team provided the following services (billing ICD-9 codes 782.3, 786.05, 786.50, and E&M codes 99231-99233, 99497-99498, and 99490 for reimbursement):

- *Day 1 – the physician evaluated pain and symptoms, and recommended prescriptions to stabilize, considering her current medications and condition; the chaplain conducted a spiritual assessment and counseling visit;*

- *Day 2 – the physician made adjustments to optimize symptom management, and communicated with other clinicians on her treatment plan;*

- *Day 3 – the social worker and nurse provided disease education and completed a patient and family needs assessment for discharge;*

- *Days 4-6 – the physician continued optimizing pain and symptom management, and coordinating care with the other clinicians; and the full IDT arranged and conducted a family meeting to discuss needs assessment, disease progression and goals of care. They also completed an advanced directive and a POLST form.*

While Mrs. Jessup was in the community, members of the palliative care team helped her transition back to the home, provided ongoing pain and symptom management, and coordinated care with the other providers (billing ICD-9 codes 782.3, 786.05, 786.50, and E&M codes 99347-99349, 99495-99496, and 99490 for reimbursement).

The social worker and chaplain were not directly reimbursed through Medicare for any of their services in the hospital or home (see CPIA section for more on their efforts).

Key Concerns and Recommendations

Through the language of cost-neutrality and the elimination of a "held-harmless" zone, Congress and CMS seek to create a normal bell curve on health care value through MIPS. Unfortunately, by design, palliative care patients are much sicker, more expensive, and more likely to have adverse outcomes than the "normal" patient population, and will subsequently always be at the high tail end of this bell curve. Even CMS acknowledged in the proposed rule that physicians treating the largest shares of the Medicare's sickest patients are most likely to incur downward adjustments under existing quality reporting programs. Furthermore, unlike other specialties or subspecialties, palliative care clinicians are rarely the primary decisionmakers in the care of their patients and unlikely to be the driver of costs. In the case of Mrs. Jessup, although the palliative care team takes a comprehensive look at her needs and goals, they do not guide resource decisions concerning her cancer and heart failure interventions. This case example indicates the potential that palliative care provides to reduce her health care costs in the long run, yet the short run calculations developed for MIPS are unlikely to reflect this.

Despite a thorough review of the proposed rule, we remain unclear on who the majority of palliative care practitioners – particularly physicians – will be compared to in both the Quality and Resource Use performance categories. Based on the proposed cost calculation methodologies, we suspect it will be other non-palliative care providers who are likely to score better on measures that are tailor-made for them. To complicate matters, we have heard from some of our clinicians who participated in the VM that their QRURs noted "insufficient data to determine" the cost composite score. To the extent that the VM is a foundation for the Resource Use category, we are left with little insight as to how our providers will fare under MIPS. We can only reiterate that holding palliative care clinicians accountable for the cost of care for the sickest and costliest patients exposes them to potential unfavorable scoring in MIPS; this could result in significant negative payment adjustments which would threaten the viability of the palliative care program, and perhaps result in less access to the care that these clinicians provide. Therefore, **we request that CMS use its authority under MACRA to re-weight the Resource Use category to zero given the potential deficiencies in the proposed set of measures**. Ideally, we would like to see CMS shift to more focused episode-based cost measures, but until it has had the opportunity to develop and implement more granular attribution mechanisms, clinicians should not be held accountable for insufficient measures. Specifically, the weight given to the Resource Use category should be redistributed to the CPIA category.

Additional Concerns and Recommendations

Use of TCM and CCM Codes for Beneficiary Attribution. We are concerned with the addition of the transitional care management (99495 and 99496) and chronic care management (99490) as triggers for beneficiary attribution. It is our expectation that palliative care clinicians are among the leaders in billing these codes, as the codes reimburse key palliative care activities. Flagging these codes as primary care services risks disproportionately identifying palliative care providers as the primary care providers, when that is generally not the case. **We urge CMS to either reconsider the use of these codes for attribution, or make available a modifier to ensure that palliative care providers are not improperly flagged as the primary care providers for these patients**.

Use of Episode Groups to Calculate Resource Use. We understand what CMS is trying to achieve by introducing the use of episode groups as part of the Resource Use calculation. Our only concern is that these groups have never been used for accountability purposes before, and some have never been included in the sQRUR. We believe that important work such as fine-tuning episode definitions and risk-adjustment and attribution methodologies is still needed to ensure these measures account for the multiple factors that contribute to the overall cost of caring for a patient. **We recommend that CMS either weigh this part of the calculation at zero while feedback is shared with clinicians, or give eligible clinicians and groups the option in the first year as to whether they want the episode group factored into their scoring**.

Use of Broad Cost Measures. We remain concerned that the continued use of broad cost measures such as total per capita spending and Medicare Spending Per Beneficiary (MSPB), which 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' proposal to remove the specialty adjustment. We support specialty adjustments, especially in regards to resource use measurement. To this end, we reiterate our previous recommendation to **re-weight the Resource Use category to zero,** particularly until CMS finalizes the patient condition groups that describe the patient's clinical history, as well as patient relationship categories and codes.

Insufficiency of Risk-Adjustment. While risk-adjustment could potentially protect palliative care clinicians who serve the highest-need patients, our experience thus far has been that risk-adjustment methodologies often underestimate the costs of care, as they fail to account for variables such as availability of family/caregiver support, housing adequacy, or literacy level. Therefore, we support the use of risk-adjustment in the calculation of Resource Use, but caution that it will not fully account for variations in spending for seriously ill patients.

Need for Timely Feedback Reports. As we discussed in our comments on the Quality performance category, it is critical that CMS be transparent in the scoring process, provide feedback early enough and clearly enough for clinicians to course-correct before the end of the reporting period, and make very clear the process for appealing decisions.

D. Clinical Practice Improvement Activity Category

CMS did an excellent job of developing the brand-new Clinical Practice Improvement Activity (CPIA) category. In particular, we appreciate that the agency: a) Made all the existing reporting mechanisms available; b) Selected a reasonable threshold for the number and timeframe of activities required in the first year; c) Compiled a rich inventory of activities which could make a meaningful difference in patient care; and d) Did not arbitrarily set a minimum number of subcategories in which clinicians must report. The proposed accommodations for small groups, rural areas, and HPSAs also seem reasonable.

In addition to the medical services provided in the home and outpatient setting (supported by the availability of a 24/7 hotline to help manage symptom crises), the palliative care team also helped coordinate social supports for Mrs. Jessup over the 90-day follow-up period. She had been a devout Catholic her entire life; unfortunately, over the last few years, she had become effectively homebound due to her illness. As part of the spiritual assessment conducted in the hospital, the chaplain helped address some of her existential concerns surrounding her illness. Once Mrs. Jessup returned home, the social worker connected with her local church which turned out to have a friendly visitor program for "shut-ins." Arranging home visits three times a week for two hours at a time helped reduce her isolation. Furthermore, the social worker was able to work with a few community-based organizations to arrange transportation to and from Mrs. Jessup's follow-up appointments as well as meal delivery.

Concerns and Recommendations

Addition of "Social and Community Involvement" Subcategory. In the proposed CPIA inventory, CMS begins to touch on some activities that could fall under the "Social and Community Involvement" subcategory, e.g., "Participation in a QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health such as food security, employment and housing", or "Develop pathways to neighborhood/community-based resources to support patient health goals". However, these do not go far enough in crediting clinicians who link patients to the social supports that we know are critical to improving care. he current John A. Hartford Foundation project, "Improving the Health of Older Adults Using Integrated Networks for Medical Care and Social Services," has already shown a decrease in readmissions of more than 50 percent, illustrating the health care and status improvements possible through improved access to social services; the recent announcement of the CMMI Accountable Health Communities model also acknowledges that provider facilitation of social services is indeed a practice improvement activity. Therefore, **we suggest that CMS add "Social and Community Involvement" to its list of subcategories under CPIA**.

Additional CPIA for Inclusion. **We urge CMS to consider adding the following CPIA to the proposed inventory:**

- Participation in recognized palliative care training, focusing on what palliative care is, basic symptom management and communication knowledge and skills, and circumstances appropriate for referral to a specialist palliative care team.
- Coordinating or participating in interdisciplinary education efforts to disseminate basic palliative care skills, such as discussing prognosis, clarifying goals of care, and overcoming common barriers to effective communication (to support this effort, we suggest that CMS refer facilities to existing communication training efforts, such as ELNEC's Geriatric Curriculum, CAPC's Online Communication Training, Vital Talk, and Harvard's Serious Illness Care Project (SICP) and Palliative Care Education and Practice (PCEP) courses);
- Inclusion of psychosocial and spiritual support services on a care team; and
- Engaging in private quality improvement initiatives, such as those sponsored by health plans and health insurers, or health and hospital systems.

E. Advancing Care Information Category

We fully support CMS's push to accelerate the use of CEHRT in patient care. Health information technology (HIT) done well can greatly improve communication between providers; this is made all the more important given the increasing emphasis on following patients over time and across care settings. We believe that all providers must be able to access to pertinent clinical information electronically, and participate in health information exchange so that information can follow the patient.

Concerns and Recommendations

All clinicians understand that they must adopt CEHRT in a rapid timeframe. Unfortunately, many small palliative care practices continue to have limited resources, but there are no longer MU incentives available to ease their transition. Therefore, **we request that CMS make new money available to help support the purchase and adoption of CEHRT for small practices that missed the opportunity to receive MU incentive payments**.

Alternative Payment Models (APMs)

Aside from our concern that the minimum requirements for consideration as an Advanced Alternative Payment Models (AAPMs) are high, we appreciate the favorable scoring that clinicians in regular APMs receive under MIPS. It seems that there is enough incentive for clinicians in non-advanced APMs to remain in these arrangements until such time as they are able to transition to the advanced models. In general, we look forward to seeing how the landscape changes as more clinicians and groups accept downside risk.

Concerns and Recommendations

As CMS refines its proposals for the APM track, these models must enable reliable and efficient care of patients with serious illness. We understand that the complicated (and potentially costly) conditions make these patients less attractive for risk-bearing entities to take on. Therefore, it is critical that CMS continuously consider the needs of patients with serious illness to ensure that the models properly incent their care.

Our most significant concern with the APM track is that the proposed timelines for AAPM participation are difficult to impossible for many palliative care providers to meet. By the time the proposed rule was released, eligible clinicians had two weeks or less to consider applying for the AAPMs whose deadlines had not already passed. Furthermore, the window to capitalize on any part of the five percent bonus in this track is short; the bonuses are available through 2024, meaning the last performance period is 2022 with an application deadline of 2021 or earlier for some models. This does not leave much time to engage in delivery system and payment transformation before the "cushion" is gone.

Our only feedback on CMS's proposed definition of "more than nominal risk" is to acknowledge that the vast majority of palliative care providers who participate in APMs have done so through Medicare Shared Savings Program (MSSP) Track 1. Many of our clinicians have been working to integrate themselves into value-based payments models, but given the high risk and costs inherent in the seriously-ill population and the field's relatively low levels of resources and reserves, our providers need risk mitigation and corridors to fully participate. **Therefore, we urge CMS to continue devising ways to support and reward those who are taking their first steps into APMs and AAPMs.** For instance, CMS should consider categorizing the Independence at Home (IAH) model as an AAPM if CMMI puts forth a version that includes downside risk.

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Conclusion

Again, we thank CMS for the opportunity to submit these comments. To reiterate, we strongly support the movement to APMs and risk-bearing arrangements as part of payment and delivery system reform, as we believe these models are the future of palliative care. To that end, we recognize that role that MACRA and MIPS will play in accelerating the movement; however, there are elements of the proposed rule that could threaten the viability of palliative care programs during this transition if not adequately addressed. We would be very happy to continue the conversation with CMS regarding ways in which we can protect palliative care clinicians, and strengthen and enlarge the field, and by extension optimally support the most vulnerable patients in the health care system.

Please do not hesitate to contact me or Stacie Sinclair, Policy Manager at stacie.sinclair@mssm.edu, should you have questions or require additional information.

Sincerely,

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