

June 27, 2016



Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence, Ave., S.W.
Washington, D.C. 20201

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. 28162 (May 9, 2016)

Dear Acting Administrator Slavitt:

We are writing collectively as members of the Patient Quality of Life Coalition, a group of over 40 organizations dedicated to advancing the interests of patients and families facing serious illness, with the overarching goal of providing patients with serious illness greater access to palliative care services. Members represent patients, health professionals, and health care systems. The Coalition appreciates the opportunity to comment on the proposed rule implementing the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive as provided under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The MACRA legislation and proposed regulations represent a good first step towards moving the Medicare program to a system that supports and encourages the delivery of high-value and high-quality care. As CMS works to finalize these proposed regulations, the Coalition reminds CMS of the value that palliative care provides to beneficiaries.

Palliative care is an interdisciplinary model of care that focuses on people living with serious and chronic diseases. It provides relief from the symptoms and stress of a serious illness, regardless of the diagnosis. Palliative care is provided by a team of physicians, nurses, social workers, chaplains, and other providers working together to provide an extra layer of support.

Palliative care is appropriate at any age and any stage in a serious illness. Palliative care services should be provided at the point of diagnosis of a serious illness, and be used alongside curative treatment. Key components of palliative care include care planning based on open, honest communication about the patient's condition and treatment options; effective control of pain, symptoms and side effects; and highly coordinated care that addresses physical, psychosocial, and spiritual needs and family/caregiver support. Given its focus on the patient and the patient's family, palliative care improves a patient's ability to tolerate medical treatments and carry on with daily life. It also empowers patients to play a greater role in their own care by facilitating communication between patients, caregivers, and providers across the care continuum.

Not only has palliative care been shown to be beneficial to patients, but research also has demonstrated that the use of palliative care services has been shown to result in cost savings to the health care system. Individuals whose care is managed by palliative care professionals have reduced

hospitalizations or re-hospitalizations.¹ Thus, encouragement of the use of palliative care services would not only improve the lives of beneficiaries, but would also support the underlying goal of the MACRA legislation.

Supporting Palliative Care Services While Avoiding Unintended Consequences

The MACRA legislation and implementing regulations will fundamentally change our health care system. While MACRA represents an important opportunity to make needed changes to incentives and systems, we strongly encourage CMS to monitor closely the effects of MACRA – specifically the Quality and Resource Use categories – on patient access to health care providers, particularly palliative care providers. We note that beneficiaries who use palliative care services are often sicker and costlier than the average Medicare beneficiary. CMS must ensure that the MIPS program does not result in the unintended consequence of discouraging providers from caring for sicker, costlier beneficiaries. We also note that palliative care providers work in varying settings of care – some providers work in hospitals, and others work in small clinics or in patients’ homes. We encourage CMS to monitor MACRA’s effects on clinicians operating in all settings.

CMS Grants to Small and Rural Providers

We are also pleased that CMS is offering grants of \$100 million over five years to organizations assisting small and rural practices implementing MIPS – specifically to individual or small group practices of 15 or fewer, focusing on those practicing in historically under resourced areas including rural areas, health professional shortage areas, and medically underserved areas. We support CMS’ commitment to assisting these practices, some of whom work with palliative care providers as part of the palliative care team.

We offer the following recommendations with respect to specific policy proposals:

II. PROVISIONS OF THE PROPOSED REGULATIONS

E. MIPS Program Details

4. MIPS Performance Period

CMS proposes that for 2019 and subsequent years, the performance period under MIPS would be the calendar year (January 1 through December 31) two years prior to the year in which the MIPS adjustment is applied.

The Coalition supports CMS’ proposal to establish the MIPS performance period on a calendar year basis. However, we note that the first reporting year would begin only a few weeks after CMS is expected to publish the final rule implementing the MIPS program. CMS may wish to consider delaying implementation of the reporting period in the first year in order to give clinicians an opportunity to review and become familiar with the final regulations before they begin reporting.

5. MIPS Category Measures and Activities

¹ For example, a 2008 study of eight diverse hospitals showed that palliative care consultations resulted in adjusted net savings of \$1,696 in direct costs per admission and \$279 in direct costs per day, including significant reductions in laboratory and ICU

b. Quality Performance Category

(3) *Quality Data Submission Criteria*

Under the proposed rule, a MIPS eligible clinician or group would be required to report at least six quality measures, including one cross-cutting measure (if patient facing) and at least one outcome measure. In instances where an applicable outcome measure is not available, CMS proposes to allow the MIPS eligible clinician or group to report on one other high priority measure (such as appropriate use, patient safety, efficiency, patient experience, and care coordination measures).

The Coalition recognizes that implementation of the MIPS program will represent a significant change for some practices. We support CMS' move towards a system that incentivizes high-quality performance. As CMS looks to the MIPS program in future years, we urge CMS to consider the following recommendations:

Patient-Reported Outcomes Measures: The Coalition believes that providing high-quality health care incorporates the patient's health care experience. Various entities have begun to develop patient-reported outcomes measures (PROMs) and patient experience measures; however, these data often are collected through patient satisfaction surveys, patient portals, or apps that are not well-integrated into current electronic health record (EHR) systems. As a result, this lack of integration inhibits incorporation of these data into the overall plan of care, and does not capture this information into a structured documentation and reporting system. As CMS continues to implement the MIPS program in future years, we encourage the agency to support the development of these measures and reporting mechanisms such as qualified clinical data registries (QCDRs), which will increase clinicians and groups' capacity to report on PROMs and patient experience measures that can demonstrate improved patient outcomes.

Quality Measures for Beneficiaries with Multiple Chronic Conditions: There currently are insufficient quality measures to address the needs of individuals with multiple chronic conditions, many of whom would benefit from palliative care services. Quality measures that work for the broader patient population may not be appropriate for evaluating the quality of care provided to individuals with multiple chronic conditions because of their unique health care needs. We recognize that it may be challenging to develop appropriate, evidence-based quality measures for individuals with multiple chronic conditions. We urge CMS to encourage and fund development of measures that are specific to, and appropriate for, assessing the care delivered to individuals with chronic conditions.

Palliative Care Measures: The Coalition has several concerns about the quality measures listed and available for clinicians to report in MIPS. First, none of the proposed measures are specifically related to the field of palliative care. Second, many of the measures that are related to palliative care are disease-specific, so will only apply to certain patients. Finally, many of the measures related to palliative care focus on end-of-life care. End-of-life care is an important component to palliative care, but does not encompass all the care a palliative care provider delivers. We urge CMS to support the development and testing of evidence-based measures of palliative care, including the Measuring What Matters project spearheaded by the American Academy of Hospice and Palliative Medicine, the Hospice and Palliative Nurses Association, and other organizations. We also note that the National Quality Forum Palliative and End of Life Care Project, announced in October 2015 and currently ongoing, is supported

under a contract provided by the Department of Health and Human Services. This project will identify and endorse performance measures that address palliative and end-of-life care.

f. Clinical Practice Improvement Activity (CPIA) Category
(6) *CPIA Subcategories*

Under MIPS, in order to receive the highest possible score of 100 percent for the Clinical Practice Improvement Activity (CPIA) performance category, clinicians must attest to performing three high-weighted CPIAs or six medium-weighted CPIAs. The proposed rule contains over 90 proposed activities from which clinicians can choose.

As CMS finalizes the proposed activities, we urge CMS to consider adding additional CPIA activities. Specifically, CMS should add a CPIA activity that supports palliative care services, described as:

- Coordinating or participating in interdisciplinary education efforts to disseminate basic advanced illness and palliative care skills, such as communication, symptom management and inter-professional collaboration.

Significant evidence has demonstrated that patients who access palliative care services starting at the point of diagnosis and onward,² have better quality of life and live longer.³ Given the value of palliative care services, we recommend that CMS categorize this proposed activity as a high-value activity. The proposed CPIA would impact not only provider teams, but patients as well. By educating providers across disciplines on the capabilities of advanced illness and palliative care interdisciplinary teams, practices can leverage best practices to reach a broader set of patients. One of the stated goals of MACRA is to encourage improvement and advancement of our health system. As such, CMS should recognize activities that leverage peer-to-peer learning and best practices between disciplines and across the care continuum. Given the value of advanced illness and palliative care across a broad spectrum of Medicare beneficiaries, these skillsets should be incorporated into all aspects of medical practice, rather than remain in a silo that could potentially limit patient access.

8. *Review and Correction of MIPS Composite Performance Score*

(6) Additional Information – Type of Information

MACRA requires that beginning July 1, 2018, CMS make available to MIPS eligible clinicians information about Medicare-covered items and services provided by other suppliers and providers of services to the MIPS eligible clinician's patients.

Care coordination is an important element of palliative care, and we believe this requirement will be helpful in increasing this coordination for Medicare beneficiaries. In particular, this requirement will benefit patients who may be seeing multiple providers and utilizing numerous Medicare services. We urge CMS to consider requiring that pharmacies that fill prescriptions under the Medicare Part D benefit provide information to the clinician regarding when and if the beneficiary filled a prescription prescribed

² Smith, TJ, Temin S, Alesi ER, Abernathy AP, Balboni TA, Basch EM, Ferrell BR, Loscalzo M, Meier DE, Paice JA, Peppercorn JM, Somerfield M, Stovall E, Von Roenn JH. American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care. *J Clinical Oncol* 2012; 30: 880-887.

³ Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med.* 2010;363:733-742.

by the physician. Currently it can be challenging for providers outside an integrated health care system or in a Medicare Advantage plan to know whether a beneficiary has actually filled a prescription.

Conclusion

On behalf of the Patient Quality of Life Coalition, we thank you for the opportunity to comment on the proposed rule implementing the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive as provided under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). If you have any questions, please contact Keysha Brooks-Coley, Executive Director of the Patient Quality of Life Coalition, at 202-661-5720 or Keysha.Brooks-Coley@cancer.org.

Sincerely,

Alzheimer's Association

American Academy of Hospice and Palliative Medicine

American Cancer Society Cancer Action Network

American Heart Association | American Stroke Association

Association of Oncology Social Work

Center to Advance Palliative Care

Coalition for Compassionate Care of California

Colon Cancer Alliance

The CSU Institute for Palliative Care

George Washington Institute for Spirituality and Health (GWish)

Hospice and Palliative Nurses Association

Motion Picture & Television Fund

Oncology Nursing Society

Physician Assistants in Hospice and Palliative Medicine

Supportive Care Coalition