National Partnership for Hospice Innovation
1299 Pennsylvania Ave., Suite 1175
Washington DC, 20004

September 10, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1693-P
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850

Re: Medicare Program; Revision to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

The National Partnership for Hospice Innovation (NPHI) greatly appreciates the opportunity to comment on the Physician Fee Schedule ("PFS") and Quality Payment Program ("QPP") Proposed Rule for Calendar Year ("CY") 2019 (CMS-1693-P). NPHI is a collaborative of the nation's most innovative, community-based, not-for-profit, hospice and palliative care providers that serve as a critical safety net in communities across the United States. In coming together, we work to identify, enhance, and spread the best practices in which our members are engaged. NPHI members have decades of experience in providing the highest-quality hospice and palliative care to those facing the final stages of their lives. This commitment is fundamental to our mission and distinguishes us as leaders whose innovative programs reflect the original intent of the Medicare Hospice benefit.

NPHI applauds CMS' commitment to the goal of revising Medicare payment structures to improve patient outcomes and the quality of care provided, and we appreciate the efforts CMS has made in this rule to reduce reporting burden so that healthcare providers can spend more time focusing on patients. While there are a number of laudable proposals in the proposed rule that NPHI concurs with, we do have significant concerns that some of the specific payment changes that CMS proposes for 2019 would have a negative impact on the ability of providers to deliver comprehensive, timely, person-centered care to hospice patients and individuals with advanced illness and their families. We are pleased to be able to offer the following comments on certain payment and programmatic changes in the proposed rule.

Physician Fee Schedule

<u>Evaluation & Management ("E/M") Payment and Documentation Requirements</u>

NPHI recognizes that CMS is resolute in its determination to reduce burden associated with E/M visits in this year's rule, and agrees with many of the proposed documentation changes. Specifically, we request

that CMS finalize the following proposals, which would better facilitate the provision of comprehensive care for seriously ill Medicare beneficiaries receiving hospice and palliative care:

- Allowing physicians to document visits based solely on the level of medical decision making (MDM) or the face-to-face time of the visit as an alternative to the current E/M coding guidelines;
- Limiting required documentation of the patient's history to the interval history gathered since the previous visit (for established patients);
- Eliminating the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient;
- Removing the need to justify providing a home visit instead of an office visit;
- Eliminating the prohibition for same-day E/M visits by practitioners of the same group and specialty.

While we support the recommendations above, **we strongly oppose the proposals to modify payment for office/outpatient evaluation and management (E/M) services** –specifically to collapse payment for level 2 through 5 visits and to establish new complexity adjustment and prolonged service add-on codes that, while well-intentioned, would not furnish adequate payment for providers that care for the sickest and most vulnerable patients, including and especially clinical providers that make up the hospice interdisciplinary care team.

Because hospice and palliative medicine clinicians care for the most seriously ill Medicare beneficiaries, they typically bill level 4 and level 5 E/M visits in the outpatient setting. Coding at these levels is completely appropriate to account for the complexity of the patient population, many of whom have serious functional limitations and are approaching the end of life. CMS' proposed revised payment methodology, based on an aggregated average of E/M visits across all specialties, would disregard the fact that visits with hospice patients and others with very advanced illness frequently require more clinician time and resources to properly address the severity of these patients' situations. As such, the payment structure would have an inordinately negative impact on providers seeing these complex patients, and would formalize a system in which payment rates are insufficient to adequately cover the more intensive services that hospice and advanced illness patients need and deserve.

If CMS were to finalize these E/M payment policies as proposed, it would be catastrophic for hospice and palliative care providers. An analysis conducted by the American Medical Association indicates that hospice and palliative care specialties would be the hardest hit by the changes, with an anticipated 20% reduction in E/M payment[i]. Payment decreases at this level would likely result in the closure of palliative care practices and the scaling back of outpatient palliative service provision by hospice providers. Additionally, were these changes to be implemented, the financial disincentives they create to treat the sickest patients would likely dissuade medical students and other early-career clinicians from entering hospice and palliative medicine, thus further exacerbating an already dire shortage in the advanced illness workforce.[ii]

Ultimately, and of greatest concern, the likely provider impacts detailed above will end up reducing access to care for hospice and palliative care patients and their families**.** Effectively penalized financially for caring for complex individuals, providers may avoid this patient population, curtail visit lengths, and/or request patients come in for multiple visits to make up for the loss of payment. Frequent, shorter visits would be uniquely burdensome for patients with serious illness in hospice given their mobility challenges, high symptom burden, functional difficulties and overtaxed family caregivers.

In light of the above issues, **NPHI urges CMS not to finalize the proposed E/M payment changes.** Instead, we recommend that CMS work with NPHI and other stakeholders to create a coding structure that better meets the agency's goals of improving patient care and reducing burden, without causing the negative consequences for patients with serious illness and the providers that care for them.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

NPHI supports CMS' proposal to pay for new communication technology-based services under the Medicare program, including the Brief Technology-based Service, Interprofessional Internet Consultation codes, and Remote Evaluation of Pre-Recorded Patient Information.

Brief Communication Technology-based Service, e.g., Virtual Check-in

NPHI supports the creation of this new code, which would be valuable to clinicians that provide care to hospice and advanced illness patients who are often physically and socially isolated. We believe that these check-ins will help improve the quality of care as they will allow physicians and other clinicians to address clinical issues sooner, and they also provide an opportunity to reduce utilization of higher cost and unnecessary services.

We also feel that a frequency limit should not be set for such encounters, as comprehensive symptom management, a key care component for hospice patients and those with advanced illness, might appropriately require several consecutive interactions to resolve.

Interprofessional Internet Consultation

NPHI supports the proposed coverage of interprofessional codes, which will greatly support the development of interdisciplinary teams that have been shown to be effective in the care of the seriously ill. These services often substitute for face-to-face specialty services or even more expensive hospitalizations, and can serve to better coordinate communications amongst a seriously ill patient's providers.

Remote Evaluation of Pre-Recorded Patient Information

NPHI supports CMS's proposal to create specific coding to pay for the remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology. Importantly, these services would not be subject to the Medicare telehealth statutory restrictions, and we believe they can be helpful in managing hospice and advanced illness patients in the home setting of their choice.

Additional Comments on Technology-Enabled Services

NPHI applauds CMS for taking steps to modernize payment polices to align with the new developments in patient care and management technologies. We encourage CMS to extend this willingness to embrace evolving technological capacities to hospice-specific barriers to care. In particular, we would recommend that CMS explore the potential of video-based communication technologies to facilitate the hospice recertification process, which currently requires a face-to-face encounter.

Finally, we would also encourage CMS to find ways to include family caregivers in virtual interactions, especially in instances where someone is caring for a hospice patient with very advanced illness.

Medicare Shared Savings Program (MSSP) Updates to Quality Measures

Proposals for changes to the CAHPS measure set

NPHI supports CMS' goal to shift the CAHPS measure set for ACOs to one that is more focused on outcomes as opposed to processes. However, we acknowledge that more work must be done to ensure that proposed outcome measures are valid and reliable, and are reflective of what matters most to patients, especially those with advanced illness and those in hospice, who often have goals of care distinct from less complex populations.

We agree with the change in CMS' data collection procedures to collect data on functional status from the same ACO-assigned beneficiaries over time. We believe this change will facilitate provider awareness of patient-specific conditions that can inform decisions to shift patients to palliative or hospice care. Along these lines, we suggest adding a distinct measure about timely transition to hospice care to the CAHPS measure set for ACOs.

Updates to the Quality Payment Program

MIPS Scoring Bonus for Complex Patients and Accounting for Social Risk Factors

In the proposed rule, CMS continues the use of a complex patient bonus of up to 5 points for eligible clinicians who care for complex patients, based on Hierarchical Condition Categories (HCC) risk scores and the percentage of dual-eligible beneficiaries treated. NPHI applauds CMS for recognizing the need to provide a bonus for treating complex patients. Hospice and palliative clinicians care for vulnerable and highly complex patient populations that often require higher resource utilization, which may impact their quality scores. We urge CMS to extend the bonus beyond the 2019 performance year and to explore increasing the cap so that it is higher than 5 points. The impact of the bonus on the final score, even when increased to five points (out of 100), may be minimal.

Furthermore, we support CMS's efforts to better account for social risk factors in the QPP. NPHI believes that appropriate risk adjustment that takes into account social risk factors is critical for the hospice and advanced illness population. We re-emphasize the need for risk adjustment to take into account socioeconomic factors and the social determinants of health, including caregiver presence and level of engagement. A more accurate risk adjustment model would help obviate the need to "cherry-pick" less complex patients to cover financial shortfalls, and would benefit the higher-risk, more complex patients who would benefit from higher-touch and more coordinated and tailored care.

Proposed Measure: Query of Prescription Drug Monitoring Program (PDMP)

NPHI supports the intent of this measure to reduce opioid abuse and diversion, but has concerns about how challenging this may be for some practitioners, particularly hospice and palliative care clinicians that prescribe opioid medications for pain and symptom management in seriously ill individuals. The query mechanics for PDMPs vary by state, with some processes involving multiple time-consuming steps. Additionally, many EMR systems are not currently optimized to efficiently access PDMPs, which

could cause backlogs and delays in queries and oversight mechanisms. Ultimately, this measure could prove to be overly burdensome if a provider cannot easily access the PDMP from their EMR. NPHI cautions that more time and technical assistance are needed for organizations to prepare for implementation of this change.

Proposed Measure Description: Opioid Treatment Agreement

NPHI has very serious concerns with this proposed measure to require documentation in the medical record that patients electronically prescribed opiates for longer than 30 days have signed an opioid treatment agreement at least once during their opioid therapy course. Because of the seriousness of their condition and the high pain and symptom burden, many hospice patients and those with advanced illness are appropriately prescribed opioids for at least 30 cumulative days within a 6-month look-back period. Requiring these patients to sign multiple opioid treatment agreements would be overly burdensome for both the individuals and their MIPS-eligible clinicians. There exists the potential for negative unintended consequences for the sickest and most vulnerable patient populations, who would experience barriers to receiving appropriate pain management.

As CMS considers finalizing its opioid-related policies, NPHI urges the agency to consider protections that could be incorporated into opioid-focused measures, such as exceptions for patients receiving hospice and palliative care and other patients with advanced-stage serious illness.

We thank you for the opportunity to provide input on this proposed rule and we look forward to continuing to work with CMS to ensure that payment and program regulations accelerate the shift to more value-based, person-centered care for hospice patients and those facing advanced illness. If you have any questions regarding this letter, please contact Davis Baird at dbaird@hospiceinnovations.org.

Sincerely,

Tom Koutsampas
President and CEO
National Partnership for Hospice Innovation

[i] American Medical Association. *Estimated Impact of CY2019 Evaluation and Management Proposed Policy by Medicare Specialty.* https://osma.informz.net/osma/data/images/HealthMatters_Docs/AMA_EM_ImpactAnalysis.pdf

[ii] Kamal, Arif H. et al. *Future of the Palliative Care Workforce: Preview to an Impending Crisis*. The American Journal of Medicine , Volume 130 , Issue 2 , 113 – 114. https://www.amjmed.com/article/S0002-9343(16)30962-7/fulltext