



June 27, 2016

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

Dear Administrator Slavitt,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on the 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* particularly with respect to the policies that would affect providers treating those with especially complex and/or advanced illness.

Background

C-TAC is a national non-partisan, not-for-profit organization dedicated to ensuring that all those with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high- quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC is made up of over 130 national and regional organizations including patient and consumer advocacy groups, providers, health plans, faith-based and community organizations, and others who share a common vision of improving advanced illness care in the U.S.

C-TAC's definition of advanced illness is when one or more conditions becomes serious enough that general health and functioning begin to decline, treatment may no longer lead to preferred outcomes, and care oriented toward comfort may take precedence over attempts to cure – a process that extends to the end of life and that for some patients and their families may lead to transition to hospice. It is with this population in mind that we comment on the following aspects of the MACRA NPRM.

Overall comment

C-TAC supports CMS's shift to a more value-based payment system for its beneficiaries. The unintended consequence of the previous fee-for-service payment system, that promoted *more* treatment rather than necessarily the *right* treatment, did not serve people living with advanced illness. Evidence shows they spend their last months and weeks in increasingly intensive interactions with the healthcare system, rather than having quality of life at home



with their families and communities. The opportunity now is to incentivize all providers to identify those patients approaching advanced illness and consider advance care planning, advanced illness care, palliative care, or hospice, as patient- and family-centered options. The goal should be to foster identifying patients' goals and wishes and to share decision-making with them to deliver treatment tailored to meet their needs, goals, and values.

MACRA NPRM Comment Areas

MIPS Quality Category

- Measures
 - Accelerate the development of appropriate measures-C-TAC very much supports the focus on quality in the rule and that 50% of the Composite Performance Score is based on performance on quality measures. However, there are few existing/validated quality measures available to providers that appropriately measure care for those with advanced illness, including palliative and end-of-life care, advance care planning, and hospice. There is also a lack of measures determining whether care provided is aligned with an individual's goals, values, and wishes-- the foundation of person-centered care. C-TAC has a joint partnership with the National Quality Forum to improve Person-Centered Advanced Illness Care. However, the current NQF process, which typically takes 7-9 years to yield validated measures for CMS use, is too slow to provide measures for 2019 MACRA implementation. **For that reason, CTAC urges CMS and ASPE to invest in accelerating the development of more appropriate quality measures for this population now.** This will require funding for both measure development and maintenance, as the palliative care, hospice, and geriatrics fields lack the resources to fund this themselves. Those measures should be patient-reported and relevant to people living with advanced illness. For example, cancer screening and many long-term prevention activities are usually no longer appropriate for this population and often lead to unnecessary, and possibly unwanted, care.
 - Measures are disease-specific- Many of the NPRM quality measures are diagnosis-specific, i.e. specific to cancer or heart failure. This reflects the evidence base behind them, but there are many other advanced illnesses. Some of these disease-specific measures likely could be modified for people with other advanced illnesses. Also, since two thirds or more of the Medicare population has at least two chronic conditions, **C-TAC specifically recommends developing relevant measures for those patients with multiple chronic conditions.**

- Type of Measure- C-TAC supports the statement that “appropriate use, patient experience, safety, and care coordination measures are more relevant than clinical process measures for improving care of patients” (page 28187). This is especially true for the advanced illness population. Many of these individuals are struggling with multiple chronic illnesses, and therefore multiple specialists. Care coordination and managing transitions of care are therefore imperative for them. Their experience of advanced illness is also important as quality of life can suffer in advanced illness when physical symptoms and psychosocial issues often cause unnecessary suffering.
- Treatment use measures- We also support CMS’ statement on appropriate use: “In consideration of which MIPS measures to identify as reasonably focused on appropriate use, we have selected measures which focus on minimizing overuse of services, treatments, or related ancillary testing that may promote overuse of services and treatments” (page 28187). C-TAC strongly believes that especially in advanced illness, individuals should only receive treatment that is aligned with their values and wishes but that many times, because of a lack of advance care planning, there is overuse and overtreatment at this time. This is especially unfortunate if that treatment is also not what the individual wanted.
- Concordance measures- **C-TAC recommends that the final MACRA rule include specific measures of over and under use related to the person’s goals and values (concordance).** One method CMS may consider to support the goal of reducing unnecessary or unwanted treatment could be to include adherence to one or multiple *Measuring What Matters* metrics, or documented adherence or reliance on *Choosing Wisely* recommendations. These could be a way of monitoring quality for care that is forgone. While these measures may help address these important issues in the interim, **C-TAC strongly recommends that CMS and ASPE invest in developing better measures of concordance between patient preferences and the care that is ultimately provided.**
- Comparison group- The rule seems to indicate that it will compare providers caring for people with advanced illness with those doing primary care, such as general internists and family practitioners. This raises concerns given that primary care providers typically treat proportionately healthier patients. The current measure benchmark approach that compares all providers, regardless of their patient mix, will significantly affect those who treat Medicare beneficiaries with advanced illness. Given the aging

population, and the increasing burden of multiple chronic conditions among Medicare beneficiaries, the need for appropriate comparisons exists for those who treat advanced illness. Alternatively, if advanced care providers are compared against each other, half will be deemed successful while half will not, and the latter accordingly penalized. **CTAC recommend that CMS address this issue and develop a comparison process that promotes advanced illness and palliative care and transition to hospice, rather than penalizes them.**

MIPS Resource Use Category

- Total per capita costs for all attributed beneficiaries – Most Americans face a substantial period of disability in the last few years of life, incurring the highest health spending over this period. Providers who treat patients during this time period may incur higher per capita costs based upon the complex needs of such individuals. To avoid unnecessarily penalizing providers of advanced illness care, **CTAC encourages CMS to create different measure benchmarks based on patient characteristics or by provider type, to eliminate comparing providers whose patients incur less costs than those treating advanced illness.** A similar approach can be taken with Medicare spending per beneficiary, defined as expenditures in the period three days prior to admission to 30 days post discharge.
- Clinical condition-based measures- Providers will be compared on resources used to treat similar care episodes and clinical condition groups. The NPRM includes 41 care episode and clinical condition-based measures, but none that apply generally to advanced illness care. This could create a problem with patient attribution to advanced illness care providers. **We recommend that CMS address this issue in the final rule.**
- Episodes of treatment- The NPRM in many cases assumes the clinical episode is initiated by a hospitalization. However, some people living with advanced illness choose not to be hospitalized and excellent advanced illness care, ideally delivered in the home, can prevent a hospitalization. Even if such patients are hospitalized, their episode of care may continue for months beyond discharge (including to the end of life), especially if they are enrolled in advanced illness management programs that care for these patients across the care continuum and settings. For that reason, **C-TAC recommends CMS enable longer episodes, perhaps up to a year for administrative purposes, to encourage care across the continuum.**

Clinical Practice Improvement Activity (CPIA) Category

- Activities- The NPRM includes over 90 proposed activities for providers to choose from. While this sounds like a large number, there are no current activities that specifically support key aspects of advanced illness or palliative care, such as undertaking education to disseminate basic advanced illness care skills like communication, symptom management, and inter-professional collaboration. C-TAC recognizes that while it is important to have specialists who can personally deliver advanced illness or palliative care, all providers need to have basic skills in this area. A key activity for current palliative care providers is to provide such education and an additional activity to promote such education is in everyone's best interest. CMS needs to specifically incentivize care coordination for advanced illness care patients that leads to advance care planning, advanced illness management, and palliative care/hospice engagement.
 - For this reason, **CTAC proposes adding a new CPIA for coordinating or participating in interdisciplinary education efforts to disseminate basic advanced illness and palliative care skills, such as advance care planning, communication, symptom management and inter-professional collaboration, with a focus on what advanced illness and palliative care is and the specific patient needs that could trigger a referral to such care.**
 - We propose this activity for consideration as an approved CPIA because of its potential to impact patient and provider teams alike. 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. As MACRA seeks to encourage improvement and advancement of our health system, 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.

APMs

The rule provides another important opportunity for promoting access to advanced illness and palliative care via the option of developing an APM that promotes this type of care. One point CMS may want to consider is adjusting their pipeline of APMs to facilitate their development and adoption. Developing and implementing an APM that would fit an advanced APM requirements takes time, investments, and ultimate provider or entity risk. While C-TAC appreciates that the lump sum bonus for those



who qualify for the advanced APM track would serve to encourage APM adoption, providers who mainly treat advanced illness currently have no real opportunities to participate. We recommend that **CMS delay the expiration of the lump sum bonus until providers have meaningful opportunities to participate in eligible models as a means of further encouraging their development.**

In addition, it is to be hoped that the Physician-Focused Payment Models Technical Advisory Committee (PTAC) recommendations, which serve as a method to streamline APM development to CMMI, will be acted upon. This is especially needed for those APMs that seek to serve persons living with advanced illness. CMS should consider permitting outside organizations, like CTAC, to also develop such models for CMMI implementation, provided that they meet certain standards (potentially more stringent than those provided for the PTAC). This alternative route for APM development would be particularly beneficial to advanced illness providers who want to participate in APMs, but who do not currently have that option. Assuming a PTAC submission receives positive recommendations, **we also recommend that there be a rapid review process** as the time necessary from submission of a model to implementation and ultimately provider participation is likely very long considering the need for PTAC review, Secretary review, further development, model announcement, and actual provider participation. Currently, this timeline is not aligned with the early adoption lump-sum bonus, which exists to incentivize providers to become early adopters of new APMs.

Conclusion

Thank you for the opportunity to comment on this proposed rule. We are excited about how it could truly improve and incentivize better care for Medicare beneficiaries at the last stage of illness via access to advanced illness care, palliative care, and appropriate and timely referral to hospice. If you have any questions, please contact Marian Grant, Director of Policy and Professional Engagement at C-TAC, at 443-742-8872 or mgrant@thectac.org.

Sincerely,

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