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Andy Slavitt
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: 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-FC)

Dear Administrator Slavitt:

The American Geriatrics Society (AGS) appreciates the opportunity to submit comments on the Centers for Medicare and Medicaid Services (CMS) Final Rule (81 Fed Reg 77008) implementing the Merit Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Medicare Physician Fee Schedule (PFS), as mandated by the Medicare and CHIP Reauthorization Act of 2015 (MACRA).

The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners ("NPPs") who are devoted to improving the health, independence, and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for physicians and other professionals paid under the PFS.

Evolution of the PFS

Over the past eight years, the AGS has worked closely with CMS and a coalition of specialty societies to improve payment for primary care and patient-centered care management. We appreciate CMS' willingness to consider our suggestions, and are pleased that the PFS now includes payments for several care coordination activities that will more accurately recognize the evolving work of primary care and other cognitive specialties. CMS has previously established policies to pay separately for transitional care management, chronic care management, and advanced care planning. We continue to work with

our coalition partners to educate our members about these services. We also appreciate CMS' decision in the 2017 Final Rule to make separate payment for complex chronic care management services, non-face-to-face prolonged evaluation and management services, and comprehensive assessment and care planning for patients with cognitive impairment. In addition, we commend CMS for making changes to reduce the administrative burden associated with the chronic care management codes.

We hope that over time, these services will become routine features of the medical care provided to Medicare beneficiaries—not because they are separately reimbursed, but because they will improve care for elderly patients and improve health outcomes by better coordinating resources across fee-for-service providers. As CMS moves forward with the implementation of MACRA, we urge the agency to continue to look for ways to use these new codes within the four MIPS performance categories to incentivize the coordination of care across multiple providers, for patients with multiple chronic conditions, and by doing so, to improve functional status, health outcomes, and quality of life for Medicare beneficiaries.

Comments on MACRA

In general, the AGS commends CMS for its work to implement the PFS provisions of MACRA under extreme time pressure. We very much appreciate that CMS is emphasizing simplification and flexibility with the “pick your pace” policy and assigning a weight of zero to the resource use performance category. We applaud the agency’s work on the Quality Payment Program (QPP) website, which we believe will be a valuable tool for physicians and NPPs to educate themselves about the reporting requirements. We urge CMS to keep this website updated as the program evolves and requirements change.

The AGS shares CMS’ commitment to the overall goal of reforming Medicare payment structures to improve patient outcomes and the quality of care provided. However, the specifics of how those reforms are implemented are critical to the success of the program and may produce unintended and undesirable outcomes unless the programs are designed and evaluated in a careful and deliberate manner.

We are concerned that many elements of the program will be implemented without a track record of how patient care and physician practice will be impacted. We feel it is critical to rapidly assess the specific impact of the proposals on clinicians by specialty, practice setting, and group size. Geriatric professionals are disproportionately dependent upon Medicare and are already in very short supply. Unintended effects of this program could further reduce access to this specialty at a time when the aging of the population and the demands of caring for the multiple comorbidities of older patients heightens the need for geriatricians. **The AGS urges CMS to fully evaluate the effects of the payment reforms and to mitigate any undue impacts on geriatrics professionals.**

Comments on the MIPS

A. Recommendation for a New Improvement Activity for 2018

The AGS has reviewed the Improvement Activities and recommends that CMS establish a new Improvement Activity for Frailty Assessment and Risk Mitigation. Approximately 15% of non-nursing

home Americans aged 65 years and older are frail and another 45% are pre-frail.¹ Frailty features can be identified in a physician's office practice, using one of several validated tools, and an assessment can be linked to interventions known to be effective in reducing risks of future disability, hospitalization, falls, institutionalization, and mortality.

Frailty meets several of CMS' proposed criteria for inclusion of an improvement activity, including (1) relevance to an existing subcategory (or a proposed new subcategory); (2) importance of an activity toward achieving improved beneficiary health outcome; and (3) evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes.

Identification of frailty in practice. Prior research has identified a set of shared risk factors for common geriatric conditions that are associated with frailty, including risk of falls, cognitive impairment, urinary incontinence, and immobility. These risks are often identified by geriatricians, but may also be identified by other physicians as well. Importantly, some risk factors for frailty are modifiable with specific interventions and monitoring.

Although no universal definition of frailty exists the concept has been often operationalized as a set of observable characteristics (phenotype) or an index. For example, the Cardiovascular Health Study (CHS)² used the five phenotypic characteristics of frailty identified in the original frailty work by Linda Fried: unintentional weight loss, exhaustion, muscle weakness, slowness while walking, and low levels of activity. Frailty items can be assessed through medical history or readily estimated during physical examination. Frailty is 3 or more of the 5 items, pre-frailty is 1-2 items and robust (non-frail) is 0 items. In prospective CHS cohort studies, the frailty score is predictive of adverse health outcomes and importantly identifies potential interventions to reverse frailty items or to prevent progression of frailty. Several other frailty measures have also been shown to be valid and predictive of future adverse health outcomes events.

Clinical interventions. Prevention of frailty through evidence-based interventions could greatly improve the quality of life of vulnerable seniors while saving billions of dollars in Medicare costs. Clinical trials involving older adults have demonstrated increased muscle strength and mass with low intensity strengthening exercises and nutritional supplements, and reduction of falls risk with multi-dimensional interventions^{3 4} (e.g., gait retraining, muscle strengthening, use of assistive devices, changes in medications) targeted to at-risk individuals.

Weighting of frailty CPIA. Geriatricians often work with interdisciplinary teams in the assessment and management of frail seniors. Physical therapy, occupational therapy, home care agencies, social services, and community-based services are readily coordinated by geriatricians and provide essential services to both patients and their family caregivers. The extra time and effort needed by geriatricians for the initial assessment and subsequent coordination of patient and family needs, and the potential cost savings to Medicare, justifies a "high" weighting score for frailty.

¹ Bandeen-Roche, K, Seplaki, CL, Huang, J, et al. Frailty in Older Adults: A Nationally Representative Profile in the United States. *J Gerontol A Biol Sci Med Sci.* 2015; 70(11), 1427-34. doi: 10.1093/gerona/glv133.

² Fried LP, Tangen, CM, Walston, J, et al. Frailty in older adults: evidence for a phenotype. *J Gerontol A Biol Sci Med Sci.* 2001;56(3):M146

³ Tinetti ME, Baker DI, McAvay G, et al. A multifactorial intervention to reduce the risk of falling among elderly people living in the community. *N Engl J Med.* 1994;331:821-827.

⁴ Close J, Ellis M, Hooper R, Glucksman E, Jackson S, Swift C. Prevention of falls in the elderly trial (PROFET): a randomised controlled trial. *Lancet.* 1999 Jan 9;353(9147):93-7.

Proposed Improvement Activity, Frailty Assessment and Risk Mitigation

(under subcategory, Patient Safety and Practice Assessment)

Subcategory	Activity	Weighting
Patient Safety and Practice Assessment	Perform frailty assessment using a validated measure of frailty and develop a care plan to either reduce or reverse risk factors for frailty (e.g., interventions to improve patient nutrition, physical functioning, gait, balance, strength, use of community-based services); and assure delivery of essential services to support the patient and caregiver.	High

B. Quality Performance Category

The AGS looks forward to working with CMS on the development of future metrics based on the care episode groups, patient condition groups, and physician-patient relationship categories. We commend CMS on promoting ways to develop new, more applicable measures, but note that these development processes require substantial resources which are beyond those of a specialty society. We also note that most of the current measures are single condition focused, whereas many Medicare beneficiaries, particularly patients in a geriatrician's practice, are likely to have multiple conditions. **We encourage CMS to facilitate and sponsor measure development for the very population CMS expends the most resources upon—that is, the multi-morbid patient with functional impairment who is not institutionalized. We recommend that CMS prioritize measures that specifically address care of the geriatric population.**

We are concerned that some quality measures that are listed in the General/Family Practice or Internal Medicine specialty measure sets are also applicable to geriatric medicine, but will measure very different patient populations for geriatricians. In particular, the AGS notes that the specifications for those measures may make them inapplicable for many geriatricians, because the criteria for inclusion of beneficiaries in the measure excludes the oldest patients. For example, the following measures exclude patients above a specific age:

- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%): Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
- Diabetes: Eye Exam: Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal or dilated eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period.
- Diabetes: Foot Exam: Percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.

Restrictions that prevent the reporting of a measure for the most elderly patients limit the applicability of those measures to many geriatricians who may not have a sufficient number of patients within the specified age range to report the measure. Even when the measure can be reported, the results may

not provide an accurate picture of the geriatrician's performance across his or her full patient population or recognize the high quality care geriatricians provide to the most senior of patients, who are often more fragile and medically complex than younger patients, as compared to others reporting the same measure. Further, because CMS is requiring reporting of all-payer data, we are concerned that the inclusion of younger, generally healthier patients in the data set used to calculate performance thresholds may disadvantage geriatricians across all of the quality measures, not just those that exclude the oldest beneficiaries.

Therefore, **the AGS recommends that CMS take necessary steps to minimize the impact of differences in the case mix of physicians' patient populations.** CMS should analyze the quality performance data looking at Medicare and non-Medicare populations separately, and should also examine whether stratifying the performance data by specialty code, site-of-service code, or both will result in more accurate measurement and fair adjustments for physicians who treat the sickest patients. We believe it will be essential for CMS to monitor results by specialty to determine if certain disciplines consistently under-perform, suggesting the process, not the clinician, is the source of low performance results. If stratifying the data by specialty type is possible, the AGS believes that comparing geriatricians who treat patients with comorbid conditions to other geriatricians who also treat patients with comorbid conditions will be more appropriate and accurate than comparing geriatricians to other primary care physicians who treat less complex cases.

C. Resource Use Performance Category

The AGS supports continued use by CMS of mathematical modeling to refine its methodology for measuring resource use, particularly with regard to risk adjustment. The AGS is concerned that the ten final Episode Groups do not include adequate adjustments to address patients with multiple chronic conditions. For those patients, we are uncertain whether CMS envisions episodes that combine commonly co-occurring conditions but would continue to treat other less common chronic condition combinations separately. Involvement of the appropriate clinicians and specialty societies will be vital in determining which conditions could be combined and how that should occur. It may be that for primary care geriatricians focused on outpatient services, total cost of care more accurately assesses resource use for persons with multiple conditions.

In addition to developing episodes specifically geared toward patients with comorbidities, **the AGS recommends that CMS test the performance of other episode groups on patients with multiple chronic conditions.** Unfortunately, with the information provided, the AGS is unable to determine how our members would be affected by the use of the ten episode groups, particularly given the need to account for patients with multiple chronic conditions. Additional variables, such as presence of dementia, should be assessed.

The AGS is also concerned that the methodology for attributing episodes to physicians is not transparent. Unless and until CMS is able to share data with physicians about the patients who were assigned to them based on claims data and help them understand not only the cost of the care they provided individually but the cost of care provided by the other physicians in close to real time, physicians will not have the necessary tools to evaluate their resource use or to succeed in the MIPS.

D. Improvement Activities

The AGS believes that CMS should use the flexibility this category affords to identify activities that will help in the management of individuals with multiple chronic conditions. The AGS supports CMS' criteria for deciding whether to include an improvement activity on its list, particularly the criteria of achieving improved beneficiary health outcomes, aligning with patient-centered medical homes, and choosing those that are feasible for small practices to implement.

The AGS recommends that CMS continue to accept a minimum of 90 days for reporting improvement activities in 2018, rather than increasing it to a full year, to allow for more realistic practice transformation in the QPP, particularly since clinicians will be required to upgrade their certified electronic health record technology (CEHRT) in 2018 for the Advancing Care Information performance category. **The AGS requests that CMS release further sub-regulatory guidance on how the attestation process for improvement activities will work, and on how CMS plans to approach any specified performance period,** especially for activities that practices began implementing prior to the start of the performance window.

However, since improvement activities are a new performance category that does not have established standards or metrics, the AGS is concerned that CMS' documentation requirements in the final rule are too vague. CMS intends to "refrain from imposing restrictive specifications" and "may retain any documentation that is consistent with the actions they took to perform each activity." CMS will verify data "as necessary" and will "publish additional detail through non-binding clarification or guidance as we are able."

We believe CMS should develop more specific guidance on its preferences for documentation of compliance with all aspects of MIPS and all performance categories. Given recent enforcement trends, the AGS recommends that CMS publish guidelines that clinicians can follow to stay in compliance. We believe this need is particularly acute for improvement activities, as they are conducted at the practice level and may not be reflected in individual patients' medical records, or attributable to individual clinicians, and urge CMS to prioritize guidance for this category.

We appreciate CMS' establishing an improvement activity of fall screening and assessment. However, we are concerned that it is narrowly defined and only addresses the performance improvement activity to prevent falls. It is also weighted as only "Medium" scoring. **The AGS recommends that CMS modify the weight of this improvement activity to "High"** because of the clinical, economic and population-based importance of falls. Falls occur in over 30 percent of Americans aged 65 years and older⁵, account for millions of visits to emergency departments⁶, result in 700,000 admissions to hospitals for serious injuries⁵ (e.g., 250,000 hip fractures annually)⁷, and incur an average hospital cost of \$35,000 with 78 percent of costs charged to Medicare.⁸

⁵ Important Facts about Falls. Home and Recreational Safety. Centers for Disease Control and Prevention Website. <http://www.cdc.gov/homeandrecreationsafety/falls/adultfalls.html>. Accessed June 17, 2016.

⁶ Data and Statistics (WISQARS). Injury Prevention and Control. Centers for Disease Control and Prevention Website. <https://www.cdc.gov/injury/wisqars/index.html>. Accessed June 17, 2016.

⁷ Health Care Use and Expenditures. Health Data Interactive. National Center for Health Statistics. Centers for Disease Control and Prevention. <http://www.cdc.gov/nchs/hdi/index.htm>. Accessed June 17, 2016.

⁸ Stevens JA, Corso PS, Finkelstein EA, Miller TR. The costs of fatal and nonfatal falls among older adults. *Inj Prev*. 2006; 12(5):290–5.

E. Advancing Care Information

The AGS urges CMS to work with vendors to ensure that vendors' products evolve as CMS' policies evolve and to ensure adequate advanced notice of upcoming changes so that physicians can trust that they will not be penalized for failing to report data their technology was not updated to collect.

F. Low Enrollment / Low Spending Threshold

The AGS appreciates the changes CMS made in the Final Rule to exclude significantly more clinicians from the MIPS by revising the low enrollment / low spending thresholds. The AGS appreciates that CMS has raised the low-volume threshold for exclusion from MIPS—to 100 or fewer Medicare Part B patients/annual Medicare Part B billing less than or equal to \$30,000—which helps smaller and rural providers who furnish services to Medicare beneficiaries in hospices and are paid primarily through Medicare Part A, but also might want to start expanding into palliative care outside the hospice benefit. A low threshold for participation in MIPS could disincentivize such an expansion, and decrease access to vital palliative care services by Medicare beneficiaries in these areas. **We urge CMS to maintain the low-volume thresholds in future years** and revisit them to make sure they are adequately high.

G. Calculating the Composite Performance Score (CPS)

The AGS appreciates CMS' simplification of the quality and improvement activities performance categories. However, the AGS continues to be concerned that the scoring approach for MIPS is too complex and will lack the transparency needed for physicians and NPPs to understand what actions they can take to improve their scores. **We urge CMS to create a simpler, less burdensome scoring formula in the interim** while EHR vendors work on their “end-to-end electronic reporting” systems that will permit reporting all of the performance categories at once. Integrated clinical and financial data will give physicians and NPPs the ability to see how their data combines to calculate the score, but most providers do not have access to it at present.

While we appreciate CMS' decision to reduce the weight of the cost performance category to zero for 2017, we are concerned that CMS will lack flexibility to modify it from the statutory 30% weight for the 2019 performance year. The change from a 10% weight to a 30% weight could have unintended consequences, as providers in MIPS may not be participating in care systems that can affect cost substantially, and thus may be negatively affected by spending beyond their scope of care. **For this reason, we urge CMS to move as quickly as possible to establish the patient relationship codes and allow physicians to use them for billing to improve the attribution methodology for costs.**

H. Performance Feedback

The AGS urges CMS to expedite the process so that partial-year data on performance in the first year of the MIPS is available to physicians prior to July 1, 2018—and preferably prior to January 1, 2018. Because there have been ongoing problems with a lack of provider awareness of the existing PQRS Feedback Reports and QRURs and difficulties accessing them through the CMS portal, **CMS should consider establishing an email list serve for physicians so that they will be notified when the QRURs are available**. We also encourage CMS to continue to work with stakeholders to improve the usability of the reports.

Comments on APMs

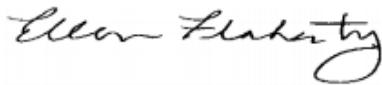
Given the relatively small number of APM entities and clinicians participating in such entities, **CMS should establish more inclusive policies regarding Advanced APMs that encourage the development of and participation in APMs generally. CMS should be encouraging these activities not only for large health care networks that can take on significant financial risk immediately, but for smaller organizations and a variety of provider types, who, relative to their size and structure, are taking on substantial risk in their own right.** High quality, patient-centered care can come in all shapes and sizes, and CMS should not limit its ability to promote transformative care by so narrowly defining payment models that will meet the definition of Advanced APMs.

As both clinicians and CMS gain experience with APMs, in subsequent years, CMS could look to set forth gradually increasing financial risk criteria that would reflect the state of APMs at that time. Such an approach would allow CMS to develop appropriate criteria for identifying Advanced APMs while encouraging APMs entities to craft innovative designs that allow them to succeed through care transformation and the provision of high-value care, and maximize clinician participation in APMs.

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Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Anna Mikhailovich, amikhailovich@americangeriatrics.org.

Sincerely,



Ellen Flaherty, PhD, APRN, AGSF
President



Nancy E. Lundebjerg, MPA
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