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Andrew Slavitt
Administrator
Center for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-5517-P Notice of Proposed Rulemaking Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Administrator Slavitt:

Most Americans will live long lives and will have a substantial period of disability in the last few years of life, and we will run up our largest costs related to health care and disability in that phase of life. Indeed, for many of us, this period will cost more than half of our life-time expenditures on health. During the final phase of life, many of us will get fragmented health care from a variety of specialists, mostly paid by Medicare, and supportive services on an erratic basis paid out-of-pocket. Eventually, we will end up needing institutional care or assisted living, or relying on family caregiving. For most of us, a great deal of money will have been spent, mostly with little gain, and we and our families will have been left anxious and battered. A few will be lucky enough to be under the care of geriatricians (and here I include nurse practitioners and physician assistants, and internists, palliative care clinicians, and family physicians who have come to focus on the advanced illnesses and disabilities associated with the last phase of life) working with interdisciplinary teams to provide comprehensive services. This begins with a care plan that is grounded in reality and aligned with the priorities that the patient and family actually have.

Geriatricians focusing on frail, sick, and disabled elders are seriously at-risk under the proposed MACRA implementation. Geriatric medicine is already a diminishing and embattled specialty, where geriatricians receive an actual reduction in income for entering this specialty. Many geriatricians cannot support a practice on Medicare fee-for-service billings alone, so most also have salaried positions (e.g., as a nursing home or home care medical director) or are

employees of hospitals or managed care entities. However, most Medicare beneficiaries in this last phase of life are in fee-for-service Medicare, and they need physicians with appropriate skills. MACRA promises to make it very difficult for geriatricians to support their team and serve their patients.

Let's begin by discussing the role that MIPS has in effecting a physician's practice and fee schedule. The major element in determining a physician's MIPS score will be quality measures (QMs). We can gerrymander enough of the proposed QMs to report six – e.g., care plans, falls risk assessment, depression assessment, medication reconciliation, and osteoarthritis and pain assessments. Care planning is only assessed as advance care planning or in transitions. Comprehensive care planning is not in evidence. Geriatricians have no real outcomes measures. Why should an elderly person living with advanced illnesses and disabilities want a geriatrician? Our special contribution to a frail elderly person's life is developing and implementing a comprehensive, continuity care plan that is honest about options, realistic, and aligned with the person's preferences. Geriatricians also have a special contribution by helping to build care systems that will deliver on that care plan, over time, in all circumstances, through to the end of life, thus relieving patient and family from fear and anxiety. Those elements are not available in current quality measures, so care of the frail and disabled elderly will be judged by standards set for other patients and other situations.

This brings us to another issue of evaluating quality measures among varying specialties. Since geriatricians will have more patients that are sick and disabled compared to general internists and family practitioners, geriatricians will be more likely to fail to score well on the quality measures. As a result, either all geriatricians (if compared with other primary care physicians) or half of geriatricians (if compared with one another) will end up with negative scores.

Of course, we could use new metrics if we developed them and put them in a registry. But our organizations are weak, with few geriatricians and few making much money, so we don't have registries in operation.

Another component of MIPS measures is to be the use of health information technology. Since many of our settings of care (nursing homes, assisted living facilities, foster homes, home care, hospice units, day care centers) have not been beneficiaries of the Meaningful Use program, most have very limited capacity for connectivity, patient portals, or interoperability. Indeed, many settings where geriatricians work have no HIT at all. Furthermore, virtually all of the social and supportive services in the community are not linked in any way with health IT. So, geriatricians are going to do badly by these criteria.

On resource use, the CMS proposal assumes that the patient course is adequately described in episodes of treatment, largely initiated by hospitalization. This is not an adequate conceptualization of our patients' courses. They are living with serious and worsening conditions, usually with multiple medical diagnoses, sensory and communication deficits, cognitive challenges, limited funds, inappropriate housing, and highly variable informal support. Every so often, the patient's condition gets worse, and sometimes that leads to hospitalization (but not always). The care plan existed before hospitalization – it did not start with hospitalization. The trip to the hospital was just a somewhat worse day in a string of difficult days. The end of the event that might have caused hospitalization is not the end of much that is important. This is very different from, for example, a pneumonia in a generally healthy adult. That person generally comes back to their baseline if they don't die, and generally within a month or so. In contrast, a fragile elderly person has pneumonia (or a fall, a urinary tract infection, a dental problem, or any of dozens of other complications) as part of their overall declining course, and they generally do not come back to baseline. Their "episode" has become lifelong, though CMS could enable year-long episodes for administrative purposes. Their pneumonia clears up, but they have deconditioned, and they've lost their aide during hospitalization, and so on. And we keep many pneumonia patients in their community or nursing home setting, because they do so poorly in the hospital, but there won't be credit given for the cost reductions that this pattern generates.

Clearly, very sick elderly patients are going to be more expensive in the hospital and just after, and often in ways that cannot be predicted by medical diagnoses alone. Once again, geriatricians are going to look bad in comparison with others, or with ourselves. Of the resource use episodes listed in the NPRM, only pneumonia is likely to be frequent enough to rely upon.

I believe that geriatricians can do as well as anyone on the quality improvement agenda, but that is a small part of the formula.

So, geriatricians are likely to lose on three of the four domains and therefore to be further limited in Medicare reimbursements, now and over time. This seems to be a formula for making geriatric practice increasingly unattractive, at a time when the country faces substantial increases in the numbers of frail and disabled elders. This is not a wise course.

Could geriatricians succeed in APMs? There is some reason to hope. CPC+ proposes a Track 2 option that would generate substantial flexibility and additional income for mature practices. Of course, only a few get to try this out, and only after a long period of development. Accountable Care Organizations might have to take on this population, over time, and having geriatric practitioners will prove to be a boon, as it has for those that have sponsored Independence at Home practices and for the Veterans Health System's Home-based Primary

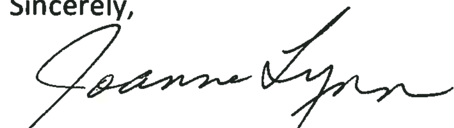
Care. Unfortunately, most ACOs will not qualify as APMs. So, we will need to develop Physician-Focused Payment Models. Unlike most specialties, we do not have the kind of access to analytics, data, and investigators that could fully develop such a payment model. We are working on it, but we will probably need more guidance and technical assistance than most other applicants.

Of course, one alternative would be to educate the skeptical public to move into capitated systems (and to adequately risk-adjust their payments), so that geriatric clinicians would be mostly salaried with some incentives.

These all seem to be substantial gambles. At a time when the major predictable health issue facing the nation is the enormous rise in elders living with advanced illnesses and disabilities, we have a thoroughly inadequate health care system to meet even current demand. Now, we add substantial challenges to sustaining and growing that expertise within effective delivery reforms.

CMS insures all of this population. CMS should be especially concerned with the overuse of medical interventions and the lack of widespread expertise in geriatric issues. Without extraordinary luck, geriatric practitioners stand to lose in MACRA. With some sustained attention, CMS could enable substantial reforms that make service delivery excellent for this phase of most lives - reliable, efficient, adherent to evidence, and aligned with patient and family priorities.

Sincerely,



Joanne Lynn, MD, MA, MS, MACP
Director, Center for Elder Care and Advanced Illness
Altarum Institute
Joanne.Lynn@Altarum.org