Business Group on Health

October 2, 2020

Submitted electronically via: www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1734-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1734-P – Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements

Dear Sir or Madam:

Business Group on Health (The Business Group) appreciates the opportunity to respond the Centers for Medicare and Medicaid Services' (CMS's) notice of payment policies under the physician fee schedule, Part B payment policies, Medicare Shared Savings Program requirements and others.

The Business Group represents a network of today's largest and most progressive employers, including 74 Fortune 100 companies, providing health coverage for 60 million workers, retirees and their families in 200 countries.

As the largest single payer for health care in the U.S., Medicare must continue to lead the way and partner with private sector payors to drive delivery transformation away from a dysfunctional fee-for-service (FFS) toward alternative payment models that will reduce overall costs and improve health outcomes, particularly those successful at managing the total cost of care, improving population health, and keeping people well.

The Business Group is encouraged by CMS' continued move towards these goals.

20 F Street, NW
Suite 200
Washington, DC 20001

202-558-3000
info@businessgrouphealth.org

Visit us at:
www. businessgrouphealth.org

Specific to the proposed rule, the Business Group is commenting on proposed changes to the Medicare Shared Savings Program, promoting telehealth, increasing access to care and coverage of opioid treatment programs (OTPs).

Medicare Shared Savings Program

The Business Group applauds CMS efforts to continuously refine the Medicare Shared Savings Program (entities participating are known as Medicare Accountable Care Organizations (ACOs)) to achieve better health outcomes for Medicare beneficiaries at reduced costs. According to a recent Health Affairs article, in 2019, "541 ACOs in the Medicare Shared Savings Program generated $1.19 billion in total net savings to Medicare". To build upon this success and generate increased savings in the future, CMS must continue to refine the ACO program as it gains in maturity.

As CMS notes, the ACO program is now in its eighth performance year. In the proposed rule, CMS recommends increasing the minimum quality performance thresholds that ACOs must meet to share in savings from the 30th percentile to the 40th percentile across all quality performance categories to be eligible for any savings. The better their performance on quality, the more they share in savings. The Business Group strongly supports CMS recommendation.

The Business Group also supports flexibility for participants in the MSSP program under the extreme and uncontrollable circumstances provision to assure that ACOs are not discouraged from continuing participation because of any adverse impacts due to the pandemic or by increasing the administrative burdens of participation at this time. This flexibility extends to 2020 performance period and includes reporting requirements, accounting for costs due to COVID-19 in the calculation of shared savings, choosing to extend participation for a year and permitting the postponement of requirements to advance along the different tracks within the program based on the number of years in the program.

The Business Group believes that consumers need better, more reliable information on clinical quality, not less. CMS' leadership is critical to efforts to provide better information on provider quality to Medicare patients as well as others. Therefore, we are concerned that CMS is proposing that, for performance year 2021, the ACO quality measure set would be reduced from 23 measures to 6 and the number they would be required to report would be reduced from 10 to the following 3:

- Quality ID#: 001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

- Quality ID#: 134 Preventive Care and Screening: Screening for Depression and Follow-Up Plan; and
- Quality ID#: 236 Controlling High Blood Pressure.

While these are important measures and screening recommendations, CMS would stop reporting on other important care measures including care coordination/patient safety (risk-standardized acute admission rates for patients with multiple chronic conditions), preventive care (tobacco use: screening and cessation intervention, breast and colorectal cancer screenings and influenza immunization) and other measures. Instead of eliminating these reporting requirements, we recommend CMS continue to include them.

Quality Payment Program

The Business Group also agrees with CMS' intent to reduce the reporting burden for providers by harmonizing the set of reporting quality measures under the Merit-based Incentive Payment System (MIPS program) and the Medicare Shared Savings Program, and helping transition clinicians from MIPS, which is FFS-based, to Alternative Payment Models (APMs) through the MIPS Value Pathways (MVP) and the newly proposed APM (APP) reporting option within the MVP framework.

Under the proposed APP, limited to providers already participating in APMs and therefore already responsible for cost containment under their respective APMs, they would report performance on six quality measures specifically focused on population health. We applaud efforts by CMS to focus on measures of population health in this new APP pathway to move clinicians away from FFS, but given the disruption caused by the pandemic, as evidenced by the flexibility that CMS is proposing for the MSSP, CMS may also want to hold off introducing a new pathway for reporting at this time.

The APP proposes that participants report on the following measures: patients' experience of care (CAHPS for MIPS), management of chronic conditions (control of hemoglobin A1c), preventive care, screening and follow-up plan for depression, control of high blood pressure, and two measures of all-cause unplanned readmissions (one measured at 30 days for all conditions, the other being risk standardized and limited to readmissions for multiple chronic conditions). Business Group on Health participates in the Core Measures Quality Collaborative, which the CMS also participates in, and the NQF's Measures Application Partnership, which advises the CMS, both of which share the goals of promoting meaningful measures, reducing the administrative burden, and aligning measures across payers and programs. Therefore, we recommend that CMS

consider the NCQA measure of all-cause readmissions at the ACO level recently recommended by the CMQC as the required measure of readmissions for the APP. It is important that private sector and public program measures be aligned to reduce provider collecting and reporting burdens and to facilitate comparisons by payers and patients.

The Business Group also supports adjustments to the performance category weights in the MIPS program, increasing the cost performance category by 5% to be weighted at 20%, with the quality category being reduced from 45% to 40% for the 2021 reporting period, which would impact payment in 2023, while maintaining the same percentage weights for promoting interoperability (25%) and performance improvement activities (15%). We also support proposals to phase-in higher increases in the weighting of cost performance for future years, with costs being weighted at 30% for 2024 and subsequent years. The changes will increase the importance of efficiency and cost control for physicians remaining in FFS and encourage more to consider migrating to APMs.

Promoting Telehealth

The Business Group supports CMS' efforts to increase access to health services provided via telehealth both during the COVID-19 public health emergency (PHE) and beyond. Medicare coverage and payment rules can facilitate increased access for employers and plan participants in private plans. Specific to the proposed rule, the Business Group supports:

- Adding services to the to the Medicare telehealth services list that will go beyond the public health emergency (PHE) under Category 1 (services similar to ones already covered by Medicare), Category 2 (services that are not similar to those currently covered by Medicare) and temporary Category 3 services (where providers or patients need to maintain physical distance to avoid exposure to COVID-19). Listed below are some examples of new approved services.
    - Some examples of category 1 services include prolonged office or other outpatient evaluation and management service, group psychotherapy, neurobehavioral status exam and others.
    - Some examples of category 2 services include initial and subsequent observation and observation discharge day management and others.
    - Some examples of category 3 services include domiciliary or rest home visits for the evaluation and management of an established patient, psychological and neuropsychological testing, and others.

However, we do have the following caveats and exception. The Business Group recommends that the CMS closely monitor and evaluate telehealth procedures to guard against fraud, waste, and abuse; ensure quality and safety, and protect patients' privacy. For example, we recommend monitoring telehealth services that when provided through telehealth have a demonstrated history of overbilling or unnecessary use. We also urge caution regarding permanent coverage of emergency services provided in a telehealth setting where a beneficiary cannot receive additional in-person care follow-up care.

Non-Physician Providers (NPPs) Flexibility

An optimized health care delivery system that bears financial risk while managing population health, would have incentives to provide access to care within the most appropriate provider and care setting. The Business Group supports CMS' efforts to steer the delivery system via changes to payment rules that seek to provide increased flexibility for telehealth in the supervision of NPPs and, in turn, flexibility for NPP supervision of other health care professionals. These flexibilities should help reduce costs without adverse impact on quality and help free up physicians and NPPs to focus on other patient care needs. Specific to the proposed rule's recommended payment changes under Part B, the Business Group supports:

- Allowing non-physician providers, such as counselors, to be supervised remotely via telehealth by physicians instead of requiring physicians to be physically present.
- Permitting certain nonphysician practitioners to supervise diagnostic tests, which would authorize Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Physician Assistants (PAs) and Certified Nurse Midwives (CNMs) to provide the appropriate level of supervision assigned to diagnostic tests, to the extent authorized under State law and scope of practice.
- Allowing physical therapists (PTs) or occupational therapist (OTs) who establish therapy maintenance programs to assign the duties to PT assistants (PTAs) or OT assistants (OTAs), as clinically appropriate, to perform maintenance therapy services.

Revaluing Evaluation and Management Services

We also support efforts by CMS to increase the relative weights to determine payments for office/outpatient evaluation and management services. Office visits, consultations with patients, and similar efforts to diagnose patients' conditions have

generally been paid much less and are often underpaid in Medicare compared to specialists and high-tech care. Yet, the right diagnosis and treatment often depends on the initial evaluation and management visit to primary care providers. Not only are patients better served when evaluation and management services are more highly valued, but the Medicare program also benefits when unnecessary care is avoided through better diagnosis and weighing of treatment options up front.

Coverage of OTPs

According to a September 2020 American Medical Association (AMA) Issue Brief the opioid crisis, officially declared a "public health emergency" in 2017, is worsening due to the COVID-19 pandemic. Opioid misuse and abuse have ramifications all payers, including employers and employees. Among employer challenges are lost productivity costs, excess medically related absenteeism and disability costs, as well as caregiver and dependent costs. Therefore, the Business Group strongly supports CMS previous actions to address the opioid crisis via Medicare payment and the following, which are specific to this proposed rule:

- Expand the list of drugs that CMS will cover for Opioid Use Disorder (OUD) to include opioid antagonist medications drugs, such as Naloxone, that can be used for emergency treatment of opioid overdose.
- Revise OUD treatments to include overdose education and including that in bundled payments for episodes of care.

Thank you for considering our comments and recommendations. Please feel free to contact me (kelsay@businessgrouphealth.org), Steve Wojcik (wojcik@businessgrouphealth.org), the Business Group's Vice President of Public Policy or Matthew Sonduck (sonduck@businessgrouphealth.org), Policy Associate to discuss.

Sincerely,

Ellen Kelsay

Ellen Kelsay
President and CEO