PREMIER TRANSFORMING HEALTHCARE TOGETHER®

October 5, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1734-P
Submitted electronically to: http://www.regulations.gov

Re: Medicare Program: 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Verma:

On behalf of the Premier healthcare alliance serving approximately 4,100 hospitals and health systems, hundreds of thousands of clinicians and 200,000 other provider organizations, we appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services CY 2021 Physician Fee Schedule. Premier maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our hospitals and health systems, their employed physicians and independent physicians aligned with them. Premier runs the largest population health collaborative in the country, the Population Health Management Collaborative, has worked with well over 200 accountable care organizations (ACOs) and is currently comprised of more than 70 ACOs.

MEDICARE SHARED SAIVNGS PROGRAM

Quality Reporting Changes

CMS proposes fundamental changes to the quality performance standard for Medicare Shared Savings Program (MSSP) ACOs. CMS proposes to align MSSP reporting requirements with the proposed APM Payment Pathway in the Merit-based Incentive Payment System (MIPS). Previously, CMS sought comments on aligning MSSP with MIPS. This proposed change includes several components:

- Elimination of the CMS Web Interface reporting mechanism, requiring ACOs to report via eCQMs or registries;
- Reducing the number of measures to five and the CAHPS survey;
- Increasing the quality performance standard from the 30th percentile to the 40th percentile;
- Changing shared savings and shared losses determinations; and
- Changing the extreme and uncontrollable circumstances policies.

Premier has long advocated for a reduction in measures and allowing ACOs options for reporting measures outside the CMS Web Interface. However, these changes would require significant time and resources to implement during a time in which providers are still actively responding to the coronavirus pandemic. We request that CMS delay significant changes to the MSSP quality standard until 2022.

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Alignment with MIPS

A delay will also allow additional time for CMS to seek broader stakeholder input on significant revisions to the MSSP quality performance standard**. We believe that the stated strategic goal of aligning the MSSP quality standard with the MIPS quality performance category is misguided**. Premier generally supports alignment across CMS programs with the aim of ensuring care outcomes for patients and reducing provider burden. However, APMs should not have to align with MIPS, but rather MIPS reporting requirements should be structured to encourage clinicians to adopt APMs. MIPS assesses the point-in-time encounters delivered by individual clinicians and groups. Moreover, MIPS reporting groups reflect clinicians related by a common financial structure. Conversely, APMs reflect total cost of care arrangements where providers are responsible for coordinating care across the continuum. Ultimately, aligning APM quality measure sets to MIPS is antithetical to the goal of moving clinicians from volume to value, that is from MIPS to APMs.

Elimination of the GPRO Web Interface

CMS proposes to retire the CMS Web Interface in concert with its proposal to revise the MSSP quality performance standard. ACOs would be required to report electronic Clinical Quality Measures (eCQMs) via EHR or MIPS CQMs via a qualified registry or Qualified Clinical Data Registry (QCDR). **Premier has long advocated for ACOs to be able to use reporting mechanisms beyond the Web Interface.** The Web Interface is time consuming and labor intensive to gather the data. Additionally, the once-yearly data collection doesn't allow for continuous tracking and quality improvement. **We applaud CMS for recognizing ACOs' need for flexibility.** We believe using other reporting mechanisms will allow CMS to evolve the MSSP quality measure set and incorporate measures that can be assessed over multiple years and novel measures, such as patient reported outcomes.

We ask that CMS provide a transition period away from the Web Interface to allow clinicians to adapt or implement new systems. ACOs use a variety of technology and infrastructure approaches for combining clinical data across the ACO. It is critically important to understand that ACOs vary widely in their electronic data extraction and reporting capabilities, with some ACOs on a single EHR instance and others with dozens or even hundreds of different source systems. This reflects ACOs varying approaches to adding participant practices to the ACO that include a range from employment to alignment. For the ACOs with multiple source systems, producing MIPS CQM or eCQMs from those disparate systems, if even possible, would be prohibitively expensive and would require a third-party vendor to merge the data from each system. Current CEHRT standards include a requirement for eCQM support. However, this is focused solely on calculating eCQMs for and from each CEHRT instance and does not require support of combining data from multiple systems to produce a single result.

Recognizing the diversity of ACOs, we appreciate options for ACOs to report quality measures. However, making the switch to these alternative reporting options will cost many ACOs considerable time, money and effort in changing workflows, paying for registries and adapting, and modifying Electronic Health Records to report eCQMs in a way that is not currently required of CEHRT. **Accordingly, we request that CMS provide more time for ACOs to adapt to new reporting options.** While some ACOs may be ready to adopt new reporting mechanisms now, others need at least one additional year to implement a new reporting method.

We believe additional time is also needed for CMS to clarify how new reporting options will apply to ACO measurement. There are several areas related to moving to eCQM or registry reporting that are not addressed in the proposed rule:

- *Benchmarks.* In MIPS, benchmarks vary by reporting mechanism. With ACOs being able to report through two separate reporting mechanisms, CMS must clarify how benchmarks will be set for MSSP ACOs. If CMS will continue to separate benchmarks by reporting mechanism, CMS must ensure ACOs are not penalized by their choice of reporting mechanism.
- *Population Assessed.* In MIPS, clinicians are assessed on total population, not just Medicare beneficiaries. With a change in reporting mechanism it is not clear if ACOs will be required to report on all patients served by participating providers. The MSSP quality performance standard should only assess the care provided to beneficiaries aligned to the ACO. It is inappropriate to assess care of patients outside the ACO as the ACO entity does not have the ability or flexibilities (i.e. waivers) to design care interventions for other patients. Additionally, MSSP ACOs are Medicare entities and lack access to information about populations covered by other payers. **CMS should limit ACO reporting to the aligned population.**
- *Data Completeness.* In MIPS, clinicians must report on 70 percent of all patients when reporting via EHRs or registries. The Web Interface currently requires reporting on approximately 300 assigned patients. **CMS should start with a lower data completeness and increase over time**, allowing ACOs time to adapt data systems. This would align with the approach CMS used for clinician and group reporting, which began with a data completeness of 40 percent and which increased gradually to current levels.
- *New ACO Entities, New Measures and Significant Measure Changes.* The proposed rule would eliminate the pay-for-reporting year for ACOs beginning an initial MSSP contract, new measures introduced to the set and measures that undergo significant changes. Providing a year of pay-for-reporting in these instances allows ACOs to evaluate current workflows, data capture and other operational strategies necessary to monitor and report a measure. Removing a pay-for-reporting option will penalize new ACOs and those with practicing providers on multiple EHR systems. **CMS should retain a pay-for-reporting option for new entities, new measures and measures with significant changes in the MSSP program.**

MSSP Quality Measure Set

In adapting the APP measure set, MSSP ACOs would be required to report three measures (HbA1c Poor Control, Depression Screening and Follow-Up Plan, Controlling High Blood Pressure) and field the CAHPS for MIPS survey, in addition to CMS scoring two measures from administrative claims (Readmissions, Admissions for Multiple Chronic Conditions). CMS also seeks comment on additional measures to be included in the measure set and if certain ACOs, such as those with large nursing home populations, should be assessed on other measures. **Premier appreciates the significant reduction in measures proposed in this rule.**

Generally, the measure set is appropriate for ACOs; however, we urge CMS to take additional time to seek stakeholder input. We are concerned with inclusion of the readmissions measure because there is very little variation between high and low performers. Accordingly, providers could be penalized for differences in care that are not meaningful. The admissions for multiple chronic conditions measures is also problematic because it relatively new to the measure set. Providers have found it difficult to design and implement interventions targeted toward multiple chronic conditions (MCCs) and would like to gain additional experience with the measure. Finally, two of the measures to be reported are approaching topped out status. CMS should use the Measure Applications Partnership (MAP) to provide input on the ideal measure set for MSSP; the statutory intent of the MAP is to evaluate quality measures to ensure the measures appropriately fit a program.

Quality Performance Standard and Shared Savings Determination

CMS proposes to increase the quality performance standard by raising the current minimum attainment level from the 30th percentile to the 40th percentile. ACOs that meet the quality performance standard would share in savings at the maximum sharing rate. The current approach is to multiply the quality score by the maximum sharing rate. **We support raising the quality performance threshold and allowing ACOs that meet the standard to receive full shared savings**, provided that this change accompanies a smaller program measure set and the standard is assessed as an average of the measures.

We would not support a 40th percentile standard applied to each measure given our concerns about several of the measures

Extreme and Uncontrollable Circumstances Changes

For performance year 2021, CMS proposes to change the extreme and uncontrollable circumstances approach to align with the proposed quality changes. CMS would set the minimum quality performance score for an ACO affected by an extreme and uncontrollable circumstance during the performance year to equal the 40th percentile MIPS Quality performance category score. **We support this change.**

CMS also proposes a change to the performance year 2020 extreme and uncontrollable circumstances to mitigate the potential reductions in performance due to COVID-19. CMS would use the higher of the ACOs 2019 or 2020 scores and CMS will not require ACOs to field the CAHPS survey, awarding full points for the CAHPS measures. **We support this change.**

Revisions to Definition of Primary Care Services in Beneficiary Assignment

CMS proposes to build on the changes adopted in COVID-related interim final rules that expanded the definition of primary care services for purposes of determining MSSP beneficiary assignment to include telehealth codes for virtual check-ins, e-visits, and telephonic communication. **Premier supports the proposed additions, as well as the permanent addition of G2010 and G2012, to the MSSP primary care services decision beginning with performance year 2021.** Virtual check-ins (G2012) and remote evaluation of patient video/images (G2010) are communications-based technology services that have proved their value across the disease spectrum and care continuum and will continue to have a place after the PHE ends.

CMS also proposes to revise the existing primary care service exclusion for professional services billed under CPT codes 99304 through 99318 that are furnished in a SNF to include services reported on a claim originating in an FQHC or RHC. **Premier applauds CMS for its quick and thoughtful consideration of this exclusion.** This change will limit alignment to the ACO to those beneficiaries with which the ACO has a relationship.

Reducing Amount of Repayment Mechanisms for ACOs

CMS proposes to allow certain ACOs to benefit from a lower repayment mechanism amount than would otherwise be required under the current regulations. CMS also proposes to allow an ACO that renewed its agreement period beginning on July 1, 2019, or January 1, 2020 to elect to decrease the amount of its repayment mechanism if upon renewal it elected to use an existing repayment mechanism and the recalculated repayment mechanism is less. **Premier supports this change.**

QUALITY PAYMENT PROGRAM

APM Performance Pathway

CMS proposes to add the APM Performance Pathway (APP) as a new option for MIPS reporting and scoring and terminate the MIPS- APM scoring standard. **Premier does not support this change.** The APM scoring standard was designed to reduce burden and increase meaningful measurement for MIPS eligible clinicians participating in MIPS APMs who are not in downside risk arrangements or do not reach QP status and thus remain subject to MIPS. The MIPS-APM scoring standard correctly used the APMs existing quality measure set and applied it to MIPS. This significantly reduced provider burden as clinicians were held accountable for one set of measures, those of the APM.

The APP would introduce additional burden for APM entities and the clinicians that participate in the entity. For example, the Comprehensive ESRD Care model measure set does not have any measures that are in the APP proposed measure set. Accordingly, to be scored in MIPS clinicians would have to separately report MIPS measures or report the APP measure as an APM entity. This would make clinicians accountable for two sets of measures, the model measures and measures for MIPS. Moreover, the APP measure set includes measures, such as HbA1c control, that are not appropriate for an ESRD population. CMS notes that the APM entity could report MIPS measures; however, the clinicians would be scored on the cost category which duplicates the cost monitoring measures inherent to an APM. **It is unclear why CMS states this proposal would reduce burden and confusion for clinicians in APMs.**

As we discuss above, we do not support aligning APM measures to MIPS. APMs should have measure sets that are unique to their patient populations. The APP creates a one-size-fits-all construct for APM measurement and fails to recognize the distinct APM populations**. CMS should continue to use the APM scoring standard, applying APM measure sets to MIPS scoring to reduce clinician burden.**

Advanced APMs

We urge CMS to commit to pay the Advanced APM incentive payment no later than June 30 in future years. The extended gap between QPP performance and incentive payment continues to present a barrier to greater adoption of Advanced APMs. Timely payment of the Advanced APM incentive payment would reflect CMS' support of the hard work that providers are doing and encourage additional movement toward advanced risk models. We also encourage CMS to implement an appeals process related to these payments.

Third Party Intermediaries

We ask that CMS establish more consistency in the self-nomination and approval process. We have experienced a lot of variation in reviews with one registry being approved for certain elements and another registry requiring additional information for the same information. This variation makes it difficult to determine information that should be included in the self-nomination.

TELEHEALTH AND OTHER SERVICES INVOLVING COMMUNICATION TECHNOLOGIES

Telehealth is an essential tool for providers in addressing the healthcare needs of Medicare beneficiaries during the COVID-19 public health emergency (PHE). **We appreciate the flexibilities that CMS has**

provided and urge CMS to continue to expand Medicare coverage and payment of all types of virtual services involving communications technologies including telehealth, online visits, and audio visits.

For the duration of the PHE, CMS has expanded the list of services to the Medicare telehealth list without going through its normal rulemaking process. Absent the PHE, CMS adds services to the telehealth list based on their similarity to other services currently on the telehealth list (Category 1) or on an assessment of whether the services demonstrate clinical benefit to the patient when provided by telehealth (Category 2). For CY 2021, CMS makes several proposals to continue to include many of the services added during the PHE on this telehealth list. CMS recognizes nine services as similar to other services currently on the telehealth list (Category 1) and proposes to add these services to the telehealth list. For the remaining services added during the PHE, CMS believes these services do not yet have evidence of clinical benefit when provided by telehealth (Category 2) and proposes a new category of telehealth services (Category 3) which would allow services to be added on a temporary basis and provide time for the development of evidence supporting the clinical benefit of having these services performed by telehealth. CMS proposes that Category 3 would expire at the end of the calendar year in which the PHE expires. CMS believes this provides sufficient time to develop the necessary clinical evidence and allow stakeholders to request additions to the telehealth list on a permanent basis through the normal rulemaking cycle.

The Premier health alliance supports CMS' proposed expansion of the Category 1 services on the telehealth list. We also support CMS' proposal to include a Category 3 for telehealth services which would temporarily add services to the telehealth list. We are concerned however, that CMS proposes to define the duration of Category 3 services to the end of the calendar year in which the PHE expires. Instead, **we recommend CMS set a defined time period, such as the end of the 2023.** This would provide sufficient time for data collection and analysis to demonstrate clinical benefit, as well as provide time for stakeholders to submit requests to CMS for moving a Category 3 service permanently to the telehealth list. Since CMS requests must be received no later than December 31 of each calendar year to be considered for the following year's proposed rule, it is not realistic for CMS to expect stakeholders will be able to meet the December 31, 2020 deadline for consideration during the 2021 rulemaking cycle that established the telehealth list for calendar year 2022. This two-year time span between submission of a request to CMS and implementation of additions to the telehealth list requires Category 3 status to continue until 2023.

During the PHE, CMS has recognized the important of mobile computing devices that include audio and video real time interactive capabilities, such as mobile telephones, for providing telehealth services. We support CMS' proposal to redefine "interactive telecommunication system as multimedia communication equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between patient and the distant site physician or practitioner."

Finally, CMS has established separate payment for audio-only telephone evaluation and management (E/M) services based on the CPT codes for telephone services. CMS acknowledges the potential need for audio-only interaction after the PHE, but it proposes to eliminate coverage for these services when the PHE ends. Telephone E/M services provide an important way for Medicare beneficiaries to have a medical discussion and potentially eliminate an in-person visit or an emergency room visit. Availability of telephone E/M services have been particularly important in instances where a beneficiary may not have access to video-capable technology or Internet or may not have the knowledge to utilize video platforms. In addition, after the PHE, Medicare audio-only E/M services allow beneficiaries to avoid other sources of potential infection. **Premier recommends that CMS continue coverage and payment for audio-only telephone E/M services.**

Telehealth in Value Models

Premier continues to believe that telehealth services offer the ability to enhance medical management between patients and providers, enable remote monitoring, and greatly improve communication and education between primary and specialty care providers. **We continue to recommend that CMS immediately allow broad telehealth flexibilities for alternative payment models (APMs)**. Specifically, the following waivers should be implemented without burdensome documentation requirements across all downside risk arrangements:

- **Originating Site Restrictions**: Several current CMS APMs include waivers for these requirements allowing patients to be outside of these geographic areas when receiving telehealth services and to use the patient's home as an originating site. These waivers greatly expand the utility of telehealth for both patients and providers but have been challenging to implement due to burdensome documentation requirements. CMS should develop uniform language for this waiver that can be incorporated into the design of future models. Additionally, CMS should look to minimize the administrative burden of implementing a telehealth waiver.
- **Asynchronous Service Delivery:** Telehealth services are generally limited to synchronous (real-time) interactions between patients and providers. Some CMS APMs (for example the Next Generation ACO model) have included waivers to allow asynchronous telehealth where images and other relevant information are transmitted to a distant site provider for review and response at a later time. This flexibility is limited to dermatology and ophthalmology and must be done using secure electronic communications systems that include visualization of the patient. CMS should retain this waiver and extend this flexibility to future APM participants. Furthermore, we recommend that CMS expand the ability to provide asynchronous telehealth to other provider types and service areas where real time communication is not essential for treatment decisions and where such a flexibility could be reasonable expected to improve patient access to services.
- **Telehealth Cost Sharing:** In response to the COVID-19 PHE, CMS waived requirements for patient cost sharing for telehealth services. The ability to reduce or waive cost sharing requirements eliminates a barrier to patient access for telehealth services. Prior CMS APMs have incorporated cost sharing waivers as an option for APM participants; however, the high prevalence of MediGap coverage, administrative burden of reporting requirements, and the fact that waived copays result in a financial loss to providers inhibited uptake. CMS should incorporate uniform waiver language eliminating patient cost sharing requirements for telehealth services in future APM model designs. Furthermore, CMS should simplify reporting requirements for this waiver and consider incorporating waived cost sharing amounts into benchmarks to limit the financial impacts on providers.
- **Cross-State Licensure**: As part of the COVID-19 PHE response, CMS implemented a temporary waiver allowing providers to deliver telehealth services across state lines as long as they met a standard set of licensure requirements. This waiver, intended to improve access during the PHE, also creates an opportunity to improve patient access to services overall and provides a pathway for improved continuity of care for patients that have moved or are traveling across state lines. CMS should work in support of state efforts to develop standards for telehealth licensure and participation in interstate medical licensure compacts that would allow for care delivery across state lines and incorporate this flexibility into the design of future APM models.
- **Remote Patient Monitoring:** In response to the COVID-19 PHE CMS expanded coverage for remote patient monitoring (RPM) to include both new and established patients, permitted the use of RPM for both acute and chronic conditions, and allowed patients to consent to RPM once annually. The use of RPM greatly expands the efficacy and utility of telehealth and, outside of the context of the COVID-19 PHE, could greatly reduce travel-related challenges for patients without

transportation or in rural areas. CMS should incorporate these flexibilities into a uniform waiver available to providers participating in future CMS APMs.

INFUSION THERAPY

Effective January 1, 2021 Medicare will cover home infusion therapy-associated professional services for certain drugs and biologicals administered intravenously or subcutaneously through a pump that is an item or durable medical equipment. Prior to furnishing home infusion therapy, the physician who establishes the plan of care is required to notify the beneficiary of the options available (such as home, physician's office, hospital outpatient department) for the furnishing of infusion therapy. CMS considered various requirements including mandating a separate form for documenting the notification. **Premier supports CMS' decision to allow physicians to continue the current practice of discussing the options available for furnishing infusion therapy and annotating these discussions in the patient's medical records**.

SCOPE OF PRACTICE RELATED ISSUES

Certain Medicare regulations impose more restrictive supervision requirements than existing state scope of practice laws which hinder healthcare professionals from practicing to the full extent of their licenses. CMS proposes a number of policies that are intended to provide greater flexibility under the Medicare program with respect to requirements for supervision. Policies providing greater flexibility to healthcare professionals have been implemented during the COVID-19 PHE and have been essential in ensuring access to healthcare for the Medicare population and permitting healthcare professionals to practice to a far greater extent than they would have otherwise been able to do. **Premier fully supports the agency's proposals to make these flexibilities permanent.**

Among the proposals presented in the proposed rule, Premier believes it is important to highlight the fundamental importance of policies that, during the COVID-19 PHE, have allowed healthcare professionals to meet supervision requirements through the use of audio/visual real-time communications technology. Audio/visual real-time communications technology has been an essential tool for healthcare providers and professionals to address healthcare needs of Medicare beneficiaries during the PHE. It continues to play a critical role in both ensuring access to care and improving the efficiency in the delivery of care during the PHE, including in meeting supervision requirements under Medicare regulations.

Premier urges CMS finalize its proposals on the use audio/visual real-time communications technology to satisfy requirements for supervision, and we believe those policies should be made permanent. If CMS is concerned that adequate oversight will not be provided, CMS should extend the policies allowed during the COVID-19 PHE for a sufficient number of years to collect robust data on patient outcomes and satisfaction and access to care for Medicare beneficiaries, especially in rural areas and in communities with shortages of healthcare personnel

ELECTRONIC PRESCRIBING FOR CONTROLLED SUBSTANCES FOR A COVERED PART D DRUG UNDER A PRESCRIPTION DRUG PLAN OR AN MA-PD PLAN

Premier has long been supportive of moving to electronic transmission of prescription information because of the many benefits it offers over written prescriptions. Electronic prescribing can increase accuracy and can improve storage capacity, accessibility, security and productivity. It can reduce prescribing errors relative to handwritten prescriptions, eliminate confusion between similar-sounding drugs, and reduce order-entry errors when transmitting prescription orders. Administrative efficiencies are increased under electronic prescribing systems because prescribers are able to access the formulary for a patient's prescription drug benefit, ensuring that they select a therapy for which the patient has coverage. It also can provide immediate feedback on any clinical edits that may apply.

Electronic prescribing systems are especially important with respect to improving care for individuals being prescribed controlled substances or who are at risk for abuse of such substances. They can alert prescribers of potentially harmful drug interactions and duplicate or overlapping drug therapy. They permit prescription information to be securely transmitted directly to the dispensing pharmacy, reducing the possibility of fraudulent prescribing. Electronic prescribing prevents patients from photocopying, altering, or otherwise tampering with written prescriptions prior to presentation at the pharmacy, substantially reducing the prevalence of fraudulent or tampered prescriptions.

In the proposed rule, CMS amends the timeline for implementing mandated electronic prescribing for Schedule II, III, IV, or V controlled substance under Medicare Part D. The SUPPORT for Patients and Communities Act (P.L. 115-271) required such systems be implemented beginning January 1, 2021. CMS would delay implementation of the requirements by one year, until January 1, 2022. CMS describes this delay as necessary to recognize the unique challenges that prescribers are facing during the COVID-19 PHE.

We appreciate CMS providing flexibility for providers who are struggling with the challenges of the current PHE and the difficulties they are facing implementing new systems or upgrades when many key personnel may be unavailable or working offsite because of the PHE**. We do urge CMS, however, to implement the requirements as expeditiously as possible once the pressures of the current PHE decline. In doing so, we believe beneficiaries will be better served, remain safer, and providers will experience greater operational efficiencies.**

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the 2021 Medicare Physician Fee Schedule proposed rule. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, vice president, policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance