



October 5, 2020

**VIA ELECTRONIC MAIL**

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD, 21244

Re: CY 2021 Revisions to Payment Policies Under the Physician Fee Schedule, Quality Payment Program, and Other Changes to Part B Payment Policies (CMS-1734-P)

Dear Administrator Verma:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule on CY 2021 Revisions to Payment Policies Under the Physician Fee Schedule, Quality Payment Program, and Other Changes to Part B Payment Policies ("Proposed Rule").

The Task Force is a consortium of private sector stakeholders that support accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, health plans, employers, and consumers – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs. Our member organizations aspire to have 75 percent of their business in value-based arrangements by the end of 2020. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

**I. Telehealth and Other Services Involving Communications Technology (section II.D.)**

The HCTTF shares the CMS belief that there is value in allowing physicians to furnish additional telehealth services via Medicare, and for patients to receive broader access to care through telehealth. While CMS is updating telehealth policy in the fee-for-service Medicare space we also encourage the Agency to update telehealth policies for Alternative Policy Models. Specifically, HCTTF recommends that CMS include the following telehealth related waivers for current and future MIPS and Advanced APM participants:

- **Originating Site Restrictions:** Social Security Act Section 1834(m) places specific geographic limitations on the use of telehealth services. These limitations generally require that telehealth services be delivered in a clinical setting and that the hospital or

physician office be located within a Health Professional Shortage Area (HPSA). These requirements essentially limited telehealth to rural areas. 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 and should be retained for current and future APMs. CMS should develop uniform language for this waiver that can be incorporated into the design of future models.

- **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 Public Health Emergency (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 and may encourage first time users otherwise reticent to use virtual care. 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 actively support 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.
- **Establishing Patient Relationships:** As part of the suite of PHE-related telehealth changes, CMS allowed providers to deliver several telehealth services to both existing and new patients. We support the decision to allow providers the ability to establish relationships

and deliver services to new patients via telehealth and encourage CMS to retain this as a waiver for APM participants after the PHE ends.

- **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 living in rural areas. We encourage CMS to incorporate these flexibilities into a uniform waiver available to providers participating in CMS APMs.
- **Direct Supervision Flexibilities:** In interim final rule 55341-IFC, CMS extended flexibilities allowing physicians to use interactive telecommunications technology to meet direct supervision requirements for some incident to services delivered during the COVID-19 PHE. The ability to meet direct supervision requirements using remote technology greatly increases the ability for care teams to efficiently treat patients, especially when patients are being treated outside a clinical setting where physician travel time for traditional direct supervision can be a limiting factor. We encourage CMS to permanently extend this flexibility for providers participating in CMS APM models.

## II. Medicare Shared Savings Program Requirements (section III.G.)

### *a. Quality and Other Reporting Requirements*

In response to the CY 2020 Physician Fee Schedule proposed rule's solicitation, the HCTTF provided input on whether the agency should alter the current quality scoring approach for Medicare Shared Savings Program (MSSP) ACOs to instead adopt the quality scoring approach used in the Merit-based Incentive Payment System (MIPS). The purpose would be to better align quality scoring methodologies across programs. The HCTTF did not oppose altering the MSSP quality scoring in the manner contemplated in the CY 2020 proposed rule so long as there is sufficient time for MSSP ACOs to adjust to the new approach and when future changes are made. Changing quality measures and reporting mechanisms impacts both analytics and operations, and ACOs need time to transition to the new requirements.

While the Task Force is directionally supportive of the proposed changes to the MSSP's quality performance standard and reporting requirements, the proposal to implement these changes for performance year 2021 provides insufficient time for MSSP ACOs to make adjustments. **We urge CMS to introduce a transition year and finalize any changes to the reporting mechanism no earlier than CY 2022 to allow providers adequate time to adapt, particularly given they continue to grapple with the impact of COVID-19 pandemic on their operations.** Earlier, CMS accepted public comment (from HCTTF and others) requesting a delay in implementing the MIPS Value Pathways due to the readiness of clinicians in making this transition. **The same leniency afforded MIPS-eligible clinicians should be afforded to ACOs.**

i. *Applying the Alternative Payment Model Performance Pathway (APP) to Shared Savings Program ACOs*

We appreciate that CMS has proposed better alignment between the reporting requirements for MIPS and Advanced APMs, which creates a better glidepath for providers for providers looking to transition away from fee-for-service. The Task Force has long encouraged CMS to establish a parsimonious set of quality measures and better alignment across APMs and quality reporting programs. The smaller, more focused APM Performance Pathway (APP) measure set is appropriate to count for both ACO and MIPS reporting as APM Entities are incentivized through the terms of the respective APM agreements to improve value. **However, we are concerned that in reducing the set of measures, CMS has removed all preventative health measures, instead shifting the focus entirely to management of illness and cost rather than prevention.** Of particular concern during the COVID pandemic, the measures selected do not allow ACOs to report results during telehealth visits. CMS should consider inclusion of quality measures that are foundational to preventive care and care coordination, as well quality measures for services performed via telehealth.

Additionally, not all providers in ACOs will meet the threshold for Qualified Advanced APMs Participants, and the alignment between MIPS and MSSP reporting requirements creates an easier pathway to move away from fee-for-service and advance to shared risk models. However, we are concerned that the APP approach is not appropriate for all APM participants (additional feedback below).

ii. *Shared Savings Program Quality Performance Standard*

CMS is proposing to revise the MSSP quality performance standard beginning with the 2021 performance year by implementing a higher quality performance standard where ACOs would now be required to receive a Quality performance score equivalent to or above the 40<sup>th</sup> percentile across all MIPS Quality performance category scores in order to share in savings or avoid owing maximum losses. It is critical to the success of delivery system reform that quality of care continues to improve over time along with expectations of cost savings. **However, HCTTF does not support implementation of this policy in 2021 as providers still manage and recover from the pandemic and are without pre-established benchmarks to measure against. The Task Force also opposes the proposal to eliminate the pay-for-reporting year.** ACOs use the pay-for-reporting year to prepare and document measures appropriately. Additionally, the pay-for-reporting year is important in that it provides a benchmark year for subsequent measurement purposes.

b. *Changes to the Extreme and Uncontrollable Circumstances (EUC) Policy for PY 2021*

The Task Force supports the proposed change to modify the EUC to consider the higher of an ACO's 2020 quality performance score or its 2019 quality performance score used for financial reconciliation. Should the COVID-19 public health emergency carry over into 2021, CMS should also consider applying the same policy to the 2021 performance year – applying the higher of the ACO's 2021 quality performance score or its 2020 quality performance score used for financial reconciliation. In CMS-1744-IFC, CMS proposed applying the higher of 1) the mean quality score across all ACOs or 2) the ACO's own quality score if that ACO could completely and accurately report all quality measures for 2020. Responding to that proposal, we stated that - given the massive shifts in care delivery sites and staffing, increased telehealth utilization, data

collection challenges and other COVID-19 related impacts in 2020 - we did not believe that the application of either an average quality score or individual ACO quality score based on data from the 2020 performance year would be feasible or appropriate. **The Task Force appreciates CMS's attention to this issue and believes the plan proposed here is a reasonable compromise on this issue.**

### III. CY 2021 Updates to the Quality Payment Program (section IV.)

#### a. Merit-based Incentive Payment System

##### i. MIPS Value Pathways (MVPs)

CMS also suggested that MVPs may include patient reported outcomes measures (PROMs), and that the Agency intends to incorporate more PROMs and patient care experience measures into MVPs. While we believe patient experience and satisfaction are important, we recommend that CMS be sure to provide equal focus on patient outcomes. Meeting patients' expectations of their health has proven to promote better mental health and personal wellbeing beyond simply treating a condition or diagnosis. The use of PROMs may result in improvements to patient outcomes in several ways—for example, by providing patient centered information and facilitates improved communication between doctors and their patients. Patients may also feel that healthcare providers are more involved in their care because providers are showing an interest in the patient's views on their expected outcome in health and wellbeing.

##### ii. APM Performance Pathway (APP)

The Proposed Rule would replace the current MIPS APM Scoring Standard, which allows APM participants to use the quality measures and scoring approaches applicable to goals of that APM while providing credit for quality improvement for providers subject to MIPS with a new APM Performance Pathway. The proposed APP creates a one-size-fits all option that would apply one set of quality measures for all APMs subject to MIPS. Participants in APMs other than MSSP would need to report not only their APM's specific quality measures, but the APP quality measures as well, which may not be applicable or appropriate to their APM. This creates significant burden for APM participants. **We urge CMS to maintain the APM Scoring Standard. While the APP eliminates burden for MSSP ACOs, the elimination of the APM scoring standard shifts that burden to non-ACO MIPS APM participants.**

#### b. Advanced APMs

**We urge CMS to commit to pay the Advanced APM incentive payment no later than June 30<sup>th</sup> in future years.** The extended gap between Quality Payment Program (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 a supportive approach by CMS to the hard work that providers are doing in partnering with Medicare and encourage additional movement toward advanced risk models. **We also encourage CMS to implement an appeal process related to these payments.**

i. *Attribution-eligible beneficiary count*

The success of the Quality Payment Program depends upon Medicare's ability to fairly assess whether a given clinician is participating in Advanced APMs to a sufficient extent. The Health Care Transformation Task Force supports the proposed revision to the definition of attribution-eligible beneficiaries to exclude Medicare beneficiaries who have been prospectively attributed to another APM Entity during a QP Performance Period. **For the same reason, we encourage CMS to make a conforming accommodation for Advanced APMs that use prospective alignment and exclude beneficiaries who were not eligible for assignment during that entity's prospective assignment lookback period (because, for example, they did not receive primary care services or did not have the qualifying Medicare enrollment status during that period of time).** This will ensure a more consistent approach and help to reduce the disparity that currently makes it harder for Advanced APMs using prospective assignment to clear QP thresholds relative to those using retrospective assignment, where significant overlap exists with the QP determination periods.

However, issues persist with the broad definition of "attribution-eligible" beneficiary that tend to penalize specialists and types of clinicians who sub-specialize in their medical practice in the following ways. First, ACOs are "pruning" their ACO Participation Lists of specialists to ensure that the primary care physicians achieve their QP Threshold. ACOs rightfully acknowledge that specialists generally have lower QP scores than primary care physicians. This is a function of the fact that specialists rely on referrals from a broader set of primary care physicians than those participating in a given ACO. Therefore, the higher the concentration of specialists in an ACO, the lower the QP Threshold. Secondly, the Medicare program has sponsored specialty payment models that capture only a minority of the patients of a given specialist, and naturally limit the penetration of APMs into specialty care. **We encourage CMS to convene a Technical Expert Panel to advise on alternative methods for defining "attribution-eligible beneficiaries" for purposes of calculating the QP Threshold for groups and individuals with specialties outside of primary care.**

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The Task Force appreciates the opportunity to advise CMS regarding updates to Medicare Part B. Please contact HCTTF Executive Director Jeff Micklos ([jeff.micklos@hcttf.org](mailto:jeff.micklos@hcttf.org)) with questions or follow up regarding these comments.

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