National Business Group on Health®

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

September 10, 2018

Ms. Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-1693-P: Medicare Program; CY 2019 Updates to the Quality Payment Program

Dear Administrator Verma:

The National Business Group on Health (the "Business Group") appreciates the opportunity to comment on CMS' proposed rule to modify the Quality Payment Program (QPP), Year 3, originally implemented as part of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA).

The National Business Group on Health represents 425 primarily large employers, including 75 of the Fortune 100, who voluntarily provide group health and other employee benefits to more than 55 million American employees, retirees, and their families. Being mostly self-funded, our employer members as well as many other employers have a vested interest in more effective, efficient health care and promote health plan designs that encourage delivery of the right care at the right time and in the right place; an emphasis on promoting health in primary and preventive care; improving value while reducing the cost of care; and, delivering services to the highest level of customer satisfaction.

We support the agency's efforts to continue to simplify the QPP program, reduce reporting burden, and encourage participation in Advanced alternative payment models (APMs). Below, we offer expanded comments on select portions of the proposal.

We applaud CMS's effort to expand access to telehealth services to the scope of statutory authority and pay appropriately for services that take full advantage of communication technologies.

- Technological innovations have increasingly diminished the need for beneficiary's face-to-face presence with a provider, for certain conditions, using any number of non-face-to-face means of communication.
- Adding services to the telehealth list will make it administratively easier for practitioners who report services in connection with a preventive service furnished via telehealth.
- Increased access to telehealth services may increase the ability to diagnose and treat a medical condition in a patient population without access to clinically appropriate in-person diagnostic

services; reduce the rate of patient complications; decrease the rate of subsequent diagnostic or therapeutic patient interventions (for example, due to reduced rate of recurrence of the disease process); decrease the number of future hospitalizations or physician visits; and, provide more rapid beneficial resolution of the disease process treatment.

- Additionally and importantly, we also support the potential for telehealth to have a positive impact on the opioid epidemic and other substance use disorders, since there are several components of Medication Assisted Therapy (MAT) that could be prescribed virtually.

We support the agency's effort to continue to evaluate appropriate reimbursement for Part B drugs but have some concerns about the proposed changes.

- We support eliminating financial incentives for prescribing a drug simply because its price is higher, but we have concerns with the proposed flat reduction as written. Specifically, we are concerned about the ability of non-hospital affiliated independent clinical oncologists to absorb the financial impact of the current proposal, which could lead to accelerated consolidation.
- We have multiple times commented on reimbursement of prescription drugs under Part B and urge CMS to continue its work with sister agencies and the Congress to identify ways to reduce overall pricing of prescription drugs as a chief driver in expenditure growth in health care.[1,2,3]

We support the proposed advancement of the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration to waive Merit-Based Incentive Payment System (MIPS) requirements for certain clinicians.

- Recognizing that while some Medicare Advantage plans are developing innovative arrangements that resemble Advanced APMs, but that participating physicians are still subject to MIPS even if they participate extensively in Advanced APM-like arrangements under Medicare Advantage, we support this effort.
- MAQI would put those physicians on more of a level playing field and test whether MIPS exemptions provided to clinicians under MAQI will increase participation in Medicare Advantage plans that are similar to Advanced APMs, thereby accelerating the transition to a healthcare system more focused on paying for value and outcomes and less focused on fee-for-service (FFS).

We support amending the definition of a "high priority" measure, to include quality measures related to fostering appropriate prescribing of opioids.

- The nation's opioid crisis has long been recognized by employers, presenting challenges that range from lost productivity costs, excess medically related employee absenteeism and disability, as well as caregiver and dependent costs.

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[1] January 25, 2018 comments to Health and Human Services Secretary Alex Azar RE: Promoting Healthcare Choice and Competition Across the United States

[2] July 16, 2018 comments to HHS Secretary Alex Azar RE: HHS Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs

[3] May 9, 2016 comments to Administrator Andy Slavitt RE: Proposed Rule for Medicare Program; Part B Drug Payment Model; CMS-1670-P

- According to the National Business Group on Health's Large Employers' 2019 Health Care Strategy and Plan Design Survey, the vast majority of employers (82%) are concerned about inappropriate use and abuse of prescription opioids, with 55% stating they are very concerned.
- The Business Group has been outspoken on the importance of focus on this issue, including urging increased access to MAT.[4] Additionally, we offer a range of tools and resources to members on this topic, which we would be happy to share with the agency. One such effort is a year-long summit: "Opioids on the Job: A Multi-part Series on Addressing a Crisis in the American Workforce."

We strongly support CMS's efforts to align payment policies for physicians in independent practice with those owned by hospitals.

- We applaud CMS's continued focus on payment parity across sites of care and encourage CMS to also consider these parity polices from a broader perspective. Namely, CMS should not pay more for the same services in the inpatient, outpatient, or ambulatory surgical center setting than in the independent physician office setting.
- We further encourage CMS to continue to create incentives for services to be performed in the most cost-effective location, such as a physician's office.
- Finally, we urge CMS to continue exploring alternative reimbursement models for off-campus hospital outpatient departments.

We support reforms to Evaluation and Management (E/M) documentation, but encourage the agency to monitor payment impact on providers caring for complex patients.

- Extensive documentation requirements for Evaluation and Management (E/M) codes have resulted in unintended consequences and contribute substantially to physician frustration with electronic health records.
- A single blended payment rate for both new and established patients for office/outpatient E/M level 2 through 5 visits would eliminate four levels of billing, thereby significantly reducing reporting burden.
- However, very sick, chronically ill patients may require longer patient visits. We urge CMS to consider how a blended rate may impact this population and ensure that it does not create a disincentive for physicians to see these highly complex patients.

We strongly support modifying the MIPS Promoting Interoperability (formerly Advancing Care Information) performance category to support greater electronic health record (EHR) interoperability and patient access while aligning with the proposed new Promoting Interoperability Program requirements for hospitals.

- Electronic health records have transformed modern medicine, giving doctors and nurses better data to guide care, supporting enhanced patient safety through new automated tools, and creating more efficient processes by connecting different health systems.

[4] May 19, 2016 comments to Jinhee Lee, Pharm.D. RE: Proposed Rule for Medication Assisted Treatment for Opioid Use Disorders (SAMHSA2016-0001)

- Aligning the MIPS' promoting interoperability performance category with those proposed for hospitals and overhauling the scoring methodology and measures would substantially enhance EHR interoperability.
- Finally, requiring MIPS-eligible clinicians to use 2015 edition certified EHRs is essential to advancing interoperability because the 2015 edition requires the use of application programing interfaces (API), which is the preferred method for the exchange of information data sharing for developers, as well as the favorable choice for compliance with the Health Insurance Portability and Accountability Act (HIPAA). Thus, futuristically speaking, EHR platforms without API will slow or impede a truly interoperable health care system.

We strongly support progress in implementing the Appropriate Use Criteria (AUC) for diagnostic imaging to promote quality and interoperability.

- **With some modifications, the program is on track to begin in 2020 and begin its use in reimbursement beginning in 2021.**
- **In addition to requiring ordering physicians to consult AUC, it also encourages radiologists and imaging managers to document the consultations, both of which promote appropriate imaging.**

We look forward to continuing to work with you to transform the nation's health care system into one that is renowned for high-quality and high-value care, through improvement initiatives which pursue a broader system of linked goals. Again, thank you for the opportunity to comment. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you want to discuss our comments in further detail.

Sincerely,

Brian Marcotte
President and CEO