BETTER MEDICARE ALLIANCE

1090 Vermont Ave NW, Suite 1250
Washington, DC 20005
202.735.0037

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

September 10, 2018

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8013

Submitted electronically via http://www.regulations.gov

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program. **CMS-1693-P**

Dear Administrator Verma:

Better Medicare Alliance (BMA) is pleased to submit the following comments on the proposed rule updating the Medicare Physician Fee Schedule and other Part B payments for calendar year 2018. BMA is a community of more than 115 ally organizations, who, like the 20 million beneficiaries who have chosen Medicare Advantage, share a commitment to a strong Medicare Advantage option. We believe that Medicare Advantage is an important part of the Medicare program. It represents a public-private partnership that is addressing the needs of today's beneficiaries and working to advance the adoption of value-based care. Medicare Advantage payment systems and flexibility are moving providers towards higher-value, higher-quality care, and improving the health care experience for physicians and their patients.

We offer brief recommendations and comments below on a selection of the proposals outlined in the proposed rule.

1. **Waive the restrictions on the provision of telehealth services to improve Medicare patients' access to care.**

Ensuring access to care requires that CMS meet beneficiaries where they are. Connected health technologies are offering new and transformative options for the delivery of care to improve patients' health outcomes. Medicare Advantage is at the forefront of leveraging these innovations with $170 billion spent in 2018 on telehealth services to enhance patients' access to preventive care, chronic disease management, and care coordination.[1] We appreciate that the Physician Fee Schedule (PFS) reflects the desire to increase beneficiaries use of telehealth services, and we encourage CMS to continue modernizing Medicare to encourage connected care innovations.

Due to the passage of the Bipartisan Budget Act of 2018 (BBA), Medicare Advantage health plans may offer additional, clinically appropriate telemedicine benefits in the annual bid, above and beyond the services currently reimbursed under Medicare Part B, starting in 2020.[2] Given that Congress defined additional telehealth benefits

[1] http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch16_sec.pdf?sfvrsn=0
[2] https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

to mean, in part, benefits available under Medicare Part B, the PFS has significant implications for the uptake of connected health technologies in Medicare Advantage.

We support the PFS proposals to reimburse physicians for brief non-face-to-face check-ins, while expanding access to store-and-forward communication technology, care management and counseling for substance use disorders. However, we encourage CMS to continue working to waive unnecessary telehealth geographic and originating site constraints. CMS should also remove overly restrictive approaches to communication technology-based services. For example, the newly defined virtual check-in physician service code, Healthcare Common Procedure Coding System (HCPCS) GVCI1, should be available to all clinical staff in addition to physicians and beneficiaries should face the barrier of a co-pay to receive necessary virtual care.

As CMS considers additional guidance on what types of telehealth items and services should be added to Medicare Advantage health plans, we oppose a FFS Medicare code-based approach. Health care stakeholders and beneficiaries would benefit from flexibility and predictability around telehealth benefits to increase utilization of high-value services. As a risk-based capitated system, Medicare Advantage should have more flexibility to develop innovative services and value-based contracts that improve beneficiary care and address the rising cost of health care.

2. **Consider unintended impacts of proposed changes to coding and documentation requirements for evaluation and management (E/M) visits on Medicare Advantage risk adjustment practices.**

BMA is supportive and appreciative of Secretary Azar's and Administrator Verma's shared goal of reducing provider burden, streamlining administrative policies, and putting patients at the center of health care. We believe that Medicare Advantage has shown that an integrated, capitated system is the most effective way to transition providers into value-based payment arrangements that reward providers for delivering high-quality care while eliminating unnecessary reporting burdens. However, we are concerned that the proposals included in this rule to reduce the documentation and coding requirements for E/M visits may inadvertently undermine the Medicare Advantage program and slow, or reverse, the success it has achieved in transitioning Medicare from volume to value.

Accurate risk adjustment in Medicare Advantage has ensured that nearly all of the millions of Medicare beneficiaries across the country have access to the cost-effective, high-quality, and fully integrated option of Medicare Advantage, regardless of their health status or care needs. In fact, the current risk adjustment model, which was fully implemented in 2007 and has been improved over time, has worked to virtually eliminate risk selection in Medicare Advantage beneficiary enrollment.[3] At the heart of successful risk-adjustment in Medicare Advantage is the ability to capture accurate diagnosis and coding information from providers. Specifically, BMA is concerned that the proposals outlined in this rule could cause providers to have disparate documentation requirements in FFS Medicare and Medicare Advantage. We believe this would go against the Administration's goal of reducing provider burden and streamlining policies across programs, and it could cause providers to avoid Medicare Advantage due to a misalignment in documentation requirements.

We urge CMS to carefully consider the potential impacts these proposed changes would have the ability of Medicare Advantage health plans to collect adequate risk adjustment data from providers. At a minimum, CMS

[3] McWilliams, JM, et al., "New Risk-Adjustment System Was Associated with Reduced Favorable Selection in Medicare Advantage," *Health Affairs.* December 2012, available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.1344.

should consider a one-year delay of the implementation of these changes to carefully examine, with the input of stakeholders, the potential challenges associated with accurate risk adjustment data collection. We request that CMS guarantee that new documentation requirements are adequate for the purposes of risk adjustment, and clearly explain those requirements in both the final regulation, as well as in the CY2020 Advance Rate Notice and Draft Call Letter.

3. **Finalize and implement the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration.**

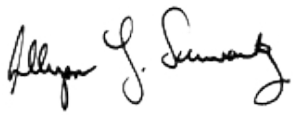
BMA applauds CMS' decision to implement the MAQI Demonstration that would test whether excluding MIPS-eligible clinicians who participate to a sufficient degree in value-based payment arrangements with Medicare Advantage health plans from the MIPS reporting requirements and payment adjustments will increase or maintain participation in payment arrangements similar to Advanced APMs with Medicare Advantage and change the manner in which they deliver care. Medicare Advantage is leading the way in transitioning providers away from volume and toward value, and we firmly believe that they should be rewarded, and not penalized, for entering into such Qualifying Payment Arrangements with Medicare Advantage health plans.

Moreover, we support CMS' proposal to ensure that the criteria around Qualifying Payment Arrangements between Medicare Advantage health plans and providers are consistent with the criteria for Other Payer Advanced Alternative Payment Models (APMs) under the Quality Payment Program as set forth in 42 CFR §414.1420, including the combined thresholds for Medicare payments or patients. We also strongly support that aggregate participation in Advanced APMs and Qualifying Payment Arrangements will be used without applying a specific minimum threshold to participation in either type of payment arrangement.

Conclusion

We are grateful for the Administration's continued effort and focus on ensuring Medicare Advantage remains a high-quality and cost-effective option for millions of Medicare Advantage. We believe many of the proposals set forth in this rule will ultimately work to strengthen the Medicare program and continue to drive toward value-based care delivery, and we appreciate your attention to our comments above. We look forward to continue working with you on these and other critical issues. Should you like to connect on anything in this letter or otherwise, we can be reached by contacting BMA's Director of Policy, James Michel, at jmichel@bettermedicarealliance.org or (202)853-3900.

Sincerely,



Allyson Y. Schwartz
President & CEO
Better Medicare Alliance