WILEMS resource group

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Department of Health and Human Services
Centers for Medicare & Medicaid Services

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Re: Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2021 [CMS-1734-P]

On behalf of Wilems Resource Group, a boutique health care firm that has supported over 100 ACOs nationwide, we are pleased to provide our comments on the CMS "Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and other Revisions to Part B for CY 2021". Wilems Resource Group works with ACOs across the country, including Medicare Shared Savings Program (Shared Savings Program), Next Generation, and commercial ACOs, to build, maintain, and oversee Compliance Programs, implement Fraud, Waste and Abuse waivers, and create Medicare Beneficiary and Provider Engagement Programs. Our leadership has extensive experience in ACO compliance, operations, and marketing. We share the Administration's goal of removing unnecessary government obstacles to care coordination and applaud HHS for its continued work toward transforming the health care system into one that provides increased incentives for high value care. We believe that this effort could be the single biggest factor in promoting a tangible shift in how providers deliver, and how the industry pays for, health care.

It is through the lens of this experience that we reviewed the NPRM and developed our recommendations. Our main goals for the Shared Savings Program include the reduction of unnecessary administrative obstacles and confusion in regard to regulatory requirements, increased tools and opportunities for beneficiary and provider engagement, and improved resources for ACOs. We truly believe that in order for the Shared Savings Program to have continued success, ACOs need guidance as well as expanded opportunities for innovation.

Wilems Resource Group therefor puts forth the following recommendations:

- HHS and the Centers for Medicare & Medicaid Services (CMS) should not remove the Pay-For-Reporting year for ACOs quality reporting;
- HHS and CMS should strengthen policies for compliance with quality performance standards; and
- HHS and CMS should amend the Beneficiary Notification requirement to remove the requirement for ACOs to complete a Beneficiary Notification prior to or at the first office visit of each performance year.

Recommendations

Pay-For-Reporting Year for ACOs

We strongly support CMS' goals of incentivizing value-base care and driving the Medicare system to greater value and quality. However, the removal of the "phase in" for quality reporting could prove detrimental to new ACOs. While reducing the reporting requirements from 10 measures to 3 decreases some of the burden on an ACO, there are many operational and compliance hurdles a new ACO must overcome before feeling confident that they can meet the pay-for-performance standards.

For 2021 and future performance years, CMS should continue the phase-in approach to quality reporting for new ACOs. New ACOs in their first performance year should meet the quality performance standard at the level of full and complete reporting (pay-for-reporting) rather than pay-for-performance. The first performance year serves as an opportunity for an ACO to build its operations and evaluate the effectiveness. This is especially true for quality reporting. In preparation for quality reporting, ACOs must educate all participating providers and staff on how to completely and accurately document quality measures, determine a process by which to abstract the quality data timely and securely from practices, accurately and completely submit the data within the appropriate tool, and develop a quality assurance process to ensure beneficiary medical records support the quality data entry. These operational hurdles may not be overwhelming for a single TIN ACO built on a strong technological foundation with a single Electronic Medical Record system, but ACOs comprised of multiple TINs with solo practitioners need the opportunity to build and test their process before possibly being penalized. The pay-for-reporting year allows ACOs an opportunity to experience quality reporting, identify any issues or concerns, conduct an internal quality measures validation audit, and streamline the process prior to meeting pay-for-performance quality standards. We believe the removal of the pay-for-reporting quality performance standard is likely to deter participation in the Medicare Shared Savings Program and adversely impact ACOs comprised of smaller physician practices vs those supported by large hospital systems and management service organizations. The loss of smaller practices, and the unique perspective they provide, would be a detriment to the model as a whole.

Policies for Compliance with Quality Performance Standards

We strongly support the CMS proposal for a new approach to monitor for, and address, an ACO's continued noncompliance with the applicable quality performance standard for performance years beginning on or after January 1, 2021. Broadening the conditions under which CMS may terminate an ACO's participation agreement when the ACO demonstrates a pattern of failure to meet the quality performance standard is an excellent way to hold ACOs to a higher standard of quality and to ensure the integrity of the program as we all work together to improve quality and care outcomes.

In line with this, we also support the proposal to align the Quality Measure Validation Audits with the MIPS Data Validation and Audit process. This will allow for the continued oversight of quality performance while reducing administrative burden on ACOs as they ensure audit readiness.

Initial Beneficiary Notification

In the *COVID-19 FAQ on Medicare FFS Billing*, CMS released the statement that the agency adopted a "temporary policy of relaxed enforcement in connection with the deadline for furnishing the standardized written beneficiary notifications required under § 425.312(a) as long as it is completed by the end of the current performance year."

While the shift in CMS policy was directly related to the public health emergency, we feel that the proactive notification requirement should be removed for 2021 and future performance years. This proactive notification requirement was in place at the beginning of the Shared Savings Program and created a large administrative burden for participant practices without much benefit to the beneficiary. The administration of this requirement is a huge burden in itself, the oversight of compliance with the requirement is another level of concern. Even the determination of which beneficiaries should receive the notification is problematic. While an ACO could notify all Medicare Fee-For-Service beneficiaries, if the beneficiary is not aligned to the ACO then the content of the notification would not apply to the beneficiary and is likely to cause confusion as to the availability ACO programs and benefit enhancements. If an ACO is only required to notify beneficiaries aligned to the ACO, then the notification process becomes a constantly moving target as alignment rosters shift throughout the year.

CMS should return to the policy utilized in previous years of relying on the Office Posters and the availability of the Notification Letter upon request in order to provide notice to the beneficiary. These are common methods of information sharing, are less expensive and less administratively burdensome, especially for ACOs comprised of many smaller practices. If CMS feels that this notification is not sufficient, they should consider using the ACO Spotlight to recommend that ACOs supply talking points to providers, rather than requiring a more proactive and burdensome beneficiary notification process.

If, on the other hand, CMS believes the proactive notification process is likely to increase beneficiary engagement, then we feel CMS should encourage ACOs to develop their own communication materials to introduce the ACO and the benefits of their provider participating in the program. These would be considered Marketing Materials requiring CMS approval prior to use, thus limiting any potential risk of beneficiary confusion or harm. Moreover, they would provide an opportunity for the ACO to engage beneficiaries in a tone and manner that is more in line with the culture of the ACO and its Participant Providers. We do not believe that a required and templated notification is an effective way to encourage beneficiary engagement.

CMS has used these recommendations to promote program success in the past with such things as recommending ACOs focus on Annual Wellness Visit completions. It is an effective technique that would serve to increase beneficiary engagement more effectively while minimizing the administrative burden on ACOs.

Conclusion

Overall, we strongly endorse and support the efforts by CMS and HHS to reduce burdens to clinicians and create meaningful quality measures. We believe that retaining the pay-for-reporting quality standard for new ACOs, expanding the conditions under which CMS can terminate an ACO related to non-compliance with quality, streamlining the quality audit process, and altering the Beneficiary Notification requirement are meaningful ways to improve the program.

Sincerely,

Kimberly Busenbark

President & CEO