



May 11, 2020

VIA ELECTRONIC SUBMISSION

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244-1850

Brad Smith
Director, Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
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Re: HCTTF Recommendations to Support APM Participants During the COVID-19 Pandemic

Dear Administrator Verma and Director Smith:

The Health Care Transformation Task Force (HCTTF or Task Force)¹ is committed to advancing value-based care during and after the COVID-19 public health emergency. We write to urge you to take specific actions to account for the impact of COVID-19 on alternative payment models and programs by providing relief for alternative payment model participants.

Task Force members have distinct views on how alternative payment models (APMs) can be supported during the COVID-19 crisis and how future APM operations and methodologies should be refined to mitigate the crisis' impact in future years. This letter leads with near term proposals for immediate relief that will promote our shared goal of continued participation in APMs followed by proposals that help stabilize and improve APMs longer-term based upon the COVID-19 experience.

I. Near term proposals to support Medicare APMs

The CARES and Paycheck Protection Program and Health Care Enhancement Acts provided funding to help fortify health care provider and supplier operations as they experience business disruption and, in key hot spots, the added cost and burden of caring for seriously ill patients. Given their importance to the future of health care, APMs should not be left behind in receiving this new aid. **The Task Force urges CMS to make APM infrastructure support payments from these new funding vehicles to all model participants in the Medicare Shared Savings Program and all participants in models qualifying as Advanced APMs. This infrastructure support payment should take the form of a per beneficiary per month dollar amount equal to \$28 per beneficiary for all PY2019 Qualifying APM Participants for a period of February 1st, 2020 and running for two months after a/the public health emergency declaration is lifted.**

¹ The HCTTF is an industry consortium representing a diverse set of organizations from various segments of the industry – including providers, health plans, employers, and consumers – all committed to adopting payment reforms that promote a competitive marketplace for value-based health care and allow health care organizations to move from a system that incentivizes volume of services to one that rewards value of care. Our member organizations aspire to have 75 percent of their business in value-based arrangements by the end of 2020.

These funds should not be included as part of medical expense in the APM participant's financial reconciliation. Additionally, CMS should also accelerate processing of shared savings payments earned but not yet paid out to participating providers for prior performance years to give providers timely access to capital to help respond to the COVID-19 pandemic.

Current APM model participants also need near term relief specific to their models to help avoid substantial departures from these programs and undesirable reversion to fee-for-service. **The Task Force urges CMS to provide clear guidance about the intent to provide relief to providers impacted by COVID-19 that are participating in all Medicare APMs.** CMS should release detailed information about unique EUC adjustments to be applied for each Advanced APM and any models where participants are at financial risk. There is insufficient information to make an informed decision about the long-term impact of COVID-19 on the value portfolio, and more time may be needed to determine what adjustments should be made to individual models, and how previously specified extreme and uncontrollable circumstances and natural disaster policies will be applied. **In the interim, CMS should communicate the general principles by which CMS will further modify alternative payment model requirements for calendar year 2020 no later than May 15th, and delay the deadline date for withdrawing from APMs to August 31st.**

We appreciate that CMS has clarified in CMS-1744-IFC *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Interim Final Rule with Comment Period (IFC)* the intent to apply EUC provisions to 100 percent of Medicare beneficiaries aligned to Medicare Shared Savings Program accountable care organizations (ACOs) for the duration of the Public Health Emergency. However, the existing EUC provisions were written envisioning a single-locality disaster, such as hurricane or flood, and EUC policy CMS proposed in the IFC is not applicable to APMs operated by the CMS Innovation Center. Additional guidance is needed CMMI model participants.

Additionally, should the Secretary lift the Public Health Emergency (PHE) declaration prior to January 1, 2021, we urge CMS to reconsider using the PHE declaration to determine the appropriate duration of model-specific adjustments and EUC policies. The EUC provisions should not be lifted before the end of 2020 at the earliest, when we will have greater clarity about the status of the pandemic.

a. Accountable care organizations (ACOs)

CMS should offer relief from risk arrangements while ensuring that ACOs do not have to resort to dropping out of the program. **Current participants in shared savings models including the Medicare Shared Savings Program (MSSP) and Next Generation ACO (NGACO) model should be allowed to notify CMS by August 31st if they don't wish to be financially reconciled nor held responsible for program requirements for the 2020 performance year *without having to fully terminate their agreement.*** Participants need more time to assess impact than the current participation agreements allow to make an informed decision on program participation, and participants should not be held to earlier arbitrary deadlines which force them to guess and potentially even leave a program unnecessarily. Some participants may wish to remain in the program with the status quo, so that option should also be made available to ACOs. As noted in *Section II.A Quality Payment Program modifications*, we also recommend an exemption or waiver for the Advanced APM criteria for 2020 if a provider's downside is changing for 2020 and only due to the impact of the COVID-19 pandemic.

The objective of a no-reconciliation option is to provide risk relief from increased costs and volatility stemming from the public health emergency while maintaining existing program participation. We also encourage CMS to remove the cap on risk score increases for MSSP and NGACO to recognize factors that could greatly affect the risk distribution of aligned beneficiaries, while retaining the cap on risk score decreases to account for the drastic decrease in volume and likelihood of missed capture of patient illness. These policies will also send a clear signal to the industry that CMS is committed to the sustainability of the largest Medicare APM program.

i. Medicare Shared Savings Program

We appreciate that CMS has made modifications to the MSSP policies to address the impact of the COVID-19 pandemic to encourage continued participation by ACOs in CMS-5531-IFC: *Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program*. We support some of the provisions including allowing ACOs whose current agreement periods expire on December 31, 2020 the option to extend their existing agreement period by one year; allowing ACOs in the BASIC track's glide path the option to elect to maintain their current level of participation for PY2021; and clarifying the applicability of the program's EUC policy to mitigate shared losses for the period of the COVID-19 PHE. We also support the decision by CMS not to conduct the Quality Measures Validation (QMV) audits for the 2019 performance years, which require auditors to visit practices and audit beneficiaries' medical records; CMS is urged to waive the QMV requirement for the 2020 performance year as well.

We recommend that CMS allow all MSSP ACO participants that wish to continue participation in PY2020 to have a choice between remaining in their current track, if higher, or electing the lower Basic Track Level B risk levels: 0% downside risk and up to 40% shared savings. The Task Force members have other concerns regarding the approach to remove all Parts A and B payments for episodes of care for treatment of COVID-19 from the determination of benchmark year and performance year expenditures for MSSP, which will be addressed further in our comments responding to CMS-5531-IFC.

ii. Next Generation ACO (NGACO)

Participants in the NGACO model have demonstrated success in terms of controlling costs for Medicare and improving care for seniors. Given NGACO is a fully two-sided risk model, we believe they should be given further flexibility to continue operating and being reconciled at a lower risk-reward profile than normal policy. We urge CMS to allow NGACOs to re-select their risk options including lowering the risk share beyond the 80 percent and 100 percent options currently available and/or submitting a new lower cap on total savings/loss. Either should allow the NGACO to reduce losses beyond their current risk selection submitted with flexibility to reduce that down to zero risk.

Further, the Task Force urges a one-year extension of the NGACO program through 2021. Extending the model will allow CMS to more accurately evaluate the impact of the model, as well as allow NGACO participants to continue support for population health infrastructure, especially in light of their not being able to transition to the MSSP program at the current program's end due to the provisions within the IFC. Additionally, CMS should waive capital requirements for existing NGACO participants that have demonstrated consistent savings to allow providers to leverage existing capital to respond to the COVID-19 crisis.

b. Clinical episode payment models

i. Bundled Payments for Care Improvement (BPCI) Advanced

The BPCI Advanced Participation Agreement includes a “natural disaster” provision that allows CMS to adjust repayment amounts for Participants located in emergency areas during an emergency period, which follows a precedent set in the Comprehensive Care for Joint Replacement (CJR) Program to apply spending caps to CJR episodes in areas recognized by FEMA as experiencing a Major Disaster.

Should this provision not be deemed applicable to the COVID-19 pandemic, the Task Force recommends CMS adopt an alternate approach to address impact of COVID-19 on BPCI participants: **exclude from BPCI Advanced Performance Period spending or in episode-based quality measure scores any Clinical Episodes that have winsorized Performance Period Clinical Episode spending greater than the final Target Price.** Participants in the BPCIA program are experiencing additional financial requirements resulting from the COVID-19 pandemic, and we strongly urge CMS to pay participants their earned Net Payment Reconciliation Amounts as scheduled and on an accelerated schedule as feasible.

ii. Oncology Care Model

The Task Force recommends that CMMI cap episodic spending at the patient specific target prices for the Oncology Care Model, following the precedent established by the Comprehensive Care for Joint Replacement Model.

c. Comprehensive Primary Care Plus (CPC+)

We support the current opportunity CMS is offering to CPC+ Track 1 and Track 2 to request Program Year (PY) 2020 Quarter 3 non-claims-based payments in advance and strongly encourage CMS to maintain this policy and extend the opportunity for Quarter 4 payments.

We also encourage CMS to extend permanent telehealth payment waivers for the CPC+ program. CMMI encouraged the use of telehealth and 24/7 access to care for CPC+, however, the Center has not extended a telehealth payment waiver (SSA 1834m) for the program. Congress permanently waived 1834m for two-sided risk ACOs in 2018 and CMS waived 1834m for Direct Contracting participants and Next Gen ACOs through guidance. Thus, we recommend conforming guidance for CPC+ as a near-term fix to help practices respond to the COVID-19 pandemic.

d. Direct Contracting and Primary Care First

CMS should delay the Implementation Period start date of Direct Contracting to January 1, 2021 and the Performance Year start date to July 1, 2021 or later to allow providers to understand how COVID-19 will impact the new models and for CMS to make appropriate adjustments to account for that impact. In addition, CMS should add a 2022 start date for Primary Care First and an additional 2021 application period for new applicants to both Primary Care First and Direct Contracting.

II. Additional recommendations to fortify value-based care and payment transformation

The COVID-19 crisis has impacted every aspect of life in our country with no sector more impacted than the health care industry. While the pandemic has been met by the health care workforce with resilience and ingenuity, it has also exposed the vulnerabilities of the U.S. health care system, as well as deep structural inequities in our nation that undermine health. Many of these vulnerabilities – including disparate access to affordable care, lack of coordination across care settings, and social determinants of health, social risk, and unmet social needs – are exactly what value-based payment and care delivery models are designed to address today or could be tackling in the future.

Many of the bright spots from the front lines include stories about providers leveraging the coordinated care infrastructure and innovative care delivery models that are hallmarks of value transformation. Indeed, many of our members have depended on the population health infrastructure supported by value-based payment models to maintain patient-centered care delivery during the pandemic, such as care management outreach to high risk patients and virtual care options.

Yet the unprecedented impact of COVID-19 on the health care delivery system has put the sustainability of value-based payment models in jeopardy. The alternative payment models of today were not designed with a public health crisis of this magnitude in mind; future alternative payment models will need to account not only for the possibility of future pandemics, but also the impact of COVID-19 on the ability to use existing methods for setting historic benchmarks and attributing beneficiaries to APMs. Moreover, given that the pandemic has starkly exposed how communities of color continue to bear the brunt of health and health care inequities, ensuring that health system transformation address disparities is more urgent than ever.

The Task Force has considered what policy actions could best support the continued participation in advanced payment models during and after the public health emergency, as well as back continued investment in the population health infrastructure that has proven critical for maintaining high-value, patient-centered care in the midst of this unprecedented crisis. Our recommendations below promote ways for policymakers to continue the momentum of value-based transformation now and in future years by supporting model participants in ways that foster continued participation.

a. Quality Payment Program modifications

The Task Force appreciates that CMS has taken steps to extend Merit-based Incentive Payment System (MIPS) data submission deadlines for MIPS eligible clinicians and offered leniency for clinicians and groups not able to complete the 2019 MIPS data submission. Similar leniency should also be applied to Advanced APM participants.

CMS should waive payment and patient count thresholds and deem all entities participating in eligible Advanced APMs to have satisfied Qualifying APM Provider (QP) thresholds for the 5% incentive payment for 2020 performance. We also recommend an exemption or waiver for the Advanced APM criteria for 2020 if a provider's downside is changing for 2020 and only due to the impact of the COVID-19 pandemic. QP determination methodologies should consider any changes to APM attribution policies, ensuring alignment.

CMS should also accelerate the 5% incentive payment payouts to PY2018 Advanced APM qualifying participants as soon as possible. The Task Force also supports Congressional proposals that would extend the Advanced APM incentive payment for 5 additional years.

b. Advanced payments and accelerated payments

The Task Force supported the HHS policy to expand Advanced Payments to Part B providers and suppliers and encourages CMS to consider reopening the opportunity to provide immediate financial relief for providers. However, the repayment timeline for Advance Payments could create a cliff when providers are still addressing and recovering from the public health epidemic. In fact, many providers were strategically delaying their application for Advanced Payments in an effort to push out the repayment date. CMS should extend the Advance Payment opportunity, extend the duration of the repayment period, and waive interest.

CMS should provide options to advance payments for any non-claims-based payment components of APMs financial models (e.g., care management fees, population-based payments), and accelerate the processing of shared savings and reconciliation payments. We appreciate that CMS is offering CPC+ Track 1 and Track 2 participants the opportunity to request Program Year (PY) 2020 Quarter 3 non-claims-based payments in advance. In communication to program participants, CMS indicated the goal of advanced payment is to provide financial relief to participating CPC+ Medicare providers working to provide treatment to patients and combat the pandemic. Our members indicate that commercial payers have offered similar advanced payments for provider participants in value-based arrangements and this has been critical to support the continued operation of care coordination activities and population health infrastructure.

a. Telehealth and virtual care

The expanded CMS eligibility for telehealth has been crucial to maintaining access to care for non-COVID-19 patients during the emergency. Telehealth – including audio-only telehealth – is also a critical mechanism to provide care while maintaining social distancing to reduce the transmission of COVID-19. HCTTF members have reported up to a ten-fold increase in the number of telehealth visits performed in a matter of weeks, which is truly a remarkable testament to the health care system’s capacity to adapt in a time of crisis. However, the increased use of telehealth visits has broad-reaching implications for Medicare programs and policies; adjustments should be made to recognize the expanded proportion of Medicare patient care provided via virtual means.

CMS should allow telehealth to be eligible for diagnosis and disease burden capture for risk adjustment in CMS programs, (e.g., the identification and (re)confirmation of hierarchical condition codes (HCCs) within Medicare Advantage (MA) or Medicare Shared Savings Program (MSSP)) during the period of the pandemic. Finally, HHS should expand waivers and flexibility for a broader set of virtual care services, including by waiving copayments for chronic care management and remote patient monitoring in order to support social distancing and the ability for providers to better leverage the limited workforce.

b. Beneficiary alignment & quality assessments

As noted above, the public health emergency stemming from COVID-19 has led HHS to issue waivers that allow more flexible use of telehealth services. Applicable models should account for virtual E&M visits towards plurality of care for beneficiary attribution purposes; CMS should exclude telehealth services provided by geographically separated physicians, which would otherwise distort assignment. Any face-to-face encounter with a preexisting provider should supersede any telehealth visits that occurred during the PHE with a new provider for assignment purposes. For prospective alignment ACOs, CMS should increase the claims-based alignment lookback period from 12 months to 24 months to account for pandemic-related changes in care patterns and provide for a more stable population. **CMS also should consider making the 2020 performance year reporting-only for any quality measurement components that can be appropriately conducted and reported under pandemic conditions for APM models.**

III. The future of value-based payment

The actions CMS takes to provide relief to APM participants and in support of value-based programs will determine the long-term sustainability of the transition to value-based payment from fee-for-service. The new funding appropriated through the CARES and Paycheck Protection Program and Health Care Enhancement Acts directs relief to healthcare entities; CMS should make every effort to ensure providers that have voluntarily participated in alternative payment models and invested in population health infrastructure are provided financial relief to continue supporting patient-centered care practices. These actions will go a long way towards confirming CMS' commitment to the value portfolio and support continued investment by providers in transforming the delivery system.

The immediate priority should be clarifying the near-term relief policies, but shortly thereafter we recommend CMS turn attention to working with ACOs, bundled payment entities, and other CMMI model participants to develop policies to account for COVID-19 impacts on benchmarks, risk adjustment and attribution for 2021 and beyond. At the very least, CMMI CMS should add clear language on EUC policies that address events on the scale of the COVID-19 pandemic into participation agreements moving forward. Additionally, CMS should evaluate the impact of waivers issued in light of the PHE and whether any of these waivers should be extended beyond the duration of the PHE.

Additionally, as CMS adjusts and evolves policies relating to APMs, value-based care, and delivery and payment transformation, it should proactively take into account the impact of these programs and models on the persistent health and health care inequities that continue to plague our country. As our nation continues to become more racially and ethnically diverse, it is imperative that we build a health care system that can deliver high quality, high value care to all. It is especially important that we guard against reinforcing existing disparities and inadvertently making them worse.

The Task Force welcomes the opportunity to meet virtually with CMS and CMMI to discuss the future of value-based payment and care delivery in more detail.

Unlike other emergencies caused by natural disasters or more limited scale outbreaks – which usually impact a limited geographic region – the COVID-19 pandemic has impacted the entire globe at once. No part of the U.S. will be completely untouched. The public health and healthcare community therefore depends on the federal government’s leadership during this emergency response. Most importantly, health care stakeholders are looking for clear and actionable guidance from federal programs to remove any uncertainty about what is expected of them.

The COVID-19 crisis has also provided yet another example of the desirability of a health care system driven by value-based payment over fee-for-service. The Task Force offers its sincere thank you to CMS and the CMS Innovation Center for driving the transformation to value for the past decade; we stand ready to continue to support sustainable change in the private and public sector programs. Please contact Jeff Micklos (jeff.micklos@hcttf.org) or Clare Pierce-Wrobel (clare.wrobel@hcttf.org) with any questions or comments about this letter and to arrange a meeting.

Sincerely,

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