



June 1, 2020

VIA ELECTRONIC SUBMISSION

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

Re: CMS-1744-IFC Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

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) final rule with comment period (1744-IFC) addressing regulatory revisions in response to the COVID-19 public health emergency (Final Rule).

The Task Force 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. 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 others, can increase the pace of delivery system transformation.

Below, HCTTF provides comments on the provisions of the Final Rule with a focus on the specific program changes of importance to our members. We also offer CMS strategies to consider in addressing some of the long-term issues that may be created by COVID-19.

I. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

HCTTF members appreciate the operational flexibility that CMS has provided through waivers of existing policies governing telehealth services. Many health care organizations have quickly deployed new or upgraded existing capabilities regarding their telehealth platforms. These investments are critical to being able to serve the medical and mental health needs of our patients and enrollees during the pandemic crisis. However, this quick upgrade of telehealth capacity is also kick-starting investment in

and deployment of a more modern approach to person-centered care delivery that should be considered as tenets of a new, modernized policy going forward.

Many of the broader flexibilities that CMS has permitted in response to the COVID-19 pandemic are set to expire once the public health emergency (PHE) is lifted. We urge CMS to use this opportunity to modernize its telehealth policies regarding value-based payment models. Given the investments being made in telehealth, an automatic return to the old telehealth policies for value-based models when the PHE concludes would be a setback for patient care and runs the risk of squandering the investments that health care entities have made during a time of crisis.

As a result, once the PHE is lifted, we urge CMS to temporarily extend waivers of normal telehealth policies for participants in the Medicare Shared Savings Program and models in the Center for Medicare and Medicaid Innovation's portfolio. During the temporary suspension (or moratorium), the Agency should engage stakeholders and consider appropriate ways to modernize Medicare's telehealth service delivery to advance value-based transformation and ensure the growth of telehealth does not exacerbate inequities in care and outcomes. HCTTF understands that any new policy will still need to balance interests of efficiency and effectiveness with concerns over quality of care and utilization. However, value-based payment models protect against these historical concerns by holding providers accountable for overall costs as well as creating stronger relationships between providers and beneficiaries, thereby reducing fragmentation of care, and addressing overutilization concerns through realigned incentives.

We encourage CMS to employ an enforcement moratorium of limited duration for these models while it crafts a balanced policy that would advance long term benefits for Medicare beneficiaries and the value-based providers that serve them. HCTTF stands ready to work with CMS to support development of such a modernized policy.

II. Innovation Center Models

a. Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Plan

The Task Force supports the proposed modifications to the MDPP program to allow beneficiaries greater access to services through telehealth during the PHE. We note that CMS has retained the requirement for in-person attendance at the first core-session and the statement from CMS that, in the event beneficiaries are prohibited from attending in-person sessions, no new cohorts will be started. Given the lack of clarity regarding the duration of the PHE and the fact that the MDPP program serves a population at high-risk for COVID-19 complication, **we request that CMS develop a contingency policy to allow beneficiaries who are unable to safely attend the first core session in-person to still participate in new MDPP cohorts.** We also urge CMS to further support supplier participation in the MDPP program by extending the application fee waivers for those impacted by the PHE. The impacts of COVID-19 on primary care presents real challenges for the effective management of chronic conditions and beneficiary access to programs like MDPP should be encouraged rather than limited due to conditions outside of the beneficiaries or providers control.

b. Changes to the Comprehensive Care for Joint Replacement (CJR) Model To Extend the Length of Performance Year 5 by Three Additional Months and To Change the Extreme and Uncontrollable Circumstances Policy To Account for the COVID-19 Pandemic

The Task Force appreciates the action CMS has taken in the Final Rule to update the CJR Extreme and Uncontrollable Circumstance (EUC) Policy in response to the impacts of the COVID-19 pandemic. We support the decision to apply the EUC starting 30 days before the PHE, however we are concerned about the decision to terminate the policy at the end of the PHE. Our members expect that few new episodes will be initiated during the PHE and anticipate a sharp increase in demand for services after the PHE ends. **Consequently, the Task Force urges CMS to consider extending the EUC policy to run for 90 days after the end of the PHE. We also encourage CMS to consider the long-term impacts of COVID-19 on CJR and offer an opportunity for feedback through a separate rulemaking.** Ideally, this rule would detail adjustments to CJR due to projected changes in utilization patterns and spending in 2020 (and potentially beyond) which will affect target pricing, benchmarking, and quality data.

c. Alternative Payment Model Treatment Under the Quality Payment Program

The Task Force recognizes the challenges that CMS is facing in responding to the changing scope and impact of the COVID-19 pandemic. We appreciate that the Final Rule acknowledges the potential need for additional rulemaking to address both impacts to specific APMs as well as the Quality Payment Program. That said, Task Force members are making decisions about program participation and the future direction of their practices based on the best available information from CMS. It is likely CMS will need to make additional modifications to APM policies that limit downside risk and account for increased volatility of the aligned beneficiary population and their risk distribution during the PHE. APM participants need some certainty about how these changes will impact their Quality Payment Program status. **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 and 2021 performance; at a minimum do not accelerate the thresholds for 2021.** We also recommend an exemption or waiver for the Advanced APM criteria for 2020 if a provider's downside risk profile 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. **Given the additional volatility in spending in PY2020, when calculating the 5% incentive payments for PY2018 and PY2019 CMS could move the spending to calculate payments back one year to both accelerate PY2018 payments and to avoid the use of 2020 for calculating PY2019 payments.** The Task Force also supports Congressional proposals that would extend the Advanced APM incentive payment for 5 additional years.

III. Change to Medicare Shared Savings Program Extreme and Uncontrollable Circumstances Policy

We appreciate that CMS has made modifications to the MSSP policies to address the impact of the COVID-19 pandemic and clarified the intent to apply EUC provisions to 100 percent of Medicare beneficiaries aligned to Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) for the duration of the PHE. We support certain 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.

However, the proposed EUC provisions do not offer sufficient relief from risk arrangements while ensuring that ACOs do not have to resort to dropping out of the program. **Current MSSP participants should be allowed to notify CMS by August 31st if they do not 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 the impact than the current participation agreement renewal period allows to make an informed decision on program participation depending on renewal of the PHE in July. 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.

If the PHE is not extended, CMS should 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 objective of providing options including a no-reconciliation option and a lower risk 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 to recognize factors that could greatly affect the risk distribution of aligned beneficiaries. This is particularly important in regions where the risk score rises more than the cap. At minimum, CMS should allow any ACOs whose regional risk score increases by more than three percent to allow the ACO's risk score to also increase beyond three percent.

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. Adjusting the benchmark will not achieve the stated goal to "treat [ACOs] equitably regardless of the extent to which their patient populations are affected by the pandemic" because it only accounts for patients who are diagnosed positive for COVID-19 and admitted to the hospital. The proposed adjustments only account for differential prevalence of COVID-19 patients among ACOs; however, ACOs will experience differential secondary impacts and the proposed relief does not account for this if it varies regionally and within region. We encourage CMS to signal to ACOs that they will be monitoring this variation and will consider remedies in future rulemaking if the variation warrants.

Finally, CMS is considering in CMS-1744-IFC whether it should apply the current EUC policy for reporting quality measures for PY 2020 and beyond. Under current regulations, when MSSP ACOs cannot report quality measures due to extreme and uncontrollable circumstances in a given performance year, CMS would apply the mean quality score across all ACOs. When impacted ACOs can completely and accurately report all quality measures, CMS would apply the higher of the mean quality score across all ACOs or the ACO's own quality score. 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 do not believe that the application of either an average quality score or individual ACO quality score based on data from the 2020 performance year is feasible or appropriate. We recommend making all MSSP quality measures pay-for-reporting for 2020.

IV. Addressing the Impact of COVID-19 on Part C and Part D Quality Rating Systems

HCTTF appreciates CMS' recognition of the risks and challenges associated with the collection of Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Health Outcomes Survey (HOS) data during the PHE. We generally support efforts to modify data collection to support social distancing efforts, limit the potential for COVID infections, and free resources for providers and plans to focus on patient care. That said, we encourage CMS to consider modifying the proposed policies for calculating Star Ratings for 2021 and 2022 to more fully account for the impacts of COVID-19 while continuing to incentivize plans to focus on quality improvement.

a. HEDIS, CAHPS, and HOS Data Collection and Submission for 2021 Star Ratings and 2022 Star Ratings

In the Final Rule, CMS suspends HEDIS and CAHPS data collection and submission requirements for Part C and D plans for 2020 and shifts the HOS survey administration from spring to late summer of 2020. The Task Force generally agrees with CMS on the need to modify data collection and submission requirements to protect those gathering data and allow providers and payers to focus on patient care during the PHE. However, Task Force members are concerned about the longer-term impacts of COVID-19 on patient care and experience measurement extending into the 2021 data collection period. For example, the HOS measures of beneficiary perceptions of physical and mental health are likely to be influenced by several COVID-19 related factors; including stay-at-home orders, timelines for vaccine development, and the high degree of uncertainty regarding the return to more normal public and economic life. **We encourage CMS to work with measure stewards and plans to develop methodologies to adjust for COVID-19 related impacts on patients self-reported and actual outcomes that are outside of the control of plans.** In cases where appropriate methodological adjustments are not possible, we urge CMS to consider using the Display Page for the impacted measures until data quality issues can be addressed. CMS should also focus attention on developing telehealth related quality measures given the increased reliance on virtual care during the PHE.

b. Adjustments to the 2021 Star Ratings Methodology Due To Lack of HEDIS and CAHPS Data; Use of 2020 Star Ratings To Substitute for 2021 Star Ratings in the Event of Extraordinarily Compromised CMS Capabilities or Systemic Data Issues; and 2022 Star Ratings

We recommend CMS reevaluate the existing Extreme and Uncontrollable Circumstances (EUC) policy for Stars rating disaster relief. The current EUC policy is triggered by the receipt of Individual Assistance (IA) from FEMA and, as of the writing of this letter, a total of 45 states have received IA and Task Force members anticipate additional states will likely become eligible throughout the remainder of the year. Consequently, there is a real risk CMS may be left with a small sample of plans in areas not significantly impacted by COVID-19 from which to calculate Stars cut points. These calculations are not likely to be representative of plan performance across most of the country and we urge CMS to reconsider the methodology.

While it is clear that CMS needed to act quickly to address concerns about 2020 data collection, we believe that data on plan quality continues to be relevant even considering the challenges presented by the PHE. In the final rule CMS notes that, while it is suspending data collection and submission

requirements, plans may continue to use any data they have gathered for internal quality improvement efforts. This proposal functionally removes any pathway for plans that successfully improved quality during the 2019 measurement period to improve their rating and limits CMS visibility into plan quality during the PHE. We encourage CMS to allow plans the option to submit data they have already collected and to consider accepting new data submissions from plans with the capacity to gather data safely. This offers CMS the ability to gather useful information on plan performance and preserves the potential for future decisions about how to manage Star Ratings.

Furthermore, until the development of an effective COVID-19 vaccine, social distancing will continue to be a necessary to manage outbreaks and, even when a vaccine is developed, it will take time to manufacture and administer to the public. Given the unpredictable timeline for a return to normal operations, **we encourage CMS to develop a strategy for evaluating plans that does not rely on pre-COVID data and reflects plan performance during COVID.** Such a strategy would need to rely on data sources that can be safely collected in light the PHE and CMS could extend exemptions to plans serving regions heavily impacted by COVID where concerns about data validity make measurement unreliable. If it is not possible to develop a strategy for resuming measurement, **we recommend that CMS use the Center for Medicare and Medicaid Innovation's demonstration authority to test alternative approaches for measuring quality under the Stars Ratings.** This model would be open to plans that have achieved a 2020 Stars Rating of 3.5 and offer them the opportunity to earn a QBP. The model could be used to evaluate the impact of different supplemental benefits on patient outcomes, test quality measures for telehealth, and develop more timely rating methodologies.

Task Force members also offered comments on elements of the methodology detailed in the rule. Of specific concern is the CMS proposal to use 2019 CAHPS submission data to calculate the 2021 Star ratings without also delaying the scheduled measure weight updates finalized in the 2019 MA and Part D policy and Technical Changes final rule which increased the CAHPS weighting for the 2021 and 2022 Star Ratings from 1.5 to 2.0. **Given that MA plans are unable to take action to impact their performance on these measures we urge CMS to revert to the prior weighting of 1.5 consistent with the methodology applicable to the 2020 Stars Ratings.**

Finally, CMS detailed plans to use some data collected in 2019 and 2020 to inform the development of 2021 and 2022 Star Ratings. Members highlighted a range of potential challenges related to COVID-19 that could reasonably be expected to impact the validity of data collected during this time frame. This includes geographic variations in the prevalence of COVID infections and social distancing policies, availability of face-to-face care appointments, and provider and patient telehealth capabilities. **We urge CMS to establish a comprehensive review process for any measures gathered during this period to evaluate the accuracy and validity of the data.**

V. Merit-based Incentive Payment System (MIPS) Updates

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.

VI. Advance Payments to Suppliers Furnishing Items and Services under Part B

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.

The HCTTF appreciates the opportunity to provide feedback on the CMS response to the COVID-19 PHE. We look forward to providing ongoing support CMS efforts to address the unprecedented impacts of COVID on the health care system by sharing the feedback and perspectives of our member payers, providers, purchasers, and patients who remain committed to the continued adoption of value-based payment models. Please contact Jeff Micklos (jeff.micklos@hcttf.org) or Clare Pierce-Wrobel (clare.wrobel@hcttf.org) with any questions or comments on this letter.

Sincerely,

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