



July 7, 2020

VIA ELECTRONIC SUBMISSION

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

Re: CMS-5531-IFC Medicare and Medicaid Programs; Additional 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 (5531-IFC) addressing new and revised regulatory actions in response to the COVID-19 public health emergency (PHE).

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 specific provisions of the Final Rule as well as feedback on specific program changes of importance to our members and strategies to address some of the long-term issues that may be created by COVID-19.

I. Medicare Shared Savings Program

HCTTF members appreciate the efforts that CMS has made to rapidly announce modifications to the Medicare Shared Savings Program (MSSP) policies to address the impact of the COVID-19 pandemic. We encourage CMS to consider the following comments regarding the specific provisions in the MSSP section of the IFC.

Task Force Members are concerned about the decision to forgo the January 1, 2021 application cycle for the program. We support the CMS decision to allow ACOs that entered a first or second agreement period with a start date of January 1, 2018 to elect to extend their agreement period for an optional fourth performance year spanning the 12 months from January 1, 2021, to December 31, 2021. **We do not support the decision to prevent new applicants from entering for the 2021 program year.** The impact of COVID-19 on the utilization rates for elective services and the resulting disruption of the fee-for-service payment models has generated increased interest in alternative payment models among providers. In this space alternative payment models like MSSP have proven to be a lifeline for providers enabling them to effectively adapt to the challenges of delivering care during the public health emergency (PHE) while requiring far less financial assistance than their FFS reliant counterparts. Furthermore, ACO arrangements facilitate person-centered care and care coordination, which is critical at a time when people with chronic conditions are most vulnerable to COVID-19. The CMS decision to bar new application in 2021 removes a critical pathway to Alternative Payment Model (APM) participation at a time when the provider interest in and patient need for such programs is growing. **We strongly encourage CMS to continue to allow new applications for the 2021 MSSP program year.** We believe there are viable pathways for generating a benchmark for 2021 new entrants and we encourage CMS to work with stakeholders to explore options such as shifting benchmark years to exclude 2020 or changing benchmark weighting to limit the impact of 2020 data.

The Task Force supports the CMS proposal to permit ACOs participating in the MSSP BASIC track glide path to elect to maintain their current risk level under the BASIC track for PY 2021. Our members are concerned with the proposal automatically advance a ACO that selects this option to the level of the BASIC track's glide path in which it would have participated during PY 2022 if it had advanced automatically to the next level for PY 2021 (unless the ACO elects to advance more quickly before the start of PY 2022). This accelerated advancement would not allow an ACO to adjust to the increased risk exposure which is the primary intent of offering a glide path option. **We request that CMS allow ACOs to freeze their current 2020 risk level for one year and then resume the glide path in PY 2022 at the risk level they would have been on in PY 2021 absent the freeze rather than jumping to the PY 2022 risk level.**

We are encouraged by CMS's commitment to review the MSSP program and make changes on an ongoing basis in response to the longer-term impacts of the pandemic. Overall, our members are concerned that the strategy of excluding Medicare Part A and B spending and members months for beneficiaries with a COVID-19 inpatient episode does not sufficiently account for variations in utilization related to the COVID-19 pandemic. There are several potential challenges we want to bring to the fore for CMS to consider as ongoing program adjustments are made.

1. The proposed COVID-19 episode is reliant on an inpatient admission. While the inpatient COVID-19 cases are clearly the most serious and costly, primary care providers remain the predominant point of interaction with the health care system for most patients, including COVID positive and presumptive COVID patients. These providers have had to adapt their workflows for patient care delivery and incur additional costs to safeguard their patients and staff against the risk of COVID exposure and spread. **We urge CMS to recognize the added pandemic-related costs incurred by ACO participants when treating patients (including the COVID cases that do not require hospitalization) and providing necessary follow-up care.**

We encourage CMS to extend financial support to offset these costs and bolster the providers tasked with managing the long-term health of Medicare beneficiaries.

2. As with all episodes, the COVID-19 episode definition depends on reliable coding. Our members have observed greater than expected coding variations related to COVID-19 that are likely to impact the accuracy of CMS adjustments. **We encourage CMS to explore additional approaches to evaluate the accuracy of the episode-based exclusion in capturing true COVID impacts such as comparing the episode results to regional COVID prevalence.** Additionally, CMS could consider leveraging the COVID-19 diagnosis-based episode definition proposed in this rule for non-IPPS facilities as a check on the inpatient admission-based definition.
3. An increasing body of evidence suggests that COVID-19 infection may cause a host of lingering health effects including serious circulatory, respiratory, and neurologic conditions. It is likely that additional health issues will be identified over the coming months as more research is done on COVID positive patients. Given the unknowns of this novel virus, neither we nor CMS can know that the 1-month post discharge end date for a COVID episode will fully address the increased resource demands required to treat these patients. **We request that CMS evaluate and publicly report data on the impacts of COVID-19 on all service utilization for patients with and without an inpatient admission.** Furthermore, CMS should commit to ongoing reevaluations of MSSP and the other APMs it operates to adjust for any changes in patient risk and resource use in future financial and quality measurement methodologies. The goal should be successfully including COVID-19 in risk adjustment methodology.

The Task Force appreciates and supports the CMS decision to expand the definition of primary care services used in the MSSP assignment methodology to include telehealth codes for the 2020 model performance year. Given the increased use of telehealth due to the PHE, this decision is an important step in supporting accurate patient attribution under the model. As CMS transitions to developing longer term telehealth policy for MSSP and other Alternative Payment Models, 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. Additionally, we urge CMS to focus on developing clear guardrails for patient attribution that balance the expanded role of telehealth post-COVID with the potential for providers to reach patient far outside their normal geographic region.

II. Payment for Audio-Only Telephone Evaluation and Management Services

HCTTF members appreciate that CMS was responsive to stakeholder feedback in the decision to update reimbursement amounts for audio-only telehealth services to reflect the resource requirements for delivering these services.

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 Joshua Traylor (Joshua.Traylor@hcttf.org) with any questions or comments on this letter.

Sincerely,

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