

March 27, 2020

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U.S. Department of Health & Human Services  
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Brad Smith  
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U.S. Department of Health & Human Services  
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Dear Administrator Verma and Deputy Administrator Smith:

The undersigned organizations write to request that the Centers for Medicare & Medicaid Services (CMS) and Center for Medicare & Medicaid Innovation (CMMI) consider providing relief and additional flexibility for those payment and delivery service models during the COVID-19 pandemic. As our organizations continue to work toward shifting the healthcare system from emphasizing volume to recognizing and rewarding value, it is imperative that in addressing the current COVID-19 pandemic that the progress that has been made in transforming the healthcare delivery system does not regress back toward an emphasis on FFS care. Considering the treatment our organizations are giving to combat COVID-19, we believe that current risk-based contracts must be modified in order to recognize current on the ground realities facing providers nationwide.

One potential solution that could provide immediate relief and stability for healthcare providers due to the uncertainty resulting from the disruption to care patterns is **modifying the 2020 reconciliation process either through delay or potentially having no reconciliation in 2020 at all.**

Another option to consider that would alleviate some of the pressures that providers suddenly find themselves facing due to the sudden COVID-19 pandemic is extending the timeline for organizations to **drop out of any program without financial penalty** until a clear picture of financial and operational realities exists. Extending the timeline a few months until September 30 (or allowing a shorter notice period for dropping bundles such as 30 days) would give providers time to weigh options and make plans that allow them to operate as smoothly as possible and ensure that high quality care can continue for patients at a time when it is most needed.

While these recommendations are much needed and would represent remarkable relief to healthcare providers stretched to the limit by the current crisis, we recognize that such general relief across care models may not be possible at the present time. Considering this fact, we have also compiled a specific set of recommendations for individual models that would address ongoing and potential issues in the areas of attribution, quality, benchmarking, coding, and waiver policies.

### **Medicare Advantage (MA) Risk Models**

As MA plans work tirelessly to care for COVID-19 patients, we ask that your agency closely monitor the impact being experienced by MA plans and create contingency plans on how best to address any fallout, up to considering additional payments to assist with the unexpected rise in costs that providers have

experienced. Because the impact of COVID-19 has varied across regions, we suggest that CMS **measure the regional increase in fee-for-service (FFS) expenditures related to the COVID-19 epidemic in the original Medicare population.** This increase can then be used to calculate a regional per member per month (PMPM) adjustment factor to account for the increased cost of care as part of disaster management.

#### Coding

We would recommend that Hierarchical Condition Categories (HCC) submission for this year **combine submissions for both 2019 and 2020** since submission for many HCC codes will be missed due to the time consumed in combating the COVID-19 pandemic. There also remains the issue of potential increased penalization for MA plans in regions with high prevalence of COVID-19 due to the widespread differences in submission that will exist due to varying prevalence of the virus nationwide that resulted in longer periods of social distancing and higher total costs of care for some. We ask that CMS take this discrepancy into account and offer relief for those MA plans that are affected.

As part of the effort to combat the spread of COVID-19, patients nationwide have been practicing social distancing. The byproduct of this effort has been a reduction in face to face visits and an increase in the use of telehealth through both telephonic correspondence and televideo. While diagnoses associated with telehealth encounters are eligible for risk adjustment in CMS's Encounter Data System, we would ask that CMS **clarify that televideo encounter submissions are acceptable for risk adjustment for 2020 and that the telephonic only G2012 code is also acceptable for risk adjustment** in cases where an encounter is long enough and clinically appropriate to evaluate and diagnose a patient over the telephone. The agency should also make clear that it does not intend to change these rules for risk adjustment payments in 2021.

#### Quality

While the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Hospital Outcomes Survey (HOS) quality measure surveys are currently underway, in light of the ongoing pandemic, their findings will not be accurate and will vary from region to region in light of COVID-19's uneven prevalence. In order to avoid punishing MA plans for circumstances beyond their control, we recommend that CMS consider **using 2019 data for the 2020 surveys** instead.

### **Accountable Care Organizations (ACO)**

#### Attribution

The nature of this pandemic has resulted in atypical patterns of care that will make attribution for ACO patients increasingly difficult. This could result in significant changes in an ACO's attributed beneficiaries that would have a negative impact on provider organizations who are trying to provide care for all who need it during a crisis but could potentially have the patient unattributed to them. Medicare Shared Savings Programs (MSSP) with retrospective assignment will be most impacted in 2020 and those with prospective assignment in 2021, as social distancing decreases the number of patients coming into offices for visits. In order to provide relief for ACOs facing disruption due to COVID-19, those organizations that are currently operating under **retrospective assignment should be given the option to opt-into prospective assignment.**

The current crisis has also called for the expansion of the use of telehealth in caring for patients with many providers pooling resources and sharing patient care regardless of where they may normally seek care. As a result, the **corresponding g-codes used for telehealth should be included in attribution** for

patients in recognition of this fact. Solving the issue with attribution may also call for a longer look back period. In addition to retrospective attribution, the pandemic could have an impact on prospective attribution next year. To prepare for possible disruption in the fallout of the crisis, the agency should consider analyzing data **from both 2019 and 2020 in determining 2021 attribution** and to look at a process for including telehealth visits with the patients' existing provider.

### Quality

The ongoing changes in care patterns may also impact focus and performance for quality within ACOs moving forward. In order to mitigate any issues and allow organizations to measure quality more accurately, there are various options that can be considered. One tactic the agency may consider is making the **next two reporting years pay for reporting**. Due to the current pandemic and the potential for its effects to reverberate past 2020, making both this year and 2021 pay for reporting years would account for the circumstances ACOs currently find themselves under. Stars, HEDIS, and utilization measures will all assuredly suffer due to the pandemic and the inevitable drop must be accounted for. Many quality measures also have very stringent timelines for adherence. In consideration of the current constraints on providers' time as they race to administer care for patients during the pandemic, it may be best to **drop those measure that have tight timelines for numerator compliance** from consideration in quality measurement altogether. Finally, lower quality benchmarks or a **reset of the targets ACOs must reach** may also be necessary in order to account for the impact the pandemic is having on organizations now.

### Benchmarking

In addressing the adverse effect the COVID-19 pandemic has had on ACOs, CMS could possibly consider mitigating downside risk for this year and potentially in 2021 as well. One possible solution may be allowing ACOs to temporarily switch to lower levels of the BASIC Track in order to provide some flexibility for those organizations that need it. It will be important for CMS to conduct an **analysis of the regional trends of COVID-19 in order to develop a more nuanced approach**. Accounting for disease prevalence and weighing each individual community's ability to respond in setting benchmarks under this new paradigm will be important.

In addition, CMS may want to consider how it incorporates 2020 into all future benchmarking from this point on. As we are all aware, this year will represent an anomaly for healthcare providers, and society at large. Taking this into account in future benchmarking ensures that providers are not punished for it in perpetuity.

### Coding

The increased usage of telehealth during this pandemic has raised an entire set of issues around the practice, one of which concerns coding. As patients seek care remotely in order to lessen rates of infection nationally, this has relegated many annual wellness visits to telehealth visits. We would ask that your agency consider allowing organizations **to conduct these visits via telehealth and receive full credit for them** even though often, certain required procedures such as weighing patients or checking blood pressure cannot be conducted. Because of the effect the pandemic will have on HCC codes this year, CMS should consider a two-year lookback for the codes, rather than the current one-year standard. We would also like for CMS to issue guidance on how best to avoid receiving different answers from different Medicare Administrative Contractors regarding the use of telehealth for annual wellness visits.

### Waiver

As outlined above, since many patients may not be home to check blood pressure or weight during telehealth check-in, CMS should consider providing clarity on **having these checks waived while social distancing is still being practiced amid this epidemic**. We would also ask for clarity on Skilled Nursing Facility (SNF) 3-day waivers, specifically how do waivers for COVID interact with the Next Generation ACO and MSSP waivers. One potential solution for addressing this problem would be for your agency to provide more flexible deadlines in 2021 for those that want to use them due to the COVID-19 pandemic.

### **Bundled Payments**

The agency should also consider reducing the discount rate for The Bundled Payments for Care Improvement (BPCI) Advanced model and the Comprehensive Care for Joint Replacement (CJR) by a minimum of 1 percentage point (i.e., from 3 percent to 2 percent), and consider additional reductions to the discount based on the number of COVID cases in the state or region. The future impact of having had COVID will be long lasting; thus, increasing the acuity of the BPCI A patients. Consideration should be given to the impact of COVID in the payment methodology. In BPCI Advanced, CMS should consider recalculating the peer adjustment trend factor to account for state level cost changes in the performance period. The realities of healthcare settings during this pandemic has changed the ability of patients to come in for elective procedures and the ability of providers to administer them. Accounting for this in financial policies would be appropriate. If the third COVID-19 Stimulus Bill includes the removal of the Medicare 2 percent sequester from May 2020 through the duration of the pandemic, CMS must account for its impact on the BPCI Advanced model. **Lifting the sequester could increase costs** while decreasing savings. Addressing this possibility through spend standardization for the current time period rather than including it as part of any downside forgiveness would be the best course of action.

### ***Benchmarking***

Benchmarks and target prices must also be updated to reflect on the ground realities for COVID-19 and to account for the higher-than-expected acuity and increased ICU and PAC utilization. Normalized target prices for future years must also be reached. This extends to baselines and benchmarks for any APMS that have a rolling baseline or otherwise factor in actual performance years to future year prices. If left unaddressed, future year target prices would be skewed by COVID-19. PCMA adjustments will be particularly critical for Pneumonia, one of the diagnosis-related groups identified for a COVID-19 admission and an episode group selected by approximately 30 percent of Episode Initiators. Additional adjustments will also likely be required **for most medical Episode Groups** as hospitals will seek to admit only the most acute cases and may have cost patterns outside of historical norms due to the unique post-acute management needs caused by COVID-19 management.

### **Conclusion**

Providers operating under value-based models hold unique advantages in their ability to offer responsibility for populations while using telehealth services, care coordination, and partnership across various care settings. These advantages become especially valuable during a pandemic that calls for cooperation across medical settings and among providers as they seek to best serve their patients and communities. It is imperative that CMS support these innovative healthcare providers as they work on the front lines to continue offer the best care at the lowest cost. We believe that the movement to risk based value models are the key to long term success in improving health in this nation. We hope that

you consider all these recommendations in weighing how best to protect providers who are participating in risk-based model amid the COVID-19 pandemic.

If you have any questions, please contact Valinda Rutledge, Senior Vice President of Federal Affairs at APG at [vrutledge@apg.org](mailto:vrutledge@apg.org) or Aisha Pittman, MPH, Vice President of Policy at Premier Inc. at [Aisha\\_Pittman@PremierInc.com](mailto:Aisha_Pittman@PremierInc.com).

Sincerely,

America's Physician Groups  
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