March 16, 2020

The Honorable Alex Azar II
Secretary
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Policies to Maintain Value Models During Coronavirus

Dear Secretary Azar and Administrator Verma:

The undersigned organizations write to urge the Department of Health & Human Services (HHS) to ensure mitigation policies are in place for providers operating in value-based arrangements and quality programs. We strongly support and share in HHS' commitment to improving quality and reducing costs through these programs. The care process improvements, partnerships and investments our organizations have made in value-based care have left us better equipped to keep our communities healthy and care for those who fall ill during this challenging time. However, the unprecedented surge in demand and shortfall of products that we are expecting requires a major shift in focus for our organizations. While providers are actively working to confront head on the threat of the coronavirus, they are also concerned that that they will be face serious financial consequences under these programs as a result of factors not under their direct control.

Given the unprecedented circumstances of COVID-19, we urge HHS to provide guidance on financial and quality mitigation policies for all quality programs and value-based arrangements. While some of these programs have extreme and uncontrollable circumstance policies in place, we do not believe the current policies are consistent or adequately address the protections needed to mitigate the impact of coronavirus. The health care system will need to ramp up capabilities to care for a large population of older Americans that will experience longer acute length of stay, more intense acute care utilization, higher skilled nursing facility utilization, increased discharges to long-term care hospitals, and an increase in ED admissions and readmissions. **These changes will have significant impacts on overall healthcare costs and quality.**

<u>Value-Based Payment Arrangements</u>

The existing extreme and uncontrollable circumstance policies in place do not adequately address circumstances related to nationwide public health emergencies. Most of these policies

were put in in place in response to natural disasters in 2016 and 2017 impacting a few regions. Moreover, several Innovation Center models lack extreme and uncontrollable circumstance policy.

We ask CMS to temporarily convert all downside risk arrangements to a no-risk model for the 2020 performance year. Many of the existing policies mitigate the potential for shared losses or repayments. For example, the Medicare Shared Savings Program (MSSP) mitigates the amount of shared losses an ACO must pay back by accounting for the total months in the performance period affected by the extreme and uncontrollable circumstance and the percentage of the ACOs beneficiaries residing in an area impacted by the extreme and uncontrollable circumstance whereas CMS caps episodes at the target price or removes episodes during an extreme an uncontrollable circumstance in bundled payment programs (e.g. Comprehensive Joint Replacement or BPCI Advanced).

The cost impacts due to coronavirus are unknown. It's feasible that some model participants costs will increase due to providing care for individuals who contract COVID-19 whereas other participants may see decreased costs due to healthier individuals avoiding health care. Importantly, **long-term disruption in care beyond the time period of the public health emergency declaration is unknown.** The current policy approach of limiting mitigation to the active emergency fails to recognize the impacts of shifts in care. For example, beneficiary avoidance of routine care could lead to exacerbations in chronic conditions that will increase costs in later months. We believe these shifts may also impact the 2021 performance year. Additionally, care coordinators are being reassigned from ACOs and Bundled payment models to COVID patients in order to deploy all available resources.

We ask that CMS suspend MIPS, ACO, and other APM quality reporting for performance year 2020 and delay reporting requirements for performance year 2019. The anticipated impacts of coronavirus directly relate to quality measures in value-based arrangements (e.g. readmissions, length of stay measures). Additionally, quality rates related to chronic conditions and prevention may be impacted as healthier beneficiaries may be avoiding seeking health care. CMS should suspend quality reporting requirements for 2020, recognizing that all quality metrics will be impacted. Additionally, many ACOs have expressed concerns about meeting the upcoming March 31 deadline for submitting PY 19 information as quality resources are being diverted to other areas of the business. Current ACOs should have at least a three-month extension to the PY19 reporting deadline.

We ask that CMS delay application deadlines for MSSP and Direct Contracting. Health care providers are consumed by changing care processes and implementing new waivers in response to coronavirus. The upcoming application deadlines associated with these models should be moved until after the conclusion of the public health emergency. **We also ask that CMS implement a one-year agreement extension for all MSSP, including Track 1 Plus, and Next Generation ACO participants whose agreements are expiring this performance period.**

We encourage CMS to explore how to mitigate the impact of coronavirus on benchmarks and target prices in future years. It's feasible that some triggering events could result much lower costs during the event. In that event it would unfairly penalize the entity to use the expenditures from the performance year with the triggering event in the determination of future benchmarks or target prices. We ask CMS to consider potential impact to aligned beneficiaries in an ACO, it is unknown if this emergency could significantly reduce the assigned beneficiaries. CMS should establish policies for ensuring an ACO that loses population through claims attribution has sufficient time to rebuild their population before the next contract cycle. Similarly, CMS should establish a low volume exception for bundled payments programs and primary care models that may have a reduction in clinical episodes or attributed beneficiaries as a result of coronavirus. Finally, risk adjustment will also be impacted in these models due to decrease in Annual Wellness Visits, increase in acuity of emergent medical admission, and decrease in elective procedures.

Medicare Advantage

Risk adjustment calculations depend on an annual face-to-face visit of MA patients to capture diagnoses present in the patient. Given the current concerns of COVID-19, especially in the senior population, this program has unprecedented significant risk to the stability of the MA population this year. Bringing in healthy seniors for an annual assessment, into the clinics where there may be risk of community infection, would not serve in the best interests of community health at this time. Further, these comprehensive assessment visits can be lengthy and impact physician time significantly.

In anticipation of growing impact to the clinics, due to COVID-19, we propose readjusting rates this year to supplement the impact of decreased risk adjustment capture in the 2021 payment year as well as potentially increased costs. We also recommend allowing telehealth visits to be utilized for risk adjustment assessments in the 2021 PY for risk score accuracy. Even if COVID-19 is contained and does not impact our communities, due to health precautions, it is likely there will be less senior assessment visits through June 30th, 2020, of which payments in the first half of PY 2021 will be affected. This will still impact our operations significantly and decrease the stability of the Medicare Advantage program.

Physician, Hospital and Other Facility Quality Programs

The extreme and uncontrollable circumstance policies across the Quality Payment Program, the hospital quality and pay for performance programs (e.g. readmissions reduction, value-based purchasing, inpatient quality reporting, promoting interoperability and other facility quality programs all require the accountable entity to submit apply for exceptions to the program. This approach can require a single provider to submit multiple applications; for example, a hospital must apply for exceptions to the pay-for performance programs and promoting interoperability separately. **CMS should consider policies to apply automatic exceptions for providers**. At a minimum, CMS should establish one streamlined application that would apply to all quality and payment related programs.

Conclusion

We support HHS's efforts to transform healthcare payment and delivery systems to one that better rewards value and incentivizes quality, well-coordinated care. We appreciate your consideration of how to ensure providers will remain in payment models and committed to quality improvement during and after the threat of novel coronavirus. If you have any questions, please contact Valinda Rutledge, Senior Vice President of Federal Affairs at APG at vrutledge@apg.org or Aisha Pittman, MPH, Vice President of Policy at Premier Inc. at Aisha_Pittman@PremierInc.com. **We encourage you to quickly issue policies across all models and programs to account for the potential of increased costs and reduced quality in the models and thus alleviate an already burdened system of additional stress.**

Sincerely,

America's Physician Groups
Premier Inc.

CC:
Brad Smith
Director, Center for Medicare & Medicaid Innovation
Senior Advisor, Value-Based Transformation