May 1, 2020

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

Re: Support for Value-Based Models of Care during COVID-19 Public Health Emergency

Dear Administrator Verma:

The undersigned organizations would like to thank you for your efforts to address the struggles that healthcare providers and systems have been faced with during the ongoing COVID-19 pandemic. Specifically, the Public Health and Social Services Emergency Fund (PHSSEF) has been integral in extending relief for healthcare providers by providing reimbursement for COVID-19 related expenses and lost revenue through the ongoing public health emergency (PHE).

As efforts continue to distribute financial relief for physicians and hospitals, it is important that assistance be provided for value-based models in order to ensure their viability in both the short and long term, and recognize and preserve the role they play in moving healthcare from volume to value.

We also appreciate the changes CMS made to the Medicare Shared Savings Program (MSSP) in an Interim final rule with comment period (IFC) released yesterday, including allowing ACOs with expiring agreements to extend one year and to remain in their current risk track for an additional year. Additionally, we are pleased CMS considered approaches beyond the current extreme and uncontrollable circumstances policy by removing COVID-19 episodes from the ACO's expenditures and reducing losses based upon the PHE duration. However, it is unclear if this policy will be adequate to mitigate exposure to losses. The regional variability in testing and changes in coding and documentation guidance may result in undercounting COVID-19 expenses. Moreover, in the absence of knowing when the public health emergency will conclude and the potential reemergence of the virus in the Fall, some ACOs with downside risk may be uncomfortable with remaining in a risk-based arrangement.

We offer the following recommendations as a way of providing value-based care models much needed financial stability during this pandemic while also preserving the future of the models and their transformative potential.

Summary of Recommendations

- **We support the current proposal in the IFC of having losses reduced by the number of months in the PHE and no change in the savings calculations.**

- **We also propose a second option for organizations to elect to move to no downside risk with modified upside risk.**
- **In addition, CMS should:**
    - **Implement extreme and uncontrollable circumstances models across all Innovation Center models, allowing model participants to remain in status quo.**
    - **Provide an opportunity for entities to enter MSSP and Direct Contracting for a January 1, 2021 start date.**
    - **Accelerate pending payments to providers.**
    - **Clarify quality mitigation approaches and expand to other models**
    - **Set at least 90 days from the IFC date to drop out of ACOs without penalty**

Organizations currently participating in value-based care models represent a diverse set of healthcare providers that run the gamut in terms of their COVID-19 impact and organizational structure. While this diversity provides these models with valuable, varied insight into how best to offer higher value care at lower costs, the diversity of their COVID-19 experiences makes a one-size-fits-all approach inappropriate.

Additionally, the COVID-19 pandemic itself has also had a diverse effect on healthcare in different regions of the country. This reality must be accounted for in any formula or plan from CMS in disseminating relief for healthcare providers. Those located in jurisdictions that have experienced greater instances of COVID-19 must receive financial relief reflecting this reality.

We support CMS's policy to allow a modification of the downside risk (with no change in savings calculations) based upon the number of months in the PHE and to remove COVID-19 expenses from an ACO's expenditures. However, we believe that a second option is needed that will allow organizations to elect to move to no downside risk with modified upside risk. This will give each organization the opportunity to choose the path most conducive to success for their specific circumstance. For some organizations, losing the opportunity to achieve full shared savings would only compound the financial hardships they are currently experiencing due to COVID-19 while others may need guarantees that repayment can be avoided in order to stave off their financial hardships while maintaining their long-term commitment toward transforming our current system on the path to value. For these organizations that need more certainty than decreasing losses based upon PHE months, avoiding downside risk must necessarily come with a tradeoff which is why upside risk will be limited in some capacity. The cap placed on upside potential could take several forms, but any option pursued by CMS is needed to properly mitigate downside risk while avoiding any undue or burdensome financial liability for the healthcare system as a whole, particularly the Medicare Trust Fund.

Implementing extreme and uncontrollable circumstances policies across all Innovation Center models will allow model participants to uphold the status quo. The Innovation Center models (e.g. Next Generation ACO (NGACO), BPCI-A, CPC+) do not have extreme and uncontrollable circumstances in place. CMS should create extreme and uncontrollable circumstances policies for these models comparable to MSSP and CJR where APM entities' potential for losses are mitigated during the PHE and COVID-19 related expenses are removed from the model. For bundled payment programs, CMS should examine additional approaches to account for higher acuity patients being prioritized as nonessential services resume. These episodes are likely to be

costlier and will unfairly penalize those in bundled payments during the initial reopening phases as the current risk adjustment and peer adjustment approaches will not account for this shift. **Additionally, CMS should extend NGACO contracts, similar to the optional extension offered for MSSP ACOs in the IFC.**

CMS should provide an opportunity for providers to enter both the MSSP and Direct Contracting models for a January 1, 2021 start date. Many healthcare organizations have dedicated substantial investments and planning in preparation for entering these programs. While we understand some organizations are unable to dedicate resources to entering new agreements, those who are willing and able should have the opportunity. Additionally, in recognition that full model details have been delayed for Direct Contracting, CMS should provide an opportunity to enter the direct contracting model for a second start date in 2022. Providing entities with certainty regarding the future of this key program and ensuring that it is ready to move forward as scheduled for January 2021 will avoid any added undue burden for healthcare providers and demonstrate that CMS is committed to continually moving the healthcare system towards value based models.

Prior years shared savings, reconciliation payments and MACRA Advanced APM bonuses should be accelerated to APM participants in recognition that many providers are facing financial difficulties. Receiving these payments earlier than in past years will provide needed cash to APM entities.

COVID-19 will undoubtedly skew quality measurement performance in 2020. While the MSSP extreme and uncontrollable circumstances policy allows ACOs to receive the average quality score if they are unable to submit data, CMS should clarify this policy applies for 2020. Moreover, other APMs do not have approaches for accounting for quality. CMS should implement approaches that allow voluntary quality reporting and hold harmless all APM entities for data submission and claims based measures. For example, in the NGACO model CMS could score all ACOs that are unable to report as average performance. Similarly, CMS could score all BPCI participants at 100 percent, removing the 10 percent quality withhold in 2020.

Allow ACO entities 90 days after the IFC is published to determine if they will remain in APM entities. APM organizations need adequate time to assess new information released from the Innovation Center. With MSSP recent changes announced on April 30, ACOs will only have 30 days to assess their options. Moreover, there has been no guidance on Innovation Center Models like NGACO or Direct Contracting. CMS should allow all ACOs 90 days to determine if they want to drop out of the program without penalty. Additionally, CMS should allow all bundled payment participants to exit from individual episodes, particularly pneumonia, sepsis and COPD which are significantly impacted by COVID-19, rather than having to exit the program completely with the 90-day notice. We also propose allowing BPCI-A participants to exit from individual episodes, particularly those impacted by COVID-19 (e.g. pneumonia, sepsis, COPD).

We again applaud you for the recent IFC (April 30,2020) but believe that additional modifications are needed to strengthen and sustain APMs during this time of crisis. We believe it is imperative that CMS send a signal that downside risk APMs are valued**. This can be**

achieved by providing a one-time incentive to two-sided risk entities and considering all clinicians in downside risk entities in 2020 to have met the QP threshold and receive the MACRA bonus. Organizations in value-based arrangements had a population health infrastructure that allowed them to more rapidly and comprehensively respond to the COVID-19 crisis.

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 at Aisha_Pittman@PremierInc.com.

Sincerely,

America's Physician Groups
Premier Healthcare Alliance