

March 18, 2020

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

Re: COVID-19 issues affecting clinicians and organizations in value-based payment models

Dear Administrator Verma,

The undersigned organizations write to express appreciation for significant efforts underway by the Centers for Medicare & Medicaid Services (CMS) to address the COVID-19 pandemic, including expanded telehealth services to help ensure the safety of patients. As physicians and hospitals are focused on defeating COVID-19 and using every resource at their disposal to do so, we urge CMS to take steps to ensure COVID-19 does not derail the Alternative Payment Model (APM) and value movement. As part of its response, CMS should allow flexibility with existing deadlines and requirements and take steps to ensure clinicians are not inappropriately penalized for the extreme costs of handling the pandemic so that they can continue to focus their energy on patient care.

In the immediate term, APM participants will be faced with difficult decisions about whether they can continue to afford to provide advanced preventative care, care coordination, and behavioral services, hallmarks of these models. Clinicians should be using every tool at their disposal to fight this epidemic; they should not fear having it count against them later. They need assurance from the administration that this will not be the case.

A crisis of this magnitude is already putting significant strain on clinical resources, staff, and finances alike. The cost to the healthcare system to deal with a pandemic like COVID-19 is unprecedented, and therefore unknown. **Clinicians in value-based arrangements face even higher levels of financial risk as a direct result of COVID-19.** Any resources they spend to mitigate the spread of COVID-19 will cost them twice, once at the onset and again when spending is evaluated at year end in the context of their value-based performance. With sixty percent of all healthcare dollars now tied to some form of value-based payment and the Healthcare Payment Learning & Action Network recently [announcing a goal](#) of tying 100 percent of all Medicare and Medicare Advantage dollars to two-sided risk by 2025, the value-based movement is at a critical juncture.

Certain programs and models do have extreme and uncontrollable circumstances policies in place. However, these vary widely across programs and payers and in most cases are not adequate to address a crisis of this magnitude. The Medicare Shared Savings Program (MSSP) for instance only mitigates shared losses and adjusts quality assessments; it does not adjust benchmarks or performance year expenditures, which will impact the program for many subsequent years.

Dealing with a pandemic of unprecedented scale requires mitigating tactics of unprecedented scale. If financial benchmarks, target prices, and measure benchmarks are not appropriately calibrated, the effects will be felt not just in 2020, but years to come because future performance will be graded against compromised benchmarks. Beyond the direct spending impact, healthy patients are avoiding physician offices for regular appointments, which impacts attribution for population-based models such as ACOs, leaving them with a disproportionately sick population, therefore compounding the effect.

Our goal is to ensure the clinicians who have accepted the risks and made the investments to participate in value-based payment models have their performance evaluated as accurately as possible. To this end, we urge CMS to implement the following recommendations.

- **Hold clinicians harmless from performance-related penalties for the 2020 performance year, particularly those in two-sided risk APMs. At a minimum, make appropriate adjustments to address the impact of COVID-19 on financial expenditures, performance scores, patient attribution, and risk adjustment.** Keep in mind not only the short-term impact on 2020 calculations, but the long-term impact on performance measures and global financial benchmarks for future performance years.
- **Hold clinicians and ACOs harmless from quality assessments and reporting obligations for the 2020 performance year.** The impact of COVID-19 on quality measurement will be profound. This will impact admissions and readmissions and patients will likely be required to postpone certain preventive health measures to allow capacity to treat more serious cases. Additionally, clinicians who would typically be involved in quality reporting may be needed to provide patient care.
- **Consider additional options to support APM participants, including up front funding opportunities and reinsurance options.** Financial resources will be depleted in the wake of COVID-19, making it more challenging to overcome entry barriers to APMs than ever before. Additional support at this time would go a long way to helping clinicians continue to transition to APMs, particularly risk-bearing APMs which are a priority for the Administration.
- **Extend application timelines and/or provide additional application opportunities to join Alternative Payment Models.** For example, commit to having a Direct Contracting Application cycle for the 2022 performance year and open up the Primary Care First 2022 application cycle to non-CPC+ clinicians. Application deadlines and participation agreement windows should be delayed and extended for the MSSP, Primary Care First, Direct Contracting, and other APMs.
- **Extend the upcoming March 31 MSSP and Merit-based Incentive Payment System (MIPS) reporting deadlines for 2019 data to at least June 30th and consider additional extensions as warranted.** As health professionals prioritize their staff and administrative resources toward fighting this crisis, their ability to meet previously scheduled regulatory requirements is compromised.

- **Extend the MIPS measure submission deadline for measure developers for the 2021 performance year to at least July 1, possibly later as the situation evolves.** In addition, CMS should consider allowing Qualifying Clinical Data Registry (QCDR) measure developers to submit a list of preliminary measures for CMS to include in proposed rulemaking as they concurrently work on completing testing and final specification changes.
- **Commit to a gradual implementation timeline for the MIPS Value Pathway,** now even more critical in the wake of the COVID-19 crisis.

The full extent of the impact of COVID-19 is not yet known, and we may not know for months to come. However, **clinicians in value-based programs, particularly risk bearing APMs, need assurance now.** For example, the Direct Contracting and Primary Care First models are vulnerable, with the participation agreements set to be signed later this year. Under the MSSP, risk-bearing ACOs that remain in the program past June 30 are accountable for losses. With more ACOs now in risk-bearing track than ever before, many are considering dropping out in advance of that deadline given the current situation and its unknown trajectory. Clinicians who are pioneering the path to value need to know that they will not be penalized in relation to those in fee for service, or it could hamper willingness to enter value-based contracts for years to come.

The undersigned organizations acknowledge there is still much unknown about the full impact of this novel pandemic, and we stand ready to work with you in the coming months to mitigate its effect on organizations that are leading the transition to value. We recognize that you and your colleagues at CMS have many demands with the response to COVID-19, and we appreciate your leadership in the face of this pandemic. Thank you for your consideration of the recommendations above. If you have any questions, please contact Allison Brennan, Senior Vice President of Government Affairs, NAACOS at abrennen@naacos.com, or Suzanne Joy, Senior Associate of Regulatory Affairs, ACP at sjoy@acponline.org.

Sincerely,

American Academy of Family Physicians
American College of Physicians
American Hospital Association
American Medical Group Association
America's Essential Hospitals
Association of American Medical Colleges
Federation of American Hospitals
Health Care Transformation Task Force
Medical Group Management Association
National Association of ACOs