PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

July 7, 2020

Submitted via regulations.gov

Mrs. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-5531-IFC; Medicare and Medicaid Programs, Basic Health Program, and Exchanges: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program

Dear Administrator Verma:

Thank you for the opportunity to comment on the Interim Final Rule with Comment (IFC) proposing modifications to the Medicare Shared Savings Program (MSSP) as a result of the COVID-19 pandemic. We appreciate the quick and decisive action taken by the Centers for Medicare & Medicaid Services (CMS) under your leadership to offer additional flexibilities, reduce administrative burden, and offer financial assistance to independent physicians and practices during the COVID-19 pandemic.

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans through a competitive health care provider market. We believe that it is impossible to achieve truly value-based care without a robust independent practice community. Our members include Aledade, American Academy of Family Physicians (AAFP), California Medical Association, Florida Medical Association, Medical Group Management Association (MGMA), and Texas Medical Association's Practice Edge. We also have individual and small medical group supporters across the country, many of whom are independent physicians or practices and wish to remain so.

Central to our mission is the belief that physicians – especially independent physician practices– are the lynch pin of our nation's health care system. They have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. In our vision of the future, this important piece of the health care system not only survives, but is thriving as a result of policies that place them on a level playing field with other providers and opportunities to test new models with components that reflect their unique circumstances.

As you know, many accountable care organizations (ACOs), including independent physician practices, continue to work hard to achieve positive results in 2020 despite the challenges associated with the COVID-19 pandemic. For example, many model participants have transitioned care to virtual platforms and/or provided care on porches or in parking lots or other outdoor settings as appropriate. Model participants are also working to establish long-term plans for triaging and treating patients with chronic conditions who are currently not seeking care because of the COVID-19 pandemic. They are doing all of this while also trying to procure the personal protective equipment (PPE) needed to treat patients in person, apply for loans, keep track of new guidance and policy changes, and make tough financial decisions related to their business.

The work of an ACO is aligned with work needed for an effective COVID response. They are not two separate efforts; rather, they are one and the same.

This was highlighted in a recent paper published by the Mark McClellan et al at the Duke University Margolis Center for Health Policy, "Value-Based Care in the COVID-19 Era: Enabling Health Care Response and Resilience," which noted that even prior to the pandemic value-based care organizations were leveraging their data infrastructure and relationships with other providers across settings to identify patients at risk for poor outcomes including hospitalizations and emergency department visits. These are the same skills that are needed for the COVID-response. ACOs, including those led by physicians, have used their value-based toolkits to undertake proactive outreach to prevent COVID-19 infection and transmission; collect and share COVID-19 related data; reorient staff and workflows to support patients during COVID-19; develop processes to address social needs; and shift site of service closer to home and community.

Many ACOs were able to pivot quickly to respond to the COVID pandemic, in part, because they are not wholly dependent on fee-for-service payment. Unlike strictly fee-for-service practices, value-based care models allow flexibility in times of crisis and can and should be leveraged to a greater extent to protect the independent physician workforce.

With respect to the provisions in the IFC, we generally support CMS' approach to addressing the uncertainty related to COVID-19 costs by removing Part A and B costs for episodes of care for the treatment of COVID-19 from the benchmark. Below is our specific feedback on other provisions in the IFC.

- **Option to Share in Savings in CY 2020:** We are pleased that CMS did not eliminate the possibility of achieving shared savings in 2020. Many ACOs have and continue to work hard to improve care and reduce costs. It is our strong belief that they should be rewarded for their efforts as appropriate.

- **Application of Extreme and Uncontrollable Circumstances Policy:** We support application of the extreme and uncontrollable circumstances policy during the public health emergency (PHE). However, we are concerned that early termination of the PHE would also terminate application of the policy and, if significant rates of COVID are still occurring, would disadvantage ACOs who may still be seeking significant disruption as a result of the pandemic. As such, we urge you to consider extending application of the extreme and uncontrollable policy to any performance year that starts during the PHE (similar to the approach proposed for expanded beneficiary assignment in the IFC as discussed in more detail below).

- **Decision Not to Have a CY 2021 Application Cycle:** While we appreciate that CMS does not wish to place additional burden on providers during the COVID pandemic, we urge CMS to reconsider its decision regarding the 2021 MSSP application cycle. To ensure we continue on the path to value-based care, it is critical for CMS to allow ACOs who are ready to join the movement to do so. While we appreciate that CMS wishes to reduce operational burden for potential ACOs who may be juggling the application process with the COVID response, we believe that it should be the physician or practice's decision. If CMS continues to believe that it will not be possible to launch a January 2021 cohort, we urge you to consider a mid-year/July cohort similar to the approach taken in the past.

- **Expanded Definition of Primary Care Services for Beneficiary Attribution:** We support the expanded definition of primary care services, as telehealth has proven to be critical for many independent physicians and practices during the pandemic. More patients than ever are using telehealth as a routine part of their care, and more clinicians and hospitals are using it. Incorporating these services into the attribution methodology ensures that ACOs are rewarded for their efforts to transform their practices from in-person to virtual to support social distancing.

- **Pay ACO Shared Savings Payments and Advanced APM Bonuses Early:** We believe that this would be impactful in ensuring that physicians and practices have the resources needed to continue to succeed in value-based care models, and to ensure that practices have resources to support COVID response. Last year, the payments and bonuses were issued in the fall. It would be helpful if they could be issued earlier this year, especially in light of the fact that CMS has discontinued its Advanced Payments Program for Part B providers, including independent physicians and practices.

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Thank you again for the opportunity to comment. Please do not hesitate if we can be a resource to you during this difficult time.

Best,

Kristen McGovern
Executive Director