OneCare Vermont

March 26, 2020

Kevin Mullin
Chair
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

Dear Chair Mullin,

We wanted to express our gratitude to the Board and your staff for working with OneCare's leadership team to identify flexibilities and support for Vermont's provider community as they continue to serve on the front lines of the COVID-19 pandemic. Assuring that the delivery system can withstand the initial and future impacts caused by the COVID-19 pandemic is critical to maintaining Vermont's health care system.

In support of our shared goal, we ask that the Green Mountain Care Board (GMCB), along with the other signers of Vermont's All Payer ACO Model agreement (APM), Agency of Human Services and Vermont's Administration, support the recommendations that were made to Centers for Medicare & Medicaid Services (CMS) from the National Association of Accountable Care Organizations (NAACOS) (see attached). Although not all of these recommendations impact Vermont, many of them do. In addition to these recommendations, we ask for additional adjustments that are specific to Vermont's Medicare ACO Initiative. The flexibility requests specific to the Medicare ACO Initiative are as follows:

1. Invoke the Medicare exogenous factors under Section XII of the contract to allow 2020 benchmarks to be reevaluated given the pandemic. Great care should be taken to assure that providers who have been leaders in reform efforts are not financially harmed and/or penalized by any changes.
2. Allow the 2020 All Inclusive Population Based Payment (AIPBP) payments to hospitals and independent practices, who are currently receiving an AIPBP, to be true fixed payments and not reconciled to fee for service at program settlement time. This allows for true predictability for front line providers in times of great uncertainty.
3. Hold clinicians harmless from quality-related penalties for the 2020 performance year, allowing 2020 to be a reporting year only.

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4. Allow for 2019 AIPBP payments that have already been made by CMS to be final and forego the reconciliation to fee for service-equivalent value during the settlement process. If this was allowed, immediate funds could be released to hospitals to support their financial sustainability. If this is not agreeable, an alternative would be to defer the recoupment process until 2021.
5. Hold the ACO harmless for any portion of the 2019 shared savings already paid out to the network to support the Medicare portion of the Blueprint for Health and Support and Services at Home.
6. Extend the date to submit the final Medicare roster for 2021 until September, which creates alignment with the roster submission of ACOs nationwide. In taking this step, we may also need to adjust the due date for agreeing on the final benchmark between the parties.
7. Open up additional funding opportunities for providers that are part of advanced APM agreements.

On the state level, we request that the signers re-evaluate scale targets and consider an extension of the term date for the APM ACO agreement given all of the uncertainties and anomalies for this calendar year.

Thank you for your consideration of these recommendations. Please feel free to contact me with any additional questions.

Respectfully,

Vicki Loner

Vicki Loner, RN.C, MCHDS
Chief Executive Officer

cc: Susan Barrett, GMCB Executive Director
Michael Barber, GMCB Attorney
John Brumsted, OneCare Board Chair

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 Contacting, 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 ssociation
National Association of ACOs