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July 7, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Verma:

On behalf of AMGA, I appreciate the opportunity to comment on the interim final rule with comment period (IFC) titled *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* [CMS-5531-IFC].

Founded in 1950, AMGA represents more than 440 multispecialty medical groups and integrated delivery systems, representing about 175,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide high-quality, cost-effective, patient-centered medical. AMGA and its membership also are dedicated to the successful transition of the healthcare system to one based on value. The novel coronavirus (COVID-19) public health emergency (PHE) has altered how providers deliver care. AMGA members, who are on the front lines of this pandemic, not only are treating those who have contracted the disease, but also are working to keep their other patients safe at home by cancelling elective procedures and shifting care to telehealth to the extent possible.

Despite the gradual reopening of various businesses across the country and the resumption of elective procedures in some locations, our members expect the ramifications from COVID-19 to continue. It is important that policies adopted now as part of the emergency response to the pandemic ensure the transition to value-based care can continue. Value-based models of care hold providers accountable for the cost and quality of the care they deliver. However, the COVID-19 pandemic has the potential to disrupt the ability of providers to monitor and care for their patients as they normally would. There is a potential for unanticipated spending variation, as providers treat newly attributed patients, while they may be unable to see other patients, including those with chronic disease. To that end, AMGA appreciates the various waivers and regulatory changes that CMS has instituted in response to the PHE, particularly those related to the Medicare Shared Savings Program (MSSP) and other value-based models of care.

We are pleased to offer the following recommendations on the IFC.

Medicare Shared Savings Program

- AMGA disagrees with the decision to cancel the 2021 application period. CMS should allow those providers that wish to enter the MSSP to do so.
- AMGA agrees with providing Accountable Care Organizations (ACOs) in the BASIC track with an option to stay at their current level for performance year 2021. However, AMGA recommends that CMS revise its policy that would require an ACO to skip a level and move into a more advanced level for performance year 2022. An ACO should not be required, for example, to advance from Level B to Level D.

Innovation Center Models

- AMGA appreciates that subsequent to this IFC's publication CMS extended the Next Generation (NextGen) ACO program through 2021. CMS should provide additional details on the Direct Contracting (DC) model as soon as possible so providers can make an informed participation decision.

Comments:

Medicare Shared Savings Program

CMS addressed changes to the MSSP in two separate interim final rules. In the interim final rule titled *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency*, CMS addressed changes to the Extreme and Uncontrollable Circumstances Policy for MSSP ACOs. In a subsequent Interim final rule titled *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*, CMS addressed other aspects of the MSSP that have been impacted by the COVID-19 PHE. AMGA is appreciative of CMS' attention to issues that influence providers' ability to continue the transition to value-based payment models in midst of the PHE.

CMS in this IFC is "forgoing the application cycle for a January 1, 2021 start date." While AMGA acknowledges that CMS is making this change in order to allow current MSSP ACOs to focus on treating patients during the pandemic, we disagree with CMS' approach and urge the agency to allow new entrants to the program in 2021. The MSSP ACO program is a voluntary model; therefore, only those who believe they are ready to move into this payment model will choose to participate. Depriving these groups of the choice to participate in the MSSP in performance year 2021 delays their ability to learn how to deliver care in a value-based model. Additionally, we are concerned about what the impact of forgoing an entire cohort of new ACOs will have on the viability and strength of the program. We urge CMS to allow new ACO applications in 2021.

CMS also is allowing BASIC track ACOs to elect to remain in their current participation track for one additional year but skip a level the following year, meaning an ACO that is currently participating in BASIC Level B in 2020 can remain at this level for performance year 2021 but must advance to Level D for performance year 2022. While we thank CMS for giving ACOs the ability to remain at their current level for an additional year, AMGA opposes the policy that would have ACOs advance to the level of the participation in which it would have participated during performance year 2022 had it automatically advanced in performance year 2021.

We do not believe that groups should be pushed into a higher risk level after they held steady in

2021. Because groups have had to divert resources to address the COVID-19 pandemic, these providers have not had adequate time and experience in risk-based arrangements. This is particularly concerning for Level B participants that would advance to Level D, which features a higher lost-sharing limit than Level C. These groups need extra time to learn how to operate in these arrangements, and allowing them to progress through to the next level they would have participated in after deferring allows that.

Addressing quality measurement for the 2020 performance period is also important for ACO participants, and AMGA is pleased that CMS has acknowledged how COVID-19 might skew quality results. AMGA recommends that quality measures for performance year 2020 be pay-for-reporting. We contend that some measures will be difficult to satisfy if patients are not engaging with their providers in office or via telehealth, which is likely due to the current pandemic. Additionally, the restriction on elective procedures may make it difficult for patients to get their breast cancer, colon cancer, and other various screenings. This problem could get worse if we see a resurgence of COVID-19 in the fall.

In the IFC, CMS includes services provided virtually, through telehealth, virtual check-in, e-visit, or telephone in the definition of *primary care services* used in the beneficiary assignment methodology. While we recognize CMS' position that including these services in the definition of primary care will "further allow for the continuity and coordination of care," AMGA's members are concerned about the unforeseen consequences of this expanded definition. We believe this revision can create issues in areas of the country where few providers are offering telehealth services. Some practices currently are attracting new patients due to CMS' expansion of payment for telehealth services. This expansion may result in having a patient attributed to a practice's ACO through a telehealth visit and the practice subsequently becoming responsible for the cost and quality of care of that patient, who may not continue to see that practice's physicians once the pandemic ends. We urge CMS to monitor and consider the unanticipated impact of this revision and ensure that ACOs had a meaningful relationship with patients assigned to them. CMS also should clarify the codes that will be used for ACO assignment.

Benchmarking and Regional Adjustments

We appreciate CMS' attention to the impact of COVID-19 expenses on MSSP expenditure and revenue calculations. However, AMGA remains concerned that the impact of COVID-19 on healthcare utilization will not be uniform nationally. With increased costs associated with COVID-19 in some regions and deferred care due both to stay-at-home orders and a fear of presenting at a healthcare facility—a fear that may linger for years—CMS should consider taking a longer term view of how expenses and quality are calculated for an ACO. Instead of looking at performance over a single year, AMGA would be interested in working with CMS and other stakeholders to develop a benchmarking and financial reconciliation process for ACOs that spans multiple years.

For the short term, however, it is critical for CMS to determine if the regional fee-for-service adjustment that is included in the program is sufficient to account for the variation in spending and utilization across the program that can be traced to COVID-19. While the program's design accounts for variations in regional spending, it is unclear if the MSSP model, which includes a limit on the regional adjustment, can account for the wide variation in expenses, divergent practice patterns that have resulted, and the unprecedented change in beneficiary behavior that has occurred. CMS asserts that the retrospective application of the historical benchmark will

“reasonably account” for lower utilization of services by non-COVID patients. While this intuitively appears to be the case, it may be that the deferred care results in higher expenses and poorer quality. Under current policy, depending on when an ACO entered the program, its update factor will be based on national growth rates, regional growth rates, or a blend of both. While a national emergency, COVID-19 also is highly localized. It is critical that CMS evaluate whether the current regional factors in the program are sufficient to account for the situation facing ACOs. Otherwise, despite the protections being designed to prevent such an outcome, the nature of the pandemic will render them less effective than intended.

Specifically, CMS should evaluate whether the 5% cap of the regional adjustment is sufficient or it needs to be increased.

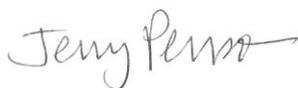
Innovation Center Models

In comments on CMS’ previous IFC (CMS-1744-IFC), AMGA emphasized the need for CMS to provide additional clarification on the status of the Next Generation (NextGen) ACO model and the Direct Contracting (DC) model. AMGA appreciates that CMS responded to this concern and subsequently provided guidance on both models.

However, in announcing the changes to the DC model’s timeframe, CMS also indicated it would release a series of specification papers that will contain additional details about model policy. Providers will need to apply before knowing the full specifications of the model. While providers are not bound to sign a participation agreement before all the details are known, CMS is expecting them to begin the process before releasing all the relevant information. AMGA strongly recommends that in the future CMS provide the information before providers begin the application process, as there is a cost associated with the staff time and resources needed to prepare an application.

We thank CMS for consideration of our comments. Should you have questions, please do not hesitate to contact Darryl M. Drevna, AMGA’s senior director of regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,



Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer
AMGA