CARAVANHEALTH.

June 9, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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,

Caravan Health thanks CMS for its quick action aimed at giving health providers nationwide the flexibility to effectively respond to the COVID-19 crisis. Caravan Health has formed and managed ACOs in the Medicare Shared Savings Program since 2014. We currently support more than 600,000 attributed Medicare beneficiaries in the MSSP, with 200,000 enrolled in Pathways to Success in 2020.

We welcome CMS allowing ACOs to freeze their 2020 risk level and not advance to a new level of risk in 2021. This is especially important for those Track 1 ACOs that would otherwise have had to transition to Pathways to Success in January 2021 or leave the program. In our conversations with clients, we heard little capacity for making big directional decisions during this public health crisis.

It is encouraging to see CMS disregard COVID-19 costs and ACO performance losses during the entire public health emergency. ACOs should not be unfairly penalized for being in a region with a high incidence of COVID-19, and they should not worry about performance losses of any kind during this crisis. As stated below, these changes do not fully account for these extraordinary circumstances and further action is needed.

Many of the changes to telehealth and virtual care will make it easier to patients to access care without a risk of infection to themselves or their care providers. These rules make it clear that many more providers can deliver a wide range of services to vulnerable populations. Some additional recommendations and clarifications for telehealth and virtual care are delineated below.

Overall, these changes do not go far enough to prevent this public health crisis from exacerbating a health care delivery crisis. Fee-for-service volume is collapsing under the conditions of the pandemic. This is primarily a function of the way we pay for traditional fee-for-service medicine, and ACOs represent a viable path for a further step away from volume-focused medicine and its problematic incentives. During this crisis period, incentives under the MSSP should be overhauled; financial savings and traditional quality measures are not an appropriate consideration for ACOs in 2020.

Caravan Health recommends that CMS take the following actions with regard to MSSP ACOs and virtual care.

- **ACO financial and quality performance in 2020 should be disregarded to the extent possible**

ACO performance data for 2020 will undoubtedly be skewed by the COVID-19 crisis. It is fundamentally unfair to assess ACO performance based on the data from this year. Although the recent rule removes COVID-19 costs from future benchmarks, it is unfair to use 2020 data for any purposes, including benchmarking or assignment of beneficiaries. CMS should allow providers to respond to the COVID-19 crisis without considering the traditional cost and savings incentives of the MSSP.

The ability of any health system or ACO to influence costs this year is likely to be dwarfed by factors outside its control. Since neither physician practices, nor hospitals, nor any other ACO participants can realistically budget and prepare for a pandemic on their own, CMS should use administrative authority to suspend charging penalties based on any performance in 2020.

Similarly, CMS should disregard any quality data for 2020 and simply pay ACOs for reporting. The circumstances of the pandemic will make precise differentiation of quality in primary care practices near impossible. Using 2020 quality data for performance evaluation would undercut the legitimacy of the program and we recommend suspending its use in establishing bonuses, penalties, and benchmarks at any point in the future.

- **CMS should implement a new incentive system for COVID-19 specific activities**

Caravan Health recommends two ways for CMS to direct ACO efforts productively instead of focusing on traditional savings, losses, and quality measures.

First, ACOs should be paid to focus on COVID-19 surveillance, data collection, and other activities. This builds directly on the population health focus that underlies the ACO model. Providing resources to ACOs to support this work would help ensure providers can keep up with evolving state and local best practices in testing and public health data collection. For example, CMS could extend credit to ACOs for the new MIPS Improvement Activity measure for participating in COVID-19 clinical trials and reporting results. Since ACOs already get 100% credit for the IA category there would otherwise be no additional incentive for ACO clinicians to engage in this work. Since the tools for this measure were introduced mid-year, we recommend relaxing the requirement for engaging the platforms within the first 60 days of the performance year for the MIPS PI registry reporting objective so that providers can get full credit for participating.

Second, ACOs should be rewarded for identifying, contacting, and serving their patients with high risk chronic diseases. These care management activities, much of which could be delivered remotely, would incentivize ACOs to reach underserved patients who often receive piecemeal care.

ACOs could be compensated for these activities through a care management fee, similar to that used in the Comprehensive Primary Care Plus program. This money should be tied to metrics such as placing 10-15% of patients under care management programs and maintaining regular contact with patients at higher risk for serious chronic conditions.

These two proposals keep CMS directly funding primary care capacity when volume is nosediving. This could keep the nearly 500,000 physician and other clinicians already in ACOs working together during a crisis, maintaining the infrastructure that has already been built. More importantly, this will provide upfront resources to manage patients whose conditions could deteriorate in the coming months, potentially catching them before we face a second wave of serious illness resulting from deferred preventive care.

- **Exempt swing beds from the MSSP calculation during the public health emergency**

Swing beds in critical access hospitals can be safer for patients in hard-hit COVID-19 areas needing post-acute care than skilled nursing facilities, but they are paid at approximately 3 times the rate. CMS should exclude these high, but short-term, costs from MSSP financial calculations during the public health emergency. This exclusion would enhance patient safety and help rural hospitals continue to succeed in value-based payment.

- **Increase payment for virtual annual wellness visits (AWVs) delivered by rural health clinics (RHCs) and federally qualified health centers (FQHCs)**

The current payment methodology is a major barrier to RHCs delivering AWVs. Under the current rules, an RHC will be paid $92 for delivering an AWV by telehealth using code G2025. This is approximately half the all-inclusive rate payment of $180 for an RHC conducting an AWV in person. This payment disparity creates an incentive to bring a patient into the clinic when the same care is available remotely. CMS should increase the payment to $120, which would match the fee-for-service payment. Further, RHCs and FQHCs should be paid their full all-inclusive rate (AIR) for distant site telehealth visits and telehealth visits should be treated the same as in-person visits for cost reporting purposes. These changes would let RHCs and FQHCs avoid a quirk of the reimbursement methodology that would require paying money back to Medicare for each telehealth visit.

- **Allow nurse-led telehealth AWVs for RHCs and FQHCs**

A team of licensed care professionals, such as nurses, medical assistants, and social workers, should be permitted to conduct an AWV without a physician joining the telehealth visit, as it works for an in-person AWV in a fee-for-service setting. Physicians should only need to review the documents and sign off on the prevention plan and be available to join the telehealth visit only if needed.

- **Allow RHCs and FQHCs to use telephone-only codes (99441, 99442, and 99443) and e-consult codes**

These providers are most likely to have patients without smart phones and internet to support telehealth, allowing telephone-only would establish a level field for care delivery to underserved communities. Allowing e-consult codes would compensate rural providers for time spent consulting with specialists on complex patient care and would allow the patient to avoid traveling to see a specialist.

- **Allow RHCs to bill for virtual AWV on the same day as an evaluation and management (E/M) visit**

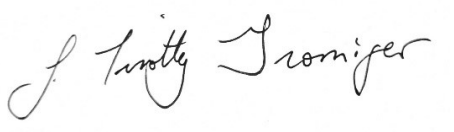
The AWV is a cornerstone of population health management for Medicare providers, especially for value-based payment models focused on proactive preventive care. An AWV is not separately billable by RHCs on the same day as an E/M visit to address specific health concerns. The RHC should be allowed to bill for both visits on the same day by telehealth or in-person. This change would allow the RHC to provide excellent and timely care while staying financially sustainable.

- **Additional telehealth and virtual care clarifications**
    - Clarify that an AWV completed via telehealth will capture vitals that patient can self-report, but otherwise may use those from the last clinic encounter. Currently, it is not clear how to meet all requirements if the provider cannot capture vital signs.
    - Clarify whether telephone E/M without video be used to capture HCC codes.
    - Clarify that telehealth services provided by licensed clinical social workers and psychologists are reimbursable if the patient is at home.
    - If ACO quality measures are required during the PHE, clarify that CMS will allow patients to self-report their blood pressure.

- CMS has not been clear about whether general care management can be billed in RHCs and FQHCs when patients meet principal care management eligibility requirements. Issue clear guidance to allow this to help meet the needs of patients who may not otherwise qualify for chronic care management or general care management.
- Clarify that capture of a current statin prescription or order of one by a clinician as part of a telehealth visit will be counted for ACO Quality Measure Prev-13.

ACOs are a valuable asset for the Medicare program, especially during this time of extreme stress on our health care system. ACOs have worked to deliver value for Medicare based on proactive population-based care over nearly ten years across hundreds of thousands of providers serving tens of millions of beneficiaries. The stress of the pandemic raises a real risk that providers, even those that have succeeded in the MSSP thus far, will leave the program if there is too much uncertainty. Disbanding ACOs by failing to account for extraordinary circumstances would be a mistake.

Sincerely,



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