CARAVANHEALTH.

September 13, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Re: CMS-1751-P, CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements

Dear Administrator Brooks-LaSure,

Caravan Health appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule for 2022. Caravan Health has formed and managed ACOs in the Medicare Shared Savings Program since 2014. We support more than 500,000 attributed Medicare beneficiaries in six collaborative ACOs in the Medicare Shared Savings Program (MSSP).

Caravan ACOs are made up of safety net and rural health systems and operate under a collaborative model. In our collaborative ACOs, unaffiliated health systems band together to benefit from larger numbers while staying independent. Our ACOs have found tremendous success under this model. In 2020, every provider in our collaborative ACOs earned shared savings, showing the power of our clinical model and collaborative approach. Our providers earned $68 million in shared savings in 2020, funds which will help providers keep their doors open during the extremely challenging conditions of the COVID-19 pandemic.

Caravan supports many of the proposed changes in the 2022 Physician Fee Schedule rule. We thank CMS for listening to the serious concerns of the ACO community about the timeline of the move to the new system for ACO quality measurement. Full implementation in 2024 rather than 2022 is a step in the right direction to mitigate concerns about provider and EMR vendor readiness for this change. In addition, the flexibility for additional telehealth services could benefit many providers in rural communities that are already struggling with health care access. The changes to the MSSP application, escrow balance, and beneficiary notification requirements would be welcome and could increase participation in the program.

In our comment letter on the 2021 Physician Fee Schedule proposed rule, we raised our concern that dramatically streamlining the number of quality measures for ACOs, as well as the drastic changes to the method by which ACOs are assessed, could have negative effects on the program. We were concerned that ACOs would not be able to distinguish themselves on the excellent care provided with more limited data. Since that time, the cost and burden of transitioning to the new system have come into sharper focus as we finish the second full year of the COVID-19 public health emergency. We are concerned that these changes focused on electronic reporting are diverting attention away from patient care and clinical workflow and instead, too much toward EMR workflows and functionality.

Caravan appreciates CMS's careful and thorough approach to the complex questions surrounding ACO benchmarking. Appropriate and fair benchmarking is central to the success of the MSSP. Caravan encourages CMS to address the problems posed by the rural glitch and the HCC risk adjustment cap as soon as possible.

Caravan is committed to increasing participation in value-based payment arrangements. We remain concerned about the ability of CMS to attract new entrants and retain current value-based payment participants, especially as providers progress to higher risk Advanced Alternative Payment Models (A-APMs). Along with many other ACO groups and advocates, we support The Value in Health Care Act, introduced in the House this past July. Several of the discussion topics raised in the proposed rule would be addressed by this legislation, including the benchmarking issue known as the rural glitch. CMS should implement these changes to the extent of their authority in the absence of Congressional action.

Small, rural providers can succeed in value-based payment with the proper support, but many of these providers do not have access to funding for the necessary investments. Caravan urges CMS to move forward with the ACO Transformation track of the Community Health Access and Rural Transformation (CHART) model that was delayed from the planned 2022 start. CHART will provide start-up funds that could be used for technology upgrades that help ACOs make the transition to electronic reporting. Caravan strongly urges CMS to implement the lessons of scale that we have demonstrated with our collaborative model and provide funding for CHART ACOs larger than 10,000 lives.

Our detailed comments on the rule are below:

ACO quality measurement

MSSP ACOs are facing an overhaul in how quality performance is measured. As mentioned above, Caravan is pleased that CMS is listening to the concerns of the ACO community in amending the timeline to ease the burden on ACOs. Despite the two-year extension in the phase-in of the new system, it is not clear that ACOs will be prepared as the mechanics of operationalizing this change are not yet established. This is especially concerning for Caravan's ACOs which are made up of unaffiliated health systems using a variety of electronic medical record (EMR) systems within systems and among our participants. We count over 40 EMRs in use by clinicians in Caravan ACOs.

Caravan recognizes CMS's challenge in appropriately setting performance incentives for a wide variety of providers, including specialist physicians, in the Medicare program. The agency must strike a balance between gaining accurate and actionable quality information and avoiding burdensome requirements that deter participation. The overhaul finalized in last year's rule was partly intended to ease burden on providers and allow them to build expertise in a simpler quality measurement system focused on a defined population health measure subset in the APM Performance Pathway (APP).

There are serious challenges in making the transition. The compatibility issues between disparate EMRs are difficult to bridge. Missing or confusing agency guidance make the transition even more difficult. Caravan's client base of mostly independent rural health systems has limited on-site technical support for addressing issues such as mapping data elements from different EMR systems. Our providers have been focused diligently on preparation, including upgrading to new EMR systems that provide better tracking and reporting functionality. Upgrades are followed by workflow redesign, training and follow up to ensure success in patient care and documentation capture. This work is expensive and time consuming, and the phase-in of the new quality measurement system is diverting staff time and other resources from responding to the COVID-19 pandemic.

Technical challenges: While Caravan offers significant technical and clinical support to our clients, we have concerns that the requirements of the new system may not accurately reflect the work of our ACO participants, at least as measured by EMR data. We know through internal audits that our quality of care is significantly higher than is reflected in the EMR, especially on the Depression Screen measure (PREV-12), slated as one of the persisting measures for eCQMs.

We applaud CMS's efforts to elevate and prioritize this important behavioral health metric, but caution that its broad specifications make it applicable to most patients and therefore would require to be performed by specialists once we move to electronic reporting on all patients and all payers in 2024. Currently this screen is only reimbursable once annually, however, many of our providers recognize the increase in depression and anxiety due to the pandemic and treat this screen like a vital – something assessed at every in-person or telehealth visit. We would support this screening being reimbursed more than once per year, perhaps every time it is performed. That would make it more attractive for specialists to perform regularly since they will be measured on it. Alternatively, CMS could provide an exemption for non-primary care providers.

More than a year since the new system of quality measurement was proposed, there are still outstanding questions about what types of files will be appropriate for electronic reporting at the ACO level. Deduplication of data, as well as aggregation of data across the ACO for reporting, is difficult and the federal guidance has not been clear. CMS needs to make and communicate key decisions about aggregated data, deduplication, and nullified files before any provider can be confident investing even more time and money to prepare.

Even with the additional two-year transition, it could be difficult for an ACO to test eCQM reporting or phase in until data aggregation solutions are determined. CMS is offering to enable ACOs to report both methods and score the higher of the two. However, to take advantage of this approach participants still need guidance on how this will work. Specifically, CMS needs to determine how data completeness standards can be met when the eligible population of a given measure is a moving target due to deduplication and beneficiaries adding or moving insurance coverage. In light of this missing information, two years may not be a long enough phase-in period for the industry to implement, test, and prepare all the systems.

Many of Caravan's small rural partners qualify for hardship exclusions set forth by CMS in the Promoting Interoperability category. Over the past few years, Caravan has identified discrepancies with Promoting Interoperability data submitted on behalf of our providers by EMR vendors. Often, these providers have already taken a waiver for this category, but unbeknownst to them, EMR vendors also submitted data that overrode the exemptions. To better support ACO participants and catch these types of issues, Caravan would like to encourage CMS to explore allowing ACOs more visibility into TIN-level promoting interoperability data during the submission period.

Role of specialists: Physician specialists are integral to the work of our ACOs. As raised in the proposed rule, CMS is appropriately concerned that the expanded reporting requirements could discourage specialists from participation. There is a real risk that these reporting requirements, rather than being strictly a tool of accountability, will end up driving how care is delivered in ACOs. The loss of specialist physicians from our ACOs due the misalignment of care delivery and quality reporting would result in fragmented care and threaten to reverse the momentum of accountable care.

CMS should recognize that, even while specialist physicians are not reporting on primary-care focused measures, the financial performance of these specialists are accounted for in the financial benchmarks. One possible approach to retaining specialists and recognizing their value in ACOs would be to introduce an APP measure focused on coordination of care between primary care and specialists to appropriately assess the team-based care approach that is foundational to an ACO.

Caravan believes that collecting all payer, all patient data could be an important step toward understanding and addressing health disparities. However, tying ACO financial rewards and incentives to non-attributed patients introduces complications that need to be fully understood in the context of value-based payment.

General Medicare payment and coverage changes:

Telehealth: Caravan appreciates that CMS is proposing to extend coverage of services delivered by telehealth through 2023. We also support the expanded mental telehealth proposal that promotes the equal treatment of physical and mental health. The pandemic has highlighted the need for our providers to play a larger role in the management of mental health and they need more tools to do so. The requirement for an in-person visit within six months of the telehealth service will help with continuity of care.

Caravan would encourage CMS to allow for delivery of in-person visits by another practitioner of the same specialty and group. As mental health services are sometimes difficult for beneficiaries to obtain under normal circumstances and often travel to those in person visits can be an obstacle to receiving timely care, this proposal opens the possibility of expansion of those services and can extend the reach that a limited number of mental health practitioners can provide.

Many providers in our ACOs have invested in telecommunication services to maintain continuity of service during the pandemic. CMS should allow for further evaluation of the benefits and costs of these expanded services. In light of cost concerns with extending telehealth to all Medicare providers, CMS should consider focusing telehealth expansion solely for participants in value-based care arrangements that are designed to save money.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Caravan works with many RHCs and FQHCs to implement value-based care in underserved communities. We support the proposal to allow RHCs and FQHCs to report and be paid for telehealth services used to diagnose, evaluate, or treat a mental health disorder, including through audio-only technology. We also support the proposal to allow RHCs and FQHCs to bill for transitional care management and other care management services furnished for the same beneficiary during the same service period. These proposals would increase the availability of necessary services to rural and often underserved populations and allow for those services to be provided in audio only format for those beneficiaries that have difficulty with connectivity and access to technology.

New CCM codes: Many Caravan Health clients have robust chronic care management (CCM) programs that are important to their population health programs. We are pleased to see the new CCM code, 99X21, describing CCM services furnished by clinical staff under the supervision of a physician or non-physician practitioner (NPP) who can bill evaluation/management (E/M) services, and CCM services personally furnished by a physician or NPP. This proposal will benefit our provider partners, as it will give them more flexibility to provide these critical services to patients with multiple chronic conditions.

Caravan is pleased to see CMS promptly implement several important changes required by statute. The increased per-visit payment limit for independent RHCs and RHCs in a hospital with 50 or more beds will help these providers to keep their doors open and is necessary to establish equity between RHCs and FQHCs. Similarly, the direct payments to Physician Assistants for professional services furnished under Part B will help to maintain access for a broad population of patients and allow professionals to be appropriately paid for their services.

MSSP Changes, including benchmarking, escrow, application, and beneficiary notification

ACO benchmarking, the "rural glitch" and capping of HCC risk adjustment. Caravan reviewed CMS's detailed analysis of the complex questions surrounding ACO benchmarking. That analysis makes it clear that the ACO benchmarking methodology could be much more fair to providers doing the hard work of reducing costs while maintaining or improving quality of care. Caravan encourages CMS to address benchmarking by making fixes as soon as possible to address the problems posed by the rural glitch and the HCC risk adjustment cap.

Caravan strongly supports fixing the rural glitch by removing an over-represented ACO's attributed beneficiaries from the regional component of the benchmark. This issue arises when an ACO has a disproportionate share of a region's market and is especially affects rural areas where the ACO may include a larger proportion of FFS beneficiaries than other areas. Since ACOs are measured against the benchmark to determine shared savings, it is fundamentally unfair to compare ACOs mostly against themselves when the regional factor is incorporated into the benchmark.

Rural ACOs have been proven to save money for Medicare and CMS should use all available tools to encourage more rural providers in accountable care. Caravan is concerned that rural ACOs are systematically penalized for reducing costs, as that lowers the benchmark and makes it harder to beat. CMS should follow through with their workable solution of adjusting the benchmark calculation by removing these ACO costs from the regional factor as soon as possible to allow rural ACOs to continue improving care in their communities.

With our extensive experience in rural accountable care, we strongly believe that CMS should take a much broader approach to addressing the obstacles to getting rural providers in value-based payment. The ACO Investment Model (AIM) ran from 2016 – 2018 and provided start-up funds to small rural ACOs. AIM was one of the most successful value-based payment programs ever offered by CMS, saving more than $380 million for Medicare over 3 years. Many of these small ACOs repaid their initial start-up funds by the end of the third year of the program.

CMS announced a new iteration of AIM in 2020, called the ACO Transformation track of the Community Health Access and Rural Transformation (CHART) model. Rural providers were anticipating the launch of the new program in January 2022. Caravan and our rural partners were disappointed when the model launch was delayed from 2022 to 2023 without any specific timeline for the application or technical guidance for the program. We urge CMS to commit to a 2023 start and issue program guidance as soon as possible.

CMS is also calling for comment on the effect of the capping the effect of HCC scoring at +3% in the ACO's benchmark. We appreciate CMS being willing to consider how this relatively new policy is working in practice, however it appears that capping the effect of the ACO risk score, while not capping the regional risk score, could lead to an unfair outcome. An ACO should not be at risk of losing money when both the ACO and regional risk score grows by more than 3%, but only the ACO is capped at 3%.

Caravan recommends that CMS consider capping the risk score for the region in addition to capping the risk score for the ACO. HCC capture should be a mechanism to level the playing field and remove any disincentive for treating high-cost patients. By including a cap on the ACO risk score, but not the region, CMS is creating new incentives that run counter to the original purpose of HCC risk adjustment.

ACO repayment mechanism changes: Caravan strongly supports the proposed change to ease the requirements for the repayment mechanisms required of ACOs in two-sided risk arrangements. In particular, the proposal to cut in half the repayment mechanism amount will encourage more providers to enter or stay in the Medicare Shared Savings Program. This is especially true for small and rural providers that have not yet had to take on risk in the program. For the 2022 performance year, Caravan urges CMS to promptly allow reimbursement for any ACOs that have overpaid escrow once this proposal is made final.

ACO beneficiary notification: Caravan appreciates the CMS proposal to ease requirements for notifying non-attributed Medicare beneficiaries. This appropriately focuses the ACOs time on their attributed beneficiaries and removes an unnecessary requirement.

MSSP application process: Caravan supports the proposed changes to the MSSP application process, which would eliminate requirements that ACOs inform CMS about past participation and remove a requirement that ACOs submit sample participant agreements. The proposal would also modify the requirement that an ACO must submit an executed ACO participant agreement for each ACO participant at renewal. Instead, it would only be required at initial application and when adding participants.

These changes would decrease the paperwork burden of the application process. At the same time, without ACOs submitting sample agreements during the application process, ACOs may not be able to rely on having CMS approve the SSPAs. If there are errors or omissions in those agreements, ACOs would have to make many contract amendments with potential negative consequences. As it is now, CMS approves the sample agreements so there is no question of compliance.

New primary care assignment codes for MSSP ACOs: Caravan supports the proposal to amend the definition of primary care services to add new codes for the MSSP assignment methodology starting on January 1, 2022. The codes include: (1) Chronic Care Management (CCM) CPT code 99X21, (2) Principal Care Management (PCM) CPT codes 99X22, 99X23, 99X24, and 99X25, (3) Prolonged office or other outpatient evaluation and management (E/M) service HCPCS code G2212; and (4) Communication Technology-Based Service (CTBS) HCPCS code G2252, pending payment for this code being made permanent. These changes, especially the addition of the CTBS services, would allow ACO beneficiaries to be appropriately assigned to their primary care provider more easily.

Request for Information: Closing the Health Equity Gap in CMS Clinician Quality Programs

CMS is calling for input about how to close the health equity gap in clinician quality programs. CMS lays out some considerations to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for hospitals, providers, and patients. Caravan thanks CMS for calling for input on this important topic.

Caravan believes that comprehensive data is the key for addressing the extensively documented and persistent health equity issues. A standardized, comprehensive, and modernized approach to collecting demographic information about our beneficiary population could help address persistent inequities and promote transparencies into disparities. As with many agencies, CMS has relied on outdated data categories that have been in use for decades. This Administration's renewed focus on addressing health disparities is an opportunity for CMS to lead and convene the development of a new approach. Such an approach could include more detailed stratification of racial and ethnic categories that more accurately reflect the diversity of the patients served by Medicare.

As part of the required fields for our EMR clinical interface specifications to our ACO data warehouse, Caravan requires that our ACO participants include patient-reported data about race, ethnicity, language, and other data points. Caravan recognizes the importance of having a picture of our own performance on reducing inequities. We intend to continue expanding how we use these data in understanding health disparities and closing the gap.

CMS's proposal to add a MIPS improvement activity for an antiracism plan could be made more useful by offering bonus points to ACOs for completing a plan. This could encourage ACOs to engage more fully in this improvement activity, since ACOs are usually awarded full credit for this MIPS category due to their extensive care coordination work that is central to ACO success. Without this, most ACOs would ignore this new opportunity to better engage with this work and create accountability. Another option for addressing health equity is to incorporate social determinants of health into risk adjustment; an idea that complements the idea of complex patient bonus on the MIPS side.

In conclusion, the Medicare Shared Savings Program had another outstanding year in 2020, returning value to Medicare even under the most challenging conditions. We appreciate the agency's support of this important value-based payment program and look forward to continued conversations.

Sincerely,

Tim Gronniger
Caravan Health CEO and President