CARAVANHEALTH.

October 5, 2020

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

Re: CMS-1734-P - Medicare Program; CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements

Dear Administrator Verma,

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 performance year 2021. Caravan Health has formed and managed ACOs in the Medicare Shared Savings Program since 2014. We support more than 600,000 attributed Medicare beneficiaries in the MSSP, with 200,000 enrolled in Pathways to Success in 2020.

Overall, we support many of the proposals in the latest PFS/QPP rule. In particular, extending access to telehealth and virtual care will be invaluable for our clients, many of them rural, who have come to rely on virtual care to maintain ongoing management of chronic disease and prevention. We also appreciate that CMS is recognizing the value of office-based evaluation and management (E/M) services by increasing reimbursement. This increased reimbursement appropriately reflects the time-intensive nature of these services, particularly when managing patients with serious chronic medical conditions.

However, we have concerns several of the proposals in the rule. Dramatically streamlining the number of quality measures on which ACOs will be assessed, as well as the drastic changes to the method by which ACOs are assessed, will have negative effects on the program. The value proposition of ACOs requires that they can distinguish themselves on the excellent care provided, as well as cost-efficiency. Reducing the number of measures to 6, from the previous 23, makes it more difficult for ACOs to stand out and earn MIPS bonuses and shared savings. While it may be appropriate to reduce the burden on providers from reporting quality measures, we are concerned that alternative payment models (APMs) would be disadvantaged compared to MIPS-eligible clinicians not participating in APMs. Similarly, making changes to the methods for submitting data during a public health emergency puts inappropriate and undue burden on providers.

Our detailed comments are below.

ACO-Specific Policies:

ACO Quality Measures

Caravan Health is concerned that the proposed reduction in the number of MSSP ACO quality measures is not fair to participants in ACOs and other APMs participating in MIPS. While standard MIPS-eligible clinicians may still have the option of choosing measures on which they will score well, ACOs would be limited to the smaller set of measures in the proposed rule. This inappropriately raises the bar for ACOs, putting them at a disadvantage compared to those outside of alternative payment models.

Further, including fewer prevention measures is a step in the wrong direction for care quality. While several of these measures that CMS proposes retaining have implicit process measures pertaining to prevention, those measures are not as robust as the current set of measures. With these changes, clinicians and patients would lose data from measures such as tobacco use, flu vaccinations, fall risk, and cancer screenings that give a fuller picture of preventive care performance.

The proposed increase in the quality performance standard could allow ACOs to more clearly differentiate themselves from non-ACO providers. However, these changes are not entirely clear. Will the threshold changes mean that the average of all measures must be at the 40th percentile, or must each individual measure meet this threshold?

Caravan is concerned about removing the option for web interface reporting, as it increases burden for ACOs who would have to adapt to a new system during a public health emergency. We also have concerns with the burden of switching from a small sample to large percentage of patients for quality reporting.

Moving to performance year benchmarking rather than historical benchmarking creates more uncertainty for providers who are already making programmatic adjustments to participate in value-based payment. Additionally, eliminating the pay for reporting year during a public health emergency creates a disincentive for new ACOs to join the program. While there may be value to considering these policies, this is not the right time for these dramatic changes.

ACO Relief Due to PHE

Caravan Health supports the option of allowing ACOs to use the higher of 2019 or 2020 ACO quality scores for 2020. We also support awarding full credit for CAHPS reporting in 2020. However, CMS can and should go much further in alleviating the result of the public health emergency on accountable care organizations. As we have commented to CMS before, we urge CMS to pay all ACOs for reporting quality in 2020 or move to a new system that would compensate for more critical activities during the public health emergency. The circumstances of the pandemic will make precise differentiation of quality in primary care practices near impossible. Using any 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.

Quality Payment Program:

Threshold for Advanced APM Qualifying Participant

The patient count and payment thresholds for APM participants to qualify for a 5% part B incentive have increased since the beginning of the program and will rise again in January 2021. The proposed rule would make some small changes to this calculation, such as excluding prospectively assigned beneficiaries from the denominator of the calculation. While we support this change to the calculation, it does not go far enough to alleviate concerns about meeting these thresholds and encouraging participants to take downside risk.

Caravan Health is asking CMS to use its administrative discretion to freeze the patient count threshold at 35% for the 2021 and 2022 performance years, rather than raising this threshold to 50%. This will serve to grow provider participation in risk-bearing arrangements, especially as many providers have slowed their path to risk while battling the public health emergency. The prospect that any ACO in a risk-bearing track would not qualify for the 5% incentive is deeply demotivating to providers trying to follow CMS's lead in pushing to risk.

Caravan Health supports the proposal to establish a targeted review process for qualifying participant (QP) determinations in certain circumstances. ACOs need to have this opportunity to challenge clerical errors leading to inaccurate QP determinations, but the proposal could go much farther to provide recourse for ACOs. The time

period for targeted review should be expanded beyond 60 days and full information about the calculation and methodology should be available to ACOs. This is especially important as the thresholds for payment and patient count rise.

Merit-Based Incentive Payment System
Aligning MIPS and ACO quality scoring is a step in the right direction, but this proposed rule does not achieve this in an even-handed way. While ACOs and other APMs would be subject to a new APM performance pathway in 2021, the previously finalized MIPS Value Pathways would be delayed until a later time. The timeline for these changes should be fully aligned.

All the providers making up an APM entity should share in accountability, rather than have the option for excluding themselves from shared reporting. Providers reporting separately could fracture the foundation of an accountable care organization, add confusion, and negate the commitment to the ACO. Caravan Health is further concerned that separately reporting on quality could disproportionately affect rural and smaller providers.

Telehealth and Virtual Care:
Audio-only services: The proposed rule mentions that CMS does not have authority to make audio-only telephone E/M services permanent and seeks comment on how they might develop new codes to fill this need. Delivery of care by telephone is particularly important to rural providers and patients where broadband infrastructure may not be available. Caravan Health supports an extension of these audio-only visits to the full extent of CMS's authority. In particular, we believe that physician time must be valued regardless of modality. One solution is to create a new code that reimburses provider time equally whether care is provided by telephone or in person. Having the home as an originating site helps rural patients overcome common transportation barriers, while low reimbursement dramatically compromises the use of this service.

*Nursing home telehealth***.** Telehealth services for nursing home patients should be extended to the full extent of CMS's authority. This modality of service improves access and avoids exposure to infectious disease.

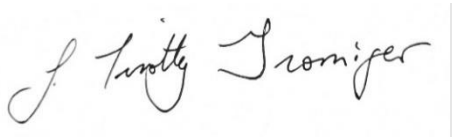
Clinical supervision. The current supervision rules for telehealth may create a barrier to care. Clinical supervisors should be immediately available to step in, just as they are for in-person care. Clinical supervisors can appropriately oversee staff through audio and visual technology without raising concerns about waste, fraud, and abuse of Medicare dollars.

Remote patient monitoring. It is appropriate to require an established physician-patient before starting remote patient monitoring (RPM). There is a risk of waste, fraud, and abuse without that pre-existing relationship, especially if patients are self-reporting, which should be acceptable under certain circumstances.

Payment for Evaluation and Management Services
Caravan Health appreciates that CMS has made adjustments to E/M reimbursement that acknowledge the time and effort required to care for Medicare patients, particularly those with time-intensive chronic conditions. The increase in payment for E/M appropriately compensates office-based specialties. We ask that CMS take all actions in their authority to not penalize procedure-based specialists due to budget neutrality requirements and will express our concern to Congress.

ACOs have returned tremendous value for Medicare, its beneficiaries, and health providers. During this time of extreme stress on our health care system, ACO should be leveraged to continue excellence in preventive care and pandemic preparedness. We urge CMS to do everything it can to protect this asset by reducing burden, minimizing uncertainty, and encouraging participation.

Sincerely,



Tim Gronniger
CEO and President, Caravan Health