American College of Physicians
Leading Internal Medicine, Improving Lives

June 12, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Verma:

On behalf of the American College of Physicians (ACP), I write to express the College's sincere appreciation for the timely actions the Centers for Medicare & Medicaid Services (CMS) has taken thus far to protect clinicians from the impact of the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE) in the context of the Quality Payment Program (QPP). This includes the recent announcement of flexibilities for various Alternative Payment Models (APMs) and previously announced Merit-based Incentive Payment System (MIPS) flexibilities for performance years (PYs) 2019 and 2020. These important changes will allow clinicians to focus on treating patients and preventing further spread of the disease while helping to mitigate the negative impact on performance. These important efforts will help to preserve physician buy-in for future value-based reform efforts while ensuring physician practices do not face further penalties at an already financially devastating time. At the same time, we are now in June and the PHE is still very much ongoing. It will take years, not weeks, to recover from the devastating impact of COVID-19. **It is imperative CMS take further action to protect clinicians against the longer-term impacts of the COVID-19 crisis. Not doing so could jeopardize the progress of value-based payment reform efforts.** Specifically, ACP urges CMS to:

- Automatically hold eligible clinicians harmless from 2020 MIPS penalties;
- Delay mandatory implementation of the new MIPS Value Pathway until 2024 at the earliest;
- Freeze removal and introduction of new mandatory MIPS measures for PY 2021;
- Adjust measure specifications, benchmarks, MIPS performance thresholds, risk adjustment, patient attribution, financial benchmarking, and target pricing methodologies as necessary;
- Hold APM participants harmless from downside risk for PY 2020;
- Not use flawed 2020 data to negatively adjust APM payments;
- Allow **all** APM participants to extend their current contracts by one year; and
- Expediently develop more APMs, particularly those that offer fixed, prospective payments.

ACP is the largest medical specialty organization and the second largest physician membership society in the United States. Our 159,000 members include internal medicine physicians, related subspecialists, and medical students who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum of health. Our members are on the front lines of the COVID-19 PHE, witnessing firsthand the devastating impact, and are uniquely positioned to understand exactly what it will take to recover and rebuild from this devastating health crisis.

I. Merit-based Incentive Payment System (MIPS)

PY 2020 Automatic Exceptions

ACP urges CMS to hold eligible clinicians harmless from MIPS penalties for PY 2020 due to the COVID-19 PHE. ACP appreciates CMS granting automatic exceptions to those that do not submit 2019 data and extreme and uncontrollable circumstances hardship exceptions to others. We urge CMS to extend similar protections to clinicians for the 2020 PY immediately. ACP further encourages CMS to apply all exceptions automatically. In cases where a clinician or group submits data, CMS should apply the threshold score or the performance score based on submitted data, whichever is more favorable, as it currently does for facility based scoring. This will reduce administrative burden, prevent unintended consequences, particularly for clinicians participating in MIPS APMs, and importantly, encourage data reporting while protecting clinicians from unexpected downturns in performance as a direct result of the PHE. CMS should also exempt any 2020 performance data from public reporting on Physician Compare because it is not an accurate representation of care. Clinicians need these assurances sooner than later so that if necessary, they can divert resources and expenses that would be directed toward data collection or quality improvement initiatives toward purchasing Personal Protective Equipment and other more urgent needs as they continue to serve patients amidst a global pandemic.

MIPS Performance Thresholds

Due to MIPS' budget neutral design, holding clinicians harmless from penalties will result in little to no budget for bonuses. **CMS should utilize the $500 million allocated by Congress for rewarding exceptional performance to incentivize 2020 data submission by setting the exceptional performance threshold equivalent to the standard MIPS performance threshold.** This will provide clinicians that are equipped to send data with an incentive for doing so. Lowering the exceptional performance threshold is also appropriate given the additional hurdles to meeting denominator requirements and collecting and submitting data during the COVID-19 PHE. For this same reason, **CMS should set the standard and exceptional performance thresholds at the 2019 level of 30 points.** It is likely CMS will have leftover funds for 2020 exceptional performance bonuses based on PY 2018 because bonuses were assessed based on pre-COVID-19 revenue levels and are being paid on a percentage basis on 2020 claims, which are unexpectedly and significantly lower due to COVID-19. Therefore, at the end of the year, **CMS should distribute any remaining funds for 2020 exceptional performance bonuses as a lump sum to qualifying practices on a sliding scale basis proportionate to their performance scores.**

Cost Category

ACP recommends CMS reweight the Cost Category to zero for PY 2020. Not doing so risks adversely penalizing clinicians for providing patients with the care they need during this PHE, particularly those in COVID-19 hot spots. Typical revenue and spending patterns have been completely upended by COVID-19. Healthy patients are postponing preventive and routine care,[1] which skews attribution toward sicker patients. At the end of May, 45% of practices reported staff furloughs or layoffs, 28% reported deferred salaries, and 14% had temporarily closed, inhibiting patient access to care.[2] According to a new report from FAIR Health, from April 2019 to April 2020, utilization of professional services fell 68% and revenue

[1] "Primary Care & COVID-19: Week 8 Survey." Primary Care Collaborative, May 6, 2020: https://www.pcpcc.org/2020/05/06/primary-care-covid-19-week-8-survey.
[2] Primary Care & COVID-19: Week 11 Surveys. Primary Care Collaborative. May 27, 2020. https://www.pcpcc.org/2020/05/26/primary-care-covid-19-week-11-surveys.

is down 48%.[3] At the same time, costs are up. A widely cited Health Affairs study estimates that COVID-19 will result in anywhere from $163 to $654 billion in direct medical costs.[4] The current cost measures are simply not equipped to account for this magnitude of disruption, with widespread implications on adverse health events, admissions, and attribution occurring simultaneously. As a result, administrative claims-based cost data should be provided to clinicians for informational purposes only for PY 2020.

Quality Category

ACP calls on CMS to make necessary adjustments to individual measure specifications, including risk adjustment and patient attribution methodologies. For example, CMS may need to lower threshold requirements or add the patient's home to the list of acceptable settings for certain measures given the rapid proliferation of telehealth services. CMS will also need to amend risk adjustment and patient attribution methodologies for PY 2020 and future years to account for the direct and indirect impacts of COVID-19, ranging from an uptick in complications and costs for treating COVID-19 patients to healthy patients deferring preventive care to reduce their risk of exposure, which skews attribution towards sicker patients. Not doing so risks intensifying existing social inequities and disparities that have already been exacerbated by a pandemic that disproportionately impacts those who are sicker, elderly, African American, and socially and/or economically disadvantaged. We urge CMS to make these updates as soon as possible so that vendors and practices can make necessary adjustments earlier in the year.

Promoting Interoperability Category (PI)

ACP urges CMS to consider adding attestation-based bonus measures that recognize the use of EHR functionalities and other health IT that interacts with Certified EHR Technology to share relevant patient data and promote patient health and safety during the COVID-19 PHE, such as telehealth technology and services. ACP has long called for reforms to this category, which at present evaluates clinicians on a rigid set of performance-based, functional use measures based on EHR functionalities that are not yet widely available, while failing to capture the myriad ways physician practices are actively leveraging innovative technologies to inform and improve care decisions at the point of care.

Improvement Activities (IA) Category

ACP commends CMS for establishing a new, high-weighted IA for participating in COVID-19 clinical trials. **We encourage CMS to create additional IAs to incentivize and reward clinicians for participating in additional COVID-19-related relief efforts**, such as those providing testing and treatment services in other locations beyond their practice. Due to the urgent and dire nature of the PHE, **ACP additionally recommends CMS further incentivize support of COVID-19 relief activities by automatically awarding full credit toward the IA Category for participating in any COVID-19 related IAs**.

Freeze on 2020 MIPS Measures

Clinicians need consistency now more than ever. **ACP urges CMS not introduce any new mandatory MIPS measures for PY 2021.** This includes the administrative claims based all-cause unplanned admissions for patients with multiple chronic conditions measure. **CMS should also not remove any**

[3] Healthcare Professionals and the Impact of COVID-19. A Comparative Study of Revenue and Utilization. June 10, 2020. https://amazonaws.com/media2.fairhealth.org/brief/asset/HealthcareProfessionalsandtheImpactofCOVID-19-ComparativeStudyofRevenueandUtilization-FAIRHealthBrief.pdf.

[4] The Potential Health Care Costs And Resource Use Associated With COVID-19 In The United States. Health Affairs. April 23, 2020. https://www.healthaffairs.org/doi/full/10.1377/=mediaadvisory.

current MIPS measures or activities ahead of PY 2021, including delaying by one year the scheduled timeframe for removing so-called "topped out" measures. ACP commends CMS for delaying by one year Qualified Clinical Data Registry measure requirements and urges CMS to also **delay scheduled CMS measure improvement efforts, including focus groups and field-testing, until at least fall 2020, preferably 2021.** The College has received numerous reports from frontline clinicians that they are currently diverting all of their energy and resources toward battling COVID-19 and do not have the bandwidth to participate in data reporting, much less measure development or improvement activities.

Future MIPS Measure Benchmarks and Performance Thresholds

Because MIPS quality measures and other performance metrics are assessed against performance from two years prior, CMS needs to consider the multi-year impact and adjust measure benchmarks and MIPS performance thresholds accordingly. Performance in 2020 cannot be reasonably evaluated against pre-COVID-19 levels. While excluding January through June 2020 claims is a start, it is now June, with no immediate end to the pandemic in sight. Even after the PHE has technically concluded, this will mark the beginning of a long recovery period, which will not be over until vaccines or treatments for COVID-19 are widely available. CMS will need to consider additional scoring adjustments, such as adjusting existing deciles for quality measures, or establishing point floors. CMS will also need to consider the impact on measure benchmarks and MIPS performance thresholds for future PYs as we gradually transition back to "normal" levels. This includes critically analyzing 2020 data compared with past PYs and using alternative data sources if possible, such as those from prior PYs, and temporarily freezing individual measure and MIPS performance thresholds at 2019 PY levels through PY 2021 as practices recover.

MIPS Value Pathway

Finally, in light of COVID-19, ACP urges CMS not to rush mandatory implementation of the new MIPS Value Pathway (MVP). ACP reiterates our earlier recommendations not to make the MVP mandatory until every specialty and subspecialty have an applicable MVP and not before the 2024 PY at the earliest, which provides at least three years to recover from the COVID-19 PHE and prepare for the transition to the new MVP.

II. Alternative Payment Models (APMs)

ACP appreciates the numerous model-specific adjustments CMS has made, particularly the recent announcement of flexibilities for various CMS Innovation Center models, which includes key application deadline and contract extensions, as well as adjustments to financial benchmarks and risk calculations to help mitigate the negative impact of COVID-19. At the same time, more changes are needed to shore up ongoing participation in APMs and reassure current participants that they will not be penalized for adverse performance as a direct result of the COVID-19 PHE. In the near-term, ACP calls on CMS to:

- Issue updates about the Primary Care First Model as soon as possible;
- Allow **all** APM Entities, including CPC+ participants, a one-year contract extension;
- Hold current APM participants harmless from risk-based payments for PY 2020;
- Provide immediate funding support to sustain ongoing advanced clinical care activities;
- Hold APM participants harmless from performance-based adjustments that will negatively impact model payments;
- Permanently incorporate recent COVID-19 telehealth and other flexibilities into APMs; and
- Make appropriate adjustments to patient attribution and risk adjustment methodologies.

These recommendations are explained in greater detail below.

Delayed Start Dates and Contract Extensions

ACP was pleased to see CMS offer delays in numerous model start dates and contract extensions and, as part of a previous announcement, allowing Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) the option to continue in their current risk track and extend current participation agreements for one year if their contract is expiring. Flexibilities like this are exactly the types of support clinicians need in order to weather this crisis and continue participating in Advanced APMs. **ACP urges CMS to allow participants in all APMs the option to extend their current contracts by one year, including those in the Comprehensive Primary Care Plus (CPC+) Model**. ACP was disappointed not to see CPC+ included among the models that were extended as part of last week's announcement. ACP recognizes that this model is not set to expire until 2021, and we are hopeful CMS is strongly considering extending this demonstration. We remind the agency that 2020 and 2021 will be rebuilding years for physician practices as they recover from this PHE. The decision to join an APM is a major one and often requires a multi-year internal consideration and approval process. Practices could use assurances during this uncertain time that they will be able to continue participating in CPC+ and other current demonstrations in 2022 and beyond.

ACP was pleased to learn that CMS plans to move forward with starting the new Direct Contracting and Primary Care First Models (PCF) with the 2021 PY. At the same time, ACP is concerned about the January 1, 2020 start date for the PCF Model considering participants are still missing key methodological details about the model, practice-specific information such as risk groups, and updates about the contract agreement process including timeline, which are all critical to evaluating the model's viability. It is critical interested practices are provided all necessary information as well as a reasonable timeframe with which to consider this information and make participation decisions. In light of the COVID-19 crisis, practices may need even longer because previous calculations will no longer be relevant and decision-making entities are likely tied up with time-sensitive matters directly related to surviving the PHE. We appreciate recent communications that letters with official statuses will be sent in summer for the standard PCF track and in the fall for the Seriously Ill Population (SIP) Track. However, we are still missing critical details on the payment, risk adjustment, and patient attribution methodologies, which were due out this past spring. **We urge CMS to release information about the PCF Model as soon as possible and to provide practices with sufficient time to make participation decisions.** ACP offers our assistance in disseminating this critical information.

Finally, ACP strongly opposes CMS' decision to cancel the 2021 MSSP solicitation cycle. CMS should be supporting and encouraging clinicians to transition to APMs more than ever, not removing opportunities to join existing APMs.

Eliminating Financial Risk Payments for PY 2020

Mitigating the impact of COVID-19 on financial risk calculations by removing patients and/or calendar months directly impacted by COVID-19 is an important start, but it will not protect clinicians from the full impact of the crisis. COVID-19 cases are under-reported,[5] so removing only those patients formally diagnosed with COVID-19 will not capture all costs associated with the PHE. Moreover, COVID-19 has completely disrupted business as usual. Healthy patients are avoiding preventive care services, which

[5] Holcombe, Madeline. "More Than Half of States May be Undercounting Coronavirus Cases by Not Following CDC Guidelines." CNN Health, June 9, 2020: https://www.cnn.com/2020/06/09/health/us-coronavirus/index.html.

results in lower revenue while disproportionately skewing attribution towards sicker patients. This increases per patient costs and leads to higher rates of complications and adverse health events, causing performance, patient attribution, risk adjustment, and utilization and spending to all suffer simultaneously. As patients gradually ease back into in-person visits, this will be a slow process. To maintain proper social distancing, practices will have to space out appointments and continue to administer more services via telehealth and telephone. APM Entities simply cannot reasonably be held to pre-COVID-19 financial standards. ACP strongly supported CMS' decision to remove downside risk by capping actual prices at target prices for episodes of care that occur during the COVID-19 PHE for the Comprehensive Care for Joint Replacement Model. **ACP strongly urges CMS to cap actual spending at expected spending across all models, thereby holding APM participants harmless from downside risk for PY 2020. At a minimum, CMS should offer participants in all Advanced APMs the option to mitigate downside risk in exchange for reduced upside risk.** ACP appreciates CMS offering reduced or no-risk options to participants in the Bundled Payments for Care Improvement Advanced, Oncology Care Model, and Medicare Shared Savings Program (MSSP) and urges the Agency to apply this policy consistency across all Advanced APMs.

Immediate Financial Support to Sustain Ongoing Advanced Clinical Care Activities

Advanced APM participants have proven to be uniquely capable of serving patients amidst this PHE due to their proactive, population-level care strategy.[6,7] This type of wholescale innovation requires a substantial amount of up-front and ongoing investment to support the necessary health IT, personnel, and performance analytics infrastructure. The participants in these models rely on model specific payments like shared savings payments to fund these important infrastructure investments. As a result, Advanced APM participants may be disproportionately more financially vulnerable during PHEs like this one. Without dedicated support in this time of immense strain on resources, a large majority of Advanced APM participants, particularly those in risk-bearing models, will not be able to sustain the ongoing costs of participation, much less downside financial risk. **ACP urges CMS to provide current APM participants with immediate, direct financial assurance so that they can continue the advanced clinical support activities that have benefited patients during this epidemic. At a minimum, CMS should reassure model participants that they can count on performance-based savings they earn.** ACP was concerned by a recent recommendation made by the Medicare Payment and Advisory Committee that recommended ACOs not be eligible to earn shared savings payments for PY 2020. ACOs and other APM Entities rely on model payments such as shared savings to fund the technology, staff, and other infrastructure investments necessary to provide population-level care services.

ACP encourages the Agency to go beyond this and consider additional funding supports to help APM Entities weather this unprecedented storm. Additional supports may include, but should not be limited to, offering advances of model payments and expediting 2018 Advanced APM bonuses.[8] Regardless of the type of support, advance payments should be paid back gradually, not before 2022, to allow practices time to recover and build back up their financial reserves. In the past, Advanced APM bonuses have been paid close to the end of the payment year. ACP and others have called attention to the importance of making these funds available much sooner,[9] which is particularly important this year.

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[6] "APM Participants Appear Better-Prepared for COVID-19." Archway Health, May 7, 2020: www.archwayhealth.com/bundled-payments-blog/2020/5/apm-participants-appear-better-prepared-for-covid-19.

[7] Premier Inc. Survey: Clinically Integrated Networks in Alternative Payment Models Expanded Value-Based Care Capabilities to Manage COVID-19 Surge. May 13, 2020. https://www.premierinc.com/newsroom/press-releases/.

[8] CMS Sign-On Letter Requesting Advance Payments for CPC+ Practices. March 29, 2020. https://www.acponline.org/acppolicy/letters/cmssignonletterrequestingadvancepaymentsforCPC+practices.pdf.

[9] ACP joins eight other groups in letter urging CMS to pay out 2017 Advanced APM bonuses. September 16, 2019. www.acponline.org/documents/advocacy/wherewestand/assets/aapmbonusletterseptember2019.pdf.

Beyond this, **ACP urges CMS to consider adjusting 2021 Advanced APM bonuses**, which are based on 2019 performance but calculated based on 2020 revenue, to compensate for the much lower than average revenue this year as a direct result of the COVID-19 epidemic. APM participants made substantial up-front investments based on projected returns including the five percent Advanced APM bonus based on typical revenue projections. Of course, no one expected COVID-19. These APMs did all that was expected of them including leverage certified EHR technology to improve patient care, complying with all quality reporting and compliance activities, and meeting advanced clinical care requirements. They should not be penalized for an unforeseen international pandemic that occurred a year after they already qualified for the Advanced APM bonus. If CMS does not make this one-time adjustment, the Advanced APM bonus could lose much of its credibility as an incentive for clinicians to move into risk-bearing models in the future. CMS could approach this adjustment in multiple ways; one option would be to make a one-time exception and base 2021 bonuses on revenue from the 2019 PY as opposed to the 2020 PY. This would also allow CMS to make Advanced APM bonus payments sooner.

Holding APM Participants Harmless from Negative Adjustments Based on 2020 Quality Performance

Notably absent from last week's announcement on CMS Innovation Center models were adjustments to account for COVID-19's impact on performance, with the exception of the MSSP. The COVID-19 PHE will have wide-reaching impacts on performance and utilization. Clinicians should be commended for rising to the occasion to care for an unexpected influx of high-risk patients under difficult circumstances including historically low revenues. They should not have to worry about facing further financial penalties for higher utilization rates or adverse outcomes, both of which are to be expected during any pandemic. We commend CMS for applying the extreme and uncontrollable circumstances exception to MSSP ACOs for both the 2019 and 2020 PYs, and we see no reason why these sorts of protections should not extend to all APM participants, particularly those in Advanced APMs. **ACP urges CMS to hold all APM participants harmless from performance-based penalties and not to lower model payments based on flawed 2020 performance data.** In cases where data is submitted, CMS should apply the neutral adjustment or the performance score, whichever is more advantageous. This is consistent with facility-based scoring policies and our recommended PY 2020 approach for MIPS. It would also ensure consistency across MIPS APMs and Advanced APMs. Clinicians who took on risk to participate in innovative, risk-bearing models that CMS strongly encouraged should not fare worse than their MIPS counterparts. Not issuing equal protections to APM participants could have dangerous implications on future confidence in APMs.

Incorporate New COVID-19-Related Telehealth and Regulatory Flexibilities into APMs Permanently

This crisis has forced physician practices to innovate business delivery models almost overnight; telehealth and telephone services have quickly emerged as an indispensable component of a care delivery structure that safely delivers necessary care services to patients while maintaining proper social distancing and preventing further spread of the disease. To reverse these policies and revert to a payment structure centered on in-person services is not an effective way to recover from this crisis, nor to prepare for future potential outbreaks. **CMS should look to incorporate recent telehealth and other regulatory flexibilities into the permanent reimbursement strategy of all current and future APMs.**

Patient Attribution

ACP calls on CMS to evaluate the need for additional attribution changes specific to each APM in the context of COVID-19. For example, ACP generally supports CMS' adjustments to the definition of primary care services for the MSSP that reflect accommodations to the way these services are delivered

in the midst of the COVID crisis, including via telehealth. **The College urges CMS to apply COVID-19-related changes to the definition of primary care services consistently across all relevant APMs, including the CPC+ Program. ACP also advises CMS to closely monitor the impact of policy adjustments related to patient assignment, including any potential unintended consequences.** We appreciate CMS acknowledging that there will likely be longer lasting effects of the COVID-19 pandemic that may necessitate additional rulemaking and adjustments to the MSSP and other APM policies, including rebounding elective procedure costs in 2021 following potentially sustained reductions in 2020, which may affect patient attribution and ACO expenditures. As ACP has previously noted, voluntary patient attribution and/or attribution through patient relationship codes are generally the ideal forms of patient attribution because they affirmatively establish a clear physician-patient relationship and would help avoid many of the complications inherent with claims-based attribution policies.

Risk Adjustment

Accurate risk adjustment is a crucial ingredient to accurate performance evaluation. This is true now more than ever in the aftermath of the COVID-19 crisis, particularly given the uneven geographic distribution.[10] **CMS should evaluate numerous approaches to supplement existing risk adjustment strategies to capture more accurately the impact of COVID-19. This might include using more current claims data and/or adding additional criteria.** Criteria might include socioeconomic or demographic factors, percentage of patients with a confirmed or suspected COVID-10 diagnosis, and/or adjustments for practices in areas with a high concentration of COVID-19 cases, such as New York City. Holding clinicians harmless from performance-based penalties based on 2020 data would go a long way in providing clinicians with necessary protection in the case that risk adjustment fails to fully account for all of the nuanced ways COVID-19 will affect performance in both MIPS and APMs.

Looking Ahead

These important steps will help to reassure APM participants and avoid a mass exodus from current models. However, more action is needed to preserve APM participation beyond 2020 and keep the momentum moving away from unpredictable fee-for-service (FFS) and towards APMs over the longer term. Specifically, ACP recommends CMS expedite development of new APMs, particularly those that offer prospective, predictable payments, and ensure these new models include up-front funding support and low- to no-risk options, particularly in the years immediately following the COVID-19 pandemic.

Expedite Development of APMs, Especially those with Predictable Prospective Payments

The COVID-19 pandemic has shown the inherent flaws of FFS as a way of compensating physicians, particularly primary care physicians. Because revenue is dependent on specific visits and procedures, as the volume of visits and procedures decline in times of crisis, physicians and their practices are unable to bring in the revenue to keep their doors open, particularly at times of heightened vulnerability. For some, this experience dealing with the unpredictability and other repercussions of the COVID-19 PHE may be an added incentive to transition out of FFS and into APMs. **ACP urges CMS to expediently develop new APMs, particularly those that offer fixed, prospective payments such as per member per month payments.** Doing so would give healthcare systems the financial consistency and predictability needed to build the necessary infrastructure to more effectively manage health at the population level and be more equipped to handle future health crises.

[10] Florida, Richard. "The Geography of Coronavirus." CityLab, April 3, 2020: https://www.citylab.com/equity/2020/04/coronavirus-spread-map-city-urban-density-suburbs-rural-data/609394/.

Up-Front Funding Support for New APMs

After months of historically low revenues due to sharp decreases in regular patient services coupled with the added costs of treating COVID-19 patients, practices are not in the same position to make up-front financial investments or take on financial risk, even if they wanted to. **ACP urges CMS to commit to additional, up-front funding supports and mechanisms to encourage growth in APM participation, particularly in the years immediately following the COVID-19 PHE when financial reserves will be drained.** This may include, but should not be limited to, loans, refinancing options, advance prospective payments, and low-risk or no-risk tracks, particularly in the near term as practices recover from the financial and infrastructure shock of dealing with this crisis. Small, rural, and independent practices have long struggled with these entry barriers. CMS should consider making these additional resources available for these types of practices on a permanent basis.

In Conclusion

The College appreciates the gravity of these requests. We strongly feel that such actions are necessary in order to ensure the future viability of the value-based movement in the face of such an unprecedented crisis. If CMS does not act quickly, we risk losing a substantial amount of the hard work, investment, and progress gained under the value-based payment reform movement, particularly risk-bearing APMs, that would far outweigh any short-term concessions. The technical conclusion of the PHE does not mark the end of the impacts of COVID-19, but rather, the beginning of a long, arduous rebuilding process. **COVID-19 flexibilities should remain in effect through the end of 2021, or until vaccines or treatments for COVID-19 are widely available with the option to extend them further based on learned experiences.** As the full impact of the COVID-19 PHE on the value-based payment reform movement continues to unfold and CMS evaluates the need for further technical refinements to measure specifications, financial benchmarks, and risk-adjustment and patient attribution methodologies, ACP would like to offer our full assistance. If you have any questions or would like to discuss the content of this letter, please contact Suzanne Joy, Senior Associate, Regulatory Affairs, at 202-261-4553 or sjoy@acponline.org.

Sincerely,

Jacqueline Fincher, MD, MACP
President
American College of Physicians