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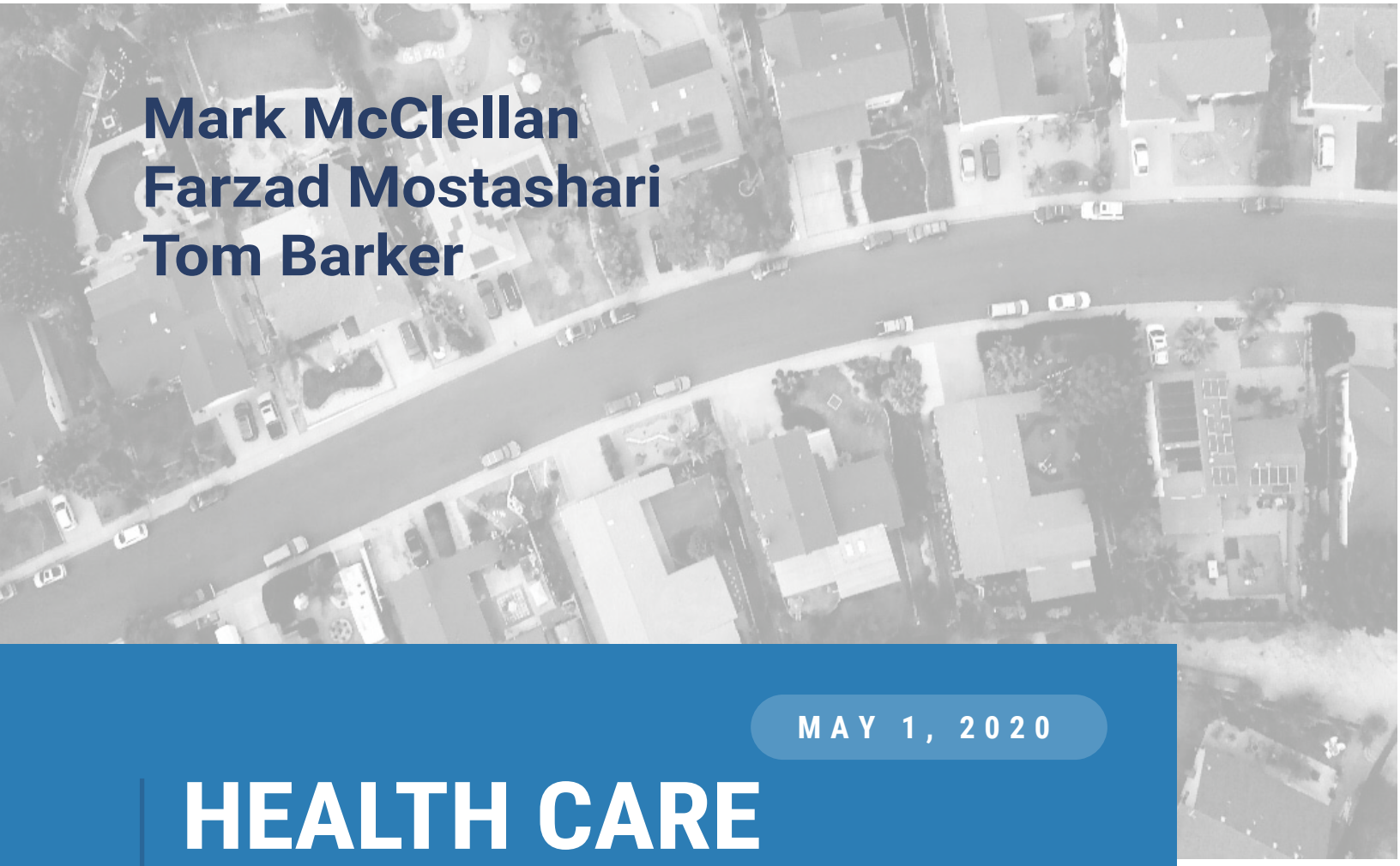

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HEALTH CARE PAYMENT TO SUPPORT COVID-19 DETECTION AND CONTAINMENT

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This Duke-Margolis resource on COVID-19 response policies is intended to inform and help guide policy makers addressing the evolving COVID-19 pandemic in the United States and around the globe, and will be updated as the pandemic and response capabilities change over time.

It contains recommendations for a U.S. Federal response as well as steps and resources for stakeholders across the health care ecosystem. We will add further resources to address a range of related, critical policy challenges.

We thank our many collaborators, co-authors, and reviewers who have contributed significant expertise and guidance on these rapidly evolving issues. Please reach out to us with additional suggestions for resources and effective policies at dukemargolis@duke.edu - we welcome your input.

Executive Summary

As the United States moves past the initial surge in COVID-19 cases and begins to reopen, containing the continuing threat of the COVID-19 outbreak will be essential for success. Substantial resources are being directed to upgrade the public health infrastructure to support better syndromic surveillance, testing, contact tracing, isolation and quarantine. But the magnitude of these tasks and the limitations of current public health capabilities mean that they will need to be augmented to achieve effective containment in all areas of the country.

Health care providers are critical partners for public health efforts to conduct COVID-19 case detection and containment. Primary care clinicians and other community health providers have long been involved in early detection of health problems, and are trusted supports for patients in treating serious infectious diseases. Many health care providers and health care payers are already taking important steps to support their patient populations in the COVID-19 context, particularly those organizations that had already moved away from fee-for-service (FFS) to alternative payment models (APMs). These steps have included use of data analytics to identify patients at elevated risk, personal digital health tools to help patients monitor and report symptoms, rapid referral for COVID-19 testing, and case management at home with telehealth support for patients with COVID-19. Moreover, many health care organizations and academic

medical centers are playing an integral role in building out regional test and trace capabilities, in partnership with public health organizations. Clinical laboratories and a growing array of community-based health organizations such as pharmacies are collaborating with providers in this major expansion of testing, and also play a critical role in informing public health authorities about new cases.

Although such collaborations are essential for COVID-19 containment, their use around the country is uneven and is impeded by the severe financial difficulty facing many health care organizations. In an effort to increase such collaborations, CMS recently announced new COVID-19 payments to reimburse a broader range of state-authorized health professionals that order diagnostic tests, and to pay for specimen collection and test performance in community settings such as pharmacies.

This report describes further payment supports for comprehensive and effective health care provider engagement in rapid case detection, management, and containment of the COVID-19 pandemic. Building on recent CMS actions, these payment reforms could be adopted individually or collectively to reinforce and support health care providers in developing the following capabilities to help contain COVID-19:

- Provider capacity to conduct COVID-19 health monitoring and case detection for their population of patients
- Test sample collection or telemedicine supervision of tests done at home
- Test performance with rapid reporting, including timely data sharing with public health authorities
- Case management at home or in the community for infected individuals
- Assistance with contact tracing, quarantine, and follow-up management

These payments could be implemented in different ways, all of which either fall within current CMS authority for provider and laboratory test payment, or within the scope of COVID-19 legislation to assist health care providers.

To support key COVID-19 public health partnerships, providers could receive one-time or periodic payments (e.g., quarterly) for attesting to or demonstrating that they have implemented the capacity to participate in regional test and trace efforts. Such payments could be linked to provider COVID-19 relief funding, to state and regional funding for testing, to partial repayment forgiveness for COVID-19 loans, or to a Medicare APM that is rapidly piloted then expanded if it leads to additional provider capacity to detect and treat COVID-10. Payments could also be implemented as straightforward adjustments or additions to FFS payment systems, as in the recent CMS payment reforms. In a companion report, we describe feasible, short-term steps to enable secure electronic data sharing between health care providers, laboratories, and public health authorities to facilitate this integrated and comprehensive approach to containment. A summary list of health care provider payment reforms for COVID-19 containment noting actions to date is provided at the end of this report.

Introduction

As the initial wave of the COVID-19 pandemic begins to subside and new infections decline, attention is turning to reopening the economy relaxing stay-in-place orders affecting most of the country. Health care organizations working with public health experts and payers were critical for the initial response. The Centers for Medicare & Medicaid Services (CMS) and other payers have taken unprecedented steps to address regulatory and payment barriers that would otherwise have hindered the delivery of care during this public health emergency.[1] Such collaborations will also be critical in this next phase, to support the massive surge in effective testing and response capacity, the accompanying contact tracing of individuals with positive test results, and the other steps needed to contain the epidemic.

Some primary care groups, health care systems, academic centers, and other health care providers are already taking steps to support syndromic surveillance and testing for COVID-19 through a range of steps - outreach tools, test referral, patient management, and potentially some data sharing capacity with labs and public health authorities to support surveillance.

But implementation is uneven and fragmented, and most providers are not participating in such activities. Primary care and specialty practices, as well as hospitals, have laid off staff in the face of severely reduced fee-for-service (FFS) payments. Recent stimulus payments have provided some direct financial relief, but such payments have provided less support for primary-care and low-income community practices, and have not been directly aligned with the goal of supporting effective health care and public health capacity and infrastructure to contain COVID-19, which in turn would reduce the need for further relief payments.

With attention focused on reopening the economy, CMS and other payers can play a critical role in supporting the effective implementation of regional, state, and national test and trace capabilities that we and others have recommended as a key element in sustaining progress.

Two types of diagnostic testing are involved in this next phase of containing the coronavirus. Most important for short-term containment is the molecular tests that determine whether an individual is actively infected and shedding the coronavirus. While timely availability of these tests and the associated materials has been challenging, these tests are becoming more widely available and efforts are underway to substantially increase their effective use. Today, almost all of these tests are being conducted by public health organizations, hospitals, and commercial clinical laboratories. If we are to successfully ramp up testing to the levels required and to rapidly test and diagnose infected individuals, we must further engage physician offices, community health centers, pharmacies, and other community health settings as well as special collection facilities and certain businesses. Health care providers are likely to remain fundamentally

[1] *See, e.g.,* Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," 85 Fed. Reg. 19230 (April 6, 2020). *See also* CMS, "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," available at https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf (last updated April 9, 2020).

important in the emerging systems needed to monitor individuals for symptoms, conduct timely tests, and share testing results to enable contact tracing, isolation, and quarantine. In addition, health care providers can reduce burdens and risk exposures in health care facilities by implementing effective strategies to support symptomatic COVID-19 patients at home. Easier, more reliable home testing and workplace testing may also be important tools to expand diagnoses, but may pose challenges for public health reporting and contact tracing.

The second type of test is serology testing to determine whether an individual has produced sufficient antibodies as a result of having coronavirus infection to create immunity. As the science of COVID-19 immunity becomes clearer, the presence of these antibodies may enable an individual to reengage in activities with a very low risk of re-infection or infecting others. Currently, significant unanswered questions remain about COVID-19 serology testing, including both the precision of available tests – do they accurately capture the level of antibodies to this particular coronavirus – and the implications of specific antibody findings for an individual's immunity. As sufficiently reliable serology testing becomes available, health care providers may also play a significant role in conducting, reporting, and acting appropriately on serologic tests.

In this report, we outline several payment modifications that CMS and other payers can adopt now to support effective provider collaboration in the nation's emerging test and trace program. We describe options that could be implemented by CMS under its current authorities, by other payers, and through Congressional support. CMS has recently taken important steps toward supporting increased testing capacity, through engaging providers and additional testing sites, providing a foundation for these further steps.

In particular, provider payments for COVID-19 containment should not only encourage timely testing in all appropriate individuals who seek testing, but also enhanced patient outreach to identify potential cases, timely sharing of results to enable contact tracing, and assistance with treatment in isolation and quarantine. In a companion report, we describe specific short-term steps that will enable much more rapid and routine data sharing to support health care and public health collaboration on COVID-19 containment. In addition, tests are more valuable if they can be used more conveniently (e.g., tests that patients can self-administer; tests for the presence of virus that can be performed reliably on spit samples rather than nasopharyngeal swabs), if they demonstrate superior performance to existing tests (i.e., lower false negative and false positive rates), or if they can provide results faster or automatically (e.g., rapid point-of-care testing and test systems that can upload results automatically). We have addressed some of these issues in our previous report on innovation in diagnostic testing.

Provider Participation in COVID-19 Testing and Tracing

Health care providers, including clinical laboratories, are currently paid by Medicare and health plans for performing covered diagnostic laboratory tests, including tests to detect the presence of the COVID-19 virus. CMS recently doubled its payment for high-throughput COVID-19 diagnostic tests, to approximately $100, to encourage the production and use of additional tests.

However, many primary care practices and other organizations that should be actively engaged in such testing programs to contain COVID-19 spread are facing financial obstacles in doing so. They are having difficulty sustaining their staff and operations in the face of far lower FFS revenue as a result of distancing restrictions. Without a clear financial path to support test and trace activities, two-thirds of primary care providers report no or limited participation.

At the same time, many health care organizations that are currently paid mainly or entirely using alternative payment models (APMs) – patient-level payments linked to improving outcomes and reducing total costs of care, not volume of services – have implemented reforms to better facilitate such testing programs. Some promising early examples include:

- Proactive outreach to high risk individuals: Carilion Clinic, an accountable care organization (ACO), has leveraged its claims and clinical data to identify individuals at high-risk for either COVID-19 or complications that may occur while social distancing practices are in place. ACO registered nurse (RN) care coordinators and support staff conducted proactive outreach to these patients to check in and offer assistance. This included answering questions about COVID-19, home preparedness, symptom monitoring and COVID related services; assisting with med refills; arranging telehealth visits with the patient's primary care provider; and connecting them with community resources (e.g., meal delivery).
- Tracking and sharing data across settings: New York City Health and Hospitals ACO has leveraged data and telehealth technologies (e.g., e-visits, remote monitoring, and chatbots to provide COVID-related education and guidance) to track COVID patients across settings of care as way to monitor potential transmission and help allocate resources.
- Improving care in post-acute settings: Kaiser Permanente, an integrated delivery system, has collaborated with post-acute care providers and public health authorities in California to improve identification and treatment of patients with COVID-19. Such partnerships are vital to identifying and containing potential COVID-19 outbreaks in older adults with chronic conditions, a group at particular high-risk for complications and mortality from the virus.

These actions likely would not have been implemented as quickly as needed had it not been for the financial flexibility to invest in care management and digital supports that comes with APM participation. These examples and others can provide a guide for engaging more providers in COVID-19 care reforms.

Hospitals, physician practices, and other health care organizations also differ in their ability to report to regional, state, and national public health authorities. This is partially due to variability in state data infrastructure, and in the data infrastructure connecting testing sites to public health agencies. As a result, testing is not widely connected in a reliable and timely way to the regional, state, and national public health programs that need to know and act on the findings of positive tests to contain the coronavirus.

Payment reforms, including payments that are part of further relief to hospitals and other health care providers, could take straightforward steps to address the need for engaging providers and connecting them to public health initiatives to contain COVID-19. These steps would not only help them recover financially, but support them in building a stronger infrastructure to protect public health even beyond the current pandemic. Medicare payment reforms could enable more support to health care organizations to address these gaps for Medicare beneficiaries, and could provide a model for similar steps by other health insurers.

Medicare Payment Reforms for COVID-19 Containment

The accompanying list of health care provider payment reforms for COVID-19 containment summarizes the specific payment reforms that could be implemented to support provider participation in comprehensive COVID-19 containment activities, in collaboration with public health authorities, businesses, and other community organizations. The payment reforms address the following key capabilities:

- Provider capacity to conduct COVID-19 health monitoring and case detection for their population of patients
- Test sample collection or telemedicine supervision of tests done at home
- Test performance with rapid reporting, including timely data sharing with public health authorities
- Case management at home or in the community for infected individuals
- Assistance with contact tracing, quarantine, and follow-up management

In the next sections, we describe how these payment reforms could be supported, either within current CMS authority or within the scope of COVID-19 legislation to assist health care providers. Providers could receive one-time or periodic payments (e.g., quarterly) for attesting to or demonstrating that they have implemented the capacity to participate in regional test and trace efforts. Such payments could be linked to provider COVID-19 relief funding, to additional funding for testing, to partial repayment forgiveness for loans already made, or to a Center for Medicare and Medicaid Innovation (CMMI) APM that is rapidly piloted then expanded if it shows additional provider capacity to detect and treat COVID-10. Payments could also be implemented as adjustments or additions to FFS payment systems, though such approaches may require more significant changes in billing processes. In a companion report, we describe feasible, short-term steps to enable secure electronic data sharing between health systems, laboratories, and public health authorities to facilitate this integrated and comprehensive approach to containment.

With Medicare action, it is more likely that commercial plans would implement similar reforms. CMS could also directly encourage similar steps in Medicare Advantage and Medicaid managed care plans. Finally, adjustments in payments to laboratories or other point-of-care or home testing organizations could be used to encourage or require electronic reporting of key COVID-19 laboratory data.

Provider-Level Payment Models for Participation in COVID-19 Containment

CMS has broad authority to test new models expected to improve outcomes, reduce total costs of care, or do both through its authorities in CMMI. **A voluntary, nationwide COVID-19 APM linked to developing the capabilities to participate effectively in test and trace could provide a practice-based or per-beneficiary payment to providers that participate.** The amount of the payment could reflect the cost of practice upgrades, as well as the expected health and cost impact on the effectiveness of COVID-19 case detection and contact tracing.

In particular, for the duration of the COVID-19 threat, CMS could provide a practice-level or per-beneficiary payment for providers that adopt any of a range of electronic practice support tools or other practice features to facilitate COVID-19 symptom detection and testing. With guidance from public health authorities and states, CMS would identify the tools or steps that could be adopted and provide some technical support in using them. Providers that attest to use of such tools or otherwise demonstrate active participation in state and national test-and-trace systems would receive the additional payments. Providers who incur the extra costs and risks associated with specimen collection for COVID-19 molecular testing could receive additional payments. These costs include the need for dedicated space for testing, disinfection, and personal protective equipment, as well as test processing.

A second component of the test-and-trace payment model could support rapid sharing of COVID-19 test data with regional, state, and federal public health authorities, in conjunction with adjustments to payments to laboratories and other entities that conduct testing. Timely sharing of such results along with other key patient data (e.g., indication for test, patient characteristics, and contact information) are critical for effective COVID-19 containment. There are multiple ways that improved electronic data sharing related to COVID-19 testing could occur, as we describe in our accompanying report; we describe feasible approaches that are least burdensome for health care providers and could have the greatest impact on more timely and comprehensive data reporting. For example, virtually all providers have secure electronic connections to clinical laboratories to order diagnostic tests, provide identifying information for billing, and receive results. These electronic systems for laboratory ordering, billing, and reporting could be modified to receive key information more reliably along with test ordering, and share it electronically with public health authorities.

These payment reforms may be most important for primary care providers, community health centers, hospitals, and skilled nursing facilities that are likely to be on the front lines for COVID-19 case detection. However, as reopening occurs, more specialists will be engaged in procedures at ambulatory care centers and in their offices. Appropriate testing and reporting for asymptomatic patients in these settings, and in any inpatient or outpatient post-acute care facilities that they use, will also be important for avoiding further outbreaks within health care systems. Specialty societies have begun to develop new guidance for COVID-19 risk monitoring and testing in these contexts, and CMS policies should support the widespread adoption of such practices along with rapid test reporting.

The program could be piloted rapidly in states that are furthest along in setting up their test-and-trace systems, or in a diverse group of states, then quickly extended nationwide if the program results in improvements in key measures like provider participation and electronic test reporting. Providers in regions or states that represent "hot spots" with higher levels or rates of COVID-19 patients could receive additional per-practice payments.

In lieu of or in addition to CMS COVID-19 provider readiness payments, similar payments for health care providers' test and trace capabilities could occur through further emergency legislation as part of efforts to support state and local programs to develop test and trace systems. Such payments could also occur through existing provider COVID-19 relief funding, through additional direct funding for testing, or through partial repayment forgiveness for loans already made to providers.

This additional payment would be the most direct and substantial way to engage providers in regional, state, or national initiatives to implement test-and-trace programs. The combination of these provider and public health system-focused payments would create an infrastructure for better long-term population health monitoring and risk detection, in collaboration with public health authorities, providing a needed capacity to address future infectious disease threats and other population health risks.

Fee-for-Service Payment Adjustments

CMS could also implement similar reforms through FFS payments in the traditional Medicare program. CMS has substantial authorities to adjust FFS payments to achieve important program goals, including improvements in population health outcomes and payment for specimen collection.

In particular, CMS has implemented the Merit-based Incentive Payment System (MIPS) based on CMS authority to develop a methodology to assess performance by a medical professional, to use that methodology to develop a performance score for the professional, and to use that performance score to adjust the professional's Medicare payments.[2]

Components of MIPS payments currently include "clinical practice improvement activities." One such activity is "population management, such as monitoring health conditions of individuals to provide timely health care interventions."[3] The statute gives CMS the authority to identify other subcategories. **Effective test-and-trace capabilities, such as adopting digital tools or electronic medical record (EMR) modifications that are now being used to support outreach to patients, referral to testing, and COVID-19 patient management fall within MIPS performance categories.**

CMS has understandably implemented steps to reduce performance reporting requirements by health care providers during the current public health emergency. However, it is also critical to

[2] Social Security Act § 1848(q)(1)(A).
[3] *Id*. at § 1848(q)(2)(B)(iii)(II).

support providers in developing the capabilities needed to respond to COVID-19. For example, CMS recently announced a new MIPS component related to participation in COVID-19 clinical studies.

The Medicare program has also adjusted fee-for-service payments to hospitals and medical professionals who are "meaningful EHR users." Hospitals and medical professionals who do not maintain status as a "meaningful EHR user" – among other requirements, defined as using EHR technology that is connected "in a manner that provides … for the electronic exchange of health information to improve the quality of health care"[4] – have a downward payment adjustment under the MIPS program. The Secretary has broad discretion to define terms under the meaningful use program. For example, the demonstration of whether or not an entity is a meaningful user must be demonstrated "to the satisfaction of the Secretary." Moreover, the Secretary "shall seek to improve the use of electronic health records and health care quality over time,"[5] and CMS regulations also define "meaningful user."[6]

Thus, Congress has given CMS sufficient authority to support "meaningful use" of COVID-19 electronic data sharing via regulatory pathways, by making additional payments to health care providers that adopt the steps described above to share COVID-19 testing data. Sharing data electronically on emergency or acute visits for respiratory or other COVID-19 symptoms could also augment syndromic surveillance programs relevant to managing COVID-19, especially before comprehensive testing is available.

Additions to Medicare Fee Schedules

As we have noted, per-practice or per-person payments are likely to be the most straightforward ways to engage providers in regional test and trace initiatives, rather than relying only on payment adjustments or new billable codes. The capabilities needed for participation in test and trace involve practice modifications that apply to all relevant patients, not just in proportion to FFS billing.

However, some additional services could be addressed through fee-for-service payments. The recent CMS announcement of a new payment for test specimen collection, and the expansion of test providers who can bill for testing, will encourage additional test performance.

To link these testing services to the other capabilities needed for effective collaboration in regional containment activities, CMS could add a new type of case-based payment to Medicare's existing prospective payment systems. In particular, CMS could create a new Ambulatory Payment Classification (APC) for hospital outpatient settings, and Healthcare Common Procedure Coding System (HCPCS) code and associated Relative Value Unit under the Physician Fee Schedule, for enhanced COVID-19 case management that would apply only to Medicare patients.

[4] Social Security Act § 1848(o)(2)(A)(ii); *id*. at § 1886(n)(3)(A)(ii).
[5] *Id*. at § 1848(o)(2)(A), in the flush sentence following clause (iii); *id.* at § 1886(n)(3)(A), in the flush sentence following clause (iii).
[6] *See, e.g.,* 42 C.F.R. § 495.4.

CMS could encourage state Medicaid agencies to take similar steps, and private payers may more readily follow suit if CMS implements a straightforward model.

Such a model could adjust payment rates based on the same measures described above for provider-level payment changes for COVID-19 participation, on top of existing payments for performing a test. For example, providers and clinical laboratories that perform tests in conjunction with the adoption of the enhanced COVID-19 risk monitoring and test reporting steps could bill for this APC or HCPCS code for each of their beneficiaries that is part of their enhanced COVID-19 testing and reporting system, or alternatively for each patient who has a positive test result. CMS would not need new authority to direct these payments; the agency has authority to implement such payments under its existing fee schedules.

Clinical Laboratories and Other COVID-19 Testing Entities

CMS has the authority, with respect to laboratory tests provided to Medicare beneficiaries, to adjust payments for laboratory testing based on features of the laboratory tests and associated laboratory services; indeed CMS recently announced significant payment increases for high-throughput COVID-19 PCR diagnostic tests. This authority is predicated upon both CMS's authority to identify resource utilization, and Medicare fee schedules that are tied to market-based payment rates. As noted above, an efficient and relatively straightforward approach to enable participation in automated, consistent, and secure reporting of COVID-19 test results may be through modifications in electronic reporting from laboratories, drawing on data from electronic orders for tests from health care providers.

An incremental payment to clinical laboratories for electronic reporting of key COVID-19 test information could enable provider test-and-trace activities to be reliably linked to public health authorities. Similar payment adjustments or requirements could be included as part of the recent CMS expansion of payments for tests performed in other community point-of-care systems. Such drive-through and pop-up sites are increasingly important for scaling up testing capacity. But in the absence of payment incentives for public health reporting, these systems may not have reliable or timely connections to critical tracing and response activities. Because Medicare payment for laboratory tests is linked to commercial payment for these tests, translating these policies from Medicare to the broader commercial market may be easier than in other areas of the Medicare program.

Medicare Advantage Plan Payments

Payments to Medicare Advantage (MA) health plans are adjusted under the "stars rating" program for better performance on CMS-designated quality metrics (i.e., five-star plans receive a higher bonus to their benchmark payments than three-star plans). Because MA plans are paid on a risk-adjusted, capitated basis, many of the plans have already developed tools and resources for their beneficiaries to encourage appropriate COVID-19 risk identification, timely testing, and management. **To align with payment changes in the traditional Medicare program, and to encourage further adoption of these tools, CMS could add an additional Stars bonus**

opportunity related to the adoption of COVID-19 risk monitoring and timely data sharing by their participating providers and clinical laboratories.

Medicaid

The Medicaid program also has leverage points for encouraging effective test and trace capacity. CMS has often provided guidance to states through letters and model waivers to encourage the adoption of certain practices, and to clarify implications of such reforms for state spending. Congress has created enhanced federal medical assistance percentage (FMAP) payments for states that encourage the adoption and use of certified EHR technology.[7] States must pursue "initiatives to encourage the adoption of EHR technology to promote health care quality."[8] **With new authority from Congress, CMS could inform states via a state Medicaid directors letter that the adoption of steps to support Medicaid laboratory test providers in the state's test-and-trace system is a new meaningful use program, or could provide a template with an expectation of enhanced Federal match for enabling provider participation.** Such a requirement would be especially important for providers that do not receive high Medicare payments, such as pediatric hospitals and community health centers and safety net clinics and hospitals. It would also align with expected additional Congressional funding to states for their investments in enhanced test and trace capabilities.

Private Health Insurers and Employer Plans

The adoption of CMS payment reforms to support provider participation in test and trace activities is likely to encourage similar reforms in private plans. Under recent COVID-19 legislation, health plans are required to pay for the full costs of COVID-19 testing. Moreover, many employers are exploring ways to support effective testing, tracing, and COVID-19 risk management in their insured populations. They may also benefit from aligning with the payment and care reforms described here.

The Administration and Congress are considering further steps, given the impact of effective testing, tracing, and treatment of COVID-19 patients to achieve containment. For example, proposals are under consideration to pay hospitals (and possibly other providers) for testing and treating uninsured COVID-19 patients. As part of their efforts to expand testing, health plans have also supported additional Federal reimbursement of costs that they incur for testing, to create a comprehensive national approach to increase test availability and use.

Similarly, Congress could direct funding to help address the costs of provider participation in effective test-and-trace activities across all payers. This could either be administered by each payer, with Federal reimbursement for their costs, or as an additional "full population" payment to each provider through Medicare's payment mechanisms. These payments would be similar to the Congressionally-mandated version of the APM described above.

[7] *Id*. at § 1903(t)(1).
[8] *Id*. at § 1903(t)(9)(C).

The Department of Health and Human Services could take steps to implement this approach as part of further disbursements from the $100 billion Public Health and Social Services Emergency Fund, enacted by Congress as part of the CARES Act. This use would be consistent with the Congressional guidance that the payments are intended to assist clinicians and health care organizations that "provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19." Additional funding could also be provided through future stimulus legislation.

Conclusion

As we move from managing the initial surge in cases to preventing further large COVID-19 outbreaks and enabling successful reopening, health care providers will have a central but evolving role in the pandemic response. Further Medicare and Medicaid payment reforms could enable providers, clinical laboratories, and other testing organizations to conduct testing and tracing as well as providing other key supports for effective COVID-19 containment across the country. Collectively, the costs of these programs would be a small fraction of total health care relief payments, and would help health care organizations and communities recover and protect against future outbreaks.

Without such payment models or linkages to emergency financial assistance for health care providers, their participation in COVID-19 will likely remain limited, given the severe stresses on their existing FFS payments. APMs linked to enhanced capabilities of providers to support better COVID-19 population testing and tracing are well-suited to avoiding the limitations of FFS payments in the current environment, and could provide an important foundation for sustaining the enhanced infrastructure needed for public health and health care organizations to prevent and contain future outbreaks.

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HEALTH CARE PROVIDER PAYMENT REFORMS FOR COVID-19 CONTAINMENT

Potential payments could enable the following critical steps for comprehensive test and trace. Most steps are within current administrative authorities of the Centers for Medicare and Medicaid Services (CMS) and could also be implemented by private payers. Congressional action could provide additional authority and support for these steps.

Provider-Level Payment for COVID-19 Test and Trace Participation

- One-time or periodic practice-level payment for practices that develop and implement capabilities to collaborate with regional test-and-trace initiatives, and related steps
- Providers could attest that they have adopted tools that support COVID-19 patient risk identification, testing referral, and case management, or otherwise demonstrate active participation in state and national test-and-trace systems would receive the additional payments.

Payment for COVID-19 Test Specimen Collection

- Recent CMS action: a new payment for specimen collection by providers who do not have labs but could support convenient collection in the community, increasing testing capacity
- Payment should be set at a level that encourages broad participation
- Payers should consider supplemental payment for using better or more accurate tests and providing complete information to labs

Payment for COVID-19 Testing with Rapid Reporting

- Recent CMS action: payment for testing by a broad range of community-based test providers, including pharmacies and other organizations performing point-of-care tests
- Additional payment for laboratories (hospital, physician office based, or commercial) and other testing sites could be linked to timely reporting requirements of key test information to ordering provider and state/Federal public health systems, including sufficient identifying information for public health contact tracing if there are positive results, as described here

Payment for COVID-19 Case Management at Home

- Augmentation of telemedicine payment with a per-case payment to include monitoring symptoms, connection to needed medical services from home or a community-based isolation setting, and other steps to avoid hospitalization and other acute health care use
- This may include assistance with collection of information for contact tracing

Payment for COVID-19 Symptom Monitoring for Quarantined Patients

- Additional payment for providing timely access to appropriate testing and symptom monitoring to rule out COVID-19 and assure appropriate further treatment

Health Care Provider Collaboration and Support for COVID-19 Public Health Activities

- Many health care organizations – including academic medical centers, health systems, and primary care groups – are beginning to provide critical support for COVID-19 contact tracing. CMS could potentially assist with CDC funds distribution through state and local public health authorities to conduct these activities
- Additional payment could be tied to the number of cases in which a provider undertakes contact tracing
- It may be feasible to do through direct payments to providers from state public health authorities, or use of existing CMS payment infrastructure could be explored
- Payments would support flexibility in encouraging locally-appropriate contact tracing mechanisms, with a focus on accountability for achieving high levels of contact tracing through assistance of health care organizations