

**COVID-19 Health Care Response and Resilience Program**  
(Draft Proposal: 7/30/2020)

Health care providers and health care organizations are reorienting their workforces, modifying facilities, and prioritizing critical services to provide effective and safe care for individuals with COVID-19 – all while facing significant continuing revenue shortfalls. The revenue shortfalls are the result of the large drop in utilization seen across the health care system. Some recovery in utilization has occurred since the spring, but the continued presence of the virus is leading to stretched hospital capacity and an ongoing need to modify health care practices.

- Primary care practices have seen [declines of up to 50% in service volume](#) since the start of the pandemic, with one analysis estimating [these practices could lose an average of \\$67,774 per full time physician](#) in 2020 as a result of COVID-19.
- Oncology, orthopedic, and pediatric practices have experienced [28%, 39%, and 47% declines in service utilization, respectively.](#)
- The American Hospital Association (AHA) reports that hospitals and health systems are [averaging declines of 19.5% in inpatient volume and 34.5% in outpatient volume](#), and estimates [hospitals and health systems will lose at least \\$323.1 billion in 2020.](#)

The way providers are paid has led to these financial crises. Fee-for-service (FFS) payment has been criticized for encouraging volume over value; now organizations are also finding that FFS offers no backstop when utilization drops in a public health emergency. Conversely, our research has shown [providers and health systems who participate in value-based payment](#) (VBP) have been more financially stable, particularly those in advanced alternative payment models who receive upfront, ongoing payments not tied to FFS. Practices receiving these payments have used them to build a wide range of capabilities that are not well supported under FFS – such as care coordination staff, patient engagement tools including apps and 24/7 help lines, robust data analysis, and infrastructures to support telehealth, remote monitoring, and home-based care. VBP providers have been able to leverage these capabilities quickly to implement an effective pandemic response, while FFS providers have had to rely on rule and payment changes to move forward with such innovations.

To help address the financial impact of COVID-19, providers are receiving \$175 billion in emergency financial support from the [Provider Relief Fund](#) and the [Paycheck Protection Program](#) (PPP). As the pandemic continues, providers will likely need additional funding assistance. It should help them implement better approaches to contain the virus and deliver better care, not simply address financial shortfalls. The additional funding should support feasible steps to help contain the pandemic, such as:

- Data sharing and coordination with public health, to provide assistance with point-of-care testing, contact tracing, and other local containment efforts
- Participating in joint planning and response across health systems and with public health authorities to manage surges in seriously ill COVID-19 patients
- Managing COVID-19 patients outside the hospital including in the home and other community-based settings

Also critical for pandemic response is the expansion of care reforms that help patients continue to get the other needed care during the pandemic, including:

- Implementing care teams focused on chronic disease, mental health, and substance abuse management using telehealth, remote monitoring, and assistance with social needs like food insecurity
- Shifting services like drug infusion and care management for complications in cancer patients to less costly home or ambulatory settings, when such shifts are clinically appropriate
- Adopting new models of care for patients with specialized health problems, such as: home dialysis for patients with end-stage renal disease rather than visits to dialysis centers; and home- and community-based care models for complex patients, like “hospital at home” care or advanced home rehabilitation services

Health care providers paid under FFS are taking steps like these as part of the COVID-19 response, despite their financial difficulties. At the same time, to increase reimbursement, especially as they look beyond the pandemic, they have to focus on reopening in-facility elective services. Many such critical services, including preventive services like mammograms, or evaluations of worrisome new symptoms of cancer or heart disease, are critical to reopen because they cannot easily be done outside the office or hospital. However, growing evidence around the country shows that much care can be delivered in new ways, and some “low-value” tests and procedures do not need to come back at all – if providers have an opportunity to participate in payment models that support such reforms.

To encourage providers to invest in COVID-19 care redesign that helps them safely and effectively meet the needs of their patient population, and make progress on health care costs and access as we emerge from the pandemic, further assistance should provide a path to make permanent new care models that are not only an effective part of pandemic response, but that can lead to more convenient access, better outcomes, and less costly approaches to care – as well as better preparedness for the next public health emergency. Relief payments that only provide a bridge to a return to FFS payments won’t achieve that goal.

Overall health care spending fell [38% in April](#), and double-digit spending reductions continue. While most of this decline reflects the loss of needed care, and some catch-up spending should be expected, some of the spending drop reflects the substitution of less costly care and the elimination of unnecessary care. But under current financial relief and FFS payments, it’s hard to sustain such reforms. For example, telehealth visits [peaked in April](#) but have declined since. Alternative payment models with less linkage to volume of services would help providers permanently sustain innovative care from the pandemic. Building on recent experience, they would help providers bring back a health care system that delivers needed services more efficiently and eliminates rather than restarts services that aren’t needed. The resulting long-term impact on health care costs could be substantial.

Simply providing financial relief for current revenue shortfalls does not help providers continue or expand reforms in care that are needed for pandemic response and for a more sustainable health care system. Giving providers financial support now that shifts payments away from FFS would not only provide needed financial relief, it would also help them respond by delivering critical health during the pandemic, and help them keep and build onto the reforms for the future.

### **The COVID-19 Health Care Relief, Response, and Resiliency (RRR) Payment Program**

Congress can provide short-term financial relief while making the health system more resilient for the long term by directing **\$50 billion** from the total provider emergency funding in the next stimulus package toward *response* and *resilience* – to expand needed reforms in care now and help make them permanent, through short- and longer-term shifts away from FFS payment.

The Department of Health and Human Services (HHS), mainly through the Centers for Medicare and Medicaid (CMS), would have the authority to provide financial support for response and resilience payments through either immediate provider-level payments, subsidized loans, or advance payments. Primary care, mental health, and providers caring for vulnerable populations, especially in areas of the country experiencing surges in COVID-19 cases and hospitalizations should be prioritized. Some of the additional funding could be provided as proportional increases in relief payments, but HHS should have discretion to determine specific allocations to achieve the program’s goals.

#### ***Relief Payments***

The relief portion of the program could include *COVID-19 relief payments* building on the financial relief in previous COVID-19 relief legislation. Providers receiving these payments would not be required to make any commitments to care reform, but would be encouraged to use the funds to invest in telehealth, data sharing tools, and other resources critical to treating COVID-19 patients. CMS would determine the most appropriate distribution methodology for these payments, with an emphasis on smaller providers and those practicing in underserved communities and communities that have been particularly hard-hit by COVID-19.

#### ***Response Payments***

Congress would direct \$15 billion of total provider relief to *COVID-19 response payments* for providers who partially or fully take needed steps in 2020 and 2021 to respond to the pandemic and to provide a foundation for better care and population health for the future. Measures of COVID-19 response include:

- Provider attestation or demonstration of *rapid electronic data sharing for COVID-19 containment*. Providers qualify for the additional response payment if they share patient information needed by clinical laboratories to fully implement [COVID-19 laboratory reporting requirements](#), and for electronic real-time reporting of test results. Such data sharing between health care and public health is currently encouraged, but requires modifications to electronic record systems (e.g., for “ask on order entry” clinical data). Establishing these systems will also improve future response capacity.
- Public health attestation of *meaningful provider collaboration in public health containment*. Providers qualify for additional payments if their regional or state public health authority attests that they participated in significant public health containment activities. HHS would describe a range of qualifying activities, such as offering testing in collaboration with public health to high-risk communities; participating in outbreak surveillance initiatives; participating in surge case management; enhancing capacity to provide home- and community-based care to free up hospital capacity for COVID-19 response; assisting isolation or quarantine programs with staffing or other material support; or participation in future public health emergency response planning. State public health authorities could establish blanket attestations for all providers participating in key initiatives.

- Commitment to participation in the resilience program as reflected in attestation to CMS and reporting of any key performance measures identified by CMS for the relevant program. For example, providers who intend to participate in the Medicare Shared Savings Program (MSSP) could report on measures included in the MSSP that are not suspended during the public health emergency. Commitment to alternative payment models along with the response payments will support investments to help patients receive needed care in home- and community settings. For health care facilities, the reforms will diminish the financial tension between increasing hospital, outpatient, and other institutional services versus keeping sufficient capacity available for COVID-19 response.

### **Resilience Payments**

Congress would direct an additional \$35 billion to *COVID-19 resilience payments* to assist providers in shifting more of their revenues into alternative payment models that support redesigned care and reduce dependence on FFS volume. Providers would receive these payments if they meet some of the conditions for COVID-19 response payments in 2020 and 2021, and enter payment reform contracts by the end of 2021. By the end of 2023, those contracts must increase the share of payments across all payers in advanced alternative payment models above a minimum threshold for significant practice redesign – 20 percentage points (e.g. from 10% to 30%) or half of the way to being fully capitated (e.g., from 70% to 85%), whichever is lower. Providers should receive larger payments for larger increases.

CMS would measure the shift with its current measures of advanced alternative payment model (APM) participation, such as its [measure](#) of participation in APMs across all payers, which CMS should review and consider updating based on stakeholder input on the performance of such APM participation measures. Qualifying APMs would be determined by CMS, but generally would include models that are offered by CMS, private plans, or states, and represent a significant shift from FFS, such as [LAN Category 3B or 4 models](#). CMS should continue to encourage copayment redesign with value-based benefits in these alternative payment models. Examples of some Medicare models that could be used by different types of health care providers are listed below. CMS would establish a mechanism for recovering resilience payments from providers that do not fulfill the conditions of the program.

CMS would also establish a **rural hospital alternative payment model** by 2021, providing an alternative payment option for all inpatient and outpatient services for hospitals (e.g., critical access hospitals, acute hospitals in rural settings) that participate. This advanced APM would convert a substantial part of a rural hospital's payments to a prospective budget, with corresponding reductions in fee schedule rates. By the end of a transition period, at least half, and potentially all, hospital reimbursement would be covered through the global budget. Participating hospitals would have the flexibility to redesign services, with model features based on approaches developed in the [Pennsylvania Rural Health Model](#) and other global hospital budget models implemented by the Center for Medicare and Medicaid Innovation (CMMI). CMS would design the multi-payer model to encourage participation by Medicaid and private payers. The model would be a qualifying APM under the RRR program.

For specialists that do not have models available, CMS would specify an alternative mechanism for partial payment. For example, this could involve participation in programs to promote patient-focused teams in delivering specialized care that have been validated to improve quality and cost, such as the [Geriatric Surgery Model and verification system](#) or the [Metabolic and Bariatric Surgery Program](#). Such

programs involve adoption of specialized systems of care and patient outcome tracking. This could be coupled with reporting on episode spending measures and patient-focused performance measures, such as patient-reported outcomes that CMS is developing (and should accelerate) as part of its [Quality Measure Development Plan](#) and in further updates of the [MIPS Value Pathway](#), which is intended to support specialist movement into alternative payment models as they become available.

Primary Care	<ul style="list-style-type: none"> <li>• Medicare Shared Savings Program (MSSP) Pathways to Success (physician-led ACO)</li> <li>• Primary Care First</li> <li>• Direct Contracting</li> </ul>
Specialized Care	<ul style="list-style-type: none"> <li>• Kidney Care Choices Model</li> <li>• Oncology Care Model/Radiation Oncology Model</li> <li>• Bundled Payments for Care Improvement-Advanced or future advanced bundled episode payment models</li> <li>• Joint participation in MSSP or Direct Contracting</li> <li>• Other specialized care APMs developed by CMS</li> </ul>
Hospitals	<ul style="list-style-type: none"> <li>• MSSP Pathways to Success</li> <li>• Direct Contracting</li> <li>• Specialized Care Models</li> <li>• Global budget APM for rural hospitals<sup>1</sup></li> </ul>
Medicaid Providers	<ul style="list-style-type: none"> <li>• Resilience Model Waiver with enhanced payments for providers with increased participation in qualifying APMs in Medicaid programs or plans<sup>1</sup></li> </ul>
Community Health Centers	<ul style="list-style-type: none"> <li>• Improved Participation in Medicaid APMs<sup>2</sup></li> </ul>

<sup>1</sup>Congress would direct CMS to develop a new payment model in this area.

<sup>2</sup>Congress would remove restrictions that prevent CHCs from receiving prospective payments in advanced alternative payment models. This may include directing CMS to develop a new payment model in this area.  
Note: This table is an illustrative not comprehensive list of all CMS models that could be used to meet the APM resilience requirement.

### **Medicaid Response Payments and Model Waiver**

Medicaid providers should also be able to qualify for response payments. CMS would develop a mechanism for distributing for resilience payments, possibly including a *model waiver for Medicaid*, to provide a template for how states can distribute upfront payments to Medicaid providers, to improve their capacity to respond to COVID-19 and implement innovative care models permanently through APMs. States that adopt the model waiver would receive a grant from the resilience program funding to implement the waiver.

For the *response* support, Medicaid providers would receive additional payments for the same or similar activities as described for the Medicare response payments, including COVID-19 data sharing with public health authorities and participation in public health response initiatives. HHS should implement these payments through the most efficient mechanism available, building on current mechanisms for distributing payments to Medicaid providers or through a model waiver process.

In the *resilience* waiver, states could provide enhanced payments to providers who increase participation in advanced alternative payment models as their practice or organization emerges from the pandemic, either directly or through their managed care organizations (MCOs). The model waiver

would provide short-term payment increases to providers, based on progress beyond the current status of APM availability and Medicaid provider readiness. Receipt of these funds would require provider adoption of reforms by 2021 that achieve a minimum of a 15 percentage-point increase in advanced APMs by 2023, with higher payments to states (for their providers) for larger increases. States would also receive additional funds for adopting a statewide Dual Eligible Special Needs Plan (D-SNP) alignment plan or Medicare/Medicaid dual-eligible care model approach by 2022.

### **Supporting Reforms for Resilience**

Other legislative actions could support the implementation of the COVID-19 Health Care RRR Payment Program:

#### ***Expanded Telehealth Coverage***

Expanded Medicare telehealth payments for covered services delivered at home should continue, with broader expansions for providers participating in advanced APMs, building on reforms such as those included in the proposed [home health payment rule](#) and in existing Medicare APMs. Covered services should include audio-visual and audio-only services, as well as remote monitoring. CMS should have the authority to determine appropriate payment rates for telehealth visits based on cost estimates, and the authority to restrict telehealth services in circumstances where there is reasonable evidence that continuing coverage after the pandemic would lead to unnecessary spending increases or significant program integrity concerns. CMS would continue to provide substantially broader telehealth coverage with the option to offer lower copays for providers participating in advanced alternative payment models, including through the RRR Program, because of enhanced opportunities for care coordination and incentives to avoid overuse.

#### ***Expanded Site-Neutral Payments***

Expanded Medicare payment for services delivered in home- or community-based settings as alternatives to inpatient, outpatient, or other facility-based settings should continue. Services that could be delivered in these settings include drug infusion, advanced rehabilitation services, intensive “hospital at home” services, and facility-based services that can be provided in physician offices or clinics. CMS would have authority to set Medicare payments at parity with its payments for similar in-person ambulatory or outpatient services, while monitoring access to care in underserved urban and rural communities. CMS would also have the authority to restrict more intensive services that cannot be safely and reliably provided at home after the public health emergency. Site-neutrality price levels should not increase Federal spending in conjunction with other provisions included in this legislation.

#### ***Enhanced Data and Transparency on the Quality and Cost of Care***

A national nongovernmental, nonprofit transparency organization would be established to provide necessary data to support assessments of the quality and cost of care across providers in the U.S. health care system. This could be accomplished by enacting Section 303 of S.1895, the Lower Health Care Cost Act, which was passed with strong bipartisan support by the Senate Health, Education, Labor and Pension Committee (HELP) in 2019. The data will provide national, timely information on utilization and payment – including for COVID-19 related services – to facilitate regional assessments of the impact of the pandemic and further responses, including for communities of color, low-income and rural communities, and others that have been differentially impacted by the pandemic. Such data will also facilitate more complete assessments of the performance of health care organizations, including

comparisons of organizations in different payment models. The availability of these data would enable better decision-making by consumers, providers, and policymakers, and support higher quality and value of health care spending.

HHS should have flexibility to implement the program in a manner that minimizes burden of data collection and promotes timeliness and consistency across states and settings, such as through the use of secure data sharing from health plans using standard application programming interfaces (APIs). HHS could phase in implementation, starting with key data for COVID-19 response, but expanding to all health care categories. Data should include race, ethnicity, geographic location, socioeconomic indicators, and other characteristics that may influence outcomes and contribute to health disparities, as such data are a foundation to developing payment and other policies that reduce disparities.

### **Budgetary Impact**

The budgetary impact of this set of provisions will be less than the \$50 billion in response and resilience payments directed to health care providers. We expect some offsetting Medicare and Medicaid program savings from increased adoption of advanced alternative payment models certified by CMS to be cost reducing. We also expect savings from interactions with the telehealth and site of service payment provisions, compared to the cost of those provisions if implemented without the RRR program. Telehealth expansion will increase spending with exact budget costs dependent on the extent of expansion. However, because telehealth expansions are less costly for providers in alternative payment models (as reflected in existing broad telehealth payments in advanced APMs), the RRR program would encourage broader adoption of telehealth in ways that do not increase health care costs. The expansion of site neutrality payments will reduce spending, to the extent that site-neutral payments are based on equalization at price levels in lower-cost settings (i.e., ambulatory vs hospital outpatient). The RRR program will lead to more adoption of care in alternative, lower-cost sites.

With the COVID-19 Health Care Relief, Response, and Resiliency Payment Program, health care providers, and the health care system as whole, will develop the capabilities and resiliency needed to quickly and effectively respond to and recover from the COVID-19 pandemic. Under this program, funds will be used to help providers meet the needs of now while also setting them on a path toward more sustainable and feasible payment models that are better able to respond to public health crises and ensure patients can receive the best possible care, particularly during difficult times. This approach enables relief payments to be an investment that will improve access and care, and reduce costs in the future.