November 20, 2017

VIA ELECTRONIC MAIL

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: CMS Request for Information: Innovation Center New Direction

Dear Administrator Verma:

The Health Care Transformation Task Force ("HCTTF" or "Task Force")[1] appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services ("CMS") on the Request for Information: Innovation Center New Direction ("RFI"). We also commend the declaration of support for value-based payment in the Administrator's accompanying op-ed in the Wall Street Journal, which provided an important signal that the federal government will be a meaningful partner with providers and payers working to implement value-based payments in commercial markets. Thank you for your leadership.

As a broad-based group of health care stakeholders, the Task Force strongly supports the transition to value-based payment and care delivery, and we stand ready to serve as a resource for CMS. Our members are well-positioned to help define the highest priority activities for the Center for Medicare & Medicaid Innovation ("CMMI") and to identify other strategies for pursuing patient-centered care models while reducing provider burden. Our membership has significant and varied experience with value-based payment models, and looks forward to sharing learnings from these experiences.

[1] The Task Force is a consortium of 42 private sector stakeholders that wish to accelerate the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry – including providers, health plans, employers, and consumers – we share a common commitment to transform our respective businesses and clinical models to deliver the triple aim of better health, better care, and reduced costs. Our member organizations aspire to put 75 percent of their business into triple aim focused, value-based arrangements by 2020. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

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Our membership's dedication to high quality, affordable care is strong, and our membership is unique. We bring together purchasers/employers, payers, providers, and patients/consumers to work collaboratively to help accelerate the transition to value-based care. In total, we represent 42 distinct organizations that are deeply invested in advancing value-based payment models.

While the industry is making considerable progress, our journey to value-based care remains challenging and requires sustained investment and engagement over time. Making a successful transition to value-based care requires a strong commitment by both the private and public sectors. To this end, the HCTTF has spent many months developing specific recommendations that are responsive to this RFI and for which we urge CMS action to support this important effort.

I. General comments on the Innovation Center's future direction

As we shared with the Department in a prior position paper[2], the HCTTF supports the CMMI structure for testing innovative payment and clinical models. It represents a significant improvement over the prior approach by its precursor, the Office of Research, Development, and Information. For innovation to be most effective, opportunities must exist for rapid-cycle action to improve and continually refine innovative projects. CMS had historically taken a more academic approach to innovation, which did not lend itself to building the momentum and positivity necessary to make meaningful progress in modernizing health care delivery.

The pace of progress under CMMI is preferable; paired with an explicit focus on building collaborative learning networks, the new testing process has allowed for sharing best practices across model participants and more dynamic model implementation. This has resulted in quicker incorporation of improvements into new models based on provider feedback and interim evaluation results. In this way, CMMI has been a more effective testing laboratory.

Going forward, we urge CMS to support an approach to innovation which, along with the private sector, is helping our Nation move toward a person-centered, value-based health care delivery system that improves quality outcomes and promotes affordability. CMS should continue to help develop new models and take steps to promote their national adoption when they work. But to enable more private sector leadership, it also requires an environment that facilitates private sector system changes and initiatives. This means enabling the private sector to move forward quickly on payment reform models by clearly outlining priorities and key performance measures, creating the necessary flexibility, and establishing an infrastructure to rapidly assess and refine these models, and a clear pathway for expanding them when successful.

[2] http://hcttf.org/resources-tools-archive/2017/6/14/the-task-force-asks-the-trump-administration-to-show-support-for-the-transition-to-value-based-payment-and-care-delivery

An effective public-private sector collaboration on delivery system reform should first align on the definition of "value." The well-attended Health Care Payment Learning and Action Network (LAN) events have established widespread agreement that value in health care broadly means providing the proper care at the lowest cost with the best outcomes for patients. As the bipartisan passage of MACRA demonstrates, the principles of value-based payment are nonpartisan and necessary to fix a system that spends too much on health care with less-than-optimal results.

To date, CMS has mostly focused on encouraging and supporting clinicians in their transition via an offering of Medicare fee-for-service-based models. We believe that Medicaid, Medicare Advantage and private plans also play a critical role in this transition and that CMMI should ensure these plans have access to innovative new models that provide the necessary flexibility to provide individualized, high-quality health care and tools to support their networks in the transition to value base care. We also recognize areas where CMMI can improve upon current efforts that will lead to more attractive, successful and sustainable payment models for providers, and more efficient operations for the federal government, which are addressed below.

A. Modify existing models to enable success

A critical focus of CMMI going forward should be using the lessons learned from providers' experience and federal evaluation of alternative payment models (APMs) and Medicaid delivery system reform efforts from the past few years to make improvements to the existing models that are showing genuine, long term promise. CMS should carefully evaluate the current models, many of which have required significant stakeholder investment and don't necessarily lend themselves to overnight success.

For example, recent results from the Medicare Shared Savings Program for Accountable Care Organizations (ACOs) demonstrate that providers participating in the program longer are more likely to achieve savings, and by greater amounts.[3] Eliminating or overcorrecting existing models before providers have a chance to realize a return on their transformation investments would jeopardize the goals of affordable and improved care, and reduced provider burden, while also causing participants to squander the investment and commitment they have made to those models over several years. Rather, CMS should focus on modifying existing models to make them more successful.

There are several ways that CMS can modify existing models to make them more successful; we recognize that some changes will be easier than others for CMS to implement, due to statutory and operational constraints. The Task Force deliberated to prioritize recommendations for CMS to consider that are feasible to implement. We urge CMS to address the following:

[3] https://oig.hhs.gov/oei/reports/oei-02-15-00450.pdf

i. Create a better business case for delivery system innovation

Providers are seeking models that offer a better balance between producing conservative savings to Medicare, and ensuring that the models are attractive for wide-scale uptake and long-term participation by offering providers a reasonable return on their investments. While realizing savings to the government is important, setting a minimum savings rate too high on two-sided risk models misses a greater opportunity to bring providers forward. This balance becomes even more imperative to support the effective implementation of MACRA, which encourages greater provider participation in Advanced APMs with two-sided risk arrangements.

CMS should support an accelerated pace of transformation for those organizations that are willing and prepared to take on additional risk, while offering attractive opportunities for new entrants to pursue and advance value-based payment. The Task Force has long supported interim steps (e.g., ACO Track 1+) that encourage participating providers to continue along the continuum to the other fully mature two-sided risk models.

Providers are also rightfully concerned with the viability of alternative payment models that require significant up-front capital investments and care delivery redesign, but may not be sustained following the initial demonstration period. The Secretary of HHS currently has the authority to expand through rulemaking the duration and scope of a model that is being tested after it has been confirmed by evaluation and certified by the CMS' Chief Actuary that model expansion would reduce (or not increase) net program spending, among other statutory requirements. Only two models have been deemed effective by the current actuarial standards: the Pioneer ACO model and the Diabetes Prevention Program.

At this time, CMS has not released publicly the actuarial assessments for models that did not meet the threshold for expansion. It would be prudent to reassess the actuarial method currently being used (including through public comment) and expeditiously bring models to scale that that have been deemed effective, which may impact provider willingness to engage in new models. CMS should also be more transparent with information about what models are not working, and why.

ii. Encourage transition to two-sided risk models

The HCTTF fully supports the adoption of two-sided risk models as a way of achieving truly person-centered, value-based care. Our principles stand on that very premise: our members aspire to have 75 percent of their business in triple-aim-focused, value-based arrangements by 2020. Yet, we recognize that such a state is unlikely to happen quickly for all stakeholders, and believe CMS should effectively chart a course toward two-sided risk that sets that as the ultimate goal, removes program barriers, and incentivizes actors to invest in models that help lead them to that goal.

We urge CMS to consider implementing a transition period to downside risk for existing MIPS APMs to qualify as Advanced APMs. CMS has routinely used transition periods in past policy making to help achieve the goal of effectively moving stakeholders to new policies. We believe that broad public policy goals similarly support a transition period in this context.

Specifically, the HCTTF urges CMS to consider establishing a transition period policy that deems MSSP Track 1 ACOs as meeting the Advanced APM definition for two years, with the expectation that those ACOs will transition to a two-sided risk model by the end of the transition period. Alternatively, CMS could tie the transition period to the existing ACO contract term. This flexible approach would recognize the ongoing progress organizations are making in those models, while establishing an appropriate expectation that those organizations will move forward toward two-sided risk models on this timeline.

iii. Provide additional levers for APM participants to control cost and quality

CMS should make available every tool in the toolbox to help APM participants meet the mutually beneficial program objectives, including:

a. Eliminate barriers to care coordination and consumer engagement

Meaningfully engaging beneficiaries as partners in care and delivering patient-centered care that meets the needs of patients and families is the best way to encourage beneficiaries to consistently seek care from providers in APMs. To this end, the Task Force supports policies that would lower the out-of-pocket cost burden in the form of lower copayments or premiums and encourage beneficiaries to seek care from APM-aligned providers under traditional Medicare and Medicare Advantage (MA).

The Task Force also supports incorporating within existing Medicare Part A/B APMs and MA approaches that would waive cost-sharing for items/services that treat a chronic condition, prevent the progression of a chronic disease or encourage use of lower-acuity settings, as it more directly addresses the needs of those with chronic illness by correlating with each patient's out-of-pocket burden.

b. Incorporate risk for Part D drug cost

We believe that CMS should incorporate accountability for Part D drug costs into a total cost of care or episodic model, which would provide an additional lever for APM participants to improve overall care and manage costs for their population of patients. The Oncology Care Model currently incorporates risk for some Part D medications related to the relevant episode; this approach should be expanded.

c. Expand telehealth waiver availability

Telehealth has moved beyond simply an innovative approach to being a critical pathway for meaningful beneficiary access to provider services, and has become a part of routine care models. The Task Force therefore supports the extension of the telehealth waiver to all MSSP tracks, so that provision of telehealth services under value-based payment arrangements is not unnecessarily limited. We also believe that the originating site requirement should be eliminated entirely for ACOs and other similar risk-bearing entities. With the assumption of risk, ACOs and other entities are held accountable for unnecessary utilization and waste, and therefore should not be restricted in their ability to provide telehealth services. Further, ACOs and other similar entities are held accountable for quality of care of their attributed patient population, and are therefore incentivized to provide face-to-face encounters with patients when it is clinically necessary.

The Task Force also supports expanding waivers to APM participants to provide telehealth services to patients in their home, as this reduces barriers to care for many patients who have mobility or transportation limitations. Bringing care to patients where they are follows a patient-centered approach that will likely improve clinician-patient relationships and increase adherence to treatment/therapy plans, all while making care more affordable.

iv. Streamline overall waiver approach

The HCTTF believes CMS should enhance its approach to regulatory relief for APM participants by streamlining the waiver process, while maintaining appropriate protections for consumers. The ability for providers to be successful in value-based payment models depends on several factors, and one key factor is the capacity to operate under a regulatory framework that is conducive to effective, efficient, patient-centered and high-quality care.

Many existing Medicare regulatory structures were designed to support a fee-for-service payment environment that focused on individual service delivery and are not ideal or necessary to support a modernized, value-based world which focuses on greater coordination and integration of care. We encourage CMS to carefully assess and modernize those regulatory structures that hinder or affect the adoption of value-based care models, which will encourage providers' successful transition to value-based delivery systems.

When physicians are financially incentivized not by the volume of services but by the efficiency of services and treatment outcomes, their economic self-interest aligns with the interest to eliminate unnecessary services. Increasingly, the laws and statutes intended to protect from overutilization and decisions based on financial interest have become a significant impediment to value-based payment models. The Task Force recommends that CMS consider modifying existing exceptions to the physician self-referral prohibition and/or create new exceptions for alternative payment model participants to allow for greater care coordination within the construct of APMs. In doing so, CMS should ensure all plans – including Medicare

Advantage, Medicaid and Medicaid managed care – have access to parallel flexibilities to transition to value-based care.

In sum, we strongly urge CMS to take action to modify its own policies as appropriate while ensuring that Medicare beneficiaries remain protected, while also championing a modernized approach to value-based care delivery with its law enforcement partners at the Office of Inspector General and the Department of Justice.

v. Better engage specialists and primary care

Some APM participants, such as ACOs and bundle payment programs like BPCI, have the ability to include specialists in the models and integration into care workflows. We support including specialty programs within the context of these broader programs, giving APM participants the flexibility to design programs specific to their patient population needs, and design shared savings/gainsharing models that align specialty physicians in achieving those outcomes while providing sufficient scale for the necessary investments in care redesign. As specialists are better engaged in new payment models, CMS should ensure that programs that permit broad participation remain a central component of team-focused, value-based care, and that primary care remains a key team member. Further, we do not support narrow, single disease "carve out" models for specialists as they typically do not provide sufficient volume for the infrastructure investments necessary to truly change how care is delivered and typically expose all but the largest participants to an untenable level of outlier risk.

Below, we offer further recommendations for synchronizing model implementations to ensure that various APM participants are able to take advantage of the synergistic effects available by leveraging the strengths of different models across the value-based population. We encourage design of all specialty programs to keep the overall outcomes central, giving APM participants the flexibility to design programs specific to their patient population needs, supported by shared savings/gainsharing models that align specialty physicians in achieving those outcomes.

vi. Improve benchmark methodology and risk adjustment

Setting spending benchmarks in APMs has been an ongoing issue for participating providers. The current benchmarking methodologies are grounded in historical fee-for-service costs, and therefore present a number of challenges when it comes to sustainability of downside-risk models for providers. Ultimately, long-term sustainability of shared-risk and/or capitated models requires moving away from a benchmarking model based on historical FFS cost, and resetting benchmarks to account for all savings – not just the shared savings portion.

Under existing models, providers that have previously participated in CMMI models or MSSP are not given adequate credit for that prior work to reduce costs and improve quality when it comes to setting the benchmark. On the flip side, providers without prior experience in

risk-based models may lack experience with coding completeness efforts, which is a key competency to ensure accurate performance under current APM methodologies. CMS should acknowledge the differences in provider administrative readiness to manage risk – including organizational competencies like coding completeness – and prior value-based payment experience, and control for those differences in the benchmarking methodology so as not to discourage providers new to risk arrangements from entering them, nor encourage existing providers to exit. Many of our members strongly believe that unless CMS makes the financial deal better, the ACO program will fall short of its true promise to change the way care is delivered.

Risk adjustment is a critical component to accurately setting targets in an alternative payment model, particularly an Advanced APM where the participant is taking risk. Model design should acknowledge that changes in health will vary between model participants. This means that for a given model participant, risk adjustment should be able to raise or lower the cost target. At the same time, we recognize that CMS has a vested interest in not rewarding model participants for changing their risk score more than the underlying health of the beneficiary population changes. At the program level, this could take the form of either a cap in year-over-year change or a program wide adjustment factor. Regardless of method CMS chooses to protect the program, an individual model participant's cost target should track changes in their risk score.

vii. Voluntary attribution

Voluntary alignment is an important component of a robust attribution model, which itself is necessary for accepting accountability for a population of patients. A robust attribution model is one that reflects a patient declaration of "Yes, this is my provider group" and a provider group declaration of "Yes, this is our patient." Robust attribution makes a population "more known," and if ACO attribution is maintained and shared by a payer (including Medicare), it can be used to support information exchange, optimize care coordination, and align incentives across all providers. Simply allowing patients to voluntarily elect to be part of an ACO is not enough, however. CMMI should provide the tools and resources necessary actively engage in outreach and education that will help patients make the best choice for their health care needs.

B. Refine existing and future operations to maximize success and efficiency

Now that value-based payments are more central to the Medicare program, it is imperative that CMS adopt a mature and consistent process for model operations, and make improvements to the underlying payment systems to improve efficiency. Specific areas for refinement are identified below:

i. Synchronize model implementation

Efficiencies can be recognized by better sharing resources and infrastructure across model teams, as well as potential opportunities for payment model alignment. The current approach to addressing model overlap – namely, excluding from one model beneficiaries or providers that are also aligned to a second model – could potentially be addressed with broader financial gainsharing or contracting opportunities that support model synergies rather than broad exclusions. We believe that better synchronization between models can ensure that the needs of individual patients are the focal point of the discussion.

ii. Define meaningful metrics for evaluating all models

Quality measure alignment and harmonization across models can also reduce burden on providers and encourage focus on key indicators of improved quality and cost containment, and will allow for meaningful comparability and true best practice identification. The past practice of evaluating each model through individual analyses and separate contracts may now be outdated. CMS should develop standard evaluation metrics that can support better cross-model comparison.

iii. Improved model transparency

Access to timely, accurate, and actionable data fuels successful population health management and patient engagement. CMS has improved the availability of Medicare claims data on attributed patients in recent years based on feedback from model participants, although data for patients with substance use disorders is still suppressed. In addition, transparency has been lacking on the underlying model methodologies and accounting approaches for CMMI models. CMS should be more forthcoming with this information so that providers can perform their own financial analysis and make informed decisions about model participation, and make APM evaluation and quality measure data available publicly in a timely manner.

iv. Support and assistance for beneficiaries

In the same way that providers receive technical assistance as new models roll out, future demonstrations should provide assistance and support to consumers so that they are able to meaningfully provide necessary input on development, implementation, and evaluation.

C. Mandatory bundled payment models that were recently proposed for cancellation should instead be offered voluntarily

We previously submitted comments supporting many of the design features in the Episode Payment Models (EPM), which aim to reduce Medicare spending and improve patient care. We believe clinical episode-related payments can promote high-quality, high-value care

for Medicare beneficiaries by enabling providers and patients to make care decisions together, which will lead to better outcomes, and encouraging coordination and efficiency among a patient's providers. The proposed cancellation of the Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG), and the Surgical Hip and Femur Fracture Treatment (SHFFT) models further contributes to the dearth of Medicare APMs available to specialists, thus limiting opportunities for eligible clinicians to qualify for Advanced APM incentive payment under the Quality Payment Program. Moreover, many providers in the selected regions have already invested time and capital preparing to participate in these models as initially finalized.

In lieu of cancelling these models, we urge CMS to consider making them available on a voluntary basis. Affected stakeholders have been preparing to implement this model and stand to lose those investments. Since the model was finalized in the EPM final rule in January, providers in the selected Metropolitan Statistical Areas (MSAs) have made infrastructure and human resource investments in anticipation of the new incentive payment model. These expenditures have included hiring new staff, purchasing and deploying new IT platforms, and modifying operations, with the reasonable expectation of return on investment when the performance period commenced. We urge CMS to offer these models on a voluntary basis in light of the proactive participant investments made in preparation for this model. If the EPMs are cancelled as proposed, the Task Force encourages CMS to introduce additional voluntary bundled payment models as soon as possible.

II. Responses to the RFI questions

The Task Force offers the following feedback in response to the RFI areas of inquiry:

A. Guiding principles and areas of focus

While we understand the desire to include new priorities as part of CMMI's new direction, it will be important for CMS to clearly articulate a macro vision for how best to promote and activate a complete industry transformation toward value-based payment and care delivery. As part of that vision, CMS should discuss how current promising models can work collaboratively with the new areas that CMS may wish to test. Industry has invested significantly – both in terms of financial resources and human capital – in current transformation efforts, and desires to understand how those investments can be coupled with any new direction that CMS puts forward. While the types of models identified in the RFI (and addressed below) represent important new areas of exploration, they remain component parts of a broader landscape and strategy, and one that needs a clear explanation from federal policymakers.

Regarding the guiding principle of transparent model design and evaluation: we urge CMS to include stakeholders in the design process in a more substantive and consistent way. We strongly believe that CMS should include private sector experts, including providers currently participating in APMs, private plans, patients and purchasers in the development of

new payment model methodologies and quality metrics. We urge CMS to meaningfully engage stakeholders appropriately in future model development through regular public requests for information and listening opportunities. We encourage CMS to actively engage the Task Force and other groups with experience designing and implementing alternate payment models (APMs), and consider stakeholder recommendations as the Agency develops new models.

The HCTTF continues to advocate for full transparency in all matters related to APMs, including details about the specific methodology for setting target prices and benchmarks for each participant. We believe this openness will lead to shorter cycle times to refine program designs while also promoting greater understanding and trust in the technical aspects of any new payment program.

B. Structure, approach, and design of potential models, and potential challenges

i. Proactively address potential model overlap

While APMs including episode-based and population-based payment models present opportunities for improvement in quality and care, they are not always in alignment. The recent implementation of APMs has resulted in instances of overlap, where multiple providers may be responsible for the same patient under different models. While this does not create a problem by itself, it can create inefficiencies and challenges that are ultimately at odds with the end goal of delivering higher quality and more integrated care.

The recommendation to test new models and subsequent implementation should proactively address model overlap, including considering adopting the following principles that promote desirable model synchronization:

- Encourage market-based solutions that allow all health care organizations committed to value-based care to collaborate in innovative ways that make it easier and less costly for each organization to better serve patients, and create a greater likelihood of successfully achieving better health through high quality care at lower cost.

- In the short term, innovative models should be allowed to run their course to develop necessary experience for model evaluation purposes, which may require setting precedence rules (such as exclusions) in some cases. When necessary, the precedence rules should strike a balance that recognizes the relative importance of total cost of care models, while also creating a landscape that will better encourage parties to find market-based solutions. Broad exclusion of providers and patients from participation in both a clinical episode model and a population-based model should not be a long-term strategy

- Approaches to addressing model overlap should: (1) do no harm to value-based payment participants by seeking a mutually beneficial solution whenever possible; (2) seek to reduce administrative burden for providers, payers and patients; and, (3) include a fair and appropriate reflection of resource use in setting target prices and savings allocations to encourage competition

To encourage better coordination of clinical episode and population-health focused value-based payment programs, the needs of individual patients should be placed at the center of the discussion. The Task Force believes that providers, payers, purchasers, and policymakers should encourage solutions that allow the market to innovate and compete on delivering the best care for patients at the lowest cost whenever possible. Market-based solutions that reflect the collaborative support and commitment of all affected stakeholders hold greater promise for promoting a sustainable value-based care environment that provides consistent and reliable health care for both purchasers and consumers.

ii. Encourage multi-payer models

The Task Force supports multi-payer models that encourage Medicaid, CHIP and private insurance carriers to adopt payment models that would qualify for MIPS or Advanced APMs. CMS should recognize that states may need a longer performance period to establish a multi-payer delivery model that could qualify as an APM, and should adjust the performance period for future state innovation models accordingly.

iii. Incorporate social determinants of health

We strongly believe that new models of value-based payment and care delivery should consider the holistic social needs of the patient population, including social determinants of health and behavioral health needs. CMS should continue to empower local and regional stakeholders to set priorities for improving the health of this population. States are uniquely positioned to support providers that seek to integrate social services into their care management through better coordination of relevant public resources. New workforce programs, such as accredited Community Health Workers training programs, and new enhanced care management programs that target high need, high cost patients are promising approaches that should be scaled.

iv. Improve information sharing and transparency

CMS should supply sufficient technical information when proposing new payment models to allow stakeholders to realistically evaluate payment impact. Models such as MSSP, BPCI, and CJR incorporate benchmarking and reconciliation processes that are both complicated and complex. Process step descriptions that are not accompanied by examples using real data do not allow model participants to accurately forecast the economic consequences of such models to their institutions, clinicians and patients. Such opacity

discourages potential participants in voluntary payment models and imposes unfair expectations upon participants in mandatory models. Payment model methodologies (including all components of those methodologies) should be transparent to all health care providers, payers, purchasers, and patients involved in an episode- or population-based payment model.

C. Engaging beneficiaries in model design and implementation

The Task Force believes it is imperative that consumers/patients and caregivers are included at every step as value-based models are developed, implemented, and assessed. In the quest for person-centered, value-driven care, there are examples of success in both the private and public sectors, but challenges and gaps remain in fully engaging consumers in a meaningful and desirable way.

In a Task Force resource[4] released last year, we advanced six guiding principles for addressing consumer priorities in value-based care: 1. Include patients/consumers/caregivers as partners in decision-making at all levels of care; 2. Deliver person-centered care; 3. Design alternative payment models (APMs) that benefit consumers; 4. Drive continuous quality improvement; 5. Accelerate use of person-centered health information technology; and 6. Promote health equity for all.

The Task Force believes that CMS can play a key role in advancing the principles; below, we offer concrete recommendations for CMS to address the consumer priority principles as a part of its current and future efforts.

i. Design alternative payment models that benefit consumers

While incentives for lowering costs are a critical piece of APM design, the Task Force believes that delivery of high-quality care appropriate to the patient/consumer's needs, goals, and preferences is paramount. APMs should be designed such that meaningful partnerships with patients/consumers and caregivers is incentivized to take place at all levels of care delivery. We urge CMS to make a firm commitment to comprehensive and well-coordinated care that treats the whole person and is consistent with each patient's unique needs and preferences. We are concerned about language in the RFI that defines patient centeredness in a way that simply means shifting costs or burden to patients. Person-centered care necessitates that APMs include both strong consumer protections and guard against financial incentives that may reduce access to necessary health care services.

We encourage CMS to revisit the regulations regarding APM participant communication with beneficiaries regarding participation in a Medicare ACO, and endeavor to streamline the process for providers to receive approval for marketing and communication materials. Our members often report that existing rules hinder meaningful communication with consumers regarding their ACO participation, thereby limiting consumer engagement. However, at the

[4] http://hcttf.org/resources-tools-archive/2016/8/30/addressing-consumer-priorities-in-value-based-care

same time, CMS should retain the ability to prevent coercive communication strategies that steer patients toward a specific provider or model.

There are various opportunities for CMS to take action on this principle by better engaging beneficiaries and consumers in model design. For example, CMS could appoint a Technical Expert Panel (TEPs) consisting of patient and consumer advocates, as well as other stakeholders, when developing any new payment models. Additionally, we urge CMS to finalize the APM Ombudsman position as a complement to the Medicare Beneficiary Ombudsman. An APM Ombudsman would allow a clear avenue for beneficiaries to provide timely feedback on new models, and provide real-time feedback to CMS from beneficiaries that the agency can use to inform updates to existing models and the development of new ones.

ii. Drive continuous quality improvement

In order to have a health care system that is both person-centered and value-driven, we strongly believe that continuous quality improvement should be at the heart of all delivery policies and practices. It is critical for new models to be transparent, and to hold providers accountable to a high-quality performance threshold. Furthermore, quality performance and price data need to be accessible to consumers, transparent, and ideally informed by their input.

It is essential that quality measures are frequently reviewed, that "topped out" measures are retired, and that, when necessary, measures are simplified and new measures are implemented to ensure continued improvement. To that end, we urge CMS to utilize patient-reported outcomes measures to both track and drive performance improvement. We commend CMS for introducing PRO measures as part of the CJR model, and we recommend incorporation of PROs into the measure sets for additional alternate payment models and MIPS quality measure sets.

iii. Accelerate the use of person-centered health information technology

It is important that the patient/consumer is at the center of accessing, managing, and sharing their electronic health information wherever they receive care. Person-centered health information technology ensures that patients/consumers are empowered to use this technology to support effective health and wellness decision-making, with appropriate privacy and safeguards in place. Patient-centered health information technology should not only allow for enhanced provider-to-provider communication, but also information sharing between provider-to-patient, consumer-to-consumer, and consumer-to-community. We support CMS's continued push through the Quality Payment Program to incentivize providers' use of certified health IT.

D. Payment waivers and flexibilities to support providers innovate care delivery

With the implementation of APMs, CMS has recognized the need to waive certain fee-for-service requirements for APM participants. Through existing waivers, APM participants have been able to better meet the needs of individual patients in a variety of innovative ways, including by implementing patient incentive waivers to support adherence to clinical goals and utilization of preventive care items or services; introducing "care at home" models to deliver outpatient and inpatient level and quality care to patients in their home at a lower cost; expanding the availability of telehealth services; and introducing financial accountability across the continuum of providers.

While helpful, the HCTTF believes CMS should enhance its approach to regulatory relief for APMs by streamlining the waiver process. We urge CMS to address the following issues to improve upon the current approach:

- Inconsistent waiver availability across APMs and inconsistent flexibility across traditional Medicare APMs and Medicare Advantage APMs creates unnecessary burden on providers to implement.
- Limited opportunities for model participants to manage model overlap fails to encourage synchronization across APMs.
- Restricting telehealth waiver availability unnecessarily limits access to provider services for two-sided risk-bearing entities that are held accountable for quality of care of their attributed patient population.
- Additional pricing flexibility within payment models that could allow for providers to accept a price that may be less than the Medicare reimbursement price to ensure that care decisions for patients are made based on clinical need and not on the lower cost alternative, especially with regard to post-acute services.

III. Comments regarding the potential models

The Task Force offers the following feedback in response to the potential models proposed in the RFI:

A. Increasing participation in Advanced Alternative Payment Models (A-APMs)

CMS should focus its policy priorities on ensuring that participation in the Quality Payment Program's Advanced APM track is more desirable for eligible clinicians than MIPS in order to drive greater adoption of A-APMs. To support this, CMS should ensure consumers, patients, and caregivers are involved in the development of the underlying models that are categorized as Advanced APMs. We continue to urge CMS to consider how to increase transparency and public input into the development and qualification of A-APMs.

Consumers and patients must be co-creators in our health care system and integral partners in developing all new models of care and payment. We believe it is critically important that all stakeholders – including patients and consumer advocates – have the opportunity to weigh in during development and implementation of new payment models through advisory committees or Technical Expert Panels, which would serve to balance the input received from industry via the Physician-Focused Payment Model Technical Advisory Committee (PTAC). This is critical to ensuring that Advanced APMs are meeting the needs and priorities of all stakeholders, especially patients and their families.

B. Consumer-directed care & market-based innovation models

Above, we commented about how expanded options such as telehealth and care in the home can provide meaningful beneficiary access to provider services while improving quality and affordability. As CMS considers consumer-directed care models in the following areas, we reiterate our encouragement that CMS allow adequate time for implementation, analysis, and evaluation, and engage stakeholders closely in any model design process. However, we would strongly caution against any model – in any form – that increases overall beneficiary out-of-pocket liability. Research to date has shown that such plans can lead to utilization reductions in necessary care, and worsened outcomes for low-income populations and those with chronic disease.[5]

i. Price and quality transparency

The Task Force supports transparency and believes that CMS should work to help consumers understand price and quality information. More and more stakeholders are providing cost and quality information to consumers to enable informed care decision making. Gross level charges, however, are not useful to patients in that it does not consider contractual allowances, plan coinsurance structures, charity care policies, mission driven expenses such as teaching programs, etc. Moreover, it is difficult to identify the actual costs associated with care because the components such as staffing, overhead, and materials costs are accounted for inconsistently across the health care system. CMS should consider ways to progress in being able to better identify costs, which would assist in estimating expected payment by the uninsured, under-insured and those patients with health savings accounts.

i. Incentivizing use of high-value providers while maintaining beneficiary choice

Meaningfully engaging beneficiaries as partners in care and delivering patient-centered care that meets the needs of patients and families is the best way to encourage beneficiaries to consistently seek care from providers in APMs. To this end, the Task Force encourages that CMS develop policies that would lower the out-of-pocket cost burden and encourage beneficiaries to seek care from APM-aligned providers. For example, CMS could test waivers of current

[5] http://www.healthaffairs.org/do/10.1377/hpb20160204.950878/full/

Medicare Advantage regulations, including those related to network adequacy and geographic boundaries of service areas, to allow MA plans to offer "wrap around" products with pricing and cost-sharing to encourage beneficiaries to use APM participating providers.

ii. Direct to primary care

The concept of "direct to primary care" is novel, and the Task Force is unable to provide reaction without a clearer explanation from CMS about what this model could entail. Should CMS pursue such a model, we encourage proactive engagement with the stakeholder community – through Request for Information, Technical Expert Panel, or rule-making – to help define both the model methodology as well as the parameters to assure proper beneficiary protections.

C. Physician specialty models

At this time, only three specialty-focused models have qualified as Advanced Alternate Payment Models: the Oncology Care Model, Comprehensive Care for Joint Replacement, and the Comprehensive ESRD Care model. Not every specialty requires their own model; rather, existing or future models should be designed to encourage participation from providers of all specialties to advance better coordinated care.

D. Prescription drug models

We encourage CMS to address prescription drug costs as part of existing or future alternate payment models rather than as a standalone model. Incorporating accountability for Part B and/or Part D drugs into a total cost of care or episodic model provides an additional lever for providers to improve overall care and manage costs for their population of patients.

E. Medicare Advantage (MA) innovation models

We support additional testing to improve quality and reduce overall cost for Medicare Advantage beneficiaries, and appreciate that CMS indicated its intent to test participation in MA Advanced APMs in the finalized updates to the CY2018 Quality Payment Program to count on an equal basis as participation in Medicare Advanced APMs. This will help ensure that MA enrollees do not face access issues as clinicians worry about meeting the A-APM participation and payment thresholds. In order to avoid unintentionally incentivizing clinicians to focus cost and quality efforts on exclusively Part B or MA beneficiaries, CMS should consider setting thresholds relative to the mix of Part B and MA A-APM participation that is proportional to a clinician's market. The Task Force would welcome further conversations with CMS as it develops a framework for this demonstration.

Furthermore, there are many organizations (including Task Force members) that have developed successful risk-based programs that specifically target high-need MA beneficiaries.

The Task Force would welcome further conversations with CMS as it develops a framework for new MA APM demonstrations. Unlike in Medicare FFS, plans have a contracted network of clinicians and health systems and wide discretion to negotiate risk-based contracts. CMMI waivers are not necessary to address some of the concerns about the FFS APMs raised by this letter. Rather, CMS models should provide plans with flexibilities in the services they can cover to better provide comprehensive, high-quality care and increase consumer engagement. For example, MA plans have long requested the flexibility to use rebate dollars to provide all services that benefit an enrollee's health – including meals, transportation, and home modifications. These types APMs would allow MA plans to help their network clinicians succeed in risk-based arrangements by addressing patients' social determinants of health.

CMS should also consider which FFS APMs could be expanded and tested within the MA program and what modifications might be appropriate. Some models that we think CMS should consider include the Medicare Care Choices model and the Care Management for High-Cost Beneficiaries Demonstration. These models target crucial aspects of care, end of life and care management for high-cost, high-need beneficiaries, and we think it is important CMS makes testing models of care for the sickest and mostly costly FFS beneficiaries a priority as the agency seeks out new ways to innovate in the Medicare program. In particular, we recommend CMS test these sort of innovative program and service delivery models in MA, giving health plans the opportunity to demonstrate that enhanced care, with better outcomes, can be provided at a lower cost. Despite being designed as a comprehensive, integrated coverage model that has provided extensive care management experience, we note that MA has not been afforded as many opportunities as FFS Medicare to test out new models of care.

The Value-based insurance design (VBID) also holds promise for improving overall health care quality. The VBID Model launched by CMMI is one such approach to better engage consumers in evidence-based care planning and to allow plans to address barriers to care for individual beneficiaries, particularly those with chronic disease. CMS should consider other VBID models, such as expanding the VBID model to additional states and to employer group MA plans, as well as to additional diagnoses that could benefit from such a model. Employers and union benefits managers are also interested in engaging retirees in their own care planning and have requested these type of innovative plan offerings.

The Task Force would welcome a conversation about how these models could be modified and tested in the MA program and believe testing these models in MA could provide additional insights given plans' experience coordinating and managing the full care needs of their enrollees.

F. State-based and local innovation, and Medicaid-focused models

The HCTTF supports state-based efforts to support better integrated, value-based care for the Medicaid population, and we encourage CMS to consider more expansive support for financially integrated models for dually-eligible Medicare-Medicaid beneficiaries, and expand

APM options for Medicaid safety net providers including community health centers and rural health clinics. We also support CMMI's current State Innovation Model initiative. Indeed, the primary goal of the SIM program – to move 80% of payments to providers from all payers to value-based payment models – aligns closely with the primary objective of the Task Force to move 75 percent of members' business into value-based care arrangements by 2020. We believe the State Innovation Model can continue to serve as a key driver for supporting providers' transition to APMs within the new context provided by MACRA. For this reason, strongly recommend that CMS commit to funding additional State Innovation Model awards.

States are uniquely positioned to advanced value-based payment adoption through state insurance regulation authority for commercial plans – including network adequacy and Qualified Health Plans oversight – and public sector insurance products (*i.e.*, Medicaid, CHIP, and state employee health plans). It will not be possible for the Task Force members to meet our goal of 75 percent in value-based payment arrangements by 2020 without commitment from state administered and regulated programs. States should be encouraged to utilize the full breadth of available policy levers to drive adoption of value-based payment within the public and commercial payer market. CMS should consider establishing more formal partnerships between SIM participants and national organizations such as the Task Force that can convene multi-payer stakeholders to drive national payer adoption of value-based payment models

The Task Force supports the design and implementation of models that encourage greater provider accountability for cost and quality outcomes, and would support additional "all-payer" models such as those being implemented by Maryland and Vermont. However, CMS should also allow flexibility to test more mature value-based payment arrangements (such as hospital global budgets) at a regional level or population-specific level, rather than just statewide. Market readiness for such an arrangement differs by region and statewide market readiness should not act to limit willing participants from entering all-payer arrangements. CMS should also exhibit caution as it implements downside-risk for Medicaid providers, to ensure that providers treating vulnerable populations are adequately prepared and supported in taking on risk.

G. Mental and behavioral health models

A rich body of research and evaluation already exists for effective integration of behavioral health into medical care, along with examples of successful integration. While the HCTTF acknowledges that this is a great first step, we also note that there has been relatively little uptake and scaling of this research. While new G-codes and CPT codes were recently introduced to improve coding and payment for behavioral health integration efforts, these codes have been limited in their applicability and uptake. The HCTTF encourages CMS to develop scalable, replicable models built on this existing body of behavioral health integration research, and to develop broader, more flexible payment structures to support these integrated approaches. Furthermore, the HCTTF encourages CMS to work with states to streamline federal and state regulations for behavioral health services.

Behavioral health needs vary significantly from patient to patient and market to market. Treatments that may be suitable for one subpopulation may not be appropriate for another; hence the challenge with a one-size-fits-all behavioral health model. The HCTTF highly encourages CMS to engage in exploration and analysis of specific patient subpopulations and market dynamics. For example, in certain geographic areas, skilled nursing facilities have closed many of their wandering dementia units due to underuse, making it difficult to locate appropriate providers and engage members in these settings. We also support the development of multiple models and/or widening the applicability of existing integration models to address a broader range of behavioral health issues.

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The HCTTF appreciates the opportunity to share this statement with CMS and stands ready to work together in the transformation to value-based payment and care delivery. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org or 202.774.1415) or HCTTF Director of Payment Reform Models Clare Wrobel (clare.wrobel@hcttf.org or 202.774.1565) with questions or information needs related to this statement.

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