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## **Task Force to CMS: Innovation is Critical, But Don't Discard Existing Models That Work**

WASHINGTON (Nov 20, 2017) –The [Health Care Transformation Task Force](#) (HCTTF) today called on the Center for Medicare and Medicaid Services (CMS) to continue refining existing alternative payment models that are showing genuine, long term promise as it reorients the Center for Medicare & Medicaid Innovation's (CMMI) agenda to explore new alternatives to the prevailing fee-for-service payment system.

The Task Force comments came in a letter responding to CMS' Request for Information (RFI) about new directions for CMMI, the agency's test lab for value-based payment models. HCTTF is the nation's leading industry consortium that brings together patients, payers, providers and purchasers in a shared commitment to accelerate the transformation of the health care system from fee-for-service to value-based care.

In the letter, HCTTF welcomed new ideas for innovation, noting that there are attractive private sector models that warrant consideration for testing in Medicare and Medicaid. Still, it urged the agency not to abandon promising current models, saying it should focus on making improvements to these models as part of its refined agenda.

"The results are clear: providers improve over time and these programs should be continued – not discarded – so that even better results can be achieved for patients," said Jeff Micklos, the Executive Director of the HCTTF. "Transformation of this magnitude takes time, and the results from the current models are paying off. The most determinative factor of success in value-based arrangements is the length of time in which a provider participates – more time allows for greater improvements in care delivery."

The CMS recently released the 2016 results of four Medicare Accountable Care Organization (ACO) programs, which reduced gross Medicare spending by \$836 million that year, returning \$70.6 million in net savings to the Medicare Trust Fund. In a recent report, the HHS Office of the Inspector General found that ACOs participating in the program longer were more likely to reduce spending, and by greater amounts.

Beyond this evidence of steady performance improvement, HCTTF also urged the CMS to recognize the major investments stakeholders have made in models such as the accountable care and bundled payment programs as it weighs its program mix going forward.

The Task Force also asked the CMS to refine models to make a better business case for delivery system innovation, noting that providers who have already implemented measures to control cost and improve quality should receive credit when setting future benchmarks.

“We continue to measure savings based on historical costs in a fee-for-service world,” said Micklos. “If we want to deliver the promise of value –better, more affordable care—then we must adopt measures that evaluate and pay for care based on value, and move completely away from the fee-for-service chassis. Our current approach is essentially evaluating oranges to apples.”

Additionally, the HCTTF presented the CMS with a framework to encourage the pursuit of models that can qualify as advanced alternate payment models (Advanced APMs) under Medicare’s Quality Payment Program (QPP). By better incentivizing providers to move beyond the QPP’s Merit-Based Incentive Program, a bolder move toward value-based payment can be realized.

The key principles that should govern the CMS design of any new models, which are also outlined in an accompanying Health Affairs [blog](#), include:

1. **Create a better business case for delivery system innovation.** *Current benchmarking methodologies are set based on historic fee-for-service costs, which punishes efficient providers for progress made prior to joining an APM.*
2. **Expand flexibilities for providers to control cost and quality.** *At the very least, CMS should relieve regulatory burden by streamlining the waiver process across all models.*
3. **Improve price, quality, and model transparency.** *Greater transparency will help providers understand where they can improve and enable informed decision-making by consumers.*
4. **Support private sector innovations.** *Alignment among public and private payers is critical in the transition to value.*
5. **Define meaningful metrics for evaluating all models.** *Common accountability targets, measures, and incentives across payers are necessary for expedited transformation, and will allow for meaningful comparability and true best practice identification. For this to occur, the CMS should develop standard evaluation metrics that will allow cross-model comparison.*

“It’s a positive sign that Administrator Seema Verma is promoting an inclusive stakeholder process. We urge CMS to continue recognizing the promise of these payments models, so that the goal of delivering better, more affordable care to patients is fully realized,” said Micklos.

### **About the Health Care Transformation Task Force**

The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. Our members are committed to rapid, measurable change, both for ourselves and our country. Our members aspire to having 75 percent of our respective businesses operating under value-based payment arrangements by 2020. To learn more, visit [www.hcttf.org](http://www.hcttf.org).