October 16, 2017

VIA ELECTRONIC MAIL

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model (CMS-5524-P)

The Health Care Transformation Task Force (HCTTF or Task Force)[1], which is comprised of 42 organizations including patients, payers, providers, and purchasers, respectfully submits our consensus comments on the proposed rule titled Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model (CMS-5524-P) ("Proposed Rule"). The rule proposes to cancel the Episode Payment Models (EPMs) and Cardiac Rehabilitation (CR) incentive payment model, and revise the Comprehensive Care for Joint Replacement (CJR) model.

In this letter, we respond to the proposed cancellations as well as the modifications to the CJR model and other provisions open for comment. Generally, our recommendations are aimed at promoting the continued transition to value-based payment and care delivery. The Task Force believes that the Centers for Medicare & Medicaid Services (CMS) has a great opportunity to assert leadership by clearly expressing support for value-based payment and encouraging industry to sustain momentum in its transition. We urge CMS to partner with the commercial sector by continuing to actively pursue value-based payment in Medicare and to support state value-based payment activities in a shared vow to achieve better quality and affordability. Additionally, we encourage CMS to publicly release federal evaluation results in a timely manner for all bundled payment programs in order to provide greater transparency about the impact of episode payments with interested stakeholders.

I. Cancellation of Episode Payment Models

We previously submitted comments supporting many of the design features in the EPM models, which aim to reduce Medicare spending and improve patient care. We believe clinical

[1] The Health Care Transformation Task Force (the Task Force) formed to accelerate the pace of delivery system transformation. We share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care and reduced costs. Our organizations aspire to put 75 percent of their business into value-based arrangements that focus on the triple aim by 2020.

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. Our prior comments regarding the original proposed rule (CMS-5519-P) and interim final rule (CMS-5519-IFC) reflected a desire to refine this important initiative to help promote programmatic success in an efficient and effective manner.

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. If the EPMs are cancelled as proposed, the Task Force encourages CMS to introduce additional voluntary bundled payment models as soon as possible.

II. Cancellation of the Cardiac Rehabilitation Incentive Payment Model

The Task Force strongly encourages CMS not to finalize the proposed cancellation of the Cardiac Rehabilitation (CR) Incentive Payment Model. Given the overwhelming endorsement from the healthcare industry as well as strong clinical evidence supporting the care model, we believe the merits of this model are well documented. The strong likelihood of improved patient outcomes for beneficiaries following an AMI or CABG episode of care should be a determining factor in deciding the path forward on this particular model.

Also, 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 reconsider this policy choice in light of the proactive participant investments made in preparation for this model.

III. Future Voluntary Bundled Payment Models

The proposed rule indicates that CMS expects to "develop new voluntary bundled payment model(s) during CY 2018 that would be designed to meet the criteria to be an Advanced APM," building on the Bundled Payment for Care Improvement (BPCI) initiative. The rule also mentions that should CMS decide to test additional voluntary bundled models – including the cancelled EPMs – it would be done by soliciting applications and securing participant agreements rather than rulemaking. We urge CMS to finalize and release the new model before the proposed voluntary election period for CJR (January 1 – January 31, 2018) to give these providers as well as participants in the BPCI program adequate time to prepare and

determine whether current arrangements can be transitioned into future programs. We are also concerned that introducing a new model in CY 2018 may create a gap in available Medicare bundled payment programs after the current BPCI initiative contracts end in September 2018, thus creating a financial strain on current bundled model participants to maintain their infrastructure investments in the interim.

The HCTTF has already provided CMS with comprehensive recommendations for the design and operation of an Advanced BPCI model, based on experience with the existing BPCI and CJR models[2]. As conveyed in our prior recommendations, we asked CMS to address model overlap between bundled payment and accountable care organization (ACO) models to better synchronize across the various alternate payment model programs. In addition to the comments therein, the Task Force encourages CMS to consider the better integration of non-physician practitioners in the design and implementation of bundled payment models, as well incentives to encourage upstream prevention and appropriate care.

IV. Proposed Modifications to CJR

It is difficult to fully assess the impact of proposed modifications to CJR without additional detail about the CY 2018 voluntary bundled payment model, as referenced in the Proposed Rule. The "Advanced BPCI" model would have several implications for both voluntary and mandatory CJR participants, as discussed further below.

a. Voluntary participation

We applaud CMS for affording providers in 34 of the 67 selected geographic regions the option to voluntarily elect to participate in the CJR model, which is critically important for those current participants that have made significant infrastructure investments and operational modifications to better care for lower extremity joint replacement patients. However, the one-time "opt-in" window illustrates the problem of many Medicare APMs having a single point of entry, rather than a recurring opportunity for providers to elect participation in subsequent performance periods based on their own readiness assessment. Additionally, the optional CJR participants would benefit from an understanding of the design parameters of the new voluntary bundled payment program before making a binding CJR participation decision. Therefore, the Task Force recommends providing participants with additional opportunities for voluntary opt-in participation.

Moreover, we encourage refinements to the methodology that would better support providers' participation in the model and incentivize participation. For example, as it relates to low-volume participants, the Task Force recommend that CMS offer a stop-loss threshold for participants defined as "low volume" in order to protect those typically smaller providers from the consequences of random variation of outcomes. We also recommend that the definition of

[2] http://hcttf.org/resources-tools-archive/2017/3/9/task-force-provides-recommendations-to-cmmi-on-new-aco-track-1-and-advanced-bpci-models

"low-volume" be defined by cases per year (i.e., annually), rather than as an aggregate of cases across historic years.

b. Gainsharing

We appreciate the opportunity to provide comment on the current gainsharing policy for the CJR model. The BPCI program has demonstrated the importance of gainsharing arrangements in the design of successful bundled payment programs. Regardless of the specified cap on gainsharing, current model participants have lacked clarity on applicability of the policy, which has limited the full utility and influence of gainsharing payments to drive performance improvement. CMS and the Office of the Inspector General should quickly coordinate on unified guidance related to the program's fraud and abuse waivers, as well as provide a mechanism for providers to ask questions about the waivers short of a full Advisory Opinion.

The Task Force supports the gainsharing policy as finalized in the "Advancing Care Coordination" final rule (CMS-5519-F), which expanded the list of providers and suppliers eligible for gainsharing as collaborators, and specifically allowed for Accountable Care Organizations (ACOs) to enter into financial arrangements with episode initiators. We strongly encourage CMS to maintain this policy to better encourage synchronization between bundled payment and ACO models, including further revisions to the cap on collaborator gainsharing and alignment payments.

c. Changes to eligible Affiliated Practitioners

The Task Force supports CMS's proposal to broaden the scope of the Affiliated Practitioner List, and we support the inclusion of additional qualified providers into the CJR model. There are a significant number of health care providers who support CJR participant hospitals but who are not included on the initial Affiliated Practitioner List, despite the critical importance of the care these providers deliver to patients included within the CJR model. The practical effect of this proposal would be to increase the number of providers that are considered Qualifying APM Participants.

Thank you for considering our recommendations. Please contact HCTTF's Executive Director Jeff Micklos (jeff.micklos@hcttf.org or 202.774.1415) or Clare Wrobel (clare.wrobel@hcttf.org) with any questions about or to follow up to this letter.

Francis Soistman
Executive Vice President and President of Government Services
Aetna

Stuart Levine
Chief Medical and Innovation Officer
agilon health

Farzad Mostashari
Founder & CEO
Aledade, Inc.

Shawn Martin
Senior Vice President, Advocacy, Practice Advancement and Policy
American Academy of Family Physicians

Hoangmai Pham, MD, MPH
Vice President, Provider Alignment Solutions
Anthem, Inc.

Peter Leibold
Chief Advocacy Officer
Ascension

Warren Hosseinion, MD
Chief Executive Officer
ApolloMed

David Terry
Founder & CEO
Archway Health

Marci Sindell
Chief Strategy Officer and Senior Vice President of External Affairs
Atrius Health

Dana Gelb Safran, Sc.D.
Chief Performance Measurement & Improvement Officer and
Senior Vice President, Enterprise Analytics
Performance Measurement & Improvement
Blue Cross Blue Shield of Massachusetts

Kevin Klobucar
Executive Vice President, Health Care Value
Blue Cross Blue Shield of Michigan

Gary Jacobs
Vice President, Strategic Partnerships
CareCentrix

Carlton Purvis
Director, Care Transformation
Centra Health

Gaurov Dayal, M.D.
Executive Vice President, Chief of Strategy & Growth
ChenMed

Kevin Sears
Executive Director, Market & Network Services
Cleveland Clinic

Susan Sherry
Deputy Director
Community Catalyst

Colin LeClair
Chief Development Officer
ConcertoHealth

Sowmya Viswanathan
Chief Physician Executive Officer
Dartmouth - Hitchcock

Elliot Fisher
Director for Health Policy & Clinical Practice
Dartmouth Institute for Health Policy and Clinical Practice

Shelly Schlenker
Vice President, Public Policy, Advocacy & Government Affairs
Dignity Health

Mark McClellan
Director
Duke Margolis Center for Health Policy

Chris Dawe
Vice President
Evolent Health

Frank Maddux
Executive Vice President for Clinical & Scientific Affairs: Chief Medical Officer
Fresenius Medical Care North America

Angelo Sinopoli, MD
Vice President, Clinical Integration & Chief Medical Officer
Greenville Health System

David Klementz
Chief Strategy and Development Officer
HealthSouth Corporation

Richard Merkin, MD
President and Chief Executive Officer
Heritage Development Organization

Anne Nolon
President and Chief Executive Officer
HRH Care Community Health

Leonardo Cuello
Director
National Health Law Program

Debra Ness
President
National Partnership for Women & Families

Martin Hickey, MD
Chief Executive Officer
New Mexico Health Connections

Kevin Schoeplein
President and Chief Executive Officer
OSF HealthCare System

David Lansky
President and Chief Executive Officer
Pacific Business Group on Health

Timothy Ferris
Senior Vice President, Population Health Management
Partners HealthCare

Jay Desai
Founder and CEO
PatientPing

Danielle Lloyd
Vice President, Policy & Advocacy
Premier

Joel Gilbertson
Senior Vice President
Providence St. Joseph

Christopher Garcia
Chief Executive Officer
Remedy Partners

Kerry Kohnen
Senior Vice President, Population Health & Payer Contracting
SCL Health

Richard J. Gilfillan, MD
Chief Executive Officer
Trinity Health

Judy Rich
President and Chief Executive Officer
Tucson Medical Center Healthcare

Mary Beth Kuderik
Chief Strategy & Financial Officer
UAW Retiree Medical Benefits Trust

J.D Fischer
Program Specialist
Washington State Heath Care Authority