



June 8, 2017

The Honorable Thomas E. Price, M.D.
Secretary
Department of Health & Human Services
220 Independence Ave, NW
Washington, DC 20201

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave, NW
Washington, DC 20201

Dear Secretary Price and Administrator Verma:

As a broad-based group of health care stakeholders, the Health Care Transformation Task Force (HCTTF) strongly supports the transition to value-based payment and care delivery. 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 recommends specific steps that we urge you to take to support this important effort.

The Department of Health & Human Services (HHS), including 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. Our members are forging ahead with committed efforts in the commercial sector, and we urge HHS to recognize and applaud these efforts to reduce cost and improve quality. HHS can 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.

The HCTTF stands ready to serve as a resource for HHS and looks forward to working with you on these important issues. 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.

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. Our members include representation from five of the of the nation's top 15 health systems and four of the top 25 health insurers, as well as leading national organizations representing employers, and patients and their families. In total, we represent 41 different organizations that are deeply invested in advancing value-based payment models.

Our payer and provider members are committed to transitioning 75 percent of their business to value-based payment by 2020. As of last year, our members reached 41 percent in

their pursuit of this goal through a range of innovative payment models across multiple programs and populations, including commercial, Medicare Advantage, Medicaid, and traditional Medicare.

To promote the continued transition to value-based payment and care delivery, the HCTTF offers the following recommendations:

(1) Align Private and Public Sector Views on the Definition of Value

Public and private sector collaboration on delivery system reform can be most successful if it aligns 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. **The LAN recently released a draft Alternate Payment Model Framework Refresh paper with a public comment period, and the HCTTF looks forward to providing input to promote continued public-private sector alignment on the “value” definition.**

We commend both of you for statements in support of the need for a system that empowers patients. The HCTTF is a strong advocate for person-centered care. Patients perceive value as care delivery that is accessible, coordinated among their medical professionals, easy to navigate, and sufficient to prevent costly and potentially avoidable medical interventions. When medical services are necessary or desirable, patients seek transparency of information to effectively choose a high-quality provider and understand their out-of-pocket costs. Value-based systems must promote this level of transparency and delivery excellence to be truly person-centered. Last September, the HCTTF released a resource titled ***Addressing Consumer Priorities in Value-Based Care: Guiding Principles and Key Questions***,¹ which advances a framework for promoting person-centered care in health care organizations. **In an example of the effectiveness of public-private partnerships, the LAN’s Consumer Priority Advisory Group endorsed and adopted the HCTTF’s consumer priority principles at its October 2016 meeting.**

Finally, the concept of value goes beyond providing person-centered care that is higher quality care at lower cost. **Value-based care positively impacts the economy by promoting investment in infrastructure to support financially and clinically integrated networks, and by stimulating the growth of entrepreneurial companies that facilitate industry’s movement to value.** New start-ups are using technology to improve patient follow-up, proactively identify and enroll patients in care management programs, and help patients and providers securely access medical records that would otherwise be trapped in data silos.

According to one health incubator, venture capital funding in data analytics and population health management companies reached \$539 million in 2016, with total private investment in digital health topping \$4 billion.² A recent Venrock survey of health care leaders revealed that 60 percent believe there will be an increase in the creation of new healthcare IT

¹ www.hcttf.org/resources-tools-archive/2016/8/30/addressing-consumer-priorities-in-value-based-care

² Rock Health. 2016 Year End Funding Report.

companies over the next two years.³ **The HCTTF is conducting further analysis into the economic impact of value initiatives in health care, and will be releasing this information publicly in the coming weeks.**

(2) Support the Ongoing Need for a Rapid-Cycle Testing Laboratory for Value-Based Payment Models

In recent years, CMS has modernized the way it tests new care delivery models. Adopting principles from successful private sector approaches to innovation, CMS now employs a rapid cycle testing laboratory (through CMMI) that adeptly refines innovative payment models based upon evaluations and stakeholder input. This approach promotes continual improvement that creates momentum for real, sustainable change.

The benefits of this new approach to innovation are reflected in improvements to the Medicare Shared Savings Program Accountable Care Organizations (ACOs) and the transition from the Pioneer ACO program to the Next Generation and Track 3 ACO programs. The waivers and design parameters offered as the models evolved reflect the willingness to improve models to address stakeholder needs in pursuit of value-based payment. While many models are in need of further refinement, the evaluation and improvement processes are generally working well.

The HCTTF urges the Department to support CMMI while endeavoring to improve upon the operations and output of this important testing laboratory. The Task Force has convened a “CMMI 2.0 Work Group” to capture feedback about stakeholder experience with CMMI. **Our initial set of recommendations for HHS advanced by this Work Group are attached as an addendum to this letter.**

(3) Maintain the Momentum by Publicly Supporting the Continued Transition to Value-Based Payment and Care Delivery

As leaders of HHS and CMS, you both have an important public platform that can play a vitally important role in driving positive change. **To seize this opportunity, the HCTTF urges HHS and CMS to make public statements in strong support of value-based payment and care delivery.** Supportive statements for the continued pace of transformation would be very timely, as health care organizations are currently budgeting for next year and are facing uncertainties in their markets about what level of commitment to maintain on value-based payment initiatives. These organizations will look for signals from the Administration indicating your enthusiasm for and prioritization of value-based care. Sending positive signals about an agenda that supports the private sector’s efforts to modernize the health care system will help stakeholders determine their own next steps to support that agenda and direction.

The HCTTF is keenly aware of the need to bend the health care cost trajectory. In pursuing the value agenda, our members want to encourage payment models that address underlying cost drivers and support person-centered, outcomes-driven care delivery. As commercial health sector innovation continues, systemic and sustainable change requires private and public sector to align on purpose and cadence of transformation.

³ Venrock. 2017 Healthcare Prognosis.

Secretary Price's comments at the April PTAC meeting in support of innovative, affordable health care are welcome and a positive first step. We urge you to build upon these positive statements with continued public support for value-based payment models that are critical to innovation and modernization. Together, we can work to address the underlying cost drivers and encourage the necessary public-private alignment to realize sustainable industry-wide change.

Accordingly, our leadership is greatly interested in meeting with you to discuss how the HCTTF can best help HHS pursue its mission in this area. Additionally, we invite you to address our full membership at an upcoming HCTTF meeting as an opportunity to meet with and address the leaders of transformation from across the spectrum of health care stakeholders. The Task Force next meets on July 17th in Washington, DC. Our Executive Director, Jeff Micklos, will reach out to your offices to see if your participation in that meeting would be possible. Jeff can be reached at jeff.micklos@hcttf.org or 202.774.1415 for any other follow up to this letter.

We wish you success in your new positions and look forward to working with you to pursue a value-based payment and care delivery system that empowers patients, inspires and rewards innovation, reduces burden on physicians and other health care professionals, and is sustainable for years to come.

Sincerely,

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ADDENDUM



HCTTF POSITION PAPER: CENTER FOR MEDICARE & MEDICAID INNOVATION 2.0

The move to value-based payment and care delivery has long received bipartisan support, and the desire to test innovative payment and clinical models for Medicare and Medicaid patients has been a hallmark of the Department of Health & Human Services for decades. For innovation to be most effective, opportunities must exist for rapid-cycle action to improve and continually refine innovative projects. As explained below, 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.

Conversely, the more recent Center for Medicare and Medicaid Innovation (CMMI) adopted a private sector approach to innovation that allows for a more nimble process to identify and act quickly upon opportunities for improvement and refinement. **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 reduces cost.** We also recognize areas where CMMI can improve upon current efforts that will lead to more attractive new payment models for providers, and more efficient operations.

1. Support an effective laboratory for testing

As the country's largest purchaser of health care, CMS has a long history of operating demonstration projects that pilot new approaches to reduce Medicaid and Medicare spending and improve quality outcomes. The precursor to CMMI – the Office of Research, Development, and Information (ORDI) – facilitated limited-scale Medicare demonstration projects with a traditional academic research approach. Results were published after the demonstration closed without a strong mechanism for translating those findings into improvements to the Medicare program, and with little room to refine a model mid-course. The Center for Medicaid and CHIP Services (and its predecessor offices) has similarly overseen Medicaid demonstrations, providing for state customization and testing of Medicaid policies under waiver authority.

CMMI's structure and authority is a significant improvement over the ORDI model in several ways. The "innovation center" concept mirrors similar structures that have been adopted by large companies, and was specifically modeled from business strategies executed at GE by innovation expert Vinjay Govindarajan. As outlined in his book, *the Other Side of Innovation: Solving the Execution Challenge*, organizational innovation is most effective when a dedicated team with a different culture and different set of resources is dedicated to innovation, while the remainder of the organization can be dedicated to operating as efficiently as possible. In other words, the performance engine should be

distinct from center of disruption. CMMI's structure endeavors to follow this private sector best practice.

CMMI was also established to perform rapid cycle evaluation and refinement of innovation at a quicker pace than ORDI's traditional academic research timeline. 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 than the previous model.

II. Align the public and private sector

The Task Force's members have set a goal of achieving 75% of their respective businesses in value-based arrangements by 2020 because it becomes easier to invest in and sustain transformation as individual payer arrangements become more aligned. Medicare and Medicaid are key players in continuing to transform the business of health care into a value-driven, person-centered delivery system. **We believe the government should facilitate testing of promising innovations, in line with activity in the private sector, and offer incentives and opportunities to accelerate the pace of transformation for those organizations that are willing and prepared to do so.** This requires CMS to make a commitment to engaging with stakeholders – including patients – in the design and implementation of new models.

Private sector payers and health care providers have seen successes in creating and testing innovative models in clinical care and payment approaches. However, providers can be limited in their ability to innovate to the extent that public and private payers are misaligned on financial incentives and measures for quality and value, or present disparate opportunities which result in different burdens on resource allocation. The CMMI models have accelerated private sector innovations by further testing concepts emanating from the private sector – accountable care organizations, patient-centered medical homes, clinical episode payments – and allowing providers to more comfortably move away from the fee-for-service payment structure.

It is critical to the goal of rapid cycle evaluation that CMMI expand its capacity to adopt recommendations from private sector stakeholders that are implementing and receiving care under these innovative models. The Task Force has appreciated the opportunity to provide this input to CMMI via formal Requests for Information, and has found that forums such as the Health Care Payment Learning and Action Network have provided valuable opportunities for private sector participants to share learnings. There are rich lessons to be gleaned from the experience of implementing payment models in the private sector that CMMI should consider when refining existing models and developing future models, and continuing these types of forums will provide CMS with that opportunity to learn from the private sector.

III. Create a better business case for delivery system innovation

Many providers are facing an important decision point when it comes to public sector value-based payment models. The Medicare and CHIP Reauthorization Act (MACRA) provides incentives for providers to adopt alternate payment models (APMs). However, the available APMs may not create strong enough financial incentives or sufficient regulatory flexibility for providers to transform their delivery of care. **We believe CMS should use the opportunity presented by MACRA to refine existing**

APMs and introduce new models that provide a stronger business case and better incentivize providers to adopt innovative approaches to contain costs and improve the quality of care for patients.

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 alternative payment models 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 alternate 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 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.

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

The initial CMMI appropriation provided the requisite financing needed to support the implementation and operation of innovative models, including data systems to collect and analyze performance data, and technical assistance for model participants. In the near term, the Physician-Based Payment Model Technical Advisory Committee (PTAC) is anticipated to create a significant work flow for CMMI, in addition to the expected increase in APM participation in response to the incentives introduced by MACRA. 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 improvement are identified below:

Synchronize model implementation. Efficiencies can be recognized by better sharing resources and infrastructure across model teams, as well as potential opportunities for alignment. The current approach to addressing model overlap – namely, excluding from one model beneficiaries or providers that are also aligned to 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. Quality measure alignment across models can also reduce burden on providers and encourage focus on key indicators of improved quality and cost containment.

Improved 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, though 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.

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 how they are experiencing the demonstration. We also strongly support the creation of an APM Ombudsman program as a complement to the Medicare Beneficiary Ombudsman, and urge CMS to move forward with establishing this function without further delay.

V. Provide relief from certain regulatory requirements to support coordinated care models

The ability for providers to be successful in value-based payment models depends on several factors. One key factor is the capacity to operate under a regulatory framework that is conducive to effective, efficient, and patient-centered care delivery and high-quality care. The Medicare fee-for-service regulatory framework has not kept pace with the payment and care delivery changes that allow for effective and efficient care delivery through alternate payment models. As a result, CMS has recognized the need to waive certain fee-for-service requirements for APM participants. While helpful, the HCTTF believes CMS should enhance its approach to regulatory relief for APMs by streamlining the waiver process.

With the plethora of APMs now being tested by CMMI, a hodgepodge of regulatory waivers exists, with different waivers applying from model to model. While the availability of waivers is welcome, the current approach to issuing waivers has not led to maximized uptake of the opportunity. Our members report uncertainty around the availability of certain waivers due to limited commentary about CMS's intended scope or applicability for particular APM participants. Given that waivers are currently available on an opt-in basis, this uncertainty has led stakeholders to pass on the opportunity out of fear for noncompliance if they implement a waiver incorrectly. Additionally, members report that the process for implementing the waivers can be burdensome and confusing as it differs among models, and requires additional data collection and reporting to comply.

To improve the current approach and maximize utilization of waivers to support improved care coordination, the HCTTF recommends the following. **We urge CMS to develop a core set of waivers that would apply to all APMs without the need for an opt-in approach.** This core set of waivers would serve as a minimum approach to regulatory relief, and CMS could add additional waivers on a model-by-model basis. With the experience of so many different models in place at this point, we believe CMS is well-positioned to identify a core set with adequate input from external stakeholders.

In developing a core set of waivers, CMS could provide commentary on how it believes the waivers should be implemented, including using case examples. This commentary would address current concerns about the uncertainty around scope and applicability. Moreover, CMS should consider a less burdensome means for providers to elect to participate and for CMS to track compliance with the available waivers which would reduce additional reporting requirements for alternate payment models participants. If CMS were to issue a core set of waivers, those should not include waiving consumer protections that safeguard patient access to care, and the agency should provide for monitoring of waivers as well as any needed enforcement to ensure patient care and access is safeguarded.

Where providers have questions about the scope of regulatory waivers, the Department also should devote the necessary resources from the legal agencies to be responsive to those questions. Creating a base of opinions on which industry can draw is one of the surest ways to promote uptake in waiver usage to support more coordinated care. Likewise, the Department should devote needed resources for any patient questions, concerns, or appeals related to waivers and be responsive to those needs. Regulatory changes to make the delivery system more efficient can only be successful if stakeholders have access to legal guidance to support their operational modifications.

In addition to a more coordinated approach to issuing waivers and responsive legal guidance, the time is ripe to move forward with meaningful regulatory reform that helps accelerate the pace of delivery system reform. Value-based care delivery will be enhanced by eliminating unnecessary barriers to where care can be received, and affording providers with discretionary payment flexibility so that markets can work effectively. The Task Force looks forward to working with HHS and CMS to implement meaningful relief from regulations that detract from the objectives of delivering high quality, patient-centered care, and we will follow up with additional recommendations in response to the Request for Information (CMS-1677-P).

Please contact Jeff Micklos (jeff.micklos@hcttf.org) or Clare Wrobel (clare.wrobel@hcttf.org) for follow up on this position paper.