April 19, 2017

VIA ELECTRONIC MAIL

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CMS- 5519-IFC

The Health Care Transformation Task Force (HCTTF or Task Force) [1], which is comprised of 37 organizations including patients, payers, providers, and purchasers, respectfully submits our consensus comments on the interim final rule with comment period (CMS- 5519-IFC) ("Interim Final Rule"). The Interim Final Rule further delays the effective date of the final rule entitled "Advancing Care Coordination Through Episode Payment Models (EPMs): Cardiac Rehabilitation Incentive Payment Model and Changes to the Comprehensive Care for Joint Replacement Model (CJR)," as well as the applicability date of the regulations at 42 CFR part 512 and effective date of specific CJR regulations.

We applaud many of the design features in the new EPM models as finalized, 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.

Finalizing changes to CJR and establishing the EPM models will provide a signal to private sector health care stakeholders who are assessing whether to pursue continued progress toward value-based payment that this Administration supports value-based payment and will encourage this transition to continue as intended under the MACRA. Our comments offered herein reflect a desire for CMS to continue support for value-based payment models, and reiterate our advocacy of model design element recommendations previously submitted by the Task Force in October 2016.

[1] The Health Care Transformation Task Force (the Task Force) came together 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.

I. Effective date delay

We appreciate CMS' solicitation of feedback on an effective date delay for episode payment model (EPM) provisions outlined in the final rule. Because AMI, CABG, and hip fracture repair patients are often of a higher clinical complexity, have multiple and various hospital entry points, and require coordination among multiple specialists, we believe further delaying the model start date from October 1, 2017 to January 1, 2018 may be beneficial for some providers to adequately prepare for the EPM model. **However, we believe that CMS should also provide an option for EPM participants to voluntarily select the October start date.** A voluntary start date of October 1, 2017 will provide an opportunity for EPM participants to gain experience with the model, and provides flexibility for willing participants to move to downside risk sooner than if they were required to wait until January 1, 2018.

Separately, the continued delay in the effective date of the changes to CJR is concerning, because it will limit the ability of CJR participants to achieve qualified provider status for participating in an Advanced APM for 2017. The delay presents a lost opportunity for providers that were intending to participate in the CJR Track 1 (CEHRT) starting in July. We encourage CMS to finalize those changes as soon as possible.

II. Clinical episode considerations of importance to the Task Force

The Task Force responds to the provisions adopted in the Final Rule and reiterates recommendations sent in October that our members believe are important to promote programmatic success in an efficient and effective manner.

A. Considerations for EPM and CJR within the Quality Payment Program

We commend CMS for finalizing its proposal to create a track for EPM and CJR participants to qualify as participating in an Advanced APM. As noted in our comments to CMS on the Merit-Based Incentive Payment System and Alternative Payment Model Incentives proposed rule, **we support CMS's proposal to provide opportunities for willing APM entities to voluntarily assume additional obligations which would help them move their transformation progress forward.** We commend CMS for allowing organizations willing to advance their transformation efforts to reap the benefits of doing so. As mentioned above, it is critical that CMS make effective the changes to CJR to ensure this opportunity is made available for CJR participants and to support the effective implementation of MACRA.

B. Make program design and monitoring data available to all participating providers, including collaborators

The Task Force appreciates the challenges related to making claims data available to EPM collaborators, including post-acute care providers that are not the responsible entity. In response to comments, CMS indicated that it was not appropriate to provide collaborators with this data directly, and that the responsible entity should decide what data they can and should share with collaborators. We believe that data sharing is critical to support care coordination capabilities, and CMS should encourage and provide more specific guidance to EPM participants about making claims data available to their business associates to support improved coordination.

C. Improve claims data quality and provide quarterly reconciliation data

The Task Force recommended that CMS endeavor to refine the data processes and support an option for eligible EPM participants to elect quarterly financial reconciliations. CMS did not accept this recommendation, and responded that the quarterly reconciliations can lead to large variation in the net payment reconciliation amount (NPRA) and is a very resource-intensive process for providers and CMS. Instead, CMS indicated that providers could assess their own performance on a more frequent basis using the available claims data. To support this, **CMS should make available and transparent the methodologies underlying the NPRA calculations.** EPM participants desire to use the claims data to understand their performance and identify potential issues at an earlier stage, but are currently unable to do so without full access to, and understanding of the payment methodology.

D. Protect minimal volume hospitals from variability

The Task Force appreciates that CMS has considered the relative difficultly for hospitals with minimal case volumes to control for variability under bundled payment programs and has finalized the proposal to establish a lower stop loss threshold for these programs. However, **we recommend that CMS continue to review and improve upon the low volume policy on an iterative basis in order to protect those typically smaller hospitals from the consequences of random variation of outcomes**. For example, CMS should utilize data from initial performance periods to determine whether an alternate approach for setting the stop loss threshold may be appropriate.

E. Explore market-based solutions to managing multiple payment models

The Task Force appreciates that CMS has recognized the broader, more comprehensive perspective of ACOs and encouraged the development of collaborative partnership agreements with EPMs. While both episode-based and population-based payments present opportunities for improvement in quality and care, they are not always in alignment, which can create inefficiencies and challenges that are ultimately at odds with the end goal of delivering higher quality and more integrated care. We believe that better synchronization between these models can ensure that the needs of individual patients are the focal point of the discussion.

To that end, the Task Force has developed a set of guiding principles to govern the development of best practices in managing overlap to better align and synchronize the goals and operations between different payment models in the public and private sector (*http://hcttf.org/resources-tools-archive/2017/2/28/principles-for-clinical-episode-and-population-based-payment-overlap*). **CMS should encourage market-based solutions that ensure patients receive high-quality care that improves outcomes and experience while lowering costs by allowing 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.**

F. Encourage patient-reported outcomes measures and streamlined submissions;

We support incentives provided for the collection of data to enable the further development of patient-reported outcomes (PROs) measures. We are pleased that CMS has continued to support this important work by proposing to incentivize SHFFT model participants that successfully submit patient-reported outcomes data. While we commend the desired collection of PRO data in the SHFFT model, we encourage CMS to continue to consider of select instruments which have been broadly tested and recommended by the International Consortium for Health Outcomes Measurement (ICHOM) for the cardiac bundles.

In closing, the HCTTF remains eager to support CMS's efforts to achieve sustainable change in value-based payment. We believe that moving forward to finalize and launch the additional Episode Payment Models is critical to provide additional Advanced APM opportunities for providers, and to continue to encourage the transition to patient-centered, value-based care. We appreciate the opportunity to provide comments on these models, and believe such models will urge the industry to continue its important evolution

to a modern payment and care delivery system.

Thank you for considering our viewpoints on this important public policy matter. For more information, please contact the Task Force's Executive Director Jeff Micklos at jeff.micklos@hcttf.org or Director of Payment Reform Models Clare Wrobel at clare.wrobel@hcttf.org.

Sincerely,

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