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VIA ELECTRONIC MAIL

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7500 Security Blvd Baltimore, MD 21244

Re: Recommendations for Advanced Bundled Payments for Care Improvement and ACO Track 1+

The Health Care Transformation Task Force (HCTTF or Task Force)[1], a consortium of patients, payers, providers, and purchasers committed to accelerating the pace of value-based payment transformation, provides the Center for Medicare and Medicaid Innovation (CMMI) with recommendations regarding alternate payment models currently in development: the Advanced Bundled Payment for Care Improvement Initiative ("Advanced BPCI") and the Medicare ACO Track 1+.

As a leading private sector, multi-stakeholder group, the HCTTF is committed to adopting payment reforms that promote a competitive marketplace for value-based health care and allow health care organizations to move health care payment from a system that rewards volume of services to one that rewards value of care. The HCTTF was encouraged by the CMS announcement of a new two-sided risk ACO track and additional bundled payment models, which may offer additional opportunities for providers to earn incentive payments under the new Quality Payment Program, and encourage providers to transition to alternative payment models that result in improved delivery of care.

While both episode-based and population-based payment models present opportunities for improvements in quality and care, we recognize that they are not always in alignment. The recent implementation of Medicare alternative payment models 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 Task Force has adopted a set of guiding principles that address overlap situations to govern the development of best practices in public and private payer models, which are provided in this letter for your consideration.

Our members have deep experience with operating accountable care and bundled payment models for Medicare as well as commercial payers. Our comments offered herein reflect a private sector perspective gained from implementing these models, coupled with a desire to refine these important initiatives in their next iteration to help promote future programmatic success in an efficient and effective manner.

[1] The Task Force is a group of 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 have 75 percent of their business in 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.

I. Design and Operational Considerations for Advanced BPCI

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. These outcomes can be achieved while ensuring access to care and freedom of choice for Medicare beneficiaries, regardless of the severity of their illnesses. Clinical episode models also provide a framework within which each program can focus innovation on how to best serve their affected patients. We applaud many of the design features of the first iteration of BPCI as a program aimed at reducing Medicare spending and improving patient care.

As noted in our comments to CMS on the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentives proposed rule, the Task Force supports CMS' proposal to provide opportunities for willing APM entities to voluntarily assume additional obligations that would help them move their transformation progress forward. We also support the proposal to implement a new voluntary bundled payment model for CY 2018 and beyond, where the model(s) would be designed to meet the criteria to be an Advanced APM under the Quality Payment Program. We commend CMS for allowing organizations willing to push their transformation efforts forward to reap the benefits of doing so.

The comments in this section reflect recommendations for the design and operation of an Advanced BPCI model, based on experience with the existing BPCI and CJR models.

A. Transparency and stakeholder engagement

In recent comment letters regarding bundled payment programs, the HCTTF has encouraged CMS to include stakeholders in the design process in a more substantive and consistent way. We strongly believe that CMS should include private sector clinical episode experts (including BPCI participants), consumers, patients and purchasers in the development of episode construction methodologies, quality metrics and the sharing of episode risk based on experience with the BPCI Initiative and private sector programs. We urge CMS to meaningfully engage stakeholders appropriately in future episode development through regular public Requests for Information (RFI) and listening opportunities. We encourage CMS to actively engage the Task Force and other groups with experience with the BPCI program, and consider stakeholder recommendations as the Agency develops a new voluntary bundled payment model.

The HCTTF continues to advocate for full transparency in all matters related to clinical episode payment programs, including details about the specific methodology for setting target prices 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 bundled payment program.

B. Episode price and payment flow

In any bundled payment program, the Task Force believes baseline prices must remain fixed for at least one to two years with a transition beginning in the third and fourth years, subject only to trending, to allow the marketplace to be rewarded for efficient, high-quality health care delivery. Such trending should take into account baseline pricing, with a lower trend applicable for high-cost regions.

Regular re-basing will create disincentives to participate in the program, as there is no longer a FFS benchmark unaffected by BPCI and ACO initiatives, and successful systems will be punished by re-basing that includes all prior year savings in new target prices. Consistent with the implementation of CJR, pricing should be provided prior to the beginning of each performance period.

The Task Force suggests that CMS use the number of cases in the bundle to determine whether or not to apply the Empirical-Bayes (EB) formula, and to actually apply the formula to each individual DRG in the bundle. This would eliminate the need for this complex case-mix adjustment and simplify the rule without reducing the impact of the policy.

We recommend modification of pricing for all Episode Initiators to more be more precise: target prices for low volume episodes should be derived from hospital-specific history, with pricing modifiers for specialty-specific risk adjustment. Additionally, we recommend that CMS pursue a voluntary disclosure model to replace PECOS as the data source for patient attribution to physician group practices.

In order to encourage bundles to be better integrated as a component of population-health focused value-based payment programs, we believe CMS should allow more flexible, market-based options where parties can mutually agree to manage model overlap based on their individual situation. However, we believe CMS should also develop an approach for testing that would allow both programs to claim a beneficiary but more fairly reconcile the payment between the two to encourage a positive interaction between population-based and clinical episode payment models. Our recommendations are discussed further in *Section III: Principles for Model Overlap between Clinical Episode and Population-Based Payment Models*, below.

C. Episode timing

Participants should be able to drop episodes quarterly and add episodes annually, with the full benefit of baseline pricing data for all available episodes. We also encourage CMS to provide claims data prior to the start of a model.

D. Episode definition

The Task Force recommends that CMS explore the feasibility of implementing bundled payments that trigger "at diagnosis" for certain clinical episodes, in addition to continuing bundles that trigger from an acute intervention. We believe select surgical bundles and other episodes that are patient-choice therapies may lend themselves to "at-diagnosis" bundled payments. While complexities exist around this type of episode, at-diagnosis triggers have the potential to capture the important clinical and patient decisions regarding pathway and site of care for a condition or disease. Given these complexities, CMS should pilot any "at diagnosis" bundled payment methodology on a small scale before testing a model more broadly.

E. Patient population

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

F. Patient engagement

As noted in our comments on the Comprehensive Joint Replacement (CJR) proposed rule, the Task Force supports incentives provided for the collection of data to enable the further development of patient-reported outcomes measures (PROMs). We are pleased that CMS has continued to support this important work by proposing to incentivize Surgical Hip/Femur Fracture Treatment (SHFFT) model participants in the Episode Payment Model (EPM) proposed rule that successfully submit patient-reported outcomes measures. We recognize that some bundles (*e.g.*, joint replacement) are further along in their development of PROMs. However, we encourage the continued development of PROMs for the remainder of bundles that are both clinically appropriate and are not overly administratively burdensome.

CMS should continue to see providers as partners in development of PROMs, making related data collection voluntary and providing incentives for those who choose to report. While valuable, PRO data is administratively burdensome to collect. The methods in development should explore how to capture this information from patients as part of the standard flow of care delivery.

G. Accountable entity

We believe a wide range of organizations dedicated to providing services, integrating and/or coordinating the work of practicing physicians and health care providers across care setting should be allowed to make and receive alignment payments and gainsharing payments under the bundled payment program. We recommend this inclusion, rather than exclusion, to encourage innovation and foster market-based arrangements dedicated to bundled payments. We also strongly recommend that as entities take on financial accountability for quality performance and value, and assume financial risk, they must likewise be able to demonstrate that they promote and support sustainable, effective, evidence-based, accessible, and patient- and family-centered care models.

H. Reconciliations

As shared in previous comments on CJR, we recommend quarterly reconciliations consistent with the BPCI Initiative. Doing so would allow organizations to produce savings that can offset the expenses associated with managing 90-day episodes, and would provide relatively faster feedback and rewards to program participants. We believe that certain categories of providers should have the option to elect annual reconciliations, recognizing the actuarial risk associated with small episode volume.

I. Type and level of risk

We encourage CMMI to explore methods to accommodate changes in mix within an episode (*e.g.*, an increase in hip fractures in the joint episode within the same MS-DRG over time) and allow for select additional exclusions for unrelated events. Current definitions create greater variation and risk in episode costs than truly exists. Appropriate risk adjustment would provide a similar compensation for the insurance risk in the current models.

As noted previously, there is a higher level of clinical risk for other surgical episodes when compared to orthopedic episodes. The Task Force believes that CMS should modify the risk adjustment policy to reflect the relative riskiness of the procedures as well as the beneficiary-specific demographic

characteristics and clinical indicators when setting the episode target price and determining the composite quality score.

J. Quality metrics

The Task Force supports quality measures principles that align with the Quality Measure Development Plan framework supporting MIPS and advanced APMs, and that reflect the episode. For SHFFT, the proposed quality metrics did not reflect the episode population. Given our members participate in both public and private payment arrangements, we also ask for continued consideration to the thoughtful development of quality measures principles that will allow for operationalization in the commercial space, given that commercial arrangements often follow Medicare models. The Task Force believes a parsimonious set of meaningful, patient centered quality metrics best serves patients and care givers alike.

We support the continuation of CMS providing monthly updates on performance on the provider-level including quality data. Additionally, we support the aggregation of regional claims data by CMS similar to CJR to offer providers a more complete picture of performance when volume for a given episode is too small.

K. Waivers and regulatory relief

The BPCI program has demonstrated the importance of gainsharing arrangements in the design of successful bundled payment programs. The Task Force recommends that CMS allow flexibility around the rules on gainsharing with physicians. If quality is met and there is no increase in case volume that can be tied to unwarranted or excessive cause, then we propose allowing hospitals and providers to reach market-based solutions that reflect the collaborative support and commitment of all affected stakeholders.

CMS and the Office of the Inspector General should expedite development of 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. We recommend that regardless of the Episode Initiator, data and information should be administered in a transparent manner with the sharing of information back and forth between all stakeholder groups.

The Task Force encourages CMS to consider additional areas for regulatory relief and more flexible in payment policies to complete the journey to a person–centered health care system that promotes choice and emphasizes high quality, efficiency, and affordable care. As the Task Force continues to consider these additional areas, we look forward to providing CMS with additional perspectives.

II. Refinements to Medicare ACO Track 1+ model

As previously discussed in Task Force comments to CMS, we support the creation of a new two-sided risk model that would provide an intermediate step along the continuum to fully mature two-sided risk models for both hospital and physician-led ACOs. We believe the new model, if structured appropriately, will effectively assist MSSP Track 1 ACOs in the transition to MSSP Tracks 2 and 3, or the Next Generation ACO model.

The comments in this section reflect recommendations for refining elements of the Medicare ACO Track 1+ as previewed in the model fact sheet.[2]

A. Shared savings rate

A maximum 50 percent shared savings rate may not provide adequate incentive for Track 1 ACOs to take on risk. By not including any possibility of reward to the ACO beyond what is available in Track 1, CMS greatly limits the appeal of Track 1+ to ACOs. **We encourage CMS to simplify the complexity of Track 1+ and to create a business case for Track 1+ for all ACOs by rewarding the risk taken with a higher shared savings rate if the ACO achieves savings.**

While the 5 percent Part B physician fee schedule lump sum payment for being in an Advanced APM may be attractive to some members of a given ACO, it may not be attractive to the ACO and/or the entirety of the ACO's provider members. The economic incentives for ACOs to participate will be dependent on structure: for example, a single TIN ACO made up completely of Part B reimbursed physicians could make the argument that they are taking on 8 percent risk to get 5 percent reward, and even in such cases, the 5 percent must be discounted by reasonable assumptions of what is possible for a high performing practice in MIPS. However, most ACOs are not single TIN. ACOs may include multiple practices, hospitals, rural health clinics, and FQHCs, all of whom would be required to take risk on their revenue as members of the ACO, while the reward is only available to some of the members of the ACO.

B. Downside risk differential

The differential of 8 percent of ACO participant Medicare FFS revenue versus 4 percent of ACO's benchmark maximum loss limit could disadvantage hospital and health-system led organizations. **The Task Force recommends that the risk level for MSSP Track 1+ align with the nominal risk threshold for Advanced APM models established under the Quality Payment Program**, which is 3 percent. The purpose of a Track 1+ is to provide ACO entities with a more gradual path to risk while also meeting the requirements of an Advanced APM. Currently, many Track 1 MSSP participants find it difficult to progress from no risk under Track 1 to 5 percent risk under Track 2. Setting the level of risk at 3 percent of the ACO's updated benchmark reflects a gradual progression of risk.

By establishing a Parts A and B threshold, CMS is disadvantaging not only hospital-based entities, but also any physician-based organization that brings a hospital into the entity by including them on the participant list. Physician-only entities are generally paid only through Part B, while any entity including a hospital will trigger the A/B threshold, thus dramatically increasing the required risk by adding Part A services and increasing the magnitude of the Part B services. This methodology runs counter to a foundational goal of entities working together to manage the health of their populations. **To ensure that all entities are similarly evaluated, we encourage CMS to limit the revenue test to Part B only.**

Additionally, the revenue level of risk option should not be limited to physician-led and small, rural (including hospitals) accountable entities. CMS should take care to avoid dissuading non-rural

[2] Medicare ACO Track 1+ Model Fact Sheet retrieved from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/New-Accountable-Care-Organization-Model-Opportunity-Fact-Sheet.pdf

hospital-led entities and entities including a hospital from continued participation or expanded participation in such models.

C. Limits to participation

We support CMS's decision to limit an ACO's participation in Track 1+ to one full three-year agreement, and to make current Track 2 and Track 3 ACOs ineligible for participation. We believe this approach is in line with previous Task Force recommendations, and critical to encourage providers to transition to more challenging models after building adequate capacity in the lower-risk model.

D. Condition-based ACOs

We recommend that CMS also consider designing additional condition-based ACOs, similar to the Comprehensive ESRD model. Such models could incorporate: (i) an assignment methodology linking Part B billings to select conditions; and (ii) elements of Track 3 ACOs, such as the option to choose the risk corridor and sharing rate, with downside risk. ACOs under such an arrangement should have the opportunity to see in advance of the Performance Year the benchmark for the specific types of patients and decide whether to accept downside risk associated with particular categories of patients. The Task Force would encourage CMS to evaluate whether the eight clinical segments as defined by Clough et al [3] for the purposes of identifying and managing high cost Medicare beneficiaries could serve as the basis for developing additional condition-based ACOs.

III. Principles for Model Overlap between Clinical Episode and Population-Based Payment Models

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.

The HCTTF adopted the following principles for managing model overlap between clinical episode and population based payment models:

- **Principle 1:** 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.
- **Principle 2:** Value-based payment model participants should strive to find mutually agreeable solutions to manage model overlap based on community and patient needs, marketplace dynamics, and their collaborative relationships.

[3] Clough, J.D. et al (2016). Patterns of care for clinically distinct segments of high cost Medicare beneficiaries. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/27637821

- **Principle 3:** 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.
- **Principle 4:** 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 on Triple Aim outcomes.
- **Principle 5:** 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 for achieving the Triple Aim.

The HCTTF is eager to work with CMS to achieve sustainable change in value-based payment, which requires alignment between the private and public sectors. We believe that offering additional episode- and population-based payment models such as Advanced BPCI and the Medicare Track 1+ ACO model will urge the industry to continue its important evolution to a modern payment and care delivery system.

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

Sincerely,

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