June 13, 2017

VIA ELECTRONIC MAIL

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: CMS-1677-P: Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information

Dear Administrator Verma:

The Health Care Transformation Task Force ("HCTTF" or "Task Force")[1] appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services ("CMS") on the provisions open for comment in CMS-1677-P: Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information.

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. Our members have committed to putting 75 percent of their business into value-based payment models by 2020. This transition is a significant undertaking and challenging by its very nature, yet it is even more so in the context of Medicare due to existing legacy regulatory structures that can impede that transition.

[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 put 75 percent of their business into 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.

The ability for providers to be successful in value-based payment models depends on several factors, and one key factor is the capacity to operate under a regulatory framework that is conducive to effective, efficient, patient-centered and high-quality care. Many existing Medicare regulatory structures were designed to support a fee-for-service payment environment that focused on individual service delivery and are not ideal or necessary to support a modernized, value-based world which focuses on greater coordination and integration of care. We encourage CMS to carefully assess and modernize those regulatory structures that hinder or affect the adoption of value-based care models, which will encourage providers' successful transition to value-based delivery systems.

Our comments herein respond specifically to the Request for Information. The Task Force has identified policies related to the operation of alternative payment models that could be modified to better support the goals of improved care and lower costs while reducing overall burden on providers and patients.

I. Improve upon existing waiver process

With the implementation of Alternate Payment Models (APMs), CMS has recognized the need to waive certain fee-for-service requirements for APM participants. Through existing waivers, APM participants have been able to better meet the needs of individual patients in a variety of innovative ways, including by implementing patient incentive waivers to support adherence to clinical goals and utilization of preventive care items or services; introducing "care at home" models to deliver outpatient and inpatient level and quality care to patients in their home at a lower cost; expanding the availability of telehealth services; and introducing financial accountability across the continuum of providers.

While helpful, the HCTTF believes CMS should enhance its approach to regulatory relief for APMs by streamlining the waiver process. We urge CMS to address the following issues with the current approach:

a. *Inconsistent waiver availability across APMs creates unnecessary burden on providers to implement.*
b. *Limited opportunities for model participants to manage model overlap fails to encourage synchronization across APMs.*
c. *Failure to account for non-covered services allowed by waivers (i.e., costs of patient incentives) in calculating baselines inaccurately captures expenditures.*
d. *Restricting telehealth waiver availability unnecessarily limits access to provider services for two-sided risk-bearing entities that are held accountable for quality of care of their attributed patient population.*
e. *Additional pricing flexibility within payment models that could allow for providers to accept a price that may be less than the Medicare reimbursement price to ensure that care decisions for patients are made based on clinical need and not on the lower cost alternative, especially with regard to post-acute services.*

II. Modernize fraud and abuse policies to support value-based care

When physicians are financially incentivized not by the volume of services but by the efficiency of services and treatment outcomes, their economic self-interest aligns with the interest to eliminate unnecessary services. Increasingly, the laws and statutes intended to protect from overutilization and decisions based on financial interest have become a significant impediment to value-based payment models. The Task Force recommends that CMS consider modifying existing exceptions to the physician self-referral prohibition and/or create new exceptions for alternative payment model participants to allow for greater care coordination within the construct of APMs.

III. Improve information sharing and transparency

CMS should supply sufficient technical information when proposing new payment models to allow stakeholders to realistically evaluate payment impact. Models such as BPCI, CJR and the pending EPMs incorporate benchmarking and reconciliation processes that are both complicated and complex. Process step descriptions that are not accompanied by examples using real data do not allow model participants to accurately forecast the economic consequences of such models to their institutions, clinicians and patients. Such opacity discourages potential participants in voluntary payment models and imposes unfair expectations upon participants in mandatory models.

The Task Force looks forward to participating in the ongoing national conversation about additional improvements that can be made to the Medicare program and the health care delivery system. Please contact HCTTF Executive Director, Jeff Micklos, at jeff.micklos@leavittpartners.com or (202) 774-1415 with any questions about this communication.

Sincerely,

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