February 16, 2018

VIA ELECTRONIC MAIL

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

Re: CMMI Bundled Payments for Care Improvement - Advanced

Dear Administrator Verma:

The Health Care Transformation Task Force ("HCTTF or Task Force")[1] would like to thank the Centers for Medicare and Medicaid Services for the recently announced Bundled Payments for Care Improvement Advanced ("BPCI Advanced") model. As a leading private sector consortium comprised of over 40 organizations including patients, payers, providers, and purchasers, 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 from a payment system that rewards volume of services to one that rewards value of care.

Our members have deep experience with operating bundled payment models for Medicare as well as commercial lines of business. We are confident that 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. With CMS's recent withdrawal of other proposed clinical episode models, our members are pleased to see other new opportunities be introduced.

I. General Comments

The BPCI Advanced model builds upon the BPCI initiative in a number of ways that improve the program and promote better alignment with the Quality Payment Program. The Task Force appreciates

[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.

that this model was designed to qualify as an Advanced APM, which will particularly benefit specialists who currently have few options to participate in alternative payment models.

The HCTTF continues to advocate for full transparency in all matters related to the bundled payment programs, including details about the specific methodology for setting target prices for each participant as well as the underlying data used to determine the price targets. The initial release of information about BPCI Advanced is very helpful, yet many important issues remain unaddressed in the BPCI Advanced Request for Applications, Target Price Specifications, and other model guidance and resources released by CMS thus far. Given the significant level of risk for all participants beginning on day one of the first performance year, general uncertainty about the model parameters in the following areas could unfortunately lead to less than optimal uptake among providers by the application deadline:

- Baseline period
- Efficiency adjustments
- Risk adjustment
- Rebasing methodology
- Precise timing of reconciliations and related payments
- Quality measure attribution methodology
- Composite quality score adjustment approach

In any bundled payment program, the Task Force believes baseline prices must remain fixed for at least one and preferably 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. Regular re-basing will create disincentives to participate in the program. The Task Force recommends that CMS release more detailed specifications prior to the application deadline to allow for interested stakeholders to make a more informed decision about whether to participate.

II. Design and Operational Considerations for BPCI Advanced

The Task Force previously shared our recommendations and considerations for BPCI Advanced with CMS while the model was under development, drawing on the private sector perspective gained from implementing existing bundled payment models.[2] We appreciate that CMS has been open to stakeholder feedback, and our comments offered herein reflect a desire for continued collaboration to help CMS refine this important initiative and promote future programmatic success in an efficient and effective manner.

A. Synchronizing various alternate payment models

We believe an important priority should be to encourage bundles to be better integrated as a component of population-health focused value-based payment programs. The Task Force has long asked that CMS allow more flexible, market-based options where parties can mutually agree to manage model overlap based on their individual situation. The BPCI Advanced policy for model overlap is a positive step in that direction. While the specifics of the NPRA sharing arrangement remain to be defined, we are supportive of the expanded flexibility for who can participate in those arrangements as

[2] https://hcttf.org/wp-content/uploads/2018/01/HCTTFtoCMS_AdvancedBPCI_Track1Plus.pdf

described in the request for application. We encourage CMS to release additional information about the governing policy in short order.

B. Precedence rules disfavor existing bundled payment participants

Current participants in the BPCI initiative (which we'll call BPCI Classic here), including hospitals and post-acute care facilities, have made significant investments in care redesign over the last four to five years and have a great deal of interest in continuing to improve care delivery and lower costs to Medicare by continuing their participation in this new model. As we understand it, the BPCI Advanced model removes any recognition for providers that have already invested in implementing the BPCI Classic program. In this same manner, by not utilizing a time preference, a participant who joins on October 1, 2018 and invests in the implementation runs the risk of losing attribution to a new group who decides to enter on January 1, 2020 or subsequent years.

The elimination of a time-based precedence rule, therefore, seems to disadvantage early adopters without consideration of the necessary provider investments in transformation. While we are supportive of bringing in new participants, this approach could have the effect of eliminating current successful participants and has the potential to disproportionately impact hospital participants under the new attribution methodology. We encourage CMS to consider a more equitable policy that recognizes the investment made by early adopters while welcoming new physician group entrants to the program.

In particular, CMS should continue to allow BPCI Classic participants currently participating in the lower extremity joint replacement clinical episode that would otherwise be mandated to participate in CJR, to continue their participation in the BPCI Advanced major joint replacement of the lower extremity episode. We see no persuasive reason for requiring BPCI Classic episode initiators interested in transitioning to BPCI Advanced to be moved into CJR in mandatory jurisdictions when they were able to opt out in the past, especially given the significant difference in pricing and program requirements for the lower extremity bundles under the different programs.

C. Encourage broader adoption

The Task Force supports greater industry-wide transition to mature, two-sided risk models. However, it is important to recognize that providers have varying levels of experience with managing risk. One of the benefits of BPCI Classic is the opportunity for providers to start at a lower risk level and to build adequate capacity before progressing to more advanced models, which this new model does not support. Combined with uncertainty regarding new methodology, quality adjustments, and inability to drop episodes on a quarterly basis, the three percent discount in BPCI Advanced may create too steep a cliff for new entrants that would have otherwise joined the model.

Thus, CMS should consider offering a scaled-in discount option that requires participants to transition to a more advanced track over the course of the model to encourage broader adoption among providers inexperienced with APMs. There are a variety of ways that a scaled-in discount could work, through a simple transition up to three percent over time for each bundle or offering a lower risk level in exchange for committing to a minimum number of bundles. The HCTTF remains committed to pursuing two-sided risk models, yet also seeks policies that promote broad model adoption and help meet stakeholders where they are while pushing them to advance in their value-based journeys on

reasonable timelines. The Medicare ACO Track 1+ model offers that opportunity for accountable care organization participants; bundled payment participants need a similar option.

Additionally, there was a great deal of interest among post-acute care (PAC) providers to participate in this next iteration of BPCI, and therefore there is disappointment in the exclusion of PAC providers from the episode initiator list. We recognize the complex pricing factors inherent in the BPCI Classic Model 3 episodes, but there are many ways for CMS to mitigate those issues based on lessons learned in the Classic model, including testing episodes that initiate at diagnosis, or following a target pricing model similar to that for physician group practices. We encourage CMS to offer leadership opportunities for PAC providers to participate in Advanced APMs, including clinical episode payment programs.

D. Engage patients in care transformation

The Task Force supports incentives provided for the collection of data to enable the further development of patient-reported outcomes measures (PROMs). For that reason, we encourage the continued development of PROMs for the BPCI Advanced episodes 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, similar to the approach in CJR. 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. We urge CMS to add an opportunity in BPCI Advanced that mirrors the opportunity available under CJR.

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The HCTTF is eager to work with CMS to achieve sustainable change in value-based care, which requires alignment between the private and public sectors. We stand ready to work together to complete the journey to a person–centered health care system that promotes choice and emphasizes high quality, efficiency, and affordable care. Thank you for considering our recommendations.

Please contact HCTTF's Executive Director Jeff Micklos (jeff.micklos@hcttf.org or 202.774.1415) or Director of Payment Reform Models Clare Pierce-Wrobel (clare.wrobel@hcttf.org or 202.774.1565) with any questions about or follow up to this letter.

Sincerely,

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