



July 30, 2018

The Honorable Mike Kelly
Co-Chair, Health Care Innovation Caucus
U.S. House of Representatives
1707 Longworth House Office Building
Washington, DC 20515

The Honorable Ron Kind
Co-Chair, Health Care Innovation Caucus
U.S. House of Representatives
1502 Longworth House Office Building
Washington, DC 20515

The Honorable Markwayne Mullin
Co-Chair, Health Care Innovation Caucus
U.S. House of Representatives
1113 Longworth House Office Building
Washington, DC 20515

The Honorable Ami Bera
Co-Chair, Health Care Innovation Caucus
U.S. House of Representatives
1431 Longworth House Office Building
Washington, DC 20515

Re: Health Care Innovation Caucus Request for Information

The Health Care Transformation Task Force (“HCTTF” or “Task Force”)¹ appreciates the opportunity to provide input to the Health Care Innovation Caucus on the Request for Information (“RFI”) to explore innovative policy ideas that improve the quality of care and lower costs for consumers.

As a broad-based group of health care stakeholders representing payers, providers, purchasers, and patients committed to the transition to value-based payment and care delivery, the Task Force stands ready to serve as a resource to legislators and regulators in this work. Our members are well-positioned to help define the highest priority activities for Congress and 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.

The imperative for the health care industry to innovate towards a value-based system remains more important than ever. The goal of affordable, high-quality health care that best meets the needs of consumers and patients is clinically, economically, and morally indisputable. As the bipartisan passage of

¹ The Task Force is a consortium of 44 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.

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. We commend the Chairpersons of this Caucus for the declarative support for accelerating the industry transition from volume to value-driven health care. As Congress considers policy to advance value-based care in Medicare and Medicaid, we would also encourage lawmakers to consider ways to encourage adoption of value-based care across additional federal programs, which could promote value transformation across commercial carriers and providers. We thank you for your leadership, and for your consideration of our comments in response to the questions in your RFI.

I. General Comments

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. There is no one solution that works for every provider, every patient, and every setting. Yet, many value models have shown tremendous promise for improving quality and reducing costs. But one thing is clear: success does not happen overnight. Evaluation results from Medicare's alternate payment models (APMs) show that performance improves over time, as organizations deploy capital to overhaul clinical/care management capabilities, technology, and administration, not to mention the cultural reengineering and retraining of personnel necessary to effectively concentrate on value.

The government is a critical partner in ensuring that the transformation to value continues apace. 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. **The HCTTF strongly supports the CMMI structure for testing innovative payment and clinical models.** The pace of progress under CMMI is preferable to the prior CMS demonstration structure; 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 diffusion of innovation and incorporation of improvements into new models based on provider feedback and interim evaluation results. CMS should continue to help develop new models and take steps to promote their national adoption when they work.

But to enable more private sector leadership, it also requires an environment that facilitates private sector system changes and initiatives. This means enabling the private sector to move forward quickly on payment reform models by clearly outlining priorities and key performance measures, creating the necessary flexibility, and establishing an infrastructure to rapidly assess and refine these models, and a clear pathway for expanding them when successful. The payer and provider members of the Task Force commit to moving 75% of their respective businesses into value by 2020 because it is only possible to make a definitive transition to value when the financial incentives are aligned. **For this reason, it is important that the public and private sectors align on the definition of "value" to make sure all incentives for stakeholders are pointing in the same direction, regardless of payer.**

States are key partners for engaging multiple payers. We urge the continuation of and building on existing cross-payer models, such as CMMI's State Innovation Model (SIM), which has driven progress in state-led health care transformation and innovation. We believe the SIM program can continue to serve as a key motivator for supporting providers' transition to APMs within the new context provided by

MACRA, and therefore strongly recommend that CMS fund additional SIM awards. States are uniquely positioned to advanced value-based payment adoption through state insurance regulation authority for commercial plans – including network adequacy and Qualified Health Plans oversight – and public sector insurance products (*i.e.*, Medicaid, CHIP, and state employee health plans). It will not be possible for the Task Force members to meet our goal of 75 percent in value-based payment arrangements by 2020 without commitment from state administered and regulated programs. States should be encouraged to utilize the full breadth of available policy levers to drive adoption of value-based payment within the public and commercial payer market.

II. Value-Based Provider Payment

We now have the benefit of several years of testing new models of value-based payment which can inform ongoing innovation. A critical focus of the government going forward should be using the lessons learned from providers' experience and federal evaluation of APMs and Medicaid delivery system reform efforts from the past few years to make improvements to the existing models that are showing genuine, long term promise. There is also a greater need for the consideration of the patient perspective on value when developing new value-based payment models to account for the diverse needs, preferences and experiences of patients.

The recommendations below are based on our members' experience with both the public and private sector value-based payment.

A. Barriers limiting the full potential of innovation in Medicare and Medicaid

i. Payment and reimbursement

Setting spending benchmarks in APMs has been an ongoing issue for participating providers. The current benchmarking methodologies are grounded in historical fee-for-service (FFS) costs, and therefore present a number of challenges when it comes to sustainability of downside-risk models for providers. There is value to starting with improvements to the existing system, but ultimately long-term sustainability of shared-risk and/or full risk models requires moving away from a benchmarking model based on historical FFS cost to budgets that reflect objective affordability and minimize unwarranted variation. **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 that encourage participating providers to continue along the continuum to fully mature two-sided risk models.

As the industry moves toward more shared risk models of provider payment, there are specific components of APM benchmarking methodology, particularly in the Medicare program, that could be better refined. Accurate risk-adjustment is a common concern. Current risk-adjustment methods do not account for individual social risk factors such as race, ethnicity, and functional status, or neighborhood-level risk such as concentrated poverty and rurality. Therefore, risk-adjustment methods as currently incorporated into Medicare APMs do not accurately reflect care for patients with more complex health and social needs and instead incentivize providers to avoid such patients.

ii. Policy and regulation

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.

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 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 Congress assess and modify the existing 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.**

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, while maintaining appropriate protections for consumers, and providing more guidance about the applicability of waivers. **For example, CMS could establish a core set of waivers available to all Advanced APMs, with the ability to add additional waivers depending on the model.** As noted above, Congress should also take action to modernize the statutory structures that hinder or affect the adoption of value-based care models, which will encourage providers' successful transition to value-based delivery systems.

iii. Data and reporting

One barrier to broader adoption of Medicare APMs is the limited insight into payment methodology for new payment models. Lack of transparency from CMS about model methodology and design contributes to an overall lack of predictability in the models that may lead to lower adoption. CMS should share information in more accessible formats so that providers can perform their own financial analysis and make informed decisions about model participation.

Any successful payment model must integrate operational data and cost transparency in order to impact change in practice. If the price of a service, the quality of a provider, and the expected outcome are not readily available to consumers on a real-time basis, providers are not incentivized to improve and compete. In the context of Medicare APMs, providers need more real-time data from CMS to understand when beneficiaries are aligned to multiple APMs in order to coordinating care for mutually-aligned beneficiaries. CMS currently makes APM participants aware of overlap at the beneficiary level at most monthly and in some cases only annually. Care coordination efforts would be most successful if APM participants can identify these beneficiaries at the time of care, or following a discharge, emergency department visit, or transition of care in order to coordinate with other APMs that have accountability for the same beneficiary.

B. Develop better outcomes measures for quality, safety, and value

A considerable amount of time and resources have already been devoted to the development of outcome measures. Disparate performance measure sets being used by public and private payers in value-based payment arrangements are prolific and misaligned. Some well-intentioned state-led initiatives to align and codify key measures create challenges for payers and providers that operate in multiple states and each state institutes its own set of measures. On the flip side, efforts to produce core measure sets at the national level – including the Core Measures work by CMS, America’s Health Insurance Plans and National Quality Forum – focused on streamlining existing measure sets, and are still be tested for broad-scale adoption. Now there is an overarching need to be moving toward the core measures sets of tomorrow.

The CMS Administrator’s expressed policy objectives to reduce provider measurement burden through the Meaningful Measures initiative and MedPAC’s strong recommendations to scrap MIPS in favor of more streamlined measures provide a timely window for more effective private sector leadership. However, there is limited value in recreating new core sets using yesterday’s measures. There is general consensus that more outcomes-oriented measures, which draw from clinical and patient-reported data, are desired over process measures. To support measure advancement, industry should rapidly adopt existing consensus-driven core measure sets while working to identify the next generation of core measures.

One area for continued measure development is patient-reported outcomes (PROs) measures. PROs are critical to understanding whether patients benefit from health care interventions in ways that matter to them, to providers and to society – for example, improved functioning, reduced pain and improved quality of life. However, patient-reported outcomes are not routinely used as outcomes measures for a number of reasons, including lack of supporting technology and provider incentives. **The Task Force fully supports the use of PROs and has committed to adopting PROs where offered in the existing APM measure sets. A value-based payment system that is truly patient-centered must better incentivize providers to collect and report on patient-reported outcomes.** Additionally, more work is needed to support collection and reporting of demographic factors (e.g., race, ethnicity, language, socioeconomic status, sex and gender identity) in value-based programs within Medicare, Medicaid, and with commercial insurers. Without the stratification of this data, there is an enormous challenge to identify and reduce health disparities.

i. Congressional support needed for CMMI to achieve its purpose

The bipartisan MACRA legislation encouraged the adoption of more Advanced APMs, however there has been a slow-down in models being introduced and tested by CMMI over the past two years. The Task Force believes that 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. **In order to truly achieve the goals of MACRA, Congress must encourage CMS to more rapidly 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.**

Congress should also consider modifying the Secretary’s authority to scale effective payment models. Currently, only two models have met the necessary criteria and scrutiny of the CMS Office of

the Actuary in order to be adopted into Medicare payment policy. It would be prudent to reassess the actuarial method currently being used and expeditiously bring models to scale that have been deemed effective, which may impact provider willingness to engage in new models. Further, at this time, CMS has not released publicly the actuarial assessments for models that did not meet the threshold for expansion. CMS should be more transparent with information about what models are not meeting that standard, and why.

CMS also needs to be adequately resourced to support providers' participation in APMs and allow for meaningful stakeholder engagement. It is critically important that all stakeholders have the opportunity to weigh in during development and implementation of new payment models, including beneficiaries. **The Department should devote needed resources for any patient questions, concerns, or appeals and be responsive to those needs.** CMS previously announced plans to implement an APM Ombudsman but has yet to do so; we've encouraged CMS to expeditiously finalize this important role.

Unfortunately, provider participation in Advanced APMs is associated with risk beyond the model's financial risk when CMS is unresponsive to provider and stakeholder questions. 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. The Department needs adequate resources to support technical assistance for providers that have voluntarily taken on new models and doing the right thing to improve patient outcomes and lower cost.

C. Looking ahead to 2025

While it is difficult to predict exactly what the world will look like in 2025, there are several ways that the government can assist in making a sustainable transition from fee-for-service to value-based care. 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. **Now that value-based payments are more central to the Medicare program, it is imperative that CMS adopt mature and consistent processes and operational principles across various models wherever possible and make improvements to the underlying payment systems to improve efficiency in the near-term.** Efficiencies can be recognized by better sharing resources, infrastructure, and methodology across CMS programs. In particular, providers are looking for greater alignment across Advanced APMs and Medicare Advantage (MA) rules and to make the flexibility that MA offers more broadly available. For example, risk adjustment policies could transcend MA and apply to payment models such as accountable care organizations.

III. Technology and Health IT

Earlier this year, the Task Force joined a multi-sector group of stakeholders of leading providers, payers, health IT companies, EHR companies, consumer platform companies, consumers, caregivers and others focused on advancing consumer-directed data exchange across the U.S. We are working collaboratively with other stakeholders and leaders in government to overcome the policy, cultural, and technological barriers to advancing consumer-directed exchange. Our vision is to rapidly advance the ability for consumers and their authorized caregivers to easily get, use, and share their digital health information when, where, and how they want to achieve their goals. Specifically, we support the ability for consumers and their authorized caregivers to gain digital access to their health information via open

application programming interfaces (APIs) and patient portals, with all functionalities turned on and actively in use such as secure email with providers, access to doctor's notes, ability to share patient-generated health data, and patient education materials.

Yet, federal leadership and action steps are still needed to move the nation more expeditiously to interoperability. While the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program (now the Promoting Interoperability Program) did successfully drive adoption of EHRs, the program remains largely government-driven rather than patient-centered, which has led to "tick the box" government requirements that have failed to advance patient care, improve clinician workflow, or make the substantial progress toward interoperability that was envisioned when the program was enacted.

IV. Oversight of the PTAC

The Task Force fully supports the primary objective of the Physician-focused Payment Model Technical Advisory Committee (PTAC), which is for the private sector to bring forward ideas and proposals for alternate payment models. **However, the Task Force believes PTAC is not maximizing its potential value under its current framework and processes, and Congress should consider revising its authority so that its full potential can be achieved.**

Recent events show that HHS is struggling with how best to interact with PTAC, and PTAC is understandably frustrated with the lack of any favorable action by HHS on its recommendations. This situation is not necessarily any one side's fault; however well intentioned, the construct of PTAC established by Congress has proven to be unwieldy and ineffective in practice.

For example, it is understandable that CMS likely is not in position or does not wish to test every model that the PTAC recommends to the Secretary. The value transformation agenda must be executed with finite resources, and it is within the Secretary's purview to set the priorities. No matter how mature a model proposal may be before the PTAC, the reality is that it would take CMS at least a year and likely longer to further develop that proposal to a point where it is ready for testing. With competing priorities, the reality is that many PTAC recommendations are unlikely to receive that level of commitment.

However, it is reasonable for the PTAC to expect that HHS would commit to testing some of its recommendations. While the authorizing statute does not impose specific obligations on the Secretary, it is hard to fathom that Congress intended for the Secretary to be able to pass on all recommendations. Given the track record to date, there is merit to the proposition that PTAC not move forward with considering additional proposals until there is a better understanding as to whether any recommendations will be accepted for testing.

Yet, a more worthwhile approach may be to pivot to identifying ways how PTAC could better serve the Secretary and CMS in support the stated goal of advancing value transformation. Under existing authority, PTAC is only allowed to act upon specific proposals presented to it; it is constrained from advising the Secretary more broadly on value-based payment. A fair observation is that what is missing in PTAC's current construct is the traditional role of a federal advisory committee.

The expertise and experience represented on the PTAC is considerable. By being limited to only acting upon what is brought to it, that panel's expertise is not being fully utilized. There would be clear advantages for PTAC to advise the Secretary on which types of models are most needed or desirable in

the marketplace, which hold the most promise for success of lowering cost and improving outcomes, and which model designs are mostly likely to effectively synchronize with other models to create a seamless value-based landscape.

Based upon the body of knowledge developed from reviewing model proposals to date, PTAC also seems well positioned to advise the Secretary on meritorious concepts, ideas and methods that it is seeing across the proposals that may be worth considering in different contexts, including being applied more broadly to existing or new models initiated by CMS. Observers of PTAC proceedings can see themes developing around certain concepts being worthy of consideration for testing, even if not in the context of a particular PTAC model proposal.

The Task Force has a number of recommendations with regard to current PTAC operations yet believes that it would be more worthwhile for the Innovation Caucus to focus its energy on evaluating the PTAC structure overall with the goal of developing recommendations for changing PTAC's authorizing statute to increase its effectiveness and value to the Secretary and which better utilizes the expertise and vision that PTAC members can clearly provide.

The HCTTF appreciates the opportunity to share this statement with Health Care Innovation Caucus and stands ready to work together in the transformation to value-based payment and care delivery. Please contact HCTTF 9 www.hcttf.org Executive Director Jeff Micklos (jeff.micklos@hcttf.org or 202.774.1415) or HCTTF Director of Payment Reform Models Clare Pierce-Wrobel (clare.wrobel@hcttf.org or 202.774.1565) with questions related to this statement.

Respectfully,

The Health Care Transformation Task Force

Aetna
agilon health
Aledade, Inc.
American Academy of Family Physicians
Anthem, Inc.
Ascension
ApolloMed
Archway Health
Atrius Health
Blue Cross Blue Shield of Massachusetts
Blue Cross Blue Shield of Michigan
Blue Cross Blue Shield of North Carolina
Blue Cross Blue Shield of South Carolina
CareCentrix
ChenMed
Cleveland Clinic
Community Catalyst
ConcertoHealth
Dartmouth Institute for Health Policy
Dignity Health

Duke Margolis Center for Health Policy
Evolent Health
Greenville Health System
Encompass Health
Heritage Development Organization
HRH Care Community Health
Kaiser Permanente
National Health Law Program
National Partnership for Women & Families
OSF HealthCare System
Pacific Business Group on Health
Partners HealthCare
PatientPing
Premier
Remedy Partners
SCL Health
Trinity Health
Tucson Medical Center Healthcare
UAW Retiree Medical Benefits Trust
Washington State Health Care Authority