



August 28, 2018

VIA ELECTRONIC MAIL

Adam Boehler
Deputy Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: Synchronizing Advanced APMs to improve care delivery and financial viability

Dear Deputy Administrator Boehler:

The Health Care Transformation Task Force (“HCTTF or Task Force”) appreciates the Centers for Medicare and Medicaid Services consideration of our recommendations in the development of the BPCI Advanced program. The Task Force is a group of private sector stakeholders that wish to accelerate the pace of delivery system transformation and clinical episode programs are important initiatives in that regard. 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 better health, better care, and reduced costs.

Our members have deep experience with operating bundled payment models for Medicare as well as commercial lines of business. The HCTTF has previously offered design and operational considerations drawing on the private sector perspective gained from implementing existing bundled payment models in March 2017 and again this past February, and also joined with other organizations in recommending an optional later start date for the BPCI Advanced model to increase participation.¹²³

Our March 2017 letter shared the Task Force principles for addressing situations where different value-based payment models overlap. With those principles as a foundation, the HCTTF has continued work to develop actionable, market-based strategies for better alignment between ACOs and bundled payment programs. This letter details our findings from this process and present recommendations for CMS to consider where model modifications and guidance would afford providers the appropriate flexibility to better coordinate patient care and with improved financial viability. We remain confident that clinical episode-related payments in coordination with population-based payment models can promote high-quality, high-value care for Medicare beneficiaries. We look forward to continued partnership with CMS to ensure the best possible implementation of this leading bundled payment program.

¹ <https://hcttf.org/2017-3-9-task-force-provides-recommendations-to-cmmi-on-new-aco-track-1-and-advanced-bpci-models/>

² <https://hcttf.org/recommendations-to-cms-on-bpci-advanced/>

³ <https://hcttf.org/bpci-advanced-flexibility-industry-letter/>

I. Recommendations for greater flexibility to support improved model alignment

The ability for organizations to be successful in ACOs, BPCI Advanced, or other APMs often depends on market factors that are independent of internal medical practice improvements. Those market dynamics can dictate whether ACOs or BPCI participants end up as financial winners or losers in instances of model overlap based on the current model methodologies. The goal of these models should be to change the way care is being delivered, rather than simply introducing opportunities to leverage market dynamics without advancing practice improvements. Therefore, CMS should provide APM participants adequate flexibility to manage model overlap based on their unique market situation in a way that encourages greater alignment and ultimately drives better outcomes for patients.

The BPCI Advanced policy for model overlap is a positive step in that direction. We support the expanded flexibility for who can participate in those arrangements and encourage CMS to consider the following refinements and prioritize actions to improve care coordination among APMs.

A. Provide more real-time data to alert APM providers to mutually-aligned beneficiaries

One of the greatest barriers preventing APM participants from coordinating care for mutually-aligned beneficiaries has a seemingly simple solution: alert providers to mutually-aligned beneficiaries. CMS currently makes APM participants aware of beneficiary overlap at best 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. Streamline the waiver process by issuing a minimum set of waivers for all Advanced APMs

The ability for providers to be successful in value-based payment models depends on several factors. One key factor is the capacity to operate under a regulatory framework that is conducive to effective, efficient, and patient-centered care delivery and high-quality care. The Medicare fee-for-service regulatory framework has not kept pace with the payment and care delivery changes that allow for effective and efficient care delivery through alternate payment models. As a result, 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.

With the plethora of APMs now being tested by CMMI, a hodgepodge of regulatory waivers exists, with different waivers applying from model to model. While the availability of waivers is welcome, the current approach to issuing waivers has not led to maximized uptake of the opportunity. Our members report uncertainty around the availability of certain waivers due to limited commentary about CMS's intended scope or applicability for particular APM participants. Given that waivers are currently available on an opt-in basis, this uncertainty has led stakeholders to pass on the opportunity out of fear for noncompliance if a waiver is implemented incorrectly. Additionally, members report that the process for implementing the waivers can be burdensome and confusing as it differs among models and requires additional and/or duplicative data collection and reporting to comply.

To improve the current approach and maximize utilization of waivers to support improved care coordination, the HCTTF recommends the following:

- CMS should designate a core set of waivers that would apply to all APMs without the need for an opt-in approach. This core set of waivers would serve as a minimum approach to regulatory relief, and CMS could add additional waivers on a model-by-model basis. With the experience of so many different models in place at this point, we believe CMS is well-positioned to identify a core set with adequate input from external stakeholders.
- In developing a core set of waivers, CMS could provide commentary on how it believes the waivers should be implemented, including using case examples. This commentary would address current concerns about the uncertainty around scope and applicability.
- Lastly, CMS should eliminate manual data collection and submission to track waiver use, and instead use claims data or other standard processes to monitor waivers.

C. Provide more guidance about the waivers' applicability

CMS and the Office of the Inspector General should provide a mechanism for providers to seek guidance about the waivers short of a full advisory opinion. The waivers for gainsharing have fairly broad applicability, but providers are hesitant to utilize the waivers without further clarity from CMS. The current process to receive guidance – requesting an advisory opinion, for a fee – is a limiting step for most APM participants. CMS is also constrained from providing technical assistance to APM participants that could be construed as legal guidance. Where providers have questions about the scope of regulatory waivers, the Department of Health and Human Services also should devote the necessary resources from its legal counsel to be responsive to those questions. Creating a base of opinions on which industry can draw is one of the surest ways to promote uptake in waiver usage to support more coordinated care. Likewise, the Department should devote needed resources for any patient questions, concerns, or appeals related to waivers and be responsive to those needs. Regulatory changes to make the delivery system more efficient can only be successful if stakeholders have access to legal guidance to support their value-based operating strategies.

D. Clarify the applicability of NPRA Shared Payments for hospitals and clinically integrated networks

As a current example of the need for waiver clarity, our members report confusion about the applicability of the NPRA Shared Payment waivers, mainly due to contradictory language in the Participation Agreement. Assuming CMS did not intend to create this confusion, we urge CMS to clarify through a modified Participation Agreement that CMS will allow BPCI Advanced Participants to execute NPRA Sharing Arrangements with all existing Hospitals, APM Entities (namely ACOs), and clinically integrated networks (CINs). This will ensure that Participants can partner with hospitals and local ACOs to more immediately and effectively achieve CMS's goals under BPCI Advanced of improved efficiency and high quality care for Medicare beneficiaries.

E. Allow ACOs participating as NPRA Sharing Partners to differentially reward downstream providers based on BPCI Advanced performance

The fraud & abuse waivers do not allow hospitals or ACOs to apportion its NPRA Shared Payments to its downstream providers according to BPCI Advanced activities. This policy limits the ability for the NPRA Sharing Partners – which in BPCI Advanced would include hospitals and ACOs – to

incentivize performance for downstream providers based on quality and cost objectives. We urge CMS to revisit these waivers and provide greater flexibility for securing downstream contracts.

F. Allow ACO Conveners to negotiate target prices for BPCI Advanced episodes

As a longer-term strategy, CMS should consider how to allow ACO conveners to negotiate target prices for BPCI Advanced episodes. CMS already employs a related policy in the Next Generation ACO (NGACO) program by allowing ACOs to negotiate downstream provider payment through fee reductions. NGACOs determine a percentage reduction to the base FFS payments of its Next Generation Participants and Preferred Providers for care supplied to NGACO-aligned beneficiaries, and NGACOs may opt to apply a different percentage reduction to different subsets of its Participants and Preferred Providers.

In this way, NGACOs have the flexibility to pay groups of providers using a variety of different methods including sub-capitation or episode-based payments for certain groups of providers. A similar policy could be replicated for ACOs that participate as Conveners in BPCI Advanced, whereby ACO Conveners would determine the target price for downstream BPCI Advanced episodes without changing the ACO's benchmark. CMS could choose to operationalize this policy in several different ways; for example, CMS could recognize the ACO-negotiated target price for the episode when administering the reconciliations, assuming the target price is at or below the target price proposed by CMS.

The HCTTF is eager to collaborate 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.

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