



March 1, 2019

VIA ELECTRONIC MAIL

Lamar Alexander
Chairman
Senate Committee on Health, Education, Labor, and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Re: Request for Information on Lowering Health Care Costs and Incentivizing High-Quality Care

Dear Chairman Alexander:

The Health Care Transformation Task Force (HCTTF or Task Force) thanks the Senate Health, Education, Labor, and Pensions (HELP) Committee for seeking information from the industry on what steps Congress should take to address America's rising health care costs. The Task Force is a consortium of over 40 private sector stakeholders – including providers, health plans, employers, and consumers – that support accelerating the pace of transforming the delivery system away from fee-for-service (FFS) into one that pays for value, increases the quality of care, and produces improved health outcomes. Our payer and provider member organizations aspire to have 75 percent of their business in value-based arrangements by 2020. The Task Force is well-positioned to serve as a resource to Congress and regulators in this work, and to help identify the highest priority strategies for pursuing value-based care models that improve patient outcomes and decrease health care costs.

In this letter, the Task Force responds to the Committee's questions regarding specific actions that Congress and the Administration can take to lower health care costs and incentivize care that improves health outcomes and increases the ability for patients to access the information needed to make informed decisions about their care. We believe it is imperative for Congress to consider that – while lowering our nation's health care costs is critical – it is paramount to ensure care delivery is of high-quality and appropriate to the patient/consumer needs, goals, and preferences. We thank you for your leadership, and for your consideration of our comments in response to the questions in your RFI.

I. Encourage Alignment on Defining Goals for Value Transformation

Making a sustainable system transition to lower costs and improved quality requires the private and public sectors to align on the definition of value. The concept of value-based payment and care delivery is subject to different interpretations across industry segments and stakeholder groups. 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.

A. Ensure a comprehensive definition of value

While the need to reduce health care costs in our country is undoubtedly clear, we strongly believe that cost reduction cannot be the sole criterion of value transformation. It is imperative that a definition of value also includes an equal emphasis on quality improvement to ensure that cost containment does not negatively impact patients or limit access to necessary care. A goal for value transformation without direct consideration of improving health outcomes and patient care will be unsustainable at best and harmful to patients’ wellbeing at worst. **Congress should encourage the Department of Health and Human Services to lead a public discussion to define patient-centered goals for value transformation.**

B. Encourage HHS to set public transformation goals

The HCTTF goal of having 75 percent of member business in value-based payment by 2020 was designed to complement the delivery system reform goals that HHS established in 2015 for moving Medicare away from paying for quantity of services. At that time, HHS announced the goal of having 90 percent of all Medicare fee-for-service payments tied to quality or value, and 50 percent of Medicare payments through alternative payment models (APMs) by the end of 2018. **HCTTF members wish to confirm whether they are still aligned with HHS on pursuing delivery system reform, or if HHS now has different views for charting an appropriate path to value-based payment what that new path may be.** We have urged HHS to publicly articulate a goal for value-based transformation, which would likely bolster industry momentum and drive the market to push forward their public and private sector initiatives. We would welcome the support of Congress in encouraging HHS to clarify its progress and commitment to this goal.

II. Accelerate the Pace of Innovation in Medicare, Medicaid, and Throughout the Federal Government

We now have the benefit of several years of testing new models of value-based payment which can inform ongoing innovation through the Center for Medicare and Medicaid Innovation (CMMI) structure at the Centers for Medicare and Medicaid Services (CMS). A critical focus of CMS going forward should be using the lessons learned from providers’ experience and the federal evaluation of APMs and Medicaid delivery system reform efforts to make improvements to the existing models that are showing genuine, long-term promise. Congress could help to

accelerate the pace of value transformation and innovation, while also ensuring that new model development does not accentuate the fragmentation of the care delivery system, in the following ways.

A. Ongoing Congressional support for CMMI

Congress established the Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures for Medicare and Medicaid while preserving or enhancing the quality of care for beneficiaries. 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. 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 should 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.** Additionally, it would be helpful for Congress to encourage CMMI to conduct public cross-model comparisons on an ongoing basis. Evaluations are currently siloed, preventing comparisons across models to identify what is working among all models.

Given the relatively limited number of available Advanced APM options and the significant number of physicians currently excluded from the Merit-based Incentive Payment System, the Quality Payment Program has not yet realized its goal of driving of value-based payment model uptake. Because the policy objective to drive all providers to advanced risk arrangements remains, we urge Congress to extend the incentive payments for eligible providers' participation in Advanced APMs beyond the current sunset year of 2024 (associated with the 2022 performance year), as established by MACRA.

Finally, we are pleased to hear that CMMI is working on models with a greater focus on primary care, behavioral health, and addressing social determinants of health as we believe these are powerful ways to improve health outcomes and decrease costs. We would appreciate the support of Congress in encouraging these focus areas for CMMI.

B. Assess the CMS determination process for certifying models for expansion

Congress granted the Secretary authority to expand the duration and scope of a payment model through rulemaking if a) the expansion of the model is expected to reduce

spending under the applicable title without reducing the quality of care, or improve the quality of care and reduce spending; and b) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such an expansion would reduce program spending under applicable titles. **Congress should evaluate the current process that CMS utilizes to determine whether a model qualifies for expansion.**

Currently, only two models have met the necessary criteria and scrutiny of the CMS Chief Actuary in order to be adopted into Medicare payment policy through rulemaking. The first part of this determination process is informed by the model evaluation, which CMMI conducts for each model tested under its authority, and results of which are made available to the public. However, CMS does not make publicly available all actuarial assessments unless the model is certified for expansion (part b, above); it is therefore impossible to ascertain what methodology, assumptions, and variables the CMS Chief Actuary uses for models that are not certified for expansion. For example, what kind of horizon is considered when determining that the expansion “reducing program spending,” or what kind of trend factors are incorporated into the analysis?

CMS should be more transparent with information about what models are not meeting the actuarial standard, and why. Future innovative models will not come to fruition unless the industry can learn from what models are not effective as well as from the ones that are. It would also be prudent to reassess the actuarial method currently being used, as the ability for CMS to more expeditiously bring models to scale that have been deemed effective may impact provider willingness to engage in new models.

C. Improve patient and stakeholder engagement mechanisms

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. **Congress should encourage the Department to 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 should direct adequate resources to support technical assistance and more timely reporting for providers that have voluntarily taken on new models and are doing the right thing to improve patient outcomes and lower cost.

D. Modify policy and regulatory barriers for alternative payment model participants

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.** We appreciate HHS Deputy Secretary Eric Hargan's recent efforts in this area to prioritize an open stakeholder process on modernizing Stark and Anti-Kickback laws. The Task Force commented on both requests for information and looks forward to forthcoming updates.

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.

E. Address barriers to more advanced value models

Various changes are needed to ensure that barriers are removed for innovative and advanced risk-sharing 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 fee-for-service 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 could instead result in providers avoiding such patients.

Additionally, setting spending benchmarks grounded in historical fee-for-service costs presents 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 one that reflects objective affordability and minimizes unwarranted variation. We look forward to working with Congress and CMS to develop a suitable alternative to the current approach that appropriately balances the complexities of the situation.

Finally, a major barrier to providers joining more advanced risk models is the limited options to do so. The Task Force has long supported interim steps that encourage participating providers to continue along the continuum to fully mature two-sided risk models, yet CMS should also 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.

F. State-based and local innovation

Congress directed CMMI to test models allowing States to evaluate systems of all-payer payment reform for the medical care of residents of the State, which has been carried out primarily through the State Innovation Model (SIM) initiative and all-payer waivers in Maryland and Vermont. The primary goal of the SIM program – to move 80% of payments to providers from all payers to value-based payment models – aligns closely with the primary objective of the Task Force to move 75 percent of members' business into value-based care arrangements by 2020. We believe the State Innovation Model can continue to serve as a key driver for supporting providers' transition to APMs within the new context provided by MACRA.

States are uniquely positioned to advanced multi-payer 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. Congress and CMS should also consider ways to incentivize state Medicaid agencies to utilize the full breadth of available policy levers to provide high-value care to Medicaid patients, including contracting directly with health care providers or Medicaid managed care plans to employ value-based arrangements. States should be encouraged to drive adoption of value-based payment within the public and commercial payer market while exhibiting caution as it implements downside-risk for Medicaid providers, to ensure that providers treating vulnerable populations are adequately prepared and supported in taking on risk. The HCTTF has also encouraged CMS to consider more expansive support for

financially integrated models for dually-eligible Medicare-Medicaid beneficiaries, and expand APM options for Medicaid safety net providers including community health centers and rural health clinics.

G. Leverage the Federal Government’s Purchasing Power to Drive Value

As Congress considers policies 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, including TRICARE and the Federal Employee Health Benefits Program, which could promote value transformation across private carriers and providers.

III. Encourage the Development of Better Outcomes Measures for Quality 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 when 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 being tested for broad-scale adoption. Now there is an overarching need to be moving toward the core measures sets of tomorrow.

One area where Congress should encourage CMS attention is in the continued development of 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 few reasons, including lack of supporting technology and provider incentives, and the administrative burden of implementation. The Task Force supports the continued development and refinement of PROs and has committed to adopting PROs where offered in the existing Medicare fee-for-service APM measure sets. 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.

IV. Maximize the Value of the Physician-Focused Payment Model Technical Advisory Committee (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 new alternative 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.** 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 a 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 that PTAC could better serve the Secretary and CMS in support of 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 several recommendations with regard to current PTAC operations yet believes that it would be more worthwhile for Congress 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 better utilizes the expertise and vision that PTAC members can clearly provide.

The Task Force appreciates the opportunity to respond to the HELP Committee's questions regarding lowering health care costs and incentivizing care that improves the health outcomes of patients. The Task Force stands ready to work with Congress to advance this important work. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org or 202.774.1415) with questions related to this statement.

Respectfully,

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