May 21, 2019

Amy Bassano
Deputy Director
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
Baltimore, MD

Re: Recommendations for design of mandatory value-based payment models

Dear Ms. Bassano:

The Health Care Transformation Task Force (HCTTF or Task Force) writes to share feedback on the development of mandatory value-based payment models. As CMS develops future mandatory models, we believe this feedback will be useful in the design and implementation of mandatory models that will effectively drive down costs and improve quality of care.

The Task Force is a consortium of over 40 private sector stakeholders that support accelerating the pace of delivery system transformation to better pay for value over volume. 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 and better care at reduced costs. Our member organizations aspire to have 75 percent of their business in 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 CMMI and other public and private stakeholders, can lead to a person-centered, value-based delivery system.

The Task Force has regularly provided CMS with constructive feedback about mandatory models, including a response to the Comprehensive Care for Joint Replacement (CJR) proposed rule in 2015[1] and feedback in reaction to cancellation of the proposed mandatory Episode Payment Models for cardiac and orthopedic services and scaling back of CJR in 2017.[2] HHS indicated planned development of additional mandatory models, including Secretary Azar's public

[1] https://hcttf.org/2015-9-23-task-force-consensus-comments-to-cms-regarding-proposed-comprehensive-care-for-joint-replacement-ccjr-program-pdf/

[2] https://hcttf.org/2017-10-18-task-force-provides-comments-to-cms-regarding-epm-cancellation-and-cjr-modifications/

comments in support of mandatory models[3] and the "Potential Model Updates" proposed rule (CMS-5527-P) currently going through clearance at OMB.[4] HCTTF presents the following recommendations for CMS to consider in future development and implementation of mandatory value-based payment models to support participants in achieving the intended outcomes of lowering costs and improving quality of care.

I. Design considerations for mandatory models

HCTTF urges CMS to include stakeholders in the design of mandatory models in a significant and consistent way. Private sector clinical experts, consumers, patients, purchasers, and multi-stakeholder groups like the Task Force are well-positioned to weigh in on model development methodology before participation is mandated. We believe simplicity and transparency are critical to the success of APMs because providers' focus should be on improving care, not trying to parse complex methodologies. There are a number of parameters that CMS should consider in designing mandatory models, including how they interact with existing voluntary alternative payment models, as detailed below.

A. Population-based payment models

Many providers are taking or planning to take on advanced risk for total cost of care through the Next Generation ACO model, MSSP Enhanced, and the recently announced Direct Contracting models. In evaluating the options for managing model overlap with existing APMs, the Task Force asks CMS to give preference to models whose participants take downside risk on total cost of care. Giving preference to these models acknowledges the investment leading organizations are making in transforming care for the entire population.

B. Acknowledge early adopters

Additionally, the Task Force recommends that CMS acknowledge early adopters who have taken on the important work of value transformation voluntarily. We encourage CMS to work with and provide exceptions for providers already in APMs whose existing models may conflict with a new mandatory model.

C. Provide additional regulatory relief

HCTTF appreciates the "regulatory sprint to coordinated care" that HHS has undertaken to examine opportunities for additional regulatory relief to encourage new value-based arrangements to be successful. CMS has also 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 and providing more guidance about the applicability of waivers. For example, CMS should establish a core set of waivers available to all Advanced APMs, with the ability to add additional waivers specific to a particular model.

[3] https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-primary-care-and-value-based-transformation.html

[4] https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201810&RIN=0938-AT89

D. Make mandatory models voluntary in other regions

HCTTF encourages CMS to make any future mandatory models voluntary in other regions to give additional providers greater opportunity to participate in APMs and voluntarily assume additional obligations that would help increase the pace of their transformation progress. Additionally, CMS could use this opportunity to evaluate differences between participants that voluntarily elect to participate and those that are mandated, which may inform future model development or refinement of existing models.

E. Provider exclusion criteria

HCTTF urges CMS to establish targeted exclusionary criteria that acknowledges the burden to comply with mandatory models for rural providers and/or providers with low volumes of targeted episodes in the case of clinical episode models. Task Force members have expressed concerns about the ramifications of mandatory participation on certain providers for whom operating mandatory models are not feasible, including bankruptcy or involuntary consolidation.

F. Gradual risk options

While still giving preference to advanced risk models, the Task Force asks that CMS design any mandatory models with the option for participants to accept gradual increases in risk-sharing over time. Hospitals and providers need to build the infrastructure necessary to comply with program specifics and gradually increasing risk levels would help alleviate the additional financial burden as participants commit resources and make early investments to be successful in the program.

G. Align quality metrics with performance periods

CMS should ensure that quality metrics are aligned with performance periods in mandatory models to allow participants to understand and develop tools to improve the quality of care for program beneficiaries. For example, in the CJR program, the composite quality score included performance on metrics with measurement windows prior to participants' mandated participation in CJR. Quality performance prior to mandated participation in the program should not impact quality scores and financial incentives.

II. Additional advanced notice

To date, CMS has used notice and comment rulemaking to implement or contemplate mandatory value-based payment models, and HCTTF believes that is the right approach. The Task Force recommends that CMS prioritize providing participants and the public additional advanced notice and information for mandatory models in order to engage stakeholders in model development and ensure that providers have adequate time to prepare for the successful implementation of a mandatory model.

A. Extended public comment periods

We request that CMS offer Advanced Notice of Proposed Rulemaking (ANPRM) public comment periods in addition to a formal Notice of Proposed Rulemaking (NPRM) to engage stakeholders in providing input on mandatory models. Engaging stakeholders in the beginning stages of the model development process is important to ensure that providers have adequate

time to consider the impact of the model and provide constructive recommendations. Alternately, CMS should provide Interim Final Rules with a public comment period.

B. Advanced data availability

The Task Force has also recommended that CMS make claims data available to providers in mandatory models further in advance of the model performance period. Providers in APMs often receive claims data while the model is already in effect. We strongly encourage CMS to provide claims data prior to the start of a mandatory model. Providers in mandatory models should be given the additional benefit of claims data on estimated attributed beneficiaries before the performance period to allow adequate time for data analysis and risk stratification to inform optimal care delivery for the aligned population. Additionally, CMS should provide clear and consistent guidance regarding data-sharing agreement requirement for providers in mandatory models.

C. Provide details on waivers in advance

HCTTF also urges CMS to provide details on beneficiary enhancements and payment waivers that will be available to mandatory model participants in advance of model implementation. Our members note that the applicability of waivers are currently difficult to interpret and utilize, and that this process will be more difficult for providers in mandatory models that may lack prior experience with alternative payment models and waivers. Further, providers need this information upfront to be able to build new partnerships, design gainsharing and data sharing agreements, and transform care delivery practices in accordance with the waiver parameters.

III. Research overlap implications

The Task Force has previously provided feedback to CMS on the importance of considering model overlap and synchronization.[5] CMS should provide APM participants adequate flexibility to manage model overlap based on their unique market situation in a way that encourages greater synergy and ultimately drives better outcomes for patients. 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. In prior communication with CMS, we outlined five principles for managing model overlap between clinical episode and population-based payment models.[6] The Agency could reference these principles in considering overlap for mandatory models. CMS should conduct a thorough review of the implications of overlap with other APMs and determine how best to integrate mandatory models with existing models.

A. Evaluate the impact of population carve-outs on existing models

HCTTF believes CMS should consider how existing overlap policies – including policies that carve out patient populations for mandatory models – have impacted existing models. Members have expressed a concern that continued proliferation of APMs, including mandatory models, could cause fragmentation in markets that would be detrimental to broader care coordination efforts if CMS does not prioritize model synchronization. While recognizing the

[5] https://hcttf.org/wp-content/uploads/2018/09/HCTTF-BPCIA-ACO-Model-Synchronization.pdf
[6] https://hcttf.org/wp-content/uploads/2018/01/HCTTFtoCMS_AdvancedBPCI_Track1Plus.pdf

promise potential mandatory models may have to drive value transformation, transformation that moves from fee-for-service silos to value-based payment silos should be avoided.

The Task Force stands ready to work with CMS as the agency designs and implements mandatory models to lower cost and improve quality. The recommendations above are intended to ensure active stakeholder engagement and participation in model design, alignment of mandatory models with existing APMs, and the feasibility of participation across various providers and geographies. 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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