



December 18, 2020

**By Electronic Mail**

The Honorable Joe Biden  
President-Elect of the United States of America  
Office of the President-Elect

The Honorable Kamala Harris  
Vice President-Elect of the United States of  
America  
Office of the President-Elect

Dear President-Elect Biden and Vice President-Elect Harris:

The Health Care Transformation Task Force (“HCTTF” or “Task Force”) congratulates you on your recent election victory. We look forward to working with your Administration to “Build Back Better” and specifically supporting your leadership to promote affordable, person-centered, value-based health care.

The HCTTF is singularly focused on advancing value-based payment and care delivery models which reduce cost, improve outcomes, and drive better population health for individuals and their communities. HCTTF’s membership is unique; we bring together 36 organizations consisting of payers, providers, patients/consumers and purchasers/employers that work collaboratively to advance and support value-based payment transformation. Our members represent a broad swath of national, regional and local organizations with a shared commitment to the health care delivery system of the future and transitioning away from the misaligned incentives of fee-for-service medicine. While our membership participates in many models or programs developed by the Centers for Medicare and Medicaid Services (CMS), it is equally driven to lead this change for all the individuals and communities they serve, regardless of payer.

The current COVID-19 pandemic and its impact on care delivery has made 2020 a very challenging year for many. Frontline workers in hospitals and clinics have confronted the virus daily for the better part of nine months and, in many areas, face physical and mental exhaustion, workforce shortages, and ongoing lack of personal protective equipment, not to mention their own increased susceptibility to contracting the virus. Early in the year, many patients forwent primary care and elective procedures out of fear of exposure to the virus and potential infection. While many patients have been negatively impacted by this disruption in care including exacerbated chronic conditions, it also created significant financial problems and challenged the viability of many medical practices.

Fortunately, many of the providers engaged in advanced value-based payment models found their practices and facilities to be [more resilient](#) in the face of the care delivery disruption.

These providers maintained their operations and personnel and flexed their population health capabilities to respond to populations at risk of COVID-19 because they were not reliant upon fee-for-service payments and necessary service flow for basic survival. This flexibility allowed for investment in innovative care modalities such as expanded telehealth services, virtual care management, and remote patient monitoring. **This experience highlights the importance of recalibrating incentives through value-based payment models, and many health organizations that have resisted such transformation now see it as necessary and desirable.**

***I. A Strategic Vision Is Needed to Realize the Potential of Value-Based Payment***

**It will be key for the Biden-Harris Administration to develop a strategic vision for advancing value-based payment efforts in Medicare and Medicaid for the next four years and beyond.** While the early years of the Center for Medicare and Medicaid Innovation (CMMI) focused on testing many diverse models and initiatives, the time is right to pause and reflect on the lessons learned across the model portfolio, develop a vision for making permanent changes to Medicare payment policy, and encourage State Medicaid programs to adopt successful value-based approaches.

**In the first 100 days of the Biden Harris Administration, we urge CMS to begin a national dialogue about the lessons learned by all stakeholders about CMMI's operations, model portfolio, and model evaluation methodologies.** The private sector is full of committed organizations and people, many of whom are CMMI alumni and close partners who were early adopters, with experienced perspectives on value-based payment and what works and what does not in both private and public payer programs.

To date, the discussion regarding successful CMMI models has focused on whether they delivered “net savings” to Medicare. The statutory language says that to expand a model, the CMS Chief Actuary certifies that such expansion would reduce (or would not result in any increase in) net program spending. We believe there are circumstances where the net savings for the total population in a model test may not be positive, but the CMS Chief Actuary could find that with adjustments in the implementation approach the model will in fact achieve savings. One such example could be if – by virtue of it being expanded and made a permanent part of the Medicare program – a model moves from voluntary to what would be considered mandatory participation.

While ideally all models would achieve the goals of better care at lower cost, we can and should learn important lessons from all models. Even models that were discontinued changed care delivery patterns in positive ways, and those lessons can be drawn upon as CMS considers its vision for advancing value-based payment in the Medicare Shared Saving Program and in CMMI's model demonstrations. **CMS should publish a Request for Information or similar notice in the Federal Register seeking public input to develop a more fully reflective public record of current perspectives and recommendations.**

Task Force staff is on record with a series of recommendations for future innovation in a February 2020 *Health Affairs* blog: [\*\*\*The Center for Medicare and Medicaid Innovation Can Be A Powerful Force for Change, But Not Without Key Reforms.\*\*\*](#) The major recommendations include our belief that CMS should prioritize the certification and expansion of existing VBP models to create a sustainable pathway for providers who have invested in moving away from fee-for-service. Also, CMS should balance innovation and scale such that CMMI models are large enough to generate

valid evaluation results but small and nimble enough to be refined or ended if they are not performing as intended. From a long-term perspective, committed organizations need to make and know their investments have a real prospect of bringing a model to scale through CMMI's expansion authority.

Moreover, rather than prioritizing maximum savings during the model test period, models should be designed to focus on long-term impacts to health care spending and quality with the goal of model expansion. With a multitude of models operating simultaneously, the interaction of these models is a critical consideration that should be structured through the ways that beneficiaries receive care, rather than service line silos mimicking fee-for-service payment structures. Finally, CMS should invest in innovative data systems; it is difficult to truly innovate payment and care delivery using antiquated data systems that do not effectively communicate with each other.

CMS's future vision should address a new definition of success defined by smarter spending priorities like greater model design and operational transparency and access to data, better benchmarking for long term model sustainability, and provider participation and designing models that work well together and are less complex for easier evaluation. CMS should also consider a variety of possible strategies for better advancing value transformation in Medicaid and working closely with states in helping them advance their initiatives.

We understand that the Biden-Harris Administration will likely take time to review the value-based payment portfolio and current model development plans at CMMI prior to making decisions about its strategy moving forward. The HCTTF and its members stand ready to assist and support CMS in any way possible or desirable, including jointly pursuing the legislative priorities mentioned in section VI below that will promote provider participation in value models long term.

## ***II. Value-Based Payment Initiatives Should Address Health Inequities, Disparities and Other Systemic Weaknesses Laid Bare by COVID-19***

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COVID-19 has laid bare the shortcomings of our health system in many respects. Health disparities which have been present for decades have become front page news given the impact of the COVID-19 virus, which has disproportionately affected Black, Brown and Native American populations. **We believe CMMI should instill addressing health equity as a key component of its mission.** Payment models and programs should operationalize mechanisms to address health equity, develop guardrails to ensure value-based care does not worsen inequities, and prioritize new models specifically designed to address disparities.

To advance this work, **CMS should develop policies that require Medicare and Medicaid providers and plans to collect and make publicly available disaggregated data by race, ethnicity, subgroup, and other important factors.** Developing a source for such data will aid in the development of related quality measures and drive reportable outcomes that will help better define problem areas and identify accountability structures and opportunities for improvement.

CMMI should place **greater emphasis on addressing the social determinants of health to promote better population health for communities.** Our members continue to make investments

that help meet the social needs and address social risk factors of those they care for and seek federal support in reforming the public health system to better address these needs.

Also, in the context of COVID-19, we are seeing an increase in the prevalence of substance use disorders that creates a growing need for behavioral health services. This highlights again the importance of advancing primary care and behavioral health integration, an area for potential testing within CMMI. The trauma experienced by those affected by COVID – patients, front line health care workers, families, and care givers – will also present a heightened need for attention, especially among the populations dually eligible for Medicare and Medicaid.

Another challenge for patients and consumers is access to value-based care in rural areas. The financial challenges of engaging federally qualified health centers, rural health clinics, and critical access hospitals in value-based payment models are significant and therefore leaving those in rural and underserved areas without adequate access to value-based care. **CMS should consider this area as a priority as it develops new model opportunities for future innovation.**

**HCTTF supports sensible public policies that drive organizations and entities engaged at every level of care delivery to pursue high quality value-based care that is equitable, person-centered, and holistic.** The HCTTF is eager to work with the incoming Biden-Harris Administration to continue advancing value-based payment efforts that aim to achieve a sustainable value-based payment and care delivery system that is resilient in both prosperous and difficult times.

### ***III. CMS Should Seek New Ways to Ensure that Patients and Consumers Are at the Center of their Health Care***

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A central tenet of value-based care is to put the patient at the center of their care delivery and promote collaborative and informed decision making. There are various ways to accomplish this objective, and we urge CMS to pursue new efforts to promote positive beneficiary experiences. As noted above, HCTTF strongly believes that the pursuit of health equity should be a primary driver for how CMMI operates, including but not only in how the Center's value-based payment models are designed and evaluated. While CMMI can rightly tout many successes, room remains to better engage beneficiaries in value-based payment and care delivery.

**HCTTF recommends that in the early days of the new Administration, CMS set up a listening session for consumer and patient groups to provide feedback on the Agency's value-based payment portfolio and patient engagement initiatives.** We believe it would be insightful to hear from these important voices early on so that CMS establishes an approach to future innovation that ensures patient perspectives are considered fully and acted upon appropriately. Our consumer members are engaged in this transformation journey yet report of a whole other cohort of patient and consumer advocates that are very disconnected from the health care policymaking currently and need to be brought along so they can lend new voices to and support for this effort. Also, CMS should consider lessons learned from organizations like PCORI that have mature processes in place to directly engage patients in selecting and refining research topics for evaluation.

There are many health care organizations that have implemented a variety of strategies designed to move positively in the direction of patient or person-centeredness. **We recommend a**

separate listening session be offered that focuses on strategies health care organizations have pursued to achieve their patient-centeredness goals and the opportunity to share their learnings on what has worked and what has not.

**IV. CMMI Should Support and Accelerate State-Led and Multi-Payer Value Transformation**

While CMMI has made investments in testing state-based innovation, the portion of CMMI's portfolio dedicated to improving outcomes and care for Medicaid beneficiaries has been less than what is needed considering the size and complex needs of that population. **We strongly urge CMMI to make more significant investments in testing new models of value-based payment and care delivery that address the holistic needs of the Medicaid population, including behavioral health and social needs, and advance health equity through community partnerships.**

States governments are uniquely positioned to better integrate health care and social services through better coordination of relevant state programs and resources to achieve optimal well-being for those who face the greatest barriers to health, regardless of payer. CMS should also support state-led efforts to accelerate the adoption of effective person-centered, value-based payment models for Medicaid and state-regulated payers and private sector health care organizations, and better align value-based incentives and guidance for Medicaid managed care plans, Medicare Advantage, and Medicare alternative payment models, including accelerating financially integrated models for the population dually eligible for Medicare and Medicaid.

CMMI should dedicate resources to transforming how maternal health care is delivered. The overall trends in maternity outcomes in the United States are concerning, particularly the growing disparities in outcomes for Black and Indigenous populations. The variations in maternity care delivery and outcomes indicate a clinical area that could be positively impacted by a value-based payment paradigm, building upon the foundation of the promising Strong Start initiative. **The Medicaid program provides a great opportunity to test and encourage adoption of alternatives to fee-for-service for maternity payment**, which pays for about half of all births in the country, and we believe a partnership with commercial payers in testing a maternity alternative payment model will amplify the model's impact.

**V. Value-Based Payment and Care Delivery Should be Championed and Supported**

Current CMS leadership have been saying that the value-based payment portfolio needs a course correction, claiming that only five of 54 models tested within CMMI were successful. **We respectfully disagree.** The facts are that value-based payment has contributed to a significant slowing of health care spending over the past decade. Specifically, in 2010, CMS Office of the Actuary's 10-year projection for healthcare spending predicted that 19.8% of gross domestic product (GDP) would be spent on healthcare in 2020. In fact, 18% of GDP is currently being spent. In total, approximately \$600 billion of that projected spending has been avoided. **We believe VBP and its implementers should be championed and supported for their contributions to bending the cost curve.**

At the core of CMS's current analysis appears to be a flawed approach to VBP model evaluations, and we believe a better way to evaluate models is needed. **The HCTTF is actively gathering perspectives on better ways to modernize evaluations of VBP models from experts**

**and will share with CMS any resulting recommendations in early 2021.** Also, CMS's current perspective appears to be premised on the conclusion that net savings to the Medicare program is the sole measure of success. We disagree here too. In a series of briefers titled [Championing the Move to Value-Based Care](#), HCTTF has outlined how many Medicare models have positively impacted beneficiaries and provider partners in ways well beyond savings to the Medicare program.

Notably, the value transformation agenda to date has been largely comprised of models in which applicants voluntarily decide to participate. Many voluntary participants make necessary investments to best position themselves for success, even if those costs of innovation are not recoverable. The reasons why many participants do not succeed may be within their own control (e.g., lack of adequate investment or insufficient commitment to voluntary models) but can as often be the result of model design, including changing rules of the road designed to ensure short term savings to Medicare – often at the expense of longer-term transformation success. Another reality is that existing fee-for-service incentives in the health care ecosystem are inconsistent with and act as a counterweight to the forward movement of value-based payment models. Sometimes, these incentives are so substantial that the model participants cannot overcome them. The Biden-Harris Administration should address these barriers so that the advancement of value-based payment models may flow more freely.

**The pioneer organizations and those that followed to voluntarily participate in value-based payment models should be applauded for their efforts and the opportunities their experiences provided for CMS to learn much about how to operate models.** These organizations also deserve the support of CMS leadership in committing to designing and implementing models that have the greatest chance of success and potential expansion into national programs.

Periodically, some have called for the dismantling of CMMI and expressed skepticism about the move to value-based payment overall. These views are reflective of constituencies which desire to remain attached to an inefficient fee-for-service system. HCTTF anticipates this voice of opposition may reappear in 2021 and it will be important to have an open and factual conversation on these topics.

**For now, it is critically important for the Biden-Harris Administration to express public support for value-based payment and the institution of CMMI and commit to continuing this important journey.** It is valuable for organizations that have made voluntary investments and commitments to these models to understand the commitment and support of policymakers going forward.

#### **VI. Other Medicare Policies Should Support Value-based Payment Transformation**

Our earlier comments reflect on CMMI's authority and operations specifically, yet the direction of other Medicare policies is also critical to support the advancement of value-based payment. Specifically, the Medicare Access and CHIP Reauthorization Act of 2015 is a bipartisan law designed, among other things, to change the way Medicare pays physicians while also incentivizing those physicians to pursue advanced alternate payment model (AAPM) opportunities. **CMS has significant discretion in implementing these provisions and should exercise its authority in a manner that maintains momentum to advance value transformation.**

Also, the HCTTF supports the Value in Health Care Act of 2020 (H.R. 7791) currently pending before the House. **Many of the Act's provisions can be achieved by administrative action and we urge CMS to consider taking that action;** we would welcome the opportunity to review those provisions with you. However, two key provisions of the bill – changing the qualifying percentages of services necessary for physicians to receive an AAPM incentive payment and extending the sunset date for the availability of those AAPM incentive payments – require legislation. **We urge the Administration to support these two priorities before the 117<sup>th</sup> Congress, which will help avoid a precipitous drop in provider participation in AAPMs.**

Also, policymakers should recognize that the current methods of developing benchmarks from which savings or losses are determined relies on historical payments made to providers and does not account for components of value-based care delivery for which there are no billing codes and therefore historical costs. For example, advanced care management, clinical practice coordination, and addressing social needs are important elements of value-based care that produce input costs not represented in Medicare payment rates. **Therefore, policymakers should reimagine payment policies and model methodologies to better account for these important elements of value-based care and make corresponding payment adjustments to cover these costs.**

Finally, advancing value-based payment through a clear and forward-thinking vision is an important step but is insufficient on its own to achieve the systemic change needed in the United States. **CMS should also develop an off ramp that disincentivizes providers from remaining in fee-for-service.** The move to value requires investment and commitment and when change is hard, it is easy to maintain the status quo, especially when the status quo is lucrative. Disincentivizing fee-for-service while aligning incentives to move to value-based payment models require a deft balance, but success requires both levers be pulled.

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We appreciate the opportunity to share our perspectives with you and welcome the opportunity to discuss them with you. Please contact HCTTF's Executive Director Jeff Micklos ([jeff.micklos@hcttf.org](mailto:jeff.micklos@hcttf.org)) or 202.288.2403) with any questions about or follow up to this letter.

Sincerely,

**Angela Meoli**  
Senior Vice President, Network Strategy &  
Provider Experience  
Aetna, A CVS Health Company

**Shawn Martin**  
Executive Vice President & Chief Executive  
Officer  
American Academy of Family Physicians

**Lisa Dombro**  
Senior Vice President, Innovation & Growth  
agilon health

**Laura Sessums, MD**  
Chief Care Transformation Medical Director  
Anthem, Inc.

**Sean Cavanaugh**  
Chief Administrative Officer  
Aledade, Inc.

**Jordan Hall**  
Executive Vice President, Accountable Care  
Operations  
ApolloMed

**David Terry**  
Founder & Chief Executive Officer  
Archway Health

**Patrick Holland**  
Chief Financial Officer  
Atrius Health

**Jamie Colbert, MD**  
Senior Medical Director, Delivery System  
Innovation and Analytics  
Blue Cross Blue Shield of Massachusetts

**Todd Van Tol**  
Senior Vice President, Health Care Value  
Blue Cross Blue Shield of Michigan

**Troy Smith**  
Vice President of Healthcare Strategy &  
Payment Transformation  
Blue Cross Blue Shield of North Carolina

**Ann T. Burnett**  
Vice President  
Provider Network Innovations &  
Partnerships Blue Cross Blue Shield of South  
Carolina

**Adam Myers, MD**  
Chief of Population Health and Chair of  
Cleveland Clinic Community Care  
Cleveland Clinic

**Shelly Schlenker**  
Executive Vice President, Chief Advocacy  
Officer  
CommonSpirit Health

**Susan Sherry**  
Deputy Director  
Community Catalyst

**Ross Friedberg**  
Chief Legal & Business Affairs Officer  
Doctor On Demand

**Mark McClellan, MD, PhD**  
Director  
Duke Margolis Center for Health Policy

**Chris Dawe**  
Chief Growth Officer  
Evolut Health

**Frederick Isasi**  
Executive Director  
Families USA

**Richard Lipeles**  
Chief Operating Officer  
Heritage Provider Network

**Will Shrank**  
Chief Medical Officer  
Humana

**Anthony Barrueta**  
Senior Vice President, Government  
Relations  
Kaiser Permanente

**Michael Esters**  
Senior Director, Population Health  
Mass General Brigham

**Nathaniel Counts**  
Senior Vice President, Behavioral Health  
Innovation  
Mental Health America

**Leonardo Cuello**  
Director  
National Health Law Program

**Sinsi Hernández-Cancio**  
Vice President for Health Justice  
National Partnership for Women & Families

**Blair Childs**  
Senior Vice President, Public Affairs  
Premier

**Jordan Asher, MD**  
Senior Vice President and Chief Physician  
Executive  
Sentara Healthcare

**Kim Holland**  
Senior Vice President, Government Affairs  
Signify Health

**Jim Sinkoff**  
Deputy Executive Officer and Chief Financial  
Officer  
Sun River Health

**Emily Brower**  
SVP Clinical Integration & Physician Services  
Trinity Health

**Debbie Rittenour**  
Chief Executive Officer  
UAW Retiree Medical Benefits Trust

**J.D Fischer**  
Program Specialist  
Washington State Health Care Authority