August 26, 2021

By Electronic Mail

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S Department of Health & Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

The Health Care Transformation Task Force ("HCTTF" or "Task Force") congratulates you on your appointment as Administrator of the Center for Medicare & Medicaid Services ("CMS"). We look forward to working with you and your team at CMS to advance a value-based delivery system that focuses on providing affordable, equitable, person-centered 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 38 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 moving away from the misaligned incentives of fee-for-service medicine as soon as possible. While our membership participates in many models or programs developed by CMS, it is equally driven to lead this change for all the individuals and communities they serve, regardless of payer.

The COVID-19 pandemic and its impact on health care delivery made 2020 a very challenging year for many. With the Delta variant now causing a surge in the United States, the pandemic will continue to stress the delivery system in 2021, especially in under-vaccinated communities which are often lower income rural and urban populations that lack access to, or confidence in, the health care system.

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 2020 care delivery disruption. These providers maintained their operations and personnel and flexed their

population health capabilities to respond to communities 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 care organizations that have resisted such transformation now see it as necessary and desirable.

The following recommendations represent the Task Force's priorities for the new Administration and CMS leadership: (1) establishing a strategic vision for the future of value-based payment; (2) integrating health equity and addressing social determinants of health as part and parcel of payment reform; (3) ensuring health care payment and delivery centers on the patient and consumer; (4) acceleration of state-led and multi-payer innovations in payment and care delivery; and, (5) alignment of other Medicare policies to advance value-based payment transformation policies. Except where noted, our comments reflect specifically on CMMI's authority and operations.

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

Realizing the potential of payment transformation requires the current Administration to set a strategic vision for advancing value-based payment and care delivery efforts in Medicare and Medicaid. 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 upon on the lessons learned across the model portfolio and the Center's operations to help inform a vision for CMMI's future state. For example, we believe MedPAC's recent recommendation to streamline the CMMI model portfolio going forward is the right strategic direction. **Task Force staff is on record with a series of other recommendations 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*.**

As a result, we appreciate the recent Health Affairs blog authored by CMS leaders on the future of CMMI and the vision for the next ten years. The Task Force is closely aligned with this vision and stands ready to continue its longstanding collaboration with CMMI in advancing value-based payment and care delivery. Success in achieving health equity can only be realized through value-based transformation; the fee-for-service system is ill equipped to advance meaningfully these goals. While the blog sets a desirable path forward, the details of how the vision will be realized will be critically important.

In addition to the blog, we understand that a white paper providing a more detailed CMMI strategy refresh is forthcoming. **We urge CMS to provide stakeholders an opportunity to provide public comments in response to these vision statements.** In addition to setting a course for public programs, CMMI's expanded vision will be critical to providing private payers who may contract with Medicare and Medicaid but also offer commercial products and who seek to create multi-payer models with an understanding of CMS' short- and long-term direction.

CMS should promote a value-based payment ecosystem focused on models with broad provider participation that integrate well with other models. The Task Force membership has considerable experience with both the Medicare Shared Savings Program ("MSSP") and various CMMI models. Conceptually, we believe that accountable care arrangements with a strong primary care and care management focus can partner well with clinical episode models that effectively engage high-value specialists to create a synchronistic value-based payment and care delivery environment. We see the flexibilities afforded by Medicare Advantage allow for the deployment of effective advanced primary care arrangements, and the CMMI models should seek to drive forward in that direction. We urge CMS to continue to drive a policy landscape that allows for these models to work collaboratively to achieve the goals of the Triple Aim and advance objectives of equity and affordability.

While generally supportive of value-based payment models, there is room to improve individual models. The Task Force recently sent a letter to the CMMI Director with specific recommendations for improving the Direct Contracting program and will send soon a letter to the Center for Medicare Director to communicate our recommendations for improving the Medicare Shared Savings Program, including the concept for a new advanced risk model that better represents the positive transformative concepts of the Next Generation ACO model. We look forward to working with your leadership team to improve upon existing models holding the greatest promise for long term, sustainable change.

With the sunsetting of the Next Generation ACO program at the end of 2021 and the pause in new entrants for the Global and Professional Tracks for the Direct Contracting program, some in our membership are concerned about CMS's ongoing commitment to advanced risk opportunities for total cost of care models. CMMI Director Liz Fowler recently spoke to our Board of Directors and her remarks aimed at allaying these concerns. It will be critical for CMMI to refine the model to ensure that the Direct Contracting Program is viable for long term investment and commitment by providers as well as driving other advanced risk options for organizations favoring total cost of care models, possibly in the MSSP program.

CMS' strategic vision should address the need for an evolved definition of success, characterized by smarter spending priorities like improved model design and operational transparency, collection of and access to race, ethnicity and language data, better benchmarking and risk adjustment for long term model sustainability, and provider participation in designing models that work well together and are less complex for easier performance evaluation.

The benefits of value-based payment and care delivery are not widely available to patients and consumers 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, which in turn leaves 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. **A first priority could be to finalize the fix for the so-called "Rural Glitch" benchmarking flaw in the MSSP program set forth in the CY 2022 Physician Fee Schedule Notice of Proposed Rulemaking**. Given inherent challenges that already exist for

provider uptake in value models in rural areas, fixing this methodological flaw would assist with APM adoption by rural providers.

More generally, HCTTF urges CMS to facilitate 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 who bring experienced perspectives on value-based payment including what works and what does not in both private and public payer programs. New CMMI leadership should leverage that expertise to help advance the Center's work in its second ten years. For example, CMS should more effectively use the expertise of the Physician-Focused Payment Model Technical Advisory Group as an advisor, as the Office of the Assistant Secretary for Planning and Evaluation recommended in its February 2021 Charting Future Directions paper. **We urge CMS to publish a Request for Information or similar notice in the Federal Register seeking public input on current model participant perspectives and recommendations.**

Recently, the Task Force convened a group of CMS officials and private sector experts to discuss improvements to CMMI's model evaluations and increased opportunities for model expansion. These discussions revealed certain limitations associated with the CMMI enabling statute – both real and perceived. They also revealed that the absence of a Conference Committee during the final passage of the Affordable Care Act contributed to certain key statutory terms going undefined and then subject to agency interpretation. **The RFI process recommended above could be used to solicit public comment and recommendations for further defining these policies and advancing the statute's objectives.**

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 V below that will promote greater 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

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 commend CMS and CMMI for indicating that addressing health equity will be the cornerstone of the Administration's mission**. Payment models and programs should operationalize mechanisms to positively impact health equity and new models that are specifically designed to address health disparities should be prioritized. The work will be challenging, yet it is an important priority whose time is now; achieving meaningful health equity will not be possible under the current fee-for-service system.

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 (or drivers) of health (SDoH) that too often create roadblocks to individuals' health and health care, with the goal of promoting better population health for all 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. **We believe that an interagency effort across all relevant federal departments that identifies and coordinates on common policy objectives and pursues blending and braiding of relevant funding streams to address SDoH has the potential to be a key initiative for the Biden Administration.**

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 CMS and CMMI 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

A central tenet of value-based care is to put the patient at the center via collaborative and informed decision-making that is responsive to and respectful of patients' needs and priorities. 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 not only in how the Center's value-based payment models are designed and evaluated, but in how the models engage with patients and consumers. While CMMI can rightly tout many successes, room remains to productively and consistently engage beneficiaries in value-based payment and care delivery.

In April, the Task Force led the convening of a Consumer Roundtable in which several CMMI officials participated and is eager to finalize plans for another Roundtable in September. These sessions are designed to share important insights from a range of prominent consumer voices so that CMS and CMMI are well advised as they establish an approach to future innovation that ensures patient perspectives are considered and acted upon fully. Such efforts will complement efforts to engage consumer voices in pursuing health equity through the Health Equity Advisory Team that was recently announced as a new Health Care Payment Learning and Action Network (LAN) initiative.

In addition to consumer perspectives, our provider and payer members also have gained experience from implementing a variety of strategies designed to move positively in the direction of patient or person-centeredness. **We are pleased that CMMI has expressed interest in HCTTF convening separate listening sessions that focus on strategies health care organizations have pursued to achieve their patient-centeredness goals and sharing learnings on what has worked and what has fallen short.**

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.** These efforts should include incentivizing state Medicaid programs to pursue direct contracting with providers in addition to any available Medicaid managed care plan offerings.

State 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. State-level engagement will also be critical to achieving broad policy objectives in advancing health equity. 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 mortality and morbidity for Black, Indigenous, and People of Color (BIPOC) 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**, **which pays for about half of all births in the country, provides a great opportunity to test and encourage adoption of alternatives to fee-for-service for maternity payment**. We also believe a partnership with commercial payers in testing a maternity alternative payment model will amplify the model's impact.

V. Other Medicare Policies Should Support Value-based Payment Transformation

Our earlier comments reflect on CMMI's authority and operations specifically, yet the overall 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.**

HCTTF also supports the Value in Health Care Act of 2021 (H.R. 4587) recently introduced in the House. Notably, 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, one key provision of the bill – extending the sunset date for the availability of Advanced APM incentive payments – requires legislation. **We urge the Administration to stand with its provider partners and support these priorities before the 118th Congress.** While the Task Force also supports legislative action to address the Rural Glitch benchmarking flaw in the MSSP program, we believe CMS should instead take direct action and finalize the proposed fix included in the CY 2022 Physician Fee Schedule Notice of Proposed Rulemaking.

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. **Although an unpopular idea with many, 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) 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

Lisa Dombro
Senior Vice President, Innovation & Growth
agilon health

Sean Cavanaugh
Chief Commercial Officer and Chief Policy Officer
Aledade, Inc.

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

Maria Stavinoha
Payment Innovation Director, Network Optimization
Anthem, Inc.

Stephanie Graham
Vice President, Payer Innovation
Apervita

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

Scott Seymour
Vice President, Network Management & Provider Partnership Innovation
Cambia Health Solutions

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

Colin LeClair
Chief Executive Officer
Connections Health Solutions

Latoya Thomas
Director, Policy and Government Affairs
Doctor On Demand

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

Chris Dawe
Chief Growth Officer
Evolent Health

Frederick Isasi
Executive Director
Families USA

Zahoor Elahi
Chief Operating Officer
Health [at] Scale

Richard Lipeles
Chief Operating Officer
Heritage Provider Network

Will Shrank
Chief Medical Officer
Humana

Anthony Barrueta
Senior Vice President, Government Relations
Kaiser Permanente

Lindsay Jubelt, MD, MS
Chief Population Health Officer
Mass General Brigham

Jeanne DeCosmo
Senior Director, Clinical Care Transformation
MedStar Health

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

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 Heath Care Authority