October 19, 2021

VIA ELECTRONIC MAIL

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Driving Health Equity and Affordability through Value-based Payment

Dear Secretary Becerra:

The Health Care Transformation Task Force (Task Force) writes to share its perspectives and recommendations on policies that can drive health equity and affordability through value-based payment and care delivery models.

The Task Force is a consortium of private sector stakeholders that support accelerating the pace of transformation in the delivery system to one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver a health system that achieves equitable outcomes through high-quality, affordable person-centered care.

We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work led by the Department of Health and Human Services and other public and private stakeholders, can increase the momentum of delivery system transformation to focus on paying for value of care over volume of services.

I. Advancing Health Equity and Affordability for Individuals and Communities

The Task Force writes to express support for the U.S. Department of Health and Human Services' (HHS) plan to put health equity and affordability at the center of all HHS policies. We believe the cornerstone of achieving health equity and affordability are payment policies that promote value for individuals by focusing on health and well-being and which move away from financial incentives centered on the volume of services provided.

The current fee-for-service system is ill-equipped to properly serve disadvantaged and underserved populations. A value-based payment and care delivery infrastructure that incentivizes the health care system to focus on whole-person care, encourages collaboration to address the social drivers of health, and holds payers and providers accountable for quality and cost outcomes is critical to advancing the Administration's health equity policy objectives. Investment in payment reforms that support population health – such as the Medicare Shared

Savings Program, Medicare Advantage, and efforts to test new payment and care delivery reforms from the Center for Medicare and Medicaid Innovation demonstrations – is critical to creating a modernized payment and care delivery system that equitably serves individuals from all populations.

Affordability of health care services remains a key concern for the Medicare program and its beneficiaries, as it is for individuals covered under state Medicaid programs and commercial plans. That is why we support HHS prioritizing affordability as one of its key policy drivers. Value-based payment, when properly done, holds promise for reducing waste, improving quality, and rewarding providers for improved outcomes, all key components to increasing affordability. For patients, value-based payment models offer a controlled environment to make care more affordable by reducing or even eliminating the cost sharing amounts related to primary and preventative care as an incentive to maintain regular contact with the health care system. Value-based payment models also benefit patients by incentivizing providers to focus on preventive care, close care gaps, and better coordinate care across the clinical care journey. Patients who avail themselves of these important well-care services will reduce the need for interventions and acute care services later as well as help reduce the onset of chronic disease, which will likely result in future savings both to individuals as well as reduce costs to the system.

While there has been much focus on the mechanics of value-based payment and how they impact providers and their participation in certain models, we applaud the direction to expand the focus on reducing the financial burden on patients who participate in these models and giving greater flexibility to provider participants to waive or reduce cost sharing without running afoul of potential compliance policies. While many fee-for-service beneficiaries have Medigap policies and would not feel the direct impact of cost sharing waivers, the system as a whole – as well as Medicare Advantage enrollees in particular – will benefit from greater flexibility in this area. In fact, the Medicare ACO program, with innovative use of waivers, could bring a lower cost Medigap option to the marketplace. Finally, it is important for HHS to develop policies that bring value-based payment and care delivery arrangements to communities that have yet to have access to these options.

II. Value-based Care Coordinates Care Among Various Independent Stakeholders and Incentivizes Cost Reductions and Improved Quality Outcomes

Achieving the promise of value-based care requires greater care coordination among providers and effective collaboration with payers. It is true that investments and commitments are needed to build this infrastructure for both payers and providers, including the use of electronic health records, data science, telehealth, and other data systems that support care management and value-based payment arrangements, and that scale is beneficial to support the costs of building and operating these systems. Some have expressed concern that value-based payment incentives may lead to provider consolidation, which in turn creates the perception of unfair market power and elevated prices. However, we believe this concern is misplaced and the exact opposite may be true.

By definition, value-based payment models are designed to reverse the trend toward raising prices and billing for more services. Value-based payment model incentive payments are usually determined by individual provider performance against a regional benchmark, such that higher prices and a failure to provide care more efficiently would lead to poor financial performance. Thus, value-based payment models reward efforts to reduce health care costs

through more effective primary and preventative care to drive better population health, reduce chronic disease, and move away from volume-based payment incentives. Value-based payment allows HHS to trade unpredictable and uncontrollable fee-for-service growth for predictable and controlled value-based payment growth.

Another positive market driver for value-based payment is the opportunity to allow independent physician practices to remain independent while moving toward value-based payment and care delivery in a coordinated way. Several Task Force members operate business models whereby they partner with independent physician practices to provide value transformation infrastructure and operational experience to help these practices develop population health capacities through accountable care type arrangements. This approach allows physician practices to transform within their own footprint and avoid being vertically integrated within health systems. The same is true for providers who join health plan virtual panels and otherwise engage with payer partners for better support of their value-based care activities.

Many accountable care organizations operate through clinically integrated networks, which are groups of providers, practitioners and other entities working together by using clinical protocols and measures to improve patient care, reduce cost, and demonstrate value to individual patients and communities. The main objective for clinically integrated networks is to organize efficiently to provide high value care, not to drive revenue through higher prices and expansive utilization. Even when financial integration is present, the incentives of value-based payment models drive behavior that reduces the volume of services so that the network participants can share in the savings generated by more effective and efficient coordinated care that drives better patient outcomes.

III. Value-Based Payment Arrangements Create a More Resilient Health Care System

Health care organizations have learned many lessons from the COVID-19 pandemic. One key lesson is that the fee-for-service system creates an industry imbalance when health care service utilization falls dramatically and quickly. Many health care providers, primarily community-based medical groups, experienced significant cash flow issues during the first half of 2020 when patients did not pursue care due to quarantines. While access to covered health care services remained in place, the actual delivery of health care services endured a major disruption; unfortunately, the pandemic elucidated the inelasticity of a health system where incentives are built around service volume.

Health plans and providers operating under advanced value-based payment arrangements had a different experience. Providers paid through shared-risk arrangements often were able to mitigate cash flow concerns by continuing to receive up-front payments or care management fees while also benefitting greatly from shared savings distributions. Up-front payments tied to quality metrics created an environment where providers had the flexibility and resources to adjust staffing to support a pivot to a combination of virtual care and lower volume of in-person visits. While many plans stepped forward to help distressed fee-for-service providers through loans or other short-term financing arrangements, the value-based arrangements in place exhibited the resiliency that should be inherent in a modernized health care delivery system, especially in the face of an environment that leads to volatility in volume of services rendered.

IV. OPM Direct-Hire Authority Should Be Requested to Ramp Up CMMI Staffing

Task Force members have expressed concern about the apparent reduction in staffing at the Center for Medicare and Medicaid Innovation ("CMMI") in recent years. A bold innovation effort requires the recruitment and retention of civic-minded thought leaders willing to lend their experience and expertise to further the Innovation Center's important mission, and talented staff prepared to take on the challenges of model design and operations. However, the normal application and vetting process for federal hiring can be cumbersome and at times creates a disincentive for strong candidates to apply for key positions.

We believe the staff attrition at CMMI represents a critical hiring need in line with the intent of the Office of Personnel Management's Direct-Hire Authority (DHA). Thus, we urge leadership at HHS to direct CMS to pursue DHA for CMMI – allowing the Center to seek desirable candidates and streamline the application and vetting process. There is precedent for this approach: CMMI successfully used DHA to fill key positions throughout much of its first four years of operation, which allowed it to find new staff with the experience and expertise needed to advance the Center's forward leaning agenda. Given the importance of CMMI in driving care delivery and payment reform efforts critical to improving the health care system, we urge HHS to focus on ensuring the Center can effectively recruit and hire the talent necessary to drive its innovation agenda as quickly as possible.

V. The Task Force Has Shared Additional Perspectives about our Common Priorities

In addition to the foregoing comments, the Task Force has several additional perspectives and priorities that were communicated to you in a September 8, 2021 letter in which the Task Force was joined by 16 other health care organizations. That letter can be found here.

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Thank you in advance for your consideration of this letter. The Task Force's Executive Committee also requests an opportunity to meet with you to discuss its content. If you or your team have questions about the letter or to coordinate about scheduling a meeting, please contact Task Force Executive Director Jeff Micklos at 202.288.2403 or jeff.micklos@hcttf.org.

Sincerely,

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