Jeff Micklos
Executive Director

November 18, 2021

Sent via Electronic Mail

Elizabeth Fowler J.D., Ph.D.
Deputy Administrator and Director, Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS Innovation Center First Listening Session

Dear Deputy Administrator Fowler:

The Health Care Transformation Task Force (HCTTF or Task Force) is a consortium of private sector stakeholders that support accelerating the pace of transforming the health care delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the health care industry – including providers, health plans, employers, and consumer/patient representatives – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs. 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 the Centers for Medicare and Medicaid Services (CMS) and other public and private stakeholders, can increase the momentum of delivery system transformation.

We appreciate the opportunity to provide written feedback on the three questions the CMS Innovation Center (or CMMI) has identified as focus areas for the First Listening Session as well as to offer verbal remarks.

1. **What is the greatest obstacle to participating in CMS Innovation Center or other value-based, accountable care model? How do you recommend the CMS Innovation Center alleviate this obstacle?**

Based on our work with alternate payment model (APM) participants, we believe there are three main obstacles to participation in accountable care models: (1) barriers to initial entry, (2) barriers to sustained participation, and (3) barriers to APM expansion.

- **Barriers to Entry**: Successful participation in these models requires upfront investments in staffing, training, and data infrastructure necessary for effectively managing population health. While some providers have been able to make these investments using reserves, private financing, or taking advantage of CMS programs like the ACO Investment Model (AIM), others have not been as fortunate. Those providers that lack these resources or missed out on early CMS investments are hard pressed to take on the more complex APMs CMMI has offered recently. **The CMS Innovation Center should: (1) offer technical assistance to providers focused on preparing to participate in APMs, (2) create new opportunities for early infrastructure investments similar to the AIM model, and (3) design on-ramp models with lower risk levels to ease the transition from fee-for-service.**

- **Barriers to Sustainability**: Current benchmarking methodologies are a serious barrier to sustainable participation in a model. Benchmarking strategies that are based on historical spending with periodic rebasing create a disincentive for APM participants to fully maximize potential savings because the long-term result is tougher benchmarks and fewer resources to sustain care delivery changes. This downward pressure on benchmarks makes participation unsustainable and will ultimately force participants out of models (especially efficient low-cost participants). The Medicare Shared Savings Program rural glitch and the differing Direct Contracting benchmarking methodologies for new versus standard Direct Contracting Entities are prime examples of how benchmarking methodologies can deter model participation. **CMMI should focus efforts on developing benchmarking methodologies that support appropriate spending levels on care, limit rebasing, and do not penalize mode participants for the savings they achieve for their assigned populations.** The CMS Innovation Center should redesign benchmarking methodologies so that ACOs are no longer on a "bridge to nowhere" as one MedPAC Commissioner characterized them at a recent meeting.

  Another major barrier to sustaining participation is the time-limited nature of CMMI models and lack of clarity regarding model certification or future participation opportunities. APM participants must make significant investments to join models that may fail to be certified for expansion (as has been the case for the majority of CMMI models to date). This uncertainty makes it difficult for providers to justify the ongoing infrastructure investments necessary to support participation and deters new providers from joining models. We recognize that CMMI models are intended to be tests and understand that it is not reasonable to expect a guarantee that any model will be continued. That said, current and potential participants should have greater predictability regarding the future of models to reasonably plan for and operate their businesses. **CMMI should provide greater transparency regarding the model lifecycle, prioritize the early development of and advance notice for any successor models, and focus on driving successful model certification and/or expansion of promising model concepts via other routes within CMS.**

- **Barriers to Expansion:** The barriers to entry and sustainability have created serious challenges for expanding APMs into new areas, especially among underserved populations. This is a particularly important issue to address if CMMI is to effectively lead the effort to advance health equity. The providers that most often care for the communities impacted by inequity (rural hospitals, critical access hospitals, federally qualified health centers, community clinics, and small practices) lack the investment resources and risk tolerance for most APMs. Additionally, current benchmarking approaches generally fail to adequately account for equity in that they assume that historic spending and utilization should/can be lowered while maintaining or improving quality. This is generally not a realistic expectation for underserved individuals and communities where providing appropriate care would likely require spending and utilization above the historic average. **CMMI should develop benchmarking and risk adjustment methodologies that establish reasonable expectations for the cost of providing efficient and high-quality care and that can adjust for historic underinvestment in communities and among specific populations.**

2. What else could the CMS Innovation Center do to support clinicians and help them be successful in models?

At their core, clinicians wish to treat their patients based on clinical needs and risks with the goal of improving health and care delivery for their entire practice. The move to value-based payment and care delivery holds great promise in that regard but can also create a paradigm where different patients may be cared for differently because of varying rules of engagement related to their insurance coverage. **The CMS Innovation Center can help support clinicians in value-based payment models by designing models that attract participation by multiple payers in an effort to bring greater consistency and uniformity to the providers furnishing value-based care.** This is why HCTTF was pleased to see multi-payer models highlighted as a priority in the recent CMS Innovation Center strategy refresh white paper and HCTTF looks forward to collaborating to help make this vision a reality.

In this regard, **CMS's leadership would be welcome in developing and advancing a parsimonious set of quality measures that can be applied consistently to different value-based models and which focus on outcomes over processes.** Quality measurement should evolve to become less about teaching to the rule and more about driving infrastructure that supports sustainable and meaningful success in delivering appropriate and equitable care based on principles of value.

CMS can also support clinicians in value-based models by creating flexibilities around care delivery that promote patient-centeredness and reducing unnecessary administrative burdens. The CMS Innovation Center models deploy a variety of waivers for regulatory and policy requirements to help practitioners deliver care in a way that is most meaningful and effective for their patients. However, model participants are often faced with uncertainty around the applicability or scope of particular waivers, and experience differing interpretations of similar waivers across various models, leading many providers to not avail themselves of those opportunities. **HCTTF has long recommended that the Innovation Center adopt a core set of**

waivers that can be applied and interpreted consistently for all CMMI models, and then add additional waivers as appropriate for specific models. A more consistent approach to applying and interpreting waivers would create a more stable base from which clinicians can practice in a value-based way while not disincentivizing the use of waivers due to compliance risk and legal concerns.

In sum, the greater consistency and flexibility that can be brought to bear through value-based models across all payers, the greater the opportunity for clinicians to best care for the patients right in front of them without worry or concern about particular rules or limitations that may be imposed by a patient's health insurance coverage. Value-based models have the ability to reduce or eliminate the perverse incentives of a system that rewards volume of services furnished. Thus, these models should also afford clinicians a more flexible and focused environment to provide equitable and affordable care. The CMS Innovation Center has a significant leadership opportunity available in this regard.

3. **How can the CMS Innovation Center better incorporate patient needs and goals in models? How should the impacts of value-based care on patients be measured?**

The Task Force appreciates the CMS Innovation Center's prioritization of patients' needs and goals as reflected in both the recent Health Affairs blog, and the Innovation Center's strategy refresh white paper. In the white paper, CMS defines patient-centeredness as "meeting patients where they are in their care journey." The Task Force agrees that concerted prioritization is required to achieve the beneficiary-specific goals related to accountable care, health equity, care innovation, affordability, and health system transformation. CMMI seeks to quantify progress toward these goals via measures of patient experience, functional status improvements, avoidable hospital admissions, coordination and care transitions across settings, access to follow-up care, and to home- and community-based care, expanded access to care via tools such as telehealth and other virtual care portals, affordability, and reduction in disparities. These metrics comprise the concept of an accountable care relationship between a beneficiary and a provider.

CMMI notes that the first step toward advancing accountable care is "educating and engaging beneficiaries on what an accountable care relationship is, and the potential value and benefits associated with these relationships." **The Task Force posits that APMs built upon the foundation of accountable care relationships should align to the following principles if they are to leverage payment and delivery reform in a way that centers patients, and prioritizes equity, access, and affordability:**

- Use all the communications channels at your disposal to promote the concept that social and economic factors have a significant effect on the health and well-being of individuals, and as such, the health care system as a whole (including public and private payers, providers, purchasers, and patients) has a role to play in addressing the challenges imposed by a lack of health equity.
- Meaningfully engage with consumers and patients as active partners in the model design and implementation process. This is particularly critical when it comes to those who have

been historically underserved and have a perspective on access and affordability challenges that may not be familiar to CMMI or other stakeholders.

- Recognize the role that health systems play in driving toward, and achieving, health equity. The starting point for this is to support the development and implementation of interoperable data collection infrastructure that is both robust and secure and can provide the necessary data for identifying needs and designing patient-centered interventions. Health systems should also engage patients and their caregivers in designing how care is delivered, coordinated, and communicated.
- Establish quantifiable goals around affordability and require transparency of costs and quality information to support consumers and patients in their health care decision-making.
- Recognize that access to care can be achieved via such tools as telehealth, flexible licensure regulations, and changes to reimbursement to allow individuals to receive care in ways that reflect technological advancements and our current environment.
- Prioritize the delivery of culturally congruent care by providing consistent, stable resources and other incentives for training, recruitment, and hiring of diverse networks of caregivers who represent the communities being served.
- Optimize channels for rapid and continuous quality improvement data to be made available to providers at the point of care, including patient-reported feedback, to allow providers to improve care to patients during their care journey. This includes supporting and investing in technology that allows for secure transmission and access to data in a way that protects patients' privacy.

We understand that CMS is planning to hold patient focus groups to understand how the agency can make certain tools work better for patients and how to incorporate patient feedback into the entire model life cycle, starting with a commitment to model co-design. We support these efforts and appreciate the opportunity to amplify ideas and promising practices for future model development that puts patients, equity, access, and affordability as the highest priorities.

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If you have questions about this letter or wish to obtain additional information, please contact me at jeff.micklos@hcttf.org or 202.288.2403.

Sincerely,

Jeff Micklos