April 5, 2022

VIA ELECTRONIC MAIL

Meena Seshamani, M.D., Ph.D.
Deputy Administrator and Director, Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

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

Re: APM Alignment Recommendations

Dear Directors Seshamani and Fowler:

The Health Care Transformation Task Force (HCTTF or Task Force[1]) writes to offer recommendations for how the Center for Medicare & Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI) can advance the goal of streamlining the alternative payment model (APM) portfolio. A recent study found that the mean number of specialist visits for Medicare beneficiaries has increased 20 percent between 2009 and 2019, with 30 percent of beneficiaries seeing five or more specialists per year. Given the increasing role of specialists in caring for the Medicare population, it is imperative that CMS devise a way to align APM designs to promote better coordination between primary care providers (PCPs) and specialists to effectively deliver high quality and cost-effective care.

The model overlap policies CMMI has implemented to avoid duplicate shared savings payments have resulted in unintended consequences, including confusion over which provider has responsibility for managing the financial risk of a patient, limited incentives for effective care coordination, and diminished opportunities for financial savings for both the Medicare Trust Fund

[1] Founded in 2014, the Task Force is an industry consortium representing a diverse set of health care stakeholders – including providers, payers, purchasers, and patient advocacy organizations – all committed to adopting payment reforms that encourage health care organizations to move from a system that incentivizes the volume of services to one that rewards the value of care delivered. The Task Force strives 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 CMS and others, can increase the pace of delivery system transformation.

and providers. Our recommendations focus on defining the barriers to improving alignment between primary care and specialty focused models and offering a strategy for promoting alignment through the design of future models.

EXECUTIVE SUMMARY

The comments offered in this letter reflect our desire to support CMMI's effort to meet the vision offered in the CMMI's Strategy Refresh. Our recommendations for advancing APM alignment efforts are organized into four main areas: barriers to APM alignment, design elements for future APMs, cross model alignment strategies, and approaches for promoting equity. Key points from these sections are summarized below.

1. **Addressing Barriers**: There are a number of actions that CMS can take to address structural barriers in the current APM landscape that interfere with alignment efforts. These include:
    - Addressing unnecessary complexity caused by overlapping model timelines by aligning new model launch schedules and application requirements so participants can compare APM opportunities side-by-side.
    - Allowing model participants greater flexibility to create high quality provider networks by extending the TIN-NPI participant selection approach to MSSP and future APMs.
    - Creating aligned incentives for quality improvement across model types by collaborating with stakeholders and using existing measure sets to develop outcome-oriented measure sets that can apply to primary care and specialist models. The quality measurement strategy should balance efforts to minimize provider reporting burden with the goal of selecting clinically meaningful and actionable measures.

2. **Future Model Design Elements:** Task Force members identified several elements of model design that CMS should consider as it refines the APM portfolio and develops new models within CMMI. These include:
    - Designing benchmarking methodologies that align across models and establish clear incentives for population-based model participants and bundled payment providers to partner. In the event that this alignment cannot be achieved, CMS should limit the potential for the benchmarks it set in one model to harm the financial performance of participants in another model.
    - Gaining broad and sustainable model adoption among a critical mass of providers with the goal of improving quality while achieving predictable and sustainable health care cost growth. To accomplish this CMS should provider on-ramps for providers new to APMs, create benchmarking options that address the ratcheting effect to reward and retain efficient providers, and explore options for alternative benchmarking approaches that do not rely on current FFS spending to promote long term sustainability.
    - Playing an active role in the design and operation of models targeting specific service lines and conditions. These efforts should focus on two areas: 1) procedural episodes where a beneficiary has a time limited relationship with a provider to address a specific issue, and 2) Chronic Condition-Specific Models built around a limited set of chronic health conditions where specialists play a predominant role in managing care longitudinally or for discrete periods of time as the condition is in an acute phase.

3. **Strategies for Cross-Model Alignment**: HCTTF recommends that CMS pursue a hierarchical model alignment strategy. This strategy should set a clear, consistent, and predictable beneficiary attribution policy supported by financial arrangements that: 1) allows providers delivering complimentary care to mutually benefit under their respective models, and 2) strives to minimize cross-model gaming opportunities that drive adverse incentives such as participant selection bias or freeriding. To do this we recommend that CMS:
    - Allow high-risk ACOs the flexibility to either:
        i. Participate in bundled payment models designed and operated by CMS. Under this option the ACO would identify a set of bundled payment arrangements and a list of participating specialists for CMS to apply the bundled payment arrangement to. The ACO would retain beneficiary attribution, CMS would make direct payments to providers under the bundled payment model, and all bundled payment spending would be reconciled against the ACO TCOC benchmark.
        ii. Opt-out of CMS designed bundles. Under this option ACO aligned beneficiaries would not be eligible for any other payment models. Instead, ACOs may choose to contract directly with specialists, receive funds from CMS, and manage downstream payments. ACOs would have the latitude to design these contracts and would retain responsibility for TCOC. ACOs would also have the discretion to not enter into any downstream contracts.
    - Establish model alignment policies for low and moderate risk ACOs that preferences models based on the nature of the clinical condition covered by the model and the degree of responsibility the provider is accepting for beneficiary care coordination, cost, and quality. Under this policy, beneficiary attribution would work as follows:
        - When a beneficiary with a chronic condition receives care under both a low or moderate risk ACO and a relevent chronic-condition model, alignment preference would go to the chronic condition model provider when the specialist serves as the central coordinating point of care for beneficiaries (such as ESRD) and is willing to accept greater risk for the total cost of care and quality.
        - When a beneficiary is receiving care from a low or moderate risk ACO model and receiving treatment from a provider participating in an procedural episode, beneficiary alignment would remain with the ACO model.
        - When a beneficiary is not receiving care from any ACO provider but is receiving care from a provider in another APM, then attribution would default to the other APM (with chronic-condition models taking precedence over procedural episodes).
    - Leverage model participation requirements to promote alignment by requiring applicants to chronic-condition models and procedural episodes to have explicit contractual relationships, defined referral pathways, and clear coordination plans with primary care providers in population-based APMs.

4. **Advancing Equity**: HCTTF fully supports the emphasis on health equity that CMS has placed at the core of new payment model design efforts. We urge CMMI to continue leveraging a multi-faceted approach to incorporating equity considerations into models. This should include:
    - Participant requirements for formal health equity plans.
    - Benchmarking and risk adjustment strategies that account for beneficiary and community level equity and are designed for providers working in underserved communities.
    - Demographic data collection standards and quality measurement strategies that encourage the closing of health equity gaps.

DETAILED COMMENTS

HCTTF member organizations have considerable experience with CMS-designed APMs and believe these models are critical for improving quality and reducing health care costs. The Task Force has consistently supported CMS efforts to develop advanced risk models that promote accountability for spending and outcomes for Medicare beneficiaries. We appreciate CMS' vision for accountable healthcare as set forth in the CMMI Strategy Refresh. The goal of having all Medicare fee-for-service beneficiaries in an accountable care relationship by 2030 sends a clear signal to stakeholders about the future direction of delivery system reform. To achieve this goal, CMS will need to expand opportunities for APM participation and implement models that drive alignment between primary care providers and specialists. The comments offered in this letter reflect our desire to support CMMI's effort to meet the vision offered in the Strategy Refresh.

A. Barriers to APM Alignment

HCTTF members identified several barriers that hamper the ability to drive alignment between primary care and specialists. While we focus on issues that are within the purview of CMS to address, we also note key barriers that require Congressional action. We mention these broader issues to offer a more holistic view of our members' experiences and perspectives.

1. Misaligned Model Timelines

HCTTF has previously commented on the considerable time and resource investments providers and organizations make evaluating and participating in CMS APMs. These challenges are compounded by the fact that many Medicare APMs operate on independent timelines for model applications and key elements of model operations such as provider list submissions and financial reconciliation. Misaligned model timelines unnecessarily complicate APM participation and increase the likelihood that participants will default to the fee-for-service (FFS) status quo rather than taking on new models. **To address these issues, CMS should align new model launch schedules and application requirements so participants can compare APM opportunities side-by-side. CMS should simplify the application and operational timelines for ACOs by leveraging the Medicare Shared Savings Program (MSSP) as a standard operating platform for aligning all future ACO models.** The Task Force detailed this concept in a letter to CMS on strategies for improving MSSP.

2. TIN Only Provider Selection

MSSP requires that accountable care organization (ACOs) be defined by their Medicare billing tax identification number (TIN). In contrast, CMMI models have allowed ACOs to define

participating providers using a combination of TIN and national provider identifier (NPI). TIN-only selection limits ACOs to including all specialist providers within a TIN regardless of how well they align with the care delivery priorities of the ACO.

With TIN-only provider selection, ACOs are more likely to exclude entire specialist provider groups, and even multi-specialty groups that include primary care providers, due to the potential impact of the specialists on their underlying model performance. This also creates an incentive for TIN-splitting, creating new separate TINs for primary care and specialists, which adds an unnecessary administrative burden for providers and CMS. The Pioneer and Next Generation ACO models allowed ACOs to use a TIN-NPI combination to identify providers which enabled them to create more focused high-performing provider networks. **We recommend that CMS extend the TIN-NPI participation approach to MSSP and future APMs to allow greater flexibility for engaging high quality specialists.**

3. **Lack of Shared Accountability in Quality Measurement**

Reliable and valid accountability measures that align quality and financial performance are central to APM expansion and the incorporation of specialists. While we appreciate past efforts to streamline the total number of performance measures, the resulting measure sets are often so narrow they exclude specialty providers. This further disincentivizes specialist participation in APMs because their work cannot be clearly tied to representative quality measures that reflect their specialty (e.g., functional outcomes for patients who undergo orthopedic surgery). **The Task Force recommends CMS collaborate with stakeholders and use existing measure sets to develop systems based on outcome-oriented measures.** This refined measure strategy should include domains focused on improving care delivery, improving health, and lowering costs while avoiding excessive process-based measures that increase provider burden. CMS should also make focused efforts to align measures across payers. Inclusion of patient-reported outcome measures (PROMs) with lessons learned from Blue Cross and Blue Shield of Massachusetts (BCBSMA) in their systematic adoption of PROMs can aid in the shift to person centered care.

4. **Current Model Overlap Policies**

Task Force Members identified clarity with respect to patient attribution as a significant barrier to model alignment. Current CMS model overlap policies often preclude a beneficiary from being aligned to more than one model at a time. While this is an effective strategy to prevent duplicate shared savings payments, these policies create clear financial disincentives for coordination across providers when such coordination could result in one provider losing attribution. The complexity of model overlap policies negatively impacts a healthcare organization's ability to prioritize care redesign efforts and dilutes potential impacts on the quality and cost of care. In the future model design section below, we offer recommendations for designing models intended to minimize overlap issues and maximize the potential for alignment between primary care providers and specialists.

5. **APM Alignment Barriers Requiring Congressional Action**

The bullets below highlight key barriers to APM alignment that generally require Congressional action to address. We highlight where we believe there is opportunity for CMS to take actions alongside Congress to help address these issues.

- **Fee-For-Service to APM Payment Policy Transition:** HCTTF believes that efforts to expand APM opportunities should be paired with actions that make APMs a more

attractive option for providers. Changing the current Medicare fee schedule is critical to incentivizing provider participation in APMs and increasing the number of Medicare beneficiaries in accountable care relationships. To date, specialist participation in ACOs has been low. The Task Force believes the low participation rates are due to a combination of APM model design issues highlighted throughout this letter and insufficient pressure on the fee-for-service (FFS) environment to spur change. We have urged Congress to build on the policies in MACRA to create long-term momentum to transition to APMs. **The Task Force also calls upon CMS to leverage its regulatory authority over FFS policies and the MIPS program to align future FFS policy changes with the long-term goal of incentivizing APM adoption.**

It is important that these FFS adjustments be paired with increased APM opportunities for specialists and primary care providers, reasonable timelines for these providers to successfully transition into APMs, and strong incentives for accepting greater accountability for cost and quality. The increasing complexity of new APMs favors well-resourced providers with capacity to accept risk over providers with fewer resources or prior experience with APMs. While several market solutions exist to help aggregate physicians and enable their success in performance-based risk models, we acknowledge that the APM movement is still leaving behind a cohort of providers and the beneficiaries they serve.

CMS can play a key role in addressing this issue by expanding access to existing models and reviving earlier model concepts that provided an on-ramp for providers interested in adopting APMs. **Specifically, we recommend that CMS encourage broader participation in MSSP as the largest permanent APM program in the country.** HCTTF offered several recommendations to improve MSSP in an earlier **comment letter** submitted to CMS. **We also encourage CMS to create targeted model opportunities for regions that lack APM availability and providers that have historically faced major headwinds in APM participation.** These models should: 1) support for providers that lack the capital to invest in the necessary infrastructure to form and operate ACOs (e.g., a new version of the CMMI ACO Investment Model), and 2) offer primary care providers without APM experience technical assistance and opportunities to engage in care transformation while gaining experience by accepting a more manageable level of risk.

- **MACRA (AAPM Incentive and Qualified Participant Threshold):** The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created incentives for providers to transition to APMs. Under the Advanced Alternative Payment Models (AAPM) track. MACRA offers a five percent incentive payment, in addition to the normal Medicare payments providers receive through their AAPM and exempts these providers from otherwise applicable reporting requirements. This policy appropriately incentivizes providers to accept greater accountability of care and higher levels of risk.
  However, the five percent bonus effectively expires with the 2022 performance year, and its lack of availability in future years is likely to have a detrimental impact on the desire of both PCPs and specialists to engage in AAPMs. Task Force members have cited the incentive payments as a key part of their recruitment efforts for both bundled payment models and ACOs and are concerned about the implications if Congress does not extend this bonus payment. **HCTTF has called upon Congress to extend the incentive payment to**

keep up momentum on value-based transformation, and we strongly urge CMS to join us in supporting efforts to extend the availability of the AAPM bonus.

Another barrier to AAPM adoption and alignment is the current Qualifying APM Participant (QP) threshold policy physicians must meet to receive AAPM incentive payments. Our members note that the current QP threshold is too high, creating a disincentive for ACOs to recruit specialists who often see patients referred from non-APM providers struggling to meet the QP threshold requirements. ACOs working to maintain performance in an AAPM are more likely to drop specialists as the QP threshold becomes more difficult to meet. Additionally, ACOs would benefit from greater transparency than is currently available regarding the QP Threshold and AAPM bonus. Specifically, ACOs need the ability to verify who of their participating providers met the QP threshold and earned the AAPM bonus. **The Task Force supports a call for Congress to take action to address the QP threshold as proposed in the Value in Health Care Act. Specifically, that CMS should be granted the authority to set the thresholds providers must meet to qualify for bonus payments under the AAPM.**

B. Future Model Design Recommendations

The Task Force agrees with recent CMMI remarks signaling a preference for population-based models to function as the core chassis for patient alignment, although we note there are cases where this will not be feasible. We recommend that CMS continue to refine a targeted set of bundled payment arrangements and implement a hierarchical model strategy to promote the nesting of specialty care models within population-based total cost of care (TCOC) models. Properly designed, this approach would create strong incentives for improved coordination between primary care providers and specialists and encourage more ACOs to take on greater levels of accountability to better manage risk. Our recommendations are divided into two broad areas: (1) design elements for future bundled payment and population-based payment models, and (2) strategies for alignment across models based on the relationship between the Medicare beneficiary and the provider – i.e., beneficiaries aligned to high-risk ACO models vs. beneficiaries aligned to low or moderate risk ACO models.

1. Design Elements for Future Models

HCTTF believes CMS should continue to play an active role in designing specialist focused bundled payment arrangements informed by collaboration with specialty specific stakeholder representatives. As discussed below, CMMI-designed bundled payment models will play a key role in a hierarchical alignment strategy and will be necessary in cases where no provider has TCOC accountability for a beneficiary. CMMI's ability to design, test, and evaluate models is critical to informing further refinement of APMs and offers a framework that less sophisticated organizations participating in population-based TCOC models could use to guide their efforts to contract with specialists.

Furthermore, without sufficient APM options to engage specialists, it will be challenging to achieve CMMI's goal of having all Medicare beneficiaries in an accountable care relationship by 2030. There are several conditions where a specialist or team of specialists play a predominant role in managing a patient's care, such as end stage renal disease or cancer care – which may involve a surgeon, medical oncologist and radiation oncologist. In the event that a specialist is not contracted with an ACO, CMMI has an interest in designing APMs focused on these providers and

beneficiaries. CMMI should consider the following elements when designing future bundled payment and population-based models:

- **Benchmarking Alignment:** Addressing the misalignment of benchmarking methodologies between ACO and bundled payment models is a critical prerequisite for successful model alignment. Model design and efforts to avoid double-counting of shared savings payments can create headwinds or tailwinds for one APM participant or the other, and potentially adverse incentives such as participant selection bias, risk selection, or gaming opportunity. For example, when beneficiaries overlap, episode target prices set based on regional averages could serve as a disincentive for ACOs already performing better than their region, while the episode provider may receive an outsized benefit from the ACO's prior improvement efforts. In short, HCTTF members have highlighted the challenges posed by bundled payment model benchmarks that are set too high – or alternatively ACO benchmarks that are set too low – to allow for mutually successful partnerships.

  To address this challenge CMS should co-design benchmarking methodologies across models with a focus on setting payment levels at a point where population-based model participants and bundled payment providers have a clear financial incentive to partner. The goal of this approach should be to encourage appropriate referrals so primary care providers and specialists are delivering the right care, in the right setting, and at the right time to promote efficiency and quality. The Task Force recognizes how challenging it is to set appropriate benchmarks. In the event that CMS is unable to successfully addresses the pricing misalignment across ACOs and bundled payment model benchmarks, we encourage CMS to establish policies to limit the financial harm to ACOs. This could include benchmark exclusion or stop-loss criteria that would limit the financial risk an ACO is exposed to as the result of benchmark price misalignment.

- **Benchmark Adjustments:** The Task Force recognizes CMS has an interest in adjusting models to reflect changing market trends. The approach to accomplishing this has typically relied on annual adjustments that rebase the model benchmark to account for broader changes in utilization and costs. Task Force members, The Medicare Payment Advisory Commission (MedPAC), and independent researchers have all identified benchmarking and frequent rebasing as a disincentive to long term model participation because it creates a ratcheting effect on benchmarks making them increasingly difficult to meet. This strategy can also hamper investment in and utilization of beneficial advancements in technology because benchmarking methodologies do not adjust for the cost of these types of investments.

  At this stage in the evolution of APMs, we believe CMS should focus on gaining broad and sustainable model adoption among a critical mass of providers with the goal of improving quality while achieving predictable and sustainable health care cost growth. To do this, we recommend that CMS:

  A. **Create a sustainable on-ramp for providers entering models.** To succeed in APMs, organizations must invest in care delivery reforms and technology to manage risk while keeping providers engaged in the model concept. This requires resources and time to develop. We support the approach CMS has used in some recent models (including ACO REACH) to maintain fixed baseline years and eliminate rebasing. We recommend that CMS continue this approach

for future models. If CMS determines that rebasing is essential to the design of a model, we recommend eliminating rebasing at least in the initial years of a model (example: years 1-3 of a five-year model) and holding benchmark adjustments to later model years (years 4-5 of a five-year model) to offer participants greater predictability in benchmarking and avoid penalizing participants for early success.

B. **Reward and retain efficient providers**. Historical benchmarking methodologies create a long-term structural disadvantage for experienced and efficient APM providers and disincentivizes maximizing efficiency. To address this, CMS should shift providers that deliver high-quality, cost-effective care to a regional benchmarking methodology. The beneficiaries assigned to these providers would need to be excluded from the regional benchmark calculation to ensure the efficient providers are not penalized for the savings they achieve for their assigned populations.

C. **Transition to predictable and sustainable benchmarks**. We believe a key long-term goal of APM reform efforts should be achieving health care spending growth that is predictable and sustainable for payers, providers, and patients. Both historical and regional benchmarking as a basis for shared savings models will become increasingly untenable if efforts to transition the majority of the health care system to APMs are successful. While this issue is not a central concern at the moment, we believe CMS should start preparing for this eventuality. Specifically, we urge CMS to explore options for designing and testing alternative benchmarking approaches that do not rely on current FFS spending. This could include the exploration of administratively set benchmarking strategies as raised in recent MedPAC committee discussions.

These proposals would allow participants additional flexibility to invest in the people, technology, and equipment necessary to achieve greater efficiencies and improved patient outcomes and would provide incentives to remain in models for the long term. Implementing these strategies might result in CMS forgoing some potential savings at the level of individual model participants but we believe this would be offset by transitioning a wider range of participants into models and increasing the number and retention rate of efficient providers.

- **Cross-Model Quality Measures:** As noted in the Barriers to APM Alignment section above, quality measures are an important lever for driving coordination across provider types. **CMS should focus on balancing efforts to minimize provider reporting burden with the selection of clinically meaningful and actionable measures.** One explicit goal of this quality measurement strategy should be to promote measure sets that encourage shared accountability across primary care providers and specialists to create incentives for partnership and efficient referrals.

  CMS should engage in continued public-private partnerships to develop and align performance measures leveraging existing collaboration including the Core Quality Measures Collaborative (CQMC) or the Measure Applications Partnership (MAP). Specialty providers should be included throughout the measure development process. Finally, while continuing to create and pressure test the next generation of

performance measures, the multitude of data infrastructure challenges that limit the success and scalability of these measures should be addressed.

Finally, Health IT interoperability – or lack thereof – is a significant factor in the feasibility of quality measure alignment. **CMS should collaborate with the Office of the National Coordinator of Health IT (ONC) to strengthen certified EHR technology**. Specifically, CMS and ONC should focus on ensuring EHRs are equipped with the appropriate level of quality measure specifications, data validation requirements, and active data dashboards needed for aligned quality reporting that is valid, reliable, and mitigates reporting burden and costs for providers and APM entities.

- **CMS Role in Episode-Based and Condition-Specific Models:** As noted earlier, we believe CMS should continue playing an active role in the design and operation of models targeting specific service lines and conditions. Whenever possible, these models should be nested within more comprehensive models – as we detail in the following section – to ensure chronically ill beneficiaries receive coordinated and person-centered care. In addition to further refining ACO models, we recommend CMS leverage the lessons learned from the past decade of model design alongside knowledge from APM stakeholders to develop models focused on two areas:

    A. **Procedural Episodes**: Episodic models built around procedures with variable cost and quality outcomes that are amenable to bundled payment arrangements. These bundled payment arrangements would focus on procedures (*e.g.*, total hip/knee arthroplasty, spinal fusion, stroke/transient ischemic attack) where a beneficiary has a time limited relationship with a provider to address a specific issue. The bundle's principal goal would be to improve quality and address unexplained variations in cost, and efficiency. Participants in these models would be responsible for managing costs and quality within the bundle – or total cost of care for that patient for the duration of the episode – but would not be eligible to serve as accountable entities for overall beneficiary care.

    B. **Chronic Condition-Specific Models**: Payment models built around a limited set of chronic health conditions where specialists play a predominant role in managing care longitudinally or for discrete periods of time as the condition is in an acute phase. If a beneficiary is not aligned to a high-risk ACO model, providers in these condition-specific models would be eligible to serve as the accountable entity for beneficiary costs and quality. This concept is discussed in more detail below in the Alignment Across Models section below.

  HCTTF recognizes that there are conditions that do not fit neatly into either of these categories. For some conditions, the nature of the beneficiary and provider relationship – time-limited or longitudinal – can only be determined after the initiation of treatment. Cancer care is a good example of this challenge. For these cases, we urge CMMI to:

    - Continue engaging with stakeholders to inform approaches to developing effective payment models that recognize the distinct – and often complimentary – components of cancer treatment: surgery, medical oncology, and radiation oncology, and

- Explore alternative APM strategies for improving quality and controlling costs for these conditions such as the Cancer Care ACO concept proposed by Third Way.

2. Alignment Across Models

HCTTF members highlighted CMMI model overlap policies that impact beneficiary attribution as the principal challenge for APM alignment. Current overlap policies – where one model participant may lose attribution when a beneficiary receives care from providers participating in another model – disincentivize cross-model partnership even when such partnerships make clinical sense. CMS should focus on setting a clear, consistent, and predictable beneficiary attribution policy supported by financial arrangements that: 1) allows providers delivering complimentary care to mutually benefit under their respective models, and 2) strives to minimize cross-model gaming opportunities that drive adverse incentives such as participant selection bias or freeriding.

The Task Force believes that CMS efforts to align ACOs and specialty focused bundled payment models should favor providers willing to accept greater levels of responsibility for the cost, quality, and coordination of a beneficiary's care. To accomplish this, we urge CMS to implement a hierarchical model alignment policy using the following approach.

- **Beneficiaries Aligned to high-risk ACO Models (i.e., MSSP Track E, Enhanced Track, and ACO-REACH):** Under a hierarchical model arrangement, when a beneficiary is aligned to a high-risk ACO– such as those in MSSP Enhanced or ACO-REACH – that relationship would take precedence over any other payment model. The ACO would retain beneficiary attribution, and the responsibility for the cost of care would be reconciled under the ACO benchmark. **To encourage provider alignment, CMS should allow high-risk ACOs two options for engaging with specialists**.
    - **Option 1**: ACOs could elect to participate in bundled payment models designed and operated by CMS. In this scenario, the ACO would identify a set of bundled payment arrangements and a list of participating specialists for CMS to apply the bundled payment arrangement to. The ACO would retain beneficiary attribution, CMS would make direct payments to providers under the bundled payment model, and all bundled payment spending would be reconciled against the ACO TCOC benchmark.
    - **Option 2**: ACOs could opt-out of CMS designed episodes. ACO aligned beneficiaries would not be eligible for any other payment models. Instead, ACOs may choose to contract directly with specialists, receive funds from CMS, and manage downstream payments. ACOs would have the latitude to design these contracts giving them full flexibility to negotiate the details of the payment arrangement (e.g., electing to design bundled payment models or enter into sub capitation agreements). ACOs would also have the discretion to not enter into any downstream contracts.

  Under both options, the ACO would keep responsibility for the TCOC of all attributed patients whether they received care from a specialist contracted with the ACO or an outside provider. This approach would allow more advanced ACOs to fully align specialists through contracting and support less advanced ACOs by allowing them to outsource the complexity of designing a custom model for specialists to CMS. ACOs would

have an incentive to coordinate care as the TCOC risk bearing entity and duplicate shared savings issues would be avoided by virtue of all beneficiary spending being reconciled against the ACO's TCOC benchmark under both options.

- **Beneficiaries Aligned to low and moderate risk ACO Models (i.e., MSSP Tracks A-D):** In situations where a beneficiary is receiving care from a provider under a low or moderate risk ACO model, CMS should advance APM alignment by establishing a model overlap policy that preferences models based on the nature of the clinical condition covered by the model and the degree of responsibility the provider is accepting for beneficiary care coordination, cost, and quality. The goal of this policy should be to limit the potential for gaming opportunities across models, align patients to providers best suited to address their clinical needs, encourage care coordination, and incentivize providers to transition to higher-risk arrangements over time. Under this policy, beneficiary attribution would work as follows:
    - **Beneficiary with Chronic Condition:** When a beneficiary with a chronic condition receives care under both a low or moderate risk ACO and a relevent chronic-condition model, alignment preference would go to the chronic condition model provider when the specialist serves as the central coordinating point of care for beneficiaries (such as ESRD) and is willing to accept greater risk for the total cost of care and quality. The goal of this policy would be to encourage specialists in chronic-condition models to take accountability for beneficiaries with conditions that could most benefit from their expertise. CMS would need to establish a threshold to preclude alignment of low-acuity beneficiaries to chronic-condition models due to on-off or intermittent consultations. Additionally, because beneficiaries often have multiple chronic conditions, CMS would need a process for determining the most appropriate accountable provider when a beneficiary could qualify for alignment to an ACO and multiple chronic-condition model.
    - **Beneficiary with Condition that Aligns to Procedural Episode:** When a beneficiary is receiving care from a low or moderate risk ACO model and receiving treatment from a provider participating in a procedure focused episode, beneficiary alignment would remain with the ACO model.
- **Beneficiaries not Aligned to any ACO:** When a beneficiary is not receiving care from any ACO provider but is receiving care from a provider in another APM, then attribution would default to the other APM (with chronic-condition models taking precedence over procedural episodes).

To further incentivize alignment across provider types, **CMMI could leverage model participation requirements by requiring applicants to chronic-condition models and procedural episodes to have explicit contractual relationships, defined referral pathways, and clear coordination plans with primary care providers in population-based APMs (unless no such providers exist within a specified geographic region).** These requirements in combination with the aligned quality measures and benchmarking methodologies mentioned above could be designed to: (1) encourage specialists to refer lower acuity patients to population-based models and (2) encourage population-based models to transition to higher-risk payment arrangements and accept greater accountability for the costs and quality of care for the beneficiaries they serve.

C. Advancing Health Equity

HCTTF fully supports the emphasis on health equity that CMS has placed at the core of new payment model design efforts. We commend CMMI's efforts to address this issue through the health equity plan requirements and benchmark adjustments in the new Accountable Care Organization Realizing Equity, Access, and Community Health (REACH) Model. In previous letters to CMS, the Task Force highlighted issues with APM design that negatively impact the ability of models to address equity and have offered recommendations to address them. Many of those recommendations are directly applicable to CMMI efforts to align APMs.

Specifically, we note that the providers most often caring for communities impacted by inequity (rural practices/hospitals, safety net practices/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 rely to some degree on historic spending and utilization as a proxy for appropriate levels of care. This is not a realistic expectation for individuals and communities that are underserved by the health care system and further entrenches historic inequities.

We urge CMMI to continue leveraging a multi-faceted approach to advancing equity including: equity plan requirements, benchmarking strategies that adjust for beneficiary and community level equity, risk adjustment methodologies tailored to providers working in underserved communities, demographic data collection, and quality measurement strategies that encourage the closing of health equity gaps. These efforts must be grounded on the establishment of reasonable expectations for the cost of providing efficient and high-quality care in a manner that adjusts for the historic underinvestment in some communities and demographic groups. To improve equity in relation to APM alignment and specialist care, CMMI could target models to communities with shortages of primary care providers and specialists and develop measures to monitor equity issues in the treatment modalities that beneficiaries receive, patient experience, and outcomes.

D. Multi-Payer Alignment

Improving multi-payer alignment is critical to spreading and sustaining APM adoption. HCTTF is supportive of the HCP-LAN efforts to convene state collaboratives and view states as key players in alignment efforts. The Task Force Board has made this issue a priority for 2022. Several HCTTF members have experience engaging specialists in APMs and working to align specialists and primary care providers. This includes examples of APM arrangements implemented in coordination with states, and purchasers, as well as commercial payer efforts to address the issue of model overlaps and duplicate payments. We would welcome the opportunity to share lessons from our members and continue the dialogue on how to achieve alignment between CMS and private sector APM efforts.

*****

The HCTTF is eager to work with CMS to achieve sustainable change in value-based payment and care delivery, a goal that requires alignment between the private and public sectors and engagement with payers, providers, purchasers, and patients. Please contact Joshua Traylor (Joshua.Traylor@hcttf.org | 202.556.0339) with any questions or comments on this letter.

Sincerely,

Angela Meoli
Senior Vice President, Enterprise Initiatives
Aetna, A CVS Health Company

Claire Mulhearn
Chief Communications & Public Affairs Officer
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.

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
Executive 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

James Grana
Vice President, Value Based Care
Blue Cross Blue Shield of South Carolina

Laura Fox
Director, Payment Innovation
Blue Shield of California

Alex Goolsby
Vice President, Network Management & Provider Partnership Innovation
Cambia Health Solutions

Stephanie Graham
Senior Solutions Lead
Clarify Health

Robert Lorenz, M.D., M.B.A., F.A.C.S.
Executive Medical Director, Market & Network Services
Cleveland Clinic

Shelly Schlenker
Executive Vice President, Chief Advocacy Officer
CommonSpirit Health

Emily Stewart
Executive Director
Community Catalyst

Colin LeClair
Chief Executive Officer
Connections Health Solutions

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

Ashley Ridlon
Vice President, Health Policy
Evolent Health

Frederick Isasi
Executive Director
Families USA

Zahoor Elahi
Chief Operating Officer
Health [at] Scale

Richard Lipeles
Chief Operating Officer
Heritage Provider Network

Ami Parekh
Chief Medical Officer
Included Health

David Nace
Chief Medical Officer
Innovaccer

Anthony Barrueta
Senior Vice President, Government Relations
Kaiser Permanente

Sara Rothstein
Vice President, Population Health Management
Mass General Brigham

Ryan Anderson, MD
Interim Vice President, 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

Jake Woods
Manager, Accountable Care Models
PSW

Srin Vishwanath
CEO
OPN Healthcare

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

Judy Zerzan, MD
Chief Medical Officer
Washington State Heath Care Authority

cc:

Liz Richter
Deputy Director
Center for Medicare

John Pilotte
Director, Performance Based Payment Policy Group
Center for Medicare

Arrah Tabe-Bedward
Deputy Director
Center for Medicare and Medicaid Innovation

Chris Ritter
Acting Deputy Director
Director, Patient Care Models Group
Center for Medicare and Medicaid Innovation

Purva Rawal
Chief Strategy Officer
Center for Medicare and Medicaid Innovation

Pauline Lapin
Director, Seamless Care Models Group
Center for Medicare and Medicaid Innovation