Jeff Micklos
Executive Director

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Sent via Electronic Mail

Meena Seshamani, M.D., Ph. D
Director, Center for Medicare
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

Dear Dr. Seshamani:

The Health Care Transformation Task Force (Task Force) is a consortium of private sector stakeholders that support accelerating the pace of transforming the delivery system into 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 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 CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

Earlier this year, the Task Force responded to the Centers for Medicare and Medicaid Services' (CMS) Medicare Advantage Advance Notice for CY 2023. In that response, the Task Force expressed support for the concept of a value-based care measure for Medicare Advantage plans. Specifically, the Task Force said:

> "In this proposal, CMS expresses interest in developing a measure that focuses on the percentage of providers in MA plans that are in value-based contracts and what types of contracts are being used. The Task Force believes that MA acts as a driver for value transformation, and therefore supports this move to collect more information on MA and value-based contracts.
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> We recommend CMS consider using the Health Care Payment Learning and Action Network's (LAN) Alternative Payment Model Framework as a starting point for the measure. Using this framework, CMS should measure MA provider participation in Framework's Category 2 versus Category 3 and 4 to see how advanced value-based contracts are in MA. This is an important distinction as

Category 3 and 4 payment models tie a financial incentive directly to a cost reduction (i.e., the participating provider shares in savings or losses), whereas Category 2 just tie bonuses to quality improvements. In the future, the Task Force would also like to see additional policies to incentivize MA plans to enter into value-based agreements with their provider networks."

Since that time, the Task Force has continued to discuss the concept of a value-based care measure in Medicare Advantage and now offers the following additional perspective for CMS's consideration:

First and foremost, the Task Force believes it is important for CMS to capture data on the types and prevalence of value-based care contracts that MA plans are using with their provider networks. Given the widespread acceptance of the LAN's APM Framework, the Task Force reiterates its earlier recommendation to use that framework as the basis for data collection. This type of reporting is already occurring through voluntary industry surveys conducted by AHIP and the Blue Cross Blue Shield Association and aggregated for public reporting by the LAN. For Task Force members, this process seems to be working effectively. If CMS is concerned that the voluntary reporting process is not adequately capturing sufficient, consistent data, the Task Force would support exploring a policy that makes this data reporting a requirement for MA plans.

The Task Force does not support developing a discrete value-based care measure solely for the purpose of inclusion in the Stars Rating system - at least not at this time. A measure of the percentage of a plan's business in value-based contracts will help achieve the goal of driving adoption of wide-scale, effective value-based networking contract arrangements, yet that may not be the ultimate goal. We do support the continued public reporting of the data collected, ideally on a CMS display page as the final Advance Notice for 2023 contemplates.

The Task Force has a unique perspective on this issue; our current guiding principle sets an aspirational goal for our payer and provider members to have 75 percent on their business in qualifying value-based payment arrangements (essentially Categories 3 and 4 of the LAN framework) by the end of 2025. However, some payers have indicated that trying to meet that goal has resulted in signing up providers for qualifying contracts when they are not ready to perform at that level, result in unsuccessful partnerships and sour relationships that required unwinding or significant redirection.

Based on this experience, we recommend CMS consider seeking information from MA plans about how they define success across various value-based contracts, either those currently operating or in the planning phase. While cost reduction and quality improvement remain cornerstones of value-based care, there are other factors that contribute to successful arrangements. The Task Force is actively working with its plan and provider members to better understand their perspectives on success metrics based on the experience of the last five to ten years. Asking for this information from MA plans may or may not lead to a specific measure designed to drive change, yet the shared learnings would be insightful to the broader movement to advanced value models across all populations.

In sum, the Task Force believes understanding the move to value-based care within MA is an important policy objective, yet one that does not readily lend itself to a measure that would be part of the existing Star Ratings program. Instead, we urge this activity should be rooted in important transparency and information sharing objectives to understand the changing marketplace. Engaging the plans on what they view as success in value-based contracts with providers is even more important from a long-term policy perspective."

The Task Force continues to believe that the Medicare Advantage program provides an important platform for value-based care that affords plans and providers the flexibility to establish person-centered, accountable care relationships for Medicare enrollees through innovative payment arrangements that emphasize cost and quality goals. We stand ready to assist CMS as it develops additional policy in this area. Should you have questions or need more information, please do not hesitate to contact me at jeff.micklos@hcttf.org or 202.288.2403.

Sincerely,

Jeff Micklos

cc: Douglas Jacobs M.D.
Cheri Rice
Jennifer Shapiro
Rebecca Paul