November 17, 2017

Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, D.C. 20001

Dear Administrator Verma:

NCHC is a nonpartisan, nonprofit organization representing more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers, and groups representing consumers, patients, women, minorities, and persons with disabilities. The Coalition is committed to advancing - through research and analysis, education, outreach, and informed advocacy – an affordable, high-value health care system for patients and consumers, payers, employers, and taxpayers.

We deeply appreciate your decision to offer this Request for Information on the future of the CMS Innovation Center and the opportunity to offer our response.

Since the middle of the last century, America’s health care costs have been driven upward by a fee-for-service reimbursement system that rewards quantity and complexity of services—not positive patient outcomes. Yet after two decades of bipartisan leadership across changes of Administration and Congressional control, federal policy has begun to pursue a more value-based path. In recent years, leading purchasers, plans, and providers, as well as forward-thinking state governments, have increasingly embraced innovative new models of health care delivery and payment.

Unfortunately, NCHC’s provider, clinician, payer, and employer members are now reporting a slowing of value-based contracting, which they attribute to remaining uncertainty about the future of alternative payment models in the current policy environment.

Therefore, the manner and speed with which you employ the Innovation Center’s unique authorities is of particular importance. Actions taken and signals sent now could well determine
whether the transition advances at a pace and scale sufficient to enhance affordability or whether most patients and clinicians remain mired in a costly fee-for-service reimbursement system.

For this reason, the National Coalition on Health Care is especially eager to work with you to maximize the Innovation Center’s impact. Our primary recommendation is that you make broadening opportunities for participation in robust Advanced Alternative Payment Models the central goal of the Innovation Center. Our detailed comments are appended, but the rest of our recommendations are summarized below:

- **Continue to test and evolve the Innovation Center’s leading models in traditional Medicare.** This requires expanding participation opportunities in proven population-based models as well as making the new voluntary bundled payment model available nationwide, on a voluntary basis, during the 2018 performance year. Additionally, to maximize impact on cost and quality, NCHC strongly supports providing advanced organizations the option of assuming full performance risk either for overall spending or primary care services.

- **Pursue broader testing of innovative payment models in Medicare Part C.** Specifically, we applaud CMS’ decision to grant credit for MA AAPM participation toward MACRA’s participation thresholds and urge CMS to swiftly implement the planned demonstration. Additionally, NCHC supports the testing of a Community-Based Institutional Special Needs Plan (CBI-SNP) Model that uses targeted home- and community-based services to prevent institutional stays among Medicare-only beneficiaries.

- **Engage consumer and patient voices in the development and implementation of new models.** Engagement of beneficiaries and their advocates is particularly important to the sustainability and impact of payment and delivery reform. As the Agency proceeds, we call for mechanisms to ensure beneficiaries and their advocates are involved in the development, implementation, and evaluation of Innovation Center models.

By aligning federal policy with the most innovative private sector and state payment reform initiatives, your leadership and the work of the Innovation Center can substantially advance the movement toward value. We look forward to working with you toward that end. Please do not hesitate to contact me at jrother@nchc.org or NCHC’s Policy Director, Larry McNeely, at lmcneely@nchc.org.

Yours truly,

John Rother
President and CEO
Detailed Comments of the National Coalition on Health Care
Innovation Center New Direction RFI

1. Do you have comments on the guiding principles or focus areas?
2. What model designs should the Innovation Center consider that are consistent with the guiding principles?
3. Do you have suggestions on the structure, approach, and design of potential models? Please also identify potential challenges or risks associated with any of these suggested models.

Increased participation in Advanced Alternative Payment Models (AAPMs):

NCHC applauds the priority given to increasing AAPM participation in this RFI. **We urge CMS to designate the expansion of AAPM participation opportunities for physicians and other eligible clinicians as the Innovation Center’s most central and immediate priority.**

For some time, providers, payers, and purchasers alike have noted that the delivery system is torn between persistent payment incentives to maximize volume and their hopes of participating in the transition to value. NCHC’s provider, clinician, payer, and employer members are now reporting a slowing of value-based contracting, which they attribute to remaining uncertainty about the future of alternative payment models in the current policy environment.

Designating the expansion of participation in AAPMs as its top priority is the clearest and most helpful signal that the Innovation Center and CMS can send. But to ensure that signal is clear, this expansion must come by widening opportunities to participate and making participation more attractive—not by substantially weakening standards for what constitutes an AAPM.

Your plan to establish a MA APM model granting MACRA-eligible clinicians credit for participation in MA-sponsored Advanced APM contracts is an important step in that direction. NCHC looks forward to engaging with you to support the strongest possible MA APM demonstration whether that be a CMS demonstration or a CMMI model. It needs to be timely and responsive to the provision of the final rule and not be subject to unnecessary delays in implementation.

Even as work on the MA APM model proceeds, NCHC urges you to aggressively pursue additional strategies to broaden participation opportunities for clinicians.

- **Evolve the Innovation Center’s Flagship Initiatives:** One of the best ways to expedite the process for providers who want to participate in an Advanced APM is to expand opportunities to participate in those types of APMs which are already producing positive results. We believe much more can be learned, and substantially broader AAPM participation can be achieved by evolving population-based ACO, episodic bundling, and
advanced primary care initiatives and continuing to offer clinicians new opportunities to participate.

- Given the success of the Pioneer and Next Generation ACO programs to date, we recommend that most advanced provider organizations have the option to assume full performance risk on at least a yearly basis moving forward. CMS should either a) build on the All-Inclusive Population-Based Payment option within Next Gen ACO, or b) establish other models that rely on global payments. Global payment arrangements offer flexibility and resources that permit advanced provider organizations to retool their operations to support upstream primary care and psychosocial interventions. The end results are reductions in downstream medical and hospital costs that outpace results from models with weaker incentives. This can best be seen in California, where Medicare Advantage plans utilize capitated payment arrangements with provider and physician organizations. In that state, statewide averages for emergency department visits, all-cause readmissions, and inpatient bed days are all between 50 percent and 75 percent higher in fee-for-service than they are for MA.¹ (NOTE: Although any global payment model would permit providers to assume substantial performance risk, organizations should not assume full insurance risk without meeting the same consumer protection and solvency requirements as health plans.)

- We urge CMS to announce the new voluntary bundled payment model (BPCI 2.0) in time to allow clinicians to qualify as AAPM participants in 2018. The current BPCI program will expire this coming year, and a gap between programs would be difficult for providers and suppliers to navigate and it would diminish the success of the follow-on program. NCHC believes that timely announcement and implementation of this model is key to broadening AAPMs opportunities for specialists.

- Building upon the current CPC and CPC + models, we encourage CMS to establish transformative primary care models or programs that combine prospective population-based payment for primary care services and shared savings based on total costs.

  - Standardize compliance, payment, and benefit waivers: We encourage CMS, working with other relevant agencies, to provide a standard set or sets of compliance and benefit waivers for AAPMs. A standardized approach to issues like telehealth geographic and originating site regulations, Stark and Anti-Kickback Law restrictions on provider relationships, beneficiary incentives and waivers of Medicare payment regulations would facilitate more

efficient development and review of model proposals and make participation more attractive to provider organizations and clinician practices.

- **Pursue alignment between Medicare and other private and public payers:** Alignment of Medicare models and metrics with other payers is essential if providers and clinicians are to receive a consistent set of signals and incentives. Failure to achieve such consistency multiplies the measurement burden and turns model participation into a compliance exercise. However, proper alignment can encourage broader participation in AAPMs in Medicare and across other payers and help more practices succeed in those models. We encourage CMS to continue to test and evaluate all- or multi-payer models. When proceeding with models that are not all- or multi-payer, alignment of model design and metrics should be a priority.

- **Strengthen Data-Sharing:** For AAPMs to attract broader participation, providers need assurance they will have timely and actionable data. We appreciate that CJR participants are now receiving more frequent performance period data. We encourage CMS to continue this policy moving forward for all Alternative Payment Models. In addition, we encourage CMS to provide useful and actionable aggregate regional data and metrics that serve as benchmarks for participants in APMs, help identify opportunities for improvement, and inform care intervention strategies. Furthermore, CMS should provide robust baseline data to potential program participants to weigh entering models.

**Consumer-Directed Care & Market-Based Innovation Models:**

NCHC encourages the Innovation Center to focus on putting in place three building blocks for meaningful, successful consumer engagement.

- **Consumer Tools:** The premise of consumer engagement should be ensuring that meaningful information is available to consumers, including through the use of consumer tools that inform consumers of the cost and quality of their care options. The information about cost and quality embedded in these tools is sometimes patchy and inconsistent. The Innovation Center could play a key role in further populating these tools and in supporting the adaptation of such tools to meet the needs of public programs.

- **Value-Based Insurance Design:** NCHC has been a strong supporter of the MA VBID demonstration. We encourage the Innovation Center to continue to develop and test VBID concepts in Medicare Part C and Part D. NCHC has supported legislation that would expand this MA VBID demonstration to all fifty states and territories. We have also supported proposals to enable Advanced APMs in traditional Medicare to waive cost-sharing for certain services. Both the MA VBID demonstration and cost-sharing waivers for AAPMs would permit beneficiaries to share in the savings that accrue when they choose high-value
options through lower or eliminated cost sharing amounts. These approaches should be part of the Innovation Center’s portfolio.

- **Patient Engagement:** Strong *patient* engagement standards are needed in any effective *consumer* model. Patients and caregivers should not only be provided with robust information about quality, but also empowered with real understanding about self-management and given the opportunity to think through the cost implications of treatment options. The Innovation Center should consider ways to apply such patient engagement standards across a range of models.

With adequate time for implementation, analysis, and evaluation, it should be possible to assess how these building blocks of consumer engagement can best be applied in Medicare.

However, we would caution against models that increase overall beneficiary out-of-pocket liability. Consumer-directed models got their start in the private market. Yet an increasing number of employers and plans are learning that merely shifting costs to beneficiaries can have harmful consequences for their long-term cost trend—particularly when imposed on chronically ill patients. Given this, an immediate embrace of consumer-driven insurance designs may not be appropriate for the Innovation Center.

Consumers with low health literacy, people with cognitive impairment, and those who are ill, in pain, or experiencing stress from their health condition face challenges actively engaging in increasingly complex decisions about care, insurance, and finance. This means that a substantial proportion of Medicare and Medicaid beneficiaries face challenges in adopting the active shopping behaviors envisioned in consumer-directed models. As a result, consumer engagement strategies in use with other populations may have significant negative consequences in the Medicare and Medicaid contexts.

In particular, balance billing would expose the Medicare beneficiary population, many of whom depend on limited Social Security and retirement income sources, to a greater financial burden. Balance billing could also confuse aging and disabled beneficiaries as to their actual liabilities, opening the door to unscrupulous scams or fraud.

Additionally, we are concerned that any models that increase overall beneficiary costs would undermine support for the constructive building block approach described above and erode the broad support which enables the Innovation Center to function.

**Physician Specialty Models:**

Under statute, the Innovation Center has broad authority to test brand new payment models. Model development is a vital part of the Innovation Center’s work, and the Center should proceed with those efforts, drawing upon the experience of the Innovation Center to date, other federal
programs, non-federal public payers, private payers, and the work of the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

However, designing and implementing brand new AAPM options will require time and expense—at a time when specialists are clamoring for immediate APM opportunities.

Fortunately, it is entirely possible to provide more opportunities to specialty practices in the short term by promoting existing approaches that are already yielding lower costs and better outcomes.

- **Provide a Follow-on Bundled Payment Option:** Episodic bundled APMs are a vital component of any strategy to promote specialist participation in AAPMs. We urge CMS to announce its planned new voluntary bundled payment model (BPCI 2.0) in time to allow participating providers to qualify as AAPM participants in 2018. We further call upon CMS to ensure this Model is available on a nationwide basis.

- **Continue to Broaden Population-based AAPM Participation:** Encouraging broader adoption of population based models is also crucial to specialist access to AAPMs. As noted in a recent meeting of MedPAC, approximately 2/3rds of MSSP ACO physicians are specialists. Broader embrace of population-based Advanced APMs, including MSSP tracks 2 and 3, Track 1+ACOs, Next Generation ACO, and ESRD ESCO, should increase the number of opportunities for specialists to qualify as AAPM participants.

- **Prepare More Specialty Practices for AAPMs:** We appreciate that many specialty practices are concerned that there is not yet an appropriate Advanced APM opportunity for them. NCHC believes that MIPS, if properly implemented, can help prepare practices for AAPM participation. Specifically, we would note that Patient-Centered Specialty Practice recognition already provides additional credit in MIPS and can play a key role in helping specialists build the capacities needed for future AAPM participation. Virtual groups represent another opportunity for smaller groups to aggregate with other like-minded providers and engage in the systematic measurement and quality activities needed for eventual AAPM participation. We recommend that the Innovation Center invest significant resources in concerted outreach and education to practices regarding PCSP recognition and virtual groups.

**Medicare Advantage (MA) Innovation Models:**

- **MA APMs:** A demonstration granting MACRA-eligible clinicians credit for participation in MA-sponsored Advanced APM contracts is a significant step forward. We greatly appreciate CMS’ announcement of its plans to establish such a demonstration. We note, however, that

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Timing is critical. We call on CMS to implement the MA APM demonstration as soon as possible. Rapid introduction of MA APM options will provide clinicians with valuable new options to participate in Advanced APMs.

- **CBI-SNP:** NCHC advocates testing of a CBI-SNP Model that uses targeted home- and community-based services to prevent institutional stays among low-income, Medicare-only beneficiaries. HR. 4006, the Community-Based Independence for Seniors Act, provides for just such a demonstration and enjoys NCHC’s support. However, the Innovation Center has the authority to proceed with such a demonstration under existing statute as well.

- **Benefit Innovation and Flexibility:** NCHC supports the added flexibility with respect to supplemental benefits included in S. 870, the CHRONIC Care Act. However, as a complement to that overall flexibility, the Innovation Center should consider testing specific benefits and interventions in Medicare Advantage. Some could be health-related, but some benefits should be able to meet the “social” needs of the patients and not necessarily be directly health-related. Rigorous testing and evaluation in the MA context could help determine whether these interventions should be incorporated into the underlying benefit for all Medicare beneficiaries. Examples include:
  
  - Targeted non-emergency transportation services and meal services, as well as targeted care management
  - Fall prevention programs, including exercise such as Tai Chi and balance training, home safety visits and modifications, recommended health education, and other techniques to prevent falls
  - Expansion of home-based services beyond the home health benefit to include meals, safety checks in the home, and periodic home health aide services

**State-and Local-Based Innovation, including Medicaid-focused Models:**

The first rule for the Innovation Center’s work with states should be to do no harm to the outcomes and affordability of care. And while health insurance coverage is not always a guarantee of strong outcomes, its absence is undoubtedly associated with poor health outcomes. The Innovation Center should not advance or support any state model that would reduce the number of individuals enjoying the basic protections of health insurance, taking into consideration Innovation Center models, Medicaid waivers, and Section 1332 waivers.

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Operating within that constraint, however, CMS can do an enormous amount to support state-led delivery and payment innovation, using both the Innovation Center’s authorities and the existing flexibilities in Medicaid statute. We identify three of the most fruitful areas below:

- **Integrated Options for Dually Eligible Beneficiaries**: NCHC believes all state Medicaid programs should be offering proven, integrated care options to dually eligible beneficiaries. The Innovation Center and the Medicare-Medicaid Coordination Office should prioritize helping states move forward aggressively with a range of integration strategies including Managed Fee-For-Service, Duals Demonstration Medicare-Medicaid Plans, Fully-Integrated D-SNPs, expanded access to Program of All-inclusive Care for the Elderly (PACE) programs, and hybrid models that align D-SNPs with state managed long-term services and supports (MLTSS) plans.

- **Maternity Care**: Childbirth is the most common reason for hospitalization in the United States. Medicaid and CHIP cover a majority of births in the United States. Unfortunately, across public and private payers, maternal and child outcomes lag behind other nations, even as our costs far surpass them. Early results from the Strong Start Model have validated evidence-based models of maternity care that substantially improve outcomes.4 In a philanthropically-funded initiative, the Pacific Business Group on Health and three southern California hospitals achieved 20% reductions in low-risk, first-time C-section deliveries.5 The Innovation Center should continue to invest in innovative, high-value maternity care approaches.

- **Long-Term Care**: We encourage CMS to consider how Innovation Center authorities can assist states in the rebalancing of Medicaid long-term care from institutional settings to home and community settings.

5. **How can CMS further engage beneficiaries in development of these models and/or participate in new models?**

As a multi-stakeholder coalition, NCHC believes soliciting input from the full range of stakeholders can contribute greatly to the Innovation Center’s work. But engagement of beneficiaries and their advocates is particularly important to transformation initiatives’ sustainability and impact. We urge CMS to adopt mechanisms that ensure beneficiaries and their advocates are involved in the development, implementation, and evaluation of Alternative Payment Models. Towards this end, we recommend the following actions:

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NCHC also supports the establishment of an APM Ombudsman. The proposed withdrawal of the EPM model rule could have the unintended consequence of cancelling the APM Ombudsman that was finalized with those models. Should the EPM cancellation be finalized, we urge you to proceed with this constructive means for consumer engagement.

6. Are there payment waivers that CMS should consider as necessary to help healthcare providers innovate care delivery as part of a model test?

We encourage the Innovation Center, working with other relevant agencies, to provide a standard set or sets of compliance and benefit waivers for AAPMs. A standardized approach to issues like telehealth geographic and originating site restrictions, Stark and Anti-Kickback Law restrictions on provider relationships, beneficiary incentives and waivers of Medicare payment regulations would facilitate more efficient development and review of model proposals and make participation more attractive to provider organizations and clinician practices.

7. Are there any other comments or suggestions related to the future direction of the Innovation Center?

As noted above, NCHC urges CMS to designate the expansion of AAPM participation opportunities for physicians and other eligible clinicians as the Innovation Center’s most central and immediate priority.

For some time, providers, payers, and purchasers alike have noted that the delivery system is torn between persistent payment incentives to maximize volume and their hopes of participating in the transition to value. NCHC’s provider, clinician, payer and employer members are now reporting a slowing of value-based contracting, which they attribute to remaining uncertainty about the future of alternative payment models in the current policy environment.
Designating the expansion of participation in AAPMs as its top priority is the clearest and most helpful signal that the Innovation Center can send. But to ensure that signal is clear, expanding AAPM participation must come by widening opportunities to participate and making participation more attractive—not by substantially weakening standards for what constitutes an AAPM.