

September 9, 2021

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

Re: Advancing Health Equity and Value Through Alternative Payment Models

Dear Secretary Becerra:

On behalf of the undersigned organizations, we look forward to working with you to advance health equity and value through innovative alternative payment models (APMs), such as the Medicare Shared Savings Program (MSSP) and models tested through the Center for Medicare & Medicaid Innovation (Innovation Center). The Innovation Center and MSSP, both of which were established under the Affordable Care Act, have given providers needed tools to innovate care, providing opportunities to collaborate across the care continuum while lowering costs and maintaining quality. Adoption of value-based payments has played a critical role in slowing healthcare spending over the last decade.¹

Advancing value-based payment is an effective tool for achieving health equity and should be a core principle of the Administration's health equity strategy. The fee-for-service (FFS) model pays for services piecemeal and does not appropriately compensate providers for promoting health and preventing acute episodes or development of chronic conditions. Through adequate payment for care coordination as well as accountability for costs and quality, providers in APMs are able to focus on wellness and care of the whole person and proactively manage care for populations. Providers in APMs routinely leverage multi-disciplinary approaches to care, assess social risk, partner with community organizations to increase access to nonmedical services, and leverage data to improve disparities in patient outcomes.

While much progress has been made, there remains opportunity to advance the movement to value. Only 36 percent of total healthcare payments and 41 percent of Medicare FFS payments flowed through an advanced APM in 2018.² Several factors have led to slower than expected APM adoption, including limited options for APM participation and improvements needed to the existing models. We appreciate that CMS has begun to chart a path for the next ten years of value and agree with many aspects of your [initial strategy](#). As part of your value strategy, we encourage you to set clear targets for APM adoption in Medicare and Medicaid. Below we offer approaches for addressing our shared priorities:

Address health equity within APMs. We agree that health equity should be considered through all stages of model design. However, current models do not consider approaches providers employ to address health equity, nor is there appropriate flexibilities and payment for APM participants to strengthen their focus on addressing health inequities. Incentives across the health care delivery and

¹ Health Care Transformation Task Force, "Getting Warmer: Health Expenditure Trends and Health System Reform," March 31, 2021: <https://hctf.org/nhe-getting-warmer/>

² Health Care Payment Learning & Action Network (LAN), APM Measurement Effort, <https://hcp-lan.org/workproducts/apm-infographic-2019.pdf>

payment system need to be aligned to promote equity and eliminate disparities. CMS should consider a wide array of approaches for addressing health equity in APMs, such as incorporating social determinants of health into risk adjustment. It is essential that APM participants are not disadvantaged for serving medically and socially complex beneficiaries and that they have the resources to continue providing vital services to their communities. CMS should consider paying for services that address social determinants of health and increasing access to standardized sociodemographic and social determinant information.

Ensure incentives for APM adoption can be reasonably met. The advanced APM incentive payments have served as an important tool for attracting clinicians to participate in advanced APMs. However, the increasingly high thresholds do not reflect the progress of the value-based care movement and have led to unintended consequences (e.g., ACO and practice restructuring). We encourage CMS to utilize its full statutory authority to ease the requirements for qualifying for the advanced APM bonus (i.e. the Qualified APM Participant (QP) threshold) to better match progress to-date. This would ensure clinicians currently participating in risk-bearing APMs will continue to receive these meaningful bonus payments and encourage other clinicians to join advanced APMs. Additionally, we are calling on Congress to ease statutory QP requirements and to extend the advanced APM bonuses an additional six years. To support continued incentives, we ask that CMS release detailed information on the advanced APM incentives paid to date.

Set a clear plan for moving beyond testing, scaling the best approaches. Over the past decade, the Innovation Center has launched 54 payments models. However, to-date only three models have been certified for nationwide expansion. Providers invest significant amounts of resources to participate in model tests. Setting a clear vision and path forward for building on the success of these models will encourage continued model participation. We appreciate CMS commitment to incorporating what works into other Innovation Center models. However, CMS should revisit its evaluation criteria and how it considers models for expansion as part of its vision. The current approach has faced several critical challenges, including issues with model overlap, beneficiary leakage across models, ignoring positive spillover effects outside of models, and the impact of provider participation in earlier models. Moreover, model evaluations tend to focus on short-term aggregate results, overlooking participant-level trends and potential for longer-term impact. CMS should work with stakeholders to improve how it evaluates models for success and to revisit its criteria for model expansion.

Address overlap in value-based care programs. As more APMs have been rolled out, model overlap has increased, causing confusion for providers regarding which models they can participate in and how beneficiaries will be aligned. While participation in multiple APMs can be complementary with aligned goals of improving quality and outcomes, providers often face conflicting financial incentives that make it difficult to participate in multiple APMs. The Innovation Center plan to focus on launching fewer models may partly address model overlap concerns. However, these concerns should not be the primary driver for fewer models as model overlap concerns must be balanced with ensuring APM participation options for all clinicians and other providers. CMS must intentionally design models and evaluation to account for model overlap. Additionally, CMS should establish clear model hierarchies and ensure providers are not disadvantaged for participating in multiple models.

Develop a stable suite of models that help clinicians advance through the value-based continuum over time. A continuum of models across payers is necessary to create model stability. Models must also be reliable from the announcement, request for application, and throughout the duration of the

implementation period, to foster trust and encourage further participation in APMs. CMS should transparently share the logic and data behind payment rates and methodologies, including changes during model tests, to allow APM participants ample time to understand and adapt to changes. CMS should solicit stakeholder feedback during the development and execution of models and provide transparent communication regarding the reasons for the development and iteration of models.

Utilize MSSP as an innovation platform. Since the MSSP launched in 2012, ACOs have been instrumental in transforming our health care system through reduced costs and improved quality. In 2020 alone, MSSP ACOs collectively generated \$1.9 billion in net savings to Medicare and had an average quality score of almost 99 percent. We appreciate the recognition that some providers may need additional tools to drive care innovations. As the only permanent total cost of care model, CMS should consider ways to adapt the MSSP to continue to advance value-based care. To date, MSSP ACOs would have to consider leaving this permanent program to take advantage of enhanced flexibilities offered in Innovation Center models. However, the Innovation Center should – as it has twice previously with the ACO Investment Model and Track 1+ – test model innovations within MSSP. We encourage CMS to provide additional flexibilities within MSSP and to test new concepts offered through Innovation Center models within MSSP (e.g., including a voluntary full risk track; testing other payment mechanisms, such as per-member-per month funding; continuation of the flexibilities offered during the COVID-19 public health emergency and flexibilities proven through other models). Additionally, CMS should address changes made to MSSP in recent years that have had a chilling effect on program participation and made MSSP less attractive and more burdensome. CMS should:

- **Encourage participation in MSSP by restoring the percent of shared savings beginner participants receive to at least 50 percent.**
- **Modify risk adjustment to be more realistic and better reflect factors participants encounter, like health and other risk variables in their communities.** We and other experts³ are also concerned that the current methodology may inadvertently lead some ACOs to avoid certain high-risk populations or drop participants who serve them, only exacerbating gaps in health equity. To more accurately account for changes in risk, CMS should raise the risk adjustment cap to be no less than 5 percent and implement a floor of no less than -5 percent.
- **Remove the arbitrary high and low revenue ACO distinction that creates an inequitable path to risk.** No ACO should be required to take on more risk than the nominal risk standard set by CMS, that is, Basic Track- Level E. High performers should be encouraged to participate in this model regardless of provider type.
- **Remove ACO beneficiaries from the regional benchmark to ensure ACOs are not penalized as they achieve savings for their assigned populations.**
- **Adopt methodologies to account for the impact of the COVID-19 public health emergency.**
- **Limit quality reporting to the ACO aligned beneficiary population** and provide a more gradual transition to the use of registries or electronic clinical quality measures (eCQMs) for reporting.

Provide greater technical support to APM participants to reduce burden associated with model participation. Participation in value models requires significant investments in clinical and care management, health IT, and analytics. We appreciate CMS' commitment to providing greater transparency and access to more real-time data to support care decisions. As part of this, CMS should recognize these investments and provide full technical information and enhanced access to data in advance of a program or model start. For providers serving vulnerable populations (e.g., safety net and

³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6394223/>

rural providers), CMS should address technical and financial barriers to APM participation. For example, CPC+ provided support to participants that Primary Care First does not and the ACO Transformation Track of the Community Health Access and Rural Transformation (CHART) Model provides upfront investments and technical support to new rural ACOs.

We thank you for your continued leadership in supporting the movement to value-based care.

Sincerely,

Aledade
Alliance for Technology Driven Health
American Academy of Family Physicians
American College of Physicians
American Medical Association
American Medical Group Association
America's Essential Hospitals
America's Physician Groups
Association of American Medical Colleges
Caravan Health
Evolent Health
Healthcare Transformation Task Force
National Association of ACOs
Medical Group Management Association
Partnership to Empower Physician-Led Care
Premier healthcare alliance
Value Based Care Coalition