November 20, 2015

VIA ELECTRONIC MAIL

Sam R. Nussbaum, MD
Chair
Alternate Payment Models Framework and Progress Tracking Work Group
Health Care Payment Learning and Action Network

Re: Comments on Draft White Paper: Alternate Payment Models (APM) Framework

Dear Chair Nussbaum:

The Health Care Transformation Task Force ("HCTTF" or "Task Force")[1] commends the work of the Health Care Payment Learning and Action Network's ("LAN") Alternate Payment Model Framework and Progress Tracking Work Group ("Work Group") on its draft White Paper on an Alternate Payment Model (APM) Framework ("White Paper" or "Framework"). The Task Force appreciates the opportunity to provide comments to the Work Group, and looks forward to collaborating with the LAN and all of its work groups to help facilitate widespread health care delivery transformation.

Executive Summary

The Task Force supports policies that promote value-based, patient-centered care and appreciates the Work Group's movement in that direction with the release of its draft White Paper. We support the White Paper's seven Principles, and urge an eight Principle be added to address the importance quality of care in APMs.

We are concerned, however, about an inference that the Framework may signal that all organizations should be proceeding up a ramp toward an "ultimate" population-based payment APM. While the framework appropriately establishes a clear path away from fee-for-service and toward patient-centered models that account for total cost of care, the appropriate

[1] The HCTTF is an emerging group of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry—including patients/consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs.

Our organizations aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

endpoint for that progression may differ depending on the needs of a particular market or community. The HCTTF believes it is too early in this innovation cycle to conclude that one type of APM is a better patient-centered model over another, as all models are in the testing and evaluation phase.

Movement toward more patient-centered APMs should continue apace, but not go too fast. The incentives in various APMs are meant to drive change in care delivery practices, yet if those changes do not take firm root and progress toward more mature APMs moves too quickly, then the effectiveness of those later APMs will likely be affected. Also, comprehensive patient engagement contemplates input at all stages of APMs, including model design and during and after care delivery, with the overall goal of affordable and attractive APM options. Finally, an important tenet of APMs should be risk-sharing and not risk-shifting, which ensures meaningful patient-centered care.

Below, the Task Force offers both general, thematic comments providing high level insights as well as specific comments addressing particular sections.

General Comments

The White Paper defines the ultimate objective of APMs to be patient-centered care. We fully support this objective. The HCTTF agrees with the White Paper's case for reforming the health care payment system and the thoughtful approach of establishing principles that underlie the APM framework. We also think the draft APM Framework infographic is a clear and understandable illustration of the Work Group's conclusions.

The overall framework, taxonomy, and points around the imperative to link payments to quality outcomes are very helpful and right on point. However, we are concerned with any inference about a "ramp" to a particular type of APM that is viewed as the ultimate model for providing patient-centered care, as we believe different types of APMs may meet the goal of patient-centered care for different communities.

1. ***APMs Take Many Forms and Provide Different Benefits Depending on the Communities They Serve***

The White Paper recognizes the many forms of current APMs, yet seems to set the target for the ultimate goal to be population-based payment operated through a limited set of APMs as defined in Category 4. **The Task Force urges the Work Group to reconsider whether models from other categories should be recognized as acceptable end points that can furnish truly patient-centered care in the communities they serve.**

Generally, the Task Force strongly urges against adopting a structure that contemplates a one-size-fits-all approach. At this point, there is no peer reviewed evidence reflecting that models under Category 4 are stronger APMs than others. Moreover, at its essence, all health care is local, and what APM can be most successful in a particular community will depend on specific market and demographic factors. And, in this early stage of 21st Century health care

innovation, it is important to foster acceptance of various types of APMs and allow for sufficient testing to full evaluate their capabilities and benefits.

The inference drawn from Figure 1: CMS Payment Framework (p. 5) and its corresponding narrative is that the Work Group envisions that all stakeholders make progress to ultimately arrive at a model listed in Category 4: Population-Based Payment. This approach creates a visual of essentially moving up a "ramp" (or climbing a mountain) to full risk-based payments, which may be the best outcome in some, if not many, health care markets. However, full-shared-risk programs many not be the best model for patient-centered care in certain communities, while APMs listed in other categories may be. As all stakeholders move toward more mature APMs, the lessons from the 1990s managed care experience should help guide the path and ensure that many different types of APMs are given the opportunity to prove to be successful patient-centered APMs. In all cases, an entity's transition to a certain kind of APM should not outpace its ability to deliver patient-centered care.

We also question whether the evolution should be characterized as a ramp that climbs to "ultimate" APMs or would be better characterized as a path that recognizes that different outcomes may be best for different communities. We urge re-consideration of the assumption that reform should emphasize the creation of "highly integrated delivery systems" to receive population-based payments. We agree that all stakeholders should be moving away from fee-for-service models in Categories 1 and 2, yet believe there no single end point that best furnishes patient-centered care.

Thus, the LAN should consider being agnostic as to the payment model and delivery system used in a particular market, which would be consistent with statements by the Medicare Payment Advisory Commission that payment policy should be synchronized across all Medicare payment models. For health care providers to achieve Medicare goals for quality, resource use, and patient-centeredness, the most appropriate payment model will differ market-by-market and, more importantly, patient-by-patient.

Finally, at this stage of movement toward APMs, it is important that the path of evolution toward mature types of APMs be further defined. For each category, there should be standards and measures for how value and quality is achieved.

2. ***The Continuum to Value-based Health Care May Be Seen as a Path to Population-based Payment, Yet Allowing the Appropriate Speed for Traveling that Path Is Critical To Building and Maintaining Effective Patient-Centered Care Models***

The HCTTF believes the White Paper should emphasize that to best serve patients, the path to any Category 4 APM should continue apace – not too fast or too slow – and carefully and methodically. The transition to an APM should not outpace an entity's ability to deliver safe, timely, effective, evidence-based, coordinated and patient-centered care. At each step along the path, providers will learn new lessons and receive financial benefits for changing their care delivery practices: positive incentives received will reinforce progressive new behaviors. These changes create value over time and the entire system benefits.

It is critical, however, that teachings and behavior change gained through participation in an earlier stage APM take firm hold *before* an entity seeks to attain a more mature, high-category APM. When true population-based payments are reached, financial incentives related to creating value may diminish. Thus, if new behaviors and changes to care delivery practices have failed to take hold before an entity seeks to transition to a higher-level APM, reaching and sustaining a population-based payment model may prove challenging.

3. Bundled Payment Programs Can Provide Effective Value-based Care as Stand Alone APMs or in Combination with Other APMs

Bundled payments are integrated into the population health and value-based payment programs of commercial insurers in some markets. They may also be integrated into full risk capitation programs managed by physician groups and health systems. While bundled payments can be a "stand-alone" value based payment, they can be very effective strategies for risk-bearing providers to engage specialists and post-acute providers in cost and quality initiatives.

As a stand-alone business model, bundled payments can be valuable to payers, capitated medical groups and other organizations taking population risk. Organizing and financing health care around an episode of care, through bundled payments, is often an attractive option for meaningful value-based payments in many commercial programs.

Additionally, the beneficial overlap of bundled payments with other value-based payment models as also become possible in public payer programs. To thrive and successfully manage the financial risk associated with an overlapping beneficiary's utilization of health care, full-risk and bundled payment participants can benefit from an inter-dependent clinical relationship. Any model that moves payers, specialists, hospitals and post-acute providers to think about care and cost differently is advantageous to those ACOs in which such providers participate. These relationships can leverage the benefits of preventative services for driving savings during the bundled payment episode as well as the value of specific, focused interventions.

The clinical models of the ACO and the bundled payment participant can be aligned in driving down post-acute care utilization and avoiding unnecessary readmissions for overlapping beneficiaries. This is accomplished by successful coordination of care between inpatient and outpatient settings. In the event that prevention does not keep an overlapping beneficiary out of the hospital, the bundled payment participant can collaborate with the ACO to implement a process of treatment and care coordination that returns that patient to the service of the ACO's physicians by the end of the episode.

While the HCTTF readily admits work remains, CMS's ongoing focus on the interplay between full-risk and bundled payment programs (*e.g.*, ACO models and the BPCI Medicare Shared Saving Programs) provides an opportunity to leverage the strengths of both models and the clinicians who are high performers in each type. This can improve overall performance in the

patient experience, quality and efficiency for ACOs and other value-based programs that may be developed.

4. Sharing of Financial Risk Should Mean Sharing of Total Responsibility for Patient Care

The White Paper presents an opportunity to highlight that sharing of financial risk under APMs goes hand-in-hand with sharing of responsibility for patient care. The White Paper appropriately focuses on providers accepting more risk, and the sharing of risk should not be viewed as abdicating or removing the responsibility for that patient's care from a health plan or a purchaser of health insurance. The Task Force believes that APMs should embrace the concept of risk-sharing, not risk-shifting, and urges that distinction be afforded greater emphasis in a final White Paper.

The Three Pillars of Patient-Centered Care (p. 2)

1. Quality Performance Plays a Critical role in APMs and Deserves its Own Principle

The HCTTF believes the importance and impact of quality performance and measurement in APMs deserves more focus, and we recommend that a new principle be added. A new principle should reflect the importance of quality performance, inclusive of patient-reported outcomes and patient-reported satisfaction and care experience, in APMs. The principle also should recognize the need to appropriately tailor quality improvement programs to the particular APM models.

We believe a new quality principle could be crafted along the lines of current Principle 7, which recognizes that certain types of care delivery models are important to effective value-based based care, but are, in and of themselves, not APMs for purposes of the White Paper's focus. Similar to Principle 7, a new quality principle would recognize the importance of quality measurement to APMs and various means by which an APM can take quality performance into account.

The descriptive narrative for a new quality principle could, for example, address specific issues like the difference between a threshold or gate and a performance scoring approach, the option of payment for health outcomes versus process measures (or conformity to a protocol), the differences in performance measurement across large populations versus performance improvement, and access of high-risk patients to proper care.

Finally, with regards to quality performance, we note that the White Paper asserts that Category 4 models result in better quality of care. We note there is no support given for this assertion, and urge the Work Group either to proffer evidence to support the claim or to remove the statement. While different APMs may have mixed incentives, there are no claims that models in Categories 1 or 2 lead to lower quality outcomes.

2. The Concept of Cost-Effectiveness Should Also Address Transparency and Pricing

The HCTTF believes that the discussion of cost-effectiveness can be enhanced. While value and system-wide cost savings are important, what is also important to account for is information

that is most meaningful for consumers and purchasers. This includes transparency of price and quality information and the ability to meaningfully use that information to make a choice of provider or care treatment option and to assess the affordability of a health care service or provider.

The concept of cost effectiveness should also address the variability of price in health care markets and consider framing cost effectiveness to also mean a level of severity-adjusted total costs (and, when relevant, unit prices). This should reflect benchmarked best achievable results, and is consistent with robust and competitive health insurance marketplaces characterized by the deployment of multiple affordable, attractive products across employer group, individual commercial and government programs sectors.

3. Patient Engagement Is Only One Element of Appropriate Consumer Involvement in APMs

We appreciate that the White Paper defines the ultimate objective of the transition to value-based payment to be patient-centered care and that it includes patient engagement as one of three pillars upon which patient-centered care rests. However, the Framework's discussion of patient engagement could be enhanced. Patient engagement at the point of care is just one element of engagement; the proper scope of patient engagement includes front-end consumer and patient input on APM design; setting quality performance measures, including measures of patient satisfaction and experience; and consumer representation on decision-making bodies and governance structures. Patient feedback after the episode of care is also very important (particularly to purchasers/employers), as it provides information on outcomes such as ongoing pain management, return to work, absenteeism, and productivity once back at work.

Using an economics analogy, our members believe the White Paper reads like an overly weighted supply side view, reflecting a care deliverer's likely perspective and is in need of appropriate balance from the demand side of what patients seek in value-based payment arrangements. While the White Paper references patient engagement and activation, those concepts should be fleshed out and applied more broadly throughout the document. Consumer input on the front end regarding value-based model design is separate and distinct from engaging a patient once a model has been established, although the two approaches are complementary. Engaging consumers in the design and governance of new models should help build a health care system that patients want to be a part of. The Task Force strongly believes patient input is essential at all levels, including in the design of new models and at the point of care, with the overall goal of ensuring affordable and attractive APM products.

The Task Force brings a unique perspective to the world of APMs in that our membership includes patients/consumers, purchasers/employers, providers and health plans. From our perspective, the White Paper could be enhanced by adding a particular focus on emphasizing the importance of patient input to the design and governance of APMs.

Similarly, the views of purchasers in what they seek in value-based models should be referenced with more emphasis throughout the document. While the positions of the patients

and purchasers are often aligned, there are important differences, too, and purchasers bring an important perspective to payment reform. The role that employers play in today's healthcare marketplace is very significant, as their needs and goals drive delivery models such as narrow provider networks and tiered pricing structures.

Principle 1 (p. 6)

Consistent with our earlier comment on the appropriate scope of consumer input, the Task Force believes the Work Group should add the phrase "to have a voice in model design" after the word "patients" in the Principle's fourth line and add the word "and" after the parenthetical in the same sentence.

Principle 2 (p. 6-7)

The HCTTF supports this Principle as drafted, but proposes furthering its scope. We recommend adding the phrase "and enables robust and competitive health insurance marketplaces" to the end of the Principle.

This section makes the point that APMs will increase integration and coordination in care delivery systems. This point is not in dispute, yet there is concern that this statement could be viewed as broadly applicable and unambiguously positive. While there are positives, the Task Force believes the paper should reflect that to be beneficial, integration within a system should truly reflect increased clinical value, equating to both improved quality and lower total severity-adjusted total cost.

Principle 2 addresses the concept of shared risk, yet is not necessarily specific with whom risk is shared. While health care payers and providers expect to be risk-sharing partners, the ultimate receiver of care – patients – should also be prepared to be part of the risk sharing partnership as APMs mature. We believe the principle's narrative should acknowledge that patients and consumers may play a role in risk-sharing in mature APMs.

Principle 3 (p. 7-8)

The Task Force agrees with this Principle. However, we urge the Work Group to recognize a nuance: the health care providers of today may not be the health care providers of tomorrow. The principle may be interpreted as assuming the current paradigm will continue, when today's marketplace may be better viewed as leaving that as an open question. The Work Group should consider adding the qualifying phrase "of today and tomorrow" after "provider" to recognize that possibility.

Principle 5 (p. 8)

The White Paper discusses the need to create value-based incentives that are high enough to influence provider behaviors. We agree with this statement, yet think it could go even further. From a broader perspective, value-based incentives need to be sufficient to foster dramatic re-engineering of both clinical and business processes, as well as the physical footprint across the

delivery system that is required to continue the creation of greater value. The discussion could also benefit from discussing the benefits to patients and their impact on care delivery transformation.

Regarding the magnitude of incentives required to promote meaningful change, The Task Force believes incentives should be of sufficient magnitude to outweigh, for providers and provider systems, the operating margin that may be realized by generating increased fees for services, thereby incentivizing the dramatic reengineering necessary for meaningful change and patient-centered care.

Category 2 Models: Fee-for-Service Linked to Quality (p. 12-13)

This discussion includes an emergency room example (p. 13). We believe that decreasing emergency department visits in a utilization model should not be an example of value solely defined as cost, when quality factors are at play that would help qualify the outcome as an improvement. We believe the example should also recognize the value related to "enhanced care being provided differently or in different settings," which reflects the reality of the situation and should qualify as improved quality.

Category 3 Models: APMs Built on Fee-for-Service Architecture (p. 13-14.)

This section states that "[p]ayments that fall under Category 3 are distinguished from those that fall under Category 4 in that payments in the latter are population-based and include a strong incentive to promote health and wellness, including lifestyle modification and preventive services, while payments in the former are still triggered by the delivery of services (even if the current FFS systems serves as the basis for setting population-based payment rates)."

We disagree with the premise that Category 3 does not include strong incentives to promote health and wellness, including lifestyle modification and preventive services. For an advanced Category 3B models where the organization is responsible for first dollar savings and losses compared against Category 4 for which "the current FFS systems serves as the basis for setting population-based payment rates," it is difficult to see any health incentive differences. We urge the Work Group to revisit and revise this statement.

Appendix B

We urge the Work Group to consider whether Appendix B should include examples of NextGen ACO and advanced Medicare Advantage models, which are arguably Category 4 APMs.

Please contact HCTTF Executive Director, Jeff Micklos, at jeff.micklos@leavittpartners.com or (202) 774-1415 with any questions about this communication.

Sincerely,

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