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Health Care Payment Learning and Action Network and the MITRE Corporation

Comments on ***Draft Alternative Payment Models (APM) Framework Principles***
Submitted by Community Catalyst, November 20, 2015

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Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society. We have been working to improve Medicaid and Medicare for consumers for more than a decade, producing tools for consumer advocates to use in state-based advocacy as well as tools for use by other stakeholders.

We appreciate the opportunity to provide comments on the ***Draft Alternative Payment Models Framework***. We have organized our comments around the seven principles, but we also want to offer overarching comments on the goal of the framework.

The Framework: We appreciate the goal of having a framework that attempts to consolidate the general payment categories from fee-for-service models that have no link to quality, to a comprehensive population based payment approach. The continuum captures this well, and we can see how this could be adapted over time as categories may be added and/or collapsed based on experience and system changes. We also support the goal of incentivizing quality and moving towards Category Four/ Population-based Payment which by its definition embraces delivery system models and reforms.

Our major concern with the framework as described in the white paper is the intentional distinction between delivery system models and payment models. We understand that there is a useful distinction to be made between them, since different payment models can be used for the same delivery system and vice versa. We encourage the LAN working group to acknowledge the importance of delivery system

capacity, innovations and person-centered processes that have to be developed in tandem with all APMs since financial incentives alone do not produce the necessary changes that improve value in care. The recent New England Journal of Medicine article [1] on the Maryland global hospital payment is a case in point. In its first year of operation we saw cost savings and improvements on some quality measures; however their patient experience scores, historically among the worst in the country, did not improve over the waiver year. Incentivizing practice changes based on payment alone won't be adequate and can even be counterproductive, to the task of improving health and lowering costs; there needs to be simultaneous upfront investments in delivery system and practice changes. This point is acknowledged in the white paper, but what is critically missing is that evolving financial incentives must be linked explicitly to the outcomes we are trying to achieve and the structures and processes necessary to achieve those outcomes. Further, that linkage becomes increasingly critical as we proceed along the continuum of APMs and the financial incentives become increasingly powerful.

Second, we are pleased that the white paper acknowledges the importance of system wide affordability and cost savings as a goal of payment reform. Equally important yet missing from the draft is the acknowledgement that affordability of health care services for consumers remains a persistent concern. This is especially problematic for older adults and others with low incomes and multiple chronic health problems.[2]

Third, we encourage/urge the framework and paper to explicitly address the need to address social determinants of health as key to risk adjustment in population based payment models. For instance, risk adjustment for consumers with multiple chronic conditions that only includes health status and clinical condition will not be adequate for those with low socio-economic status who may face issues such as housing and food insecurity that undermines their health and response to medical interventions. Payments not only must be adequate to address these challenges, but payment systems should be organized to redirect resources into community supports and services, which will support the physical and mental health well-being of community members and

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[1] Patel A, Rajkumar R, Colmers J M, Kinzer D, Conway P H, Sharfstein, J M. Maryland's Global Hospital Budgets — Preliminary Results from an All-Payer Model. N Engl J Med 2015; 373:1899-1901November 12, 2015DOI: 10.1056/NEJMp1508037

[2] Rowland D. The Medicare and Medicaid Partnership at 50. Generations: Journal of the American Society on Aging. Summer 2015. Vol. 39. No. 2. 35 https://kaiserfamilyfoundation.files.wordpress.com/2015/06/generations-the-medicare-and-medicaid-partnership-at-50-rowland.pdf

reduce the need for unnecessary medical services. (the New Jersey community-based ACO model is a good example of this approach.)

Fourth, we appreciate the emphasis in this paper on patient engagement as fundamental to quality outcomes. In the paper's section on making the case for payment reform, you outline three core pillars for defining patient-centered: quality, cost effectiveness, and patient engagement. In the latter, we fully support the inclusion of patient experience and shared decision-making as key elements. We suggest two important changes: (1) We recommend that the paper endorse not only getting ongoing feedback from patients but encourage formal mechanisms for patient/consumer input into continuous quality improvement and payment issues. At the individual level, systems should require that the goals and experience of each patient be integrated into the caregiving process and the measurement of payment/quality outcomes. At the delivery system level, there should be organized systems to recruit, train and support patients and patient advocates who will then play a role in the process of continuous quality improvement. Finally, at the policy development and monitoring level, consumer advocates must have a seat at the decision-making table along with payers and providers.

(2) We urge the LAN to use the term person-centered as opposed to patient-centered. This acknowledges the patient as a whole person not defined by their particular health condition or status. It is a term that many organizations are embracing, including the National Quality Forum, which recommended to CMS: "One single term cannot apply to all individuals in all situations; in actuality, an individual with many needs may self-identify as a person, client, or patient at a single point in time…"[3] We recommend using the word 'person' as an over-arching term to encompass the health and healthcare needs of all individuals, regardless of age, setting, or health status.

Finally, we agree with the goal of aligning payments from across payers in order to reduce the administrative burden of transitioning to new APMs. Likewise, consistent with our concern with the need for concurrent delivery system reforms, there is a need for harmonized consumer oriented quality measurement and reporting across systems. This will reduce both provider and consumer burdens for reporting and free up time for patient care and improve communication between providers and patients.

[3] http://www.qualityforum.org/projects/person_family_centered_care/)

Framework Principles:

Principle 1: As we discussed above, we agree with the first part of this principle: "the financial reward to providers is only one way to stimulate and sustain innovative approaches to patient-centered care." However, have concerns about the beginning of the second sentence: "*In the future*…it will be important….to monitor progress in initiatives that empower patients to seek care from high-value providers and become active participants in clinical and shared-decision making". While we agree with the paper's explanation that "additional efforts to engage patients and consumers will be needed to achieve a patient-centered, coordinated health care system", we believe these efforts must occur simultaneously - and not "in the future". Similarly, we believe that efforts to reduce disparities based on income, race/ ethnicity, disability, gender identity and sexual orientation should be linked to changes in payment.

Principle 2: We generally support this principle, but urge that LAN recognize that not every type of service is optimally reimbursed in the context of a globally capitated payment. For example, paying for some screening and preventative services on a fee-for service basis might be the most direct and efficient way to encourage their delivery.

Principle 3: We agree with this principle, "that to the greatest extent possible, value-based incentives reach the providers that directly provide deliver care", those at the frontlines of care delivery. In order to operationalize this principle, we believe that there needs to be not only the right mix of providers (e.g. including the key role of care coordinators/managers and community health workers for example) but also that the incentives must include investment to support providers' capacity to respond to the incentives.

Bonuses for savings must be tied not only to meeting certain outcome measures but also to a demonstrated capacity to reengineer care appropriately. Further, the attributes of good care that are the most meaningful to consumers should be based on the need to address identified gaps in quality for low-income consumers and vulnerable populations, including those who are dually eligible for Medicare and Medicaid. Finally, the phrase "to the greatest extent possible" is an important qualifying clause that needs further explication. On the one hand, we seek to move beyond a point where financial incentives are held by a large institution--whether an MCO or an integrated provider system--while care underneath that umbrella is reimbursed on the same fee-for-service platform. At the same time, there have been some unfortunate experiences in the past with pushing too much risk onto provider units that have been too small to manage that risk.

Principle 4: We support the importance of distinguishing between those payment models that are based on quality and value from those that are not, and we agree that the latter should not be considered part of this framework evolution.

Principle 5: This principle incorporates several important concepts, but it also could potentially have negative impacts on consumers, particularly those with lower incomes. First is the importance of incentives that are high enough to influence provider behaviors. One concern is that financial incentives could result in provider behavior that is not in the best interest of patients. As noted above there is some past negative experience with this that has left many consumers with a wary outlook toward something that looks like "managed care." We must ensure that the proper safeguards are in place so that consumers can trust that their doctor or other provider is doing what is best for the consumer's own care and not based on a financial incentive.

Granted that the move to APMs is to combat existing fee-for-service financing incentives that are not in the best interests of patients—e.g. inappropriately intensive care, uncoordinated and duplicative care, care based on volume rather than the best evidence. However, new incentives in APMs must be based both on outcome measures (including patient reported outcome measures) and also on the presence of mechanisms that provide safeguards to ensure that minimum standards are met to avoid new problems, such as stinting on care or barriers to access. This will require ongoing feedback loops and examination of data such as consumer complaints and utilization patterns of subpopulations, especially looking at health disparities based on race, ethnicity, disability, SES, or sexual orientation and gender identity.

Second, a key to successfully moving along the progression toward population based payment is the need for good risk adjustment and the ability to measure outcomes for all populations and subpopulations. The tools to implement appropriate risk-adjustment and to measure person-centered care and access to care should be just as robust as the methods for measuring cost reductions. The model needs to promote appropriate payment to providers who care for patients identified with high levels of complexity based on a risk stratification tool that factors in social determinants of health. Such payments to providers will also help prevent costs being shifted onto individuals. In addition, appropriate payments will ensure access to important community based services via contracts with integrated care systems.

Third is the need to monitor the different incentives utilized and the impact on quality and patient experience and patient reported outcomes. Research is needed to find what may be an incentive "tipping point" so that increasing the intensity of financial incentives over time yields more than cost savings but also shows an increased

investment in upstream services that address health disparities and improved health status.

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This white paper will be the foundation for further work. It should be strengthened to include the concept that in order to implement APMs in a way that truly drives value and without adverse outcomes, the innovations must build in upfront the necessary standards, measurement and investments that will help providers and consumers achieve person-centered care. While some unintended consequences will be inevitable and hopefully identified by robust outcomes measures, APM innovations should avoid problems and harm to patients by incorporating what we already know about the capacities needed to deliver quality, integrated, person-oriented care. We have learned this through years of health system research, private and public value-based care demonstration projects, as well as monitoring and input from consumer advocates.

The principles and caveats about what a payment framework does and doesn't capture are generally well-articulated in the paper, but they should be reflected in the APM models themselves. The framework appropriately identifies the presence or absence of quality measurement as an important distinguishing feature of payment models, but it is not the only important feature. Quality measurement itself is not adequately represented by a binary yes/no choice, and other structural features become increasingly important and should be recognized as we proceed to more far-reaching types of alternative payment models. The authors should consider reflecting this directly in the continuum chart or include a parallel chart on delivery system model standards to show that these are "two sides of the same coin" that must be considered in tandem.

In closing we'd like to reiterate the overarching areas we find significant and that should be reflected in the paper: beneficiary engagement, education and support; disparities reduction; and fostering and incentivizing a culture of partnership and learning:

Beneficiary Engagement and Support: In order for the proposed payment reforms to be effective, beneficiaries must be engaged and educated about decisions being made and changes to their care. Beneficiary engagement in care is a critical part of achieving better health outcomes, especially for those with chronic conditions. Beneficiaries and their caregivers must be seen as key members of care teams, not as passive recipients. We encourage incentives to ensure beneficiary engagement and education and suggest opportunities for engagement to happen in meaningful ways.

Disparities Reduction and Risk Adjustment: Disparities in quality of care and health outcomes remain compelling and persistent for people in low-income households, including many people of color. Indeed, some disparities related to chronic disease have actually grown larger over time. We believe it is critical to address health care disparities by incorporating data stratified by race, ethnicity, gender, disability, sexual orientation and other measures of health equity in quality measurement and reporting. This is a necessary step for building our understanding of disparities facing populations with disproportionately poor health outcomes.

Fostering and Incentivizing a Culture of Partnership and Learning: We appreciate the acknowledgement that greater involvement of patients and their families in decision-making, self-care, activation and understanding of their health condition and its effective management, which has potential to improve person-centered care. The potential also lies in the ability of providers and provider organizations to collaborate with patients and their families as partners in the care experience and in efforts to improve health outcomes. While collecting and reporting patient-reported outcomes and experiences is a good step for improving person-centered care, providers and provider organizations also need to understand how to use this data in a meaningful way. Building this understanding will require long-term support and system-level infrastructure, substantial incentives, and new processes for implementing changes based on patient experience and feedback. Furthermore, meaningful involvement of patients and their families will require a shift to a culture of learning and partnership among providers and patients, and we encourage payment reform models that have potential to foster and incentivize that culture.

Just as the framework makes a meaningful distinction between risk-bearing arrangements that do and do not measure quality, so too should it clarify the presence or absence of other key system elements, especially in the context of payment models that accept the greatest degree of financial risk.

Thank you for your consideration,
Sincerely,
Michael Miller
Director of Strategic Policy