# ALTERNATIVE PAYMENT MODEL (APM) FRAMEWORK

## Summary of Public Comments

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## Introduction

In an effort to maximize transparency and seek input at an early stage, the Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group of the Health Care Payment Learning & Action Network (LAN) released a draft version of the APM Framework White Paper on October 22, 2015. The Work Group solicited input from LAN participants, stakeholder communities, and the general public on the overall draft White Paper and the proposed framework; the descriptions associated with each category; and the boundaries that differentiate the categories. The APM FPT Work Group received a total of 113 comments totaling 285 pages from 79 unique stakeholders, of which just over half represented organizations. The comments reflected input from patient and consumer advocacy groups, medical associations, public and private payers, purchaser groups, physicians and provider organizations, and the medical device and pharmaceutical industries.

What follows is a summary of the main themes that appeared in the comments submitted to the APM FPT Work Group. The Work Group has indicated its perspective on these comments, and, where appropriate, discussed how the comments were incorporated into the final draft of the White Paper. It is the Work Group's hope that this document will be read in conjunction with the final White Paper, and that members of the community can use it to gain deeper insight into the thinking behind the White Paper's key findings.

## "Patient-Centered" vs. "Person-Centered" Care

Several commenters suggested that the term "patient-centered care" was outdated because it does not include instances when healthy people engage the health care system. The Work Group agrees that this term is in fact obsolete, and it has changed the terminology to "person-centered" care to reflect the cogent points that commenters raised.

### Definition of "Person-Centered Care"

Many commenters provided recommendations on how to strengthen the draft White Paper's nominal definition of person-centered care. Several commenters specifically recommended employing the Institute of Medicine's (IOM) definition of person-centered care, which is:

> *…an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. It redefines traditional roles and relationships by emphasizing collaboration, valuing the unique expertise and experience of patients and families, and seeking their partnership not just at the point of care but at all levels and across settings.*

The Work Group agrees that it is important to carefully define person-centered care, because this notion lies at the heart of the argument for transitioning away from fee-for-service (FFS). The Work Group agrees that IOM establishes a critical concept, and it appreciates the IOM's emphasis on redefining traditional roles and establishing mutually beneficial partnership with providers. However, the Work Group's intention in the White Paper is to put forward a more all-encompassing definition, which also includes cost and quality considerations in addition to consideration about patient engagement. Although the Work Group did not adopt the IOM definition, it appreciates the comments suggesting how to define person-centered care, which the final White Paper now defines as: "high-quality care that is evidence-based, delivered in an efficient manner, where patients' and caregivers' individual preferences, needs, and values are paramount." As indicated in the draft White Paper, the intention of the definition is to support the recommendations advanced in the final White Paper. Further, the Work Group does not anticipate that this definition will be applied more widely.

## Patient Engagement

### Terminology of "Patient Engagement"

Several commenters expressed an interest in expanding the terminology of "patient engagement" to more explicitly include family and caregivers who are instrumental in care delivery, particularly for children and patients who may have trouble effectively engaging with providers. Some suggestions for alternate terminology included "patient and family engagement" and "patient and caregiver engagement."

The Work Group appreciates that family members and other caregivers are instrumental in the delivery of person-centered care, particularly when patients are children, developmentally or intellectually disabled, or too sick to effectively advocate on their own behalf. In order to enhance readability, the Work Group decided to retain the terminology of "patient engagement," but whenever possible the final White Paper now explicitly includes family members and caregivers when discussing the importance of engagement.

### Meaning of "Patient Engagement"

Many commenters, representing multiple stakeholder groups, provided suggestions about ways to strengthen the discussion on patient engagement as one of three "pillars" of person-centered care. For example, commenters indicated that patients should be engaged at every level of care delivery, including discussions about plan and delivery design, as opposed to only at the point of care. Commenters also indicated that patient engagement should not be characterized as solely reflective of "non-clinical" aspects of care, that patient engagement should include assurances that patients are not discriminated against, and that should have official means of recourse if they believe that their access to care is inappropriately restricted.

The Work Group deeply appreciates these comments and the patient-centered focus that they add to the White Paper. The White Paper has been revised to reflect comments on the meaning of patient engagement, such that the term now includes:

- Patient and caregiver participation in the design of payment and delivery models, as well as on governance boards and decision-making bodies;
- Patient and caregiver participation in setting treatment plans and goals;
- Patient and caregiver participation in identifying fruitful connections to social support services;
- Routine communication and engagement with caregivers who are intimately involved in ensuring that patients who are unable effectively advocate on their own behalf receive person-centered care;
- Assurances that patients will not be discriminated against and will have available official processes to appeal decisions they feel inappropriately restricts their access to care; and
- Assurances that patients' choice of providers will not be unduly limited.

## Meaning of "Cost-Effectiveness"

Several commenters provided recommendations on how to define "cost-effectiveness" in the discussion in the draft White Paper about what constitutes person-centered care. Specifically, commenters noted that cost-effective care is not simply a matter of comparing actual versus expected costs, but that costs need to be severity-adjusted and benchmarked to best achievable results in a way that promotes robust and competitive health insurance marketplaces. Other commenters recommended stating that costs for patients should be transparent to patients, along with information about financial incentives that providers receive from plans. The Work Group appreciates this input, and this is now explicitly reflected in the final version of the White Paper.

## Risk Associated with Transitioning to APMs

Many commenters stressed that the transition from fee-for-service (FFS) to alternative payment models (APMs) is complex and financially risky, and may result in negative consequences for patients. Accordingly, commenters urged the Work Group to emphasize that payers should help providers establish the infrastructure they need to support APMs, that providers should understand the risk associated with participation in APMs, and that provider participation in APMs should be voluntary. Another commenter noted that patients and consumers should also be prepared to take on financial risk, and to be prepared to experience subtle and not-so-subtle changes in their care.

The Work Group agrees with these comments and believes that their addition appropriately emphasizes the difficulties (and some of the potential unintended consequences) associated with the adoption of APMs. The Work Group, and the LAN as a whole, continues to believe that alignment across payment models in the public and private sectors will alleviate administrative burdens, incentivize investments in clinical infrastructure, and simplify the transition to APMs. The Work Group agrees that it is important to identify potential pratfalls so that APMs can be designed to avoid or mitigate them; accordingly, the final White Paper now explicitly draws attention to them.

## Under-Representation of Certain Provider Types

Commenters representing certain provider types raised questions about whether they would be systematically excluded from participating in APMs, and where and how their practice might fit into the framework. For example, primary care physicians, pediatricians, geriatricians, and others questioned whether their specialties were underrepresented in the draft White Paper.

The Work Group continues to believe that participation in APMs should be an option for all types of providers, and it does not intend to exclude any type of provider from the APM Framework. Part of the miscommunication on this point might be traced to the Category 3 and 4 examples provided in the framework illustration (i.e., Figure 3). The Work Group has revised these examples to identify specific types of provider arrangements that are more familiar to stakeholders than the more generic examples that appeared in the draft illustration. For example, partial population-based primary care is now highlighted as an example of a Category 4A arrangement; similarly, population-based payment for comprehensive geriatric or pediatric care is now highlighted as an example of a Category 4B arrangement. Additionally, the Work Group notes that specialists may choose to participate in accountable care organizations (ACOs) that participate in shared-savings/shared-risk programs, in which case they would part of a Category 3B arrangement. Although it was not possible to identify how every type of provider could participate in an APM, the Work Group hopes that the final White Paper now clearly communicates that no providers should be systematically excluded from doing so.

## Category 4

### Transition to Category 4

Many commenters noted that it is unrealistic to expect all providers to participate in Category 4 payment models, and that certain markets and provider types are inherently ill-suited for these types of payment arrangements.

The Work Group acknowledges that Category 4 payments will not be appropriate for all providers and all markets, and it has clarified its intent through revisions to the discussion of Principle 2. Specifically, the final White Paper now clarifies that movement to Category 4 payments is the goal for the U.S. health care system as a whole, not a goal for each and every provider. This point is further reinforced in “Future State” portion of Figure 3, which indicates that significant investments in Categories 2 and 3 will continue through the foreseeable future. Additionally, the discussion of Principle 2 now identifies certain types of providers and markets that might be less likely to participate in Category 4 payment models.

Other commenters questioned the Work Group’s underlying assumption that payments in Category 4 are more conducive for person-centered care than payments in other categories. These commenters stressed that this proposition is not supported by robust evidence.

The Work Group agrees that robust evidence on the impact of Category 4 payments on patient care has yet to be established, and this point is now clarified in the final White Paper. Nevertheless, the Work Group believes that Category 4 payments hold tremendous promise,

based on foundational principles. As discussed in the draft White Paper, population-based payments do not provide an inherent incentive to increase volume, and they may in fact provide better compensation for services that are currently undervalued in FFS. Additionally, much anecdotal evidence suggests that highly integrated payment and delivery systems employing population-based payment have achieved incredibly high quality care, while reducing or keeping costs constant. Accordingly, the Work Group believes that it is appropriate, at present, to initiate movements towards Category 4, while continuing to collect more information about what works, so that these considerations can be taken into account as the health care system continues the transition away from FFS.

### Addition of a Potential Category 4C

Some commenters recommended that the Work Group create a Category 4C, which would capture payments within highly integrated payment and delivery systems, such as provider-sponsored health plans. Commenters also expressed concerns that these integrated systems would not fit into Category 4B.

The Work Group long considered the question of whether to add a Category 4C to the APM Framework to differentiate highly integrated arrangements from population-based payments from plans to providers. On the one hand, the Work Group believes that these types of arrangement are ideally suited for delivering person-centered care because they: 1) force transformational thinking about delivery system reform; 2) optimize coordination of infrastructure investments; 3) most fully remove financial incentives for volume; and 4) expedite community investment and engagement. This position is now explicitly articulated in the final White Paper. Nevertheless, as a taxonomic exercise, the Work Group does not believe that highly integrated payment and delivery systems and population-based payments from plans to providers are categorically distinctive payment models. Additionally, differentiating these two types of payment arrangements appeared to pose significant methodological issues for the progress-tracking effort that will accompany the final White Paper. Accordingly, the Work Group decided not to create a Category 4C, but it did revise the final White Paper to clearly indicate that these arrangements are highly desirable and included in Category 4B.

## Outside of APM FPT Work Group Scope

### Quality and Quality Measurement

Many commenters provided recommendations on approaches to quality measurement, such as the inclusion of patient-reported outcomes and behavioral health measures, the incorporation of risk-adjustment methodologies, and the use of harmonized measure sets. Other commenters stressed that patients and caregivers should be easily able to access and understand quality information. As indicated in the draft White Paper, the Work Group was not asked to make specific recommendations on quality measurement. Nevertheless, the Work Group does support the majority of the comments it received on this subject, and the final White Paper now indicates a set of very general principles for quality measurement that are consistent with

the Work Group's position. Please note that subsequent LAN publications will more directly tackle the subject of quality measurement.

## Health Information Technology and Data Sharing

Many commenters provided recommendations on approaches to health information technology and data sharing, such as the use of interoperable systems, the minimization of reporting requirements, and the availability of easy and free access to health information for patients and caregivers. As indicated in the draft White Paper, the Work Group was not asked to make specific recommendations on health information technology and data sharing. Nevertheless, the Work Group does support the majority of the comments it received on this subject, and the final White Paper now indicates a set of general principles for health information technology and data sharing that are consistent with the Work Group's position. Please note that subsequent LAN publications will likely more directly tackle the subject of health information technology and data sharing.

## Model Plan Design

Many commenters submitted recommendations on the desirable characteristics of payment models, or requested that the Work Group make recommendations on these characteristics. For example, commenters recommended that plans include incentives to provide behavioral health services, cover medically recommended services for specific populations (e.g., pediatrics), cover services that address social determinants of health, direct payments to teams of providers, and structure incentives for provider participation in some ways and not others.

The Work Group appreciates these recommendations and agrees that they are worth considering. Nevertheless, recommendations on model plan design are squarely outside the Work Group's charge, which is limited to developing a framework for payment models and initiating the collection of data to measure progress towards payment reform. Some issues related to plan design will be considered in forthcoming LAN work.

## Delivery System Reform

Many commenters submitted recommendations on desirable reforms to delivery systems, or requested that the Work Group make recommendations on these reforms. For example, commenters made recommendations on how to create, monitor, and modify patient-care plans; on how to engineer provider work patterns and flows; on the types of training programs that providers should attend; and on the types of infrastructure supports that providers should invest in.

The Work Group appreciates these recommendations and agrees that they are worth considering. Nevertheless, recommendations on desirable delivery system reforms fall outside the charge of the Work Group and that of the entire LAN.