Consumer-Purchaser
ALLIANCE
Better information. Better decisions. Better health care.

January 12, 2017

Members of the Physician-Focused Payment Model Technical Advisory Committee
c/o Angela Tejada
Office of the Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

RE: ACS-Brandeis Advanced Alternative Payment Model proposal

Dear members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC):

The Consumer-Purchaser Alliance is a collaboration of leading consumer, labor, and employer organizations committed to improving the quality and affordability of health care through the use of performance information to guide consumer choice, payment, and quality improvement.[1] We appreciate the opportunity to provide input on the proposed models for physician-focused payment models, including the ACS-Brandeis proposal for a payment model based on multiple procedural and condition episodes.

We encourage the PTAC to consider how physician-focused payment models will meet the needs of many stakeholders. Through the Health Care Payment Learning and Action Network (LAN) and Health Care Transformation Task Force (HCTTF), consumers and purchasers have laid out key principles for new payment and care delivery models.[2] The table below summarizes our analysis of how the ACS-Brandeis proposal addresses these key principles, and additional comments on select components of the model follow. Overall, we support the direction of the proposed model, particularly the design to promote coordinated and team-based care, and the concept of the Surgical Phases of Care measure set that brings the performance of various clinicians on multiple components of care into a cohesive picture of an episode of care.

[1] For brevity, we refer in various places in our comments to "patient" and "care," given that many Medicare Part B programs are rooted in the medical model. People with disabilities frequently refer to themselves as "consumers" or merely "persons." Choice of terminology is particularly important for purposes of care planning and care coordination, when the worlds of independent living and health care provider often intersect.

[2] The LAN consumer and patient principles are available here: http://hcp-lan.org/workproducts/cpag-principles.pdf. The HCTTF guiding principles and key questions for addressing consumer priorities are available here: http://hcttf.org/resources-tools-archive/2016/8/30/addressing-consumer-priorities-in-value-based-care. Purchaser principles are not finalized as of 1/12/17; our comments rely on draft principles developed by the LAN Purchaser Affinity Group.

Pacific Business Group on Health
575 Market Street, Suite 600, San Francisco, CA 94105
415.281.8660 | tel

National Partnership for Women & Families
1875 Connecticut Avenue, NW Suite 650, Washington, DC 20009
202.986.2600 | tel

Consumer/Purchaser Principle	**Analysis of ACS-Brandeis proposal**
Include patients/consumers as partners in decision-making at all levels of care	• We appreciate that ACS has proactively sought consumer input on the design of the model and on the approach to the Surgical Phases of Care (SPC) measure set, and the proposal reflects this input. • Little information is provided for how patients, consumers, families, and caregivers would be engaged in the implementation of this model on the ground, such as in the design of individual A-APM contracts or the establishment of new care workflows to support these episodes. • The SPC measure set includes multiple measures that could engage patients, families, and caregivers; it is not clear whether these measures will be weighted preferentially to encourage such engagement or meaningful shared decision-making.
Positive impact on patient care and health is paramount	• The SPC measure set emphasizes the central role of patient care and health through personalized risk assessment, care goal establishment and periodic assessment, and outcome measures.
Measures of performance and impact should be meaningful, actionable, and transparent	• We support the direction of the performance measurement strategy proposed here and have detailed questions and comments below.
Primary care services are foundational and must be effectively coordinated with other aspects of care	• The proposal emphasizes team-based care and appropriately incorporates the need for coordination and collaboration among a clinical team through model design, quality measures in the SPC set, and fiscal attribution. • The model includes post-discharge quality metrics and the episode grouper design allows for post-acute care to be included in the episodes. Without greater detail about the specific episodes proposed, it is unclear whether the episodes include the cost and quality of, thereby promoting coordination and integration with, post-acute care services, community services and supports, and other services delivered through non-traditional settings and modalities that meet patient needs.

Promote health equity for all	• We support the risk adjustment described in Appendix D of the proposal. As we have noted in other settings, we strongly prefer that risk adjustment for sociodemographic factors not be built into quality measure calculations; instead, measures should be stratified to show performance for the various patient groups. ACS-Brandeis notes that sociodemographic factors can impact clinical performance and health outcomes; nonetheless, a complex patient population deserves high quality care that yields good outcomes. We support approaches to address sociodemographic factors via payment, and we would be glad to discuss possible approaches to modify an APM entity's or individual QP's fiscal incentives based on the sociodemographic factors of their patient population.
Accelerate use of person-centered health information technology	• We urge ACS-Brandeis to describe how this model would accelerate the use of person-centered health information technology. Though interoperability between CEHRT and registries has many benefits, it does not advance information sharing between patients and their care teams.
Use transparent, meaningful, and aligned incentives that drive accountability for quality outcomes, patient experience, and total cost of care	• We applaud ACS-Brandeis for developing a nuanced proposal that promotes team-based care and accountability for patient experience, patient outcomes, and episode cost. The combined use of the episode grouper for Medicare and the designated clinician roles and weights for procedural and condition episodes is innovative and well positioned to meet the goals of the MACRA A-APM track. • The proposal is well designed to facilitate multi-payer alignment. However, it may be more complex to implement this model in markets where population-based payment models such as ACOs are also in place. • We are eager to see how this model might evolve over time, including maturation of specific procedural and condition episodes and the exploration of a shift toward population-based risk models. • We recommend that ACS-Brandeis make clear whether the model includes any measures of appropriateness that would ensure patients are not receiving more intensive services than necessary, nor that case mix severity adjustments result in upcoding.

Additional comments on the proposed approach to quality measurement

- We acknowledge the need for transitional periods that allow clinicians to gain experience with a program and that support the maturation of measure sets. A measurement strategy that focuses on participation is appropriate for the initial implementation of this model. We commend ACS-Brandeis for including the requirement that an "Excellent" rating can only be achieved through top performance on at least one measure. We support the directional statements that in more mature phases of the program, assignment of quality tiers will be based on performance. At the same time, we acknowledge that this evolution may require different timelines for different types of measures; for example, the model may retain a pay-for-reporting approach for patient-reported outcomes or patient-reported outcome measures (PROs and PROMs, respectively) to support development and testing of de novo PROMs for some time even after quality tier assignment is based on composite performance.
- Transparency of measures and performance is a key requirement for alternative payment and care models that effectively serve consumers and purchasers. We support the proposal's direction to rely on Qualified Registries and Qualified Clinical Data Registries that already have reporting mechanisms and requirements for sharing performance information with CMS. We encourage public reporting of performance information as a key component of any registry used for the quality components of an alternative payment model.
- We urge ACS-Brandeis to clarify the details of the measures available for the episodes already defined and the quality measurement approach, even in the early transition period of the model. Regarding the SPC measure set, some of the individual measures appear to be low value documentation and process measures (e.g., documentation of any single major co-morbid condition prior to surgery, with no assurance that all major co-morbid conditions are identified). However, the measure framework has the potential to promote highly patient-centered care with meaningful information to support quality improvement and accountability, if the individual measures are useful and appropriately prioritized. We are interested in more information about the weighting of various measures available in both the All Patient-based and Episode-based quality categories. We recommend that greater weight be given to higher value measures, such as unplanned readmissions and patient experience. The Consumer-Purchaser Alliance has published criteria for high value measures here: http://www.consumerpurchaser.org/docs/files/CP%20Alliance_10_Measure_Criteria.pdf.
- The proposal notes that in the Episode-based quality category, any acceptable rating is only available to those clinicians or APM Entities who demonstrate their ability to collect PROMs in at least one episode for some percentage of patients. However, the details about the PROMs under consideration for the model are unclear. Are these established PROMs? Are these PRO tools in wide use that are good candidates for measure development? Would this requirement allow clinicians and APM entities to collect information about any PRO tool relevant to the episode at their discretion? We strongly support the use of PROMs in alternative payment models and also support any concerted effort to build the development and testing of new PROMs into an alternative payment model to improve care and outcomes in ways that matter to patients.
- We encourage ACS-Brandeis to consider opportunities to expand the All Patient-based quality category to include PROs and PROMs that are cross-cutting or address health-related quality of life, such as PROMIS-Global or VR-12. Alternatively, the category could offer some incentive for a clinician or APM Entity to use PRO tools that directly assess their primary area of practice.

Thank you again for the opportunity to comment on the proposed alternative payment model. Episode payment models present a significant opportunity to improve our nation's health care system through better quality, improved care coordination, lower costs, and greater transparency. If you have any questions about our comments, please contact Stephanie Glier, Senior Manager for the Consumer-Purchaser Alliance, at sglier@pbgh.org.

Sincerely,

Bill Kramer
Executive Director, National Health Policy
Pacific Business Group on Health
and
Co-Chair, Consumer-Purchaser Alliance

Debra Ness
President
National Partnership for Women & Families
and
Co-Chair, Consumer-Purchaser Alliance