**June 12, 2017**
**Health Care Payment Learning & Action Network (LAN)**
**Re: Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group, Draft APM Framework Refresh White Paper Comments**

## NAACOS Comments to LAN on the APM Framework Refresh White Paper

NAACOS appreciates the opportunity to provide feedback on the Health Care Payment Learning & Action Network (LAN) Alternative Payment Model (APM) Framework Refresh White Paper. NAACOS supports the LAN's ongoing work and commitment to encouraging the shift away from the current fee-for-service model of payment in our health care system to one that pays providers for quality care and improved health.

As the largest association of ACOs, representing more than 3.5 million beneficiary lives through 230 Medicare Shared Savings Program (MSSP) ACOs, Next Generation, and commercial ACOs we care deeply about this issue. NAACOS is an ACO member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, coordinated patient-centric care process. Our recommendations reflect our expectation and desire to see ACOs achieve the long-term sustainability necessary to enhance care coordination and health outcomes for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program. NAACOS' APM principles are further described in the attached principles statement for the Work Group's reference.

It is critical that the Alternative Payment Model Framework and Progress Tracking (APMFPT) Work Group's recommendations ensure the continued success of APMs that are focused on comprehensive population health payment and delivery models. As the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) further accelerates the creation of new APMs, we urge the APMFPT Work Group and LAN to recognize that APMs must work toward the goal of integrating care for a patient rather than continuing the segmented approach to health care that results from the current fee-for-service (FFS) payment system. As the APMFPT and LAN consider the APM Framework they must also consider the interaction of the various models that take place in practice. The proliferation of specialty specific care models created in a vacuum without proper incentives to simultaneously work on the goal of population health and total cost of care for a patient has the potential to degrade the work that has been accomplished to date in breaking down these very silos by focusing on population health and whole person care. An example of this in practice is the increasing interaction of various Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (Innovation Center) models.

Currently, there are a number of Bundled Payment for Care Improvement (BPCI) models that operate simultaneously with other CMS bundled payments such as the Oncology Care Model (OCM) bundles as well as episode payments for the Comprehensive Care for Joint Replacement (CJR) model. At the same time, the very patients treated for these episodes can also be cared for by ACOs or even practices participating in

both ACOs and the Comprehensive Primary Care Plus (CPC+) model. When CMS looks at these overlapping initiatives and efforts, the agency currently gives precedence to bundled payment episode initiators in the majority of instances. This creates adverse incentives for bundlers who can benefit from the care coordination practices of an ACO and remain the sole recipient of the savings achieved. This perverse incentive not only harms ACOs' financially, but it can also create gaps in care for a patient who may not receive the best available follow-up care after the completion of the episode. Additionally, a payment model that focuses on one disease state or condition may not be held accountable for increased utilization.

For these reasons, NAACOS urges the APMFPT Work Group and LAN to emphasize the importance of whole person care and APMs that are accountable for total costs of care rather than a specific disease state. Payment and delivery reform's ultimate goal should be accountability for total cost of care to further incentivize clinicians to work together to care for a patient's total health needs rather than exacerbating the silos that have historically existed and remain in place in our health care system. While the financial incentives to increase the volume of services provided are inherent in FFS payments as the White Paper discusses, the same is true for condition-specific episode payments. For this reason, we urge the LAN to further emphasize the need to prioritize APMs that incentivize collaboration, focus on population health, and are accountable for total cost of care not just for a specific condition but rather a population.

On page 26, the White Paper states "taken together, Categories 4A, 4B, and 4C represent the furthest departure from traditional FFS payments, while simultaneously ensuring that providers possess the strongest possible incentives to deliver high-quality and efficient care." Placing condition-specific population based payments in this category is inappropriate and may have the unintended consequence of furthering the fragmented care we see in the current landscape. As the APMFPT Work Group looks forward to proposing an approach for measuring APM adoption across the U.S. health care system, we urge the Work Group and LAN to focus their efforts on moving the industry toward population health and total cost of care focused payment and delivery models that are truly accountable for the entirety of a patient's health needs. We appreciate this opportunity to provide feedback on the APM Framework and Progress Tracking Work Group's ongoing evaluation of APMs.

Sincerely,

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President and CEO
National Association of ACOs

**NAACOS APM PRINCIPLES STATEMENT**

NAACOS supports the following APM principles which are further described below. These principles focus on the key elements necessary to achieve high performing, successful APMs. To create an environment of success, we recommend that APMs:

- Transition providers to risk-based arrangements over time and only through voluntary initiatives rather than forcing providers into risk before they are ready.
- Prioritize population health focused payment and delivery models and refrain from further segmenting care.
- Encourage the integration of primary care and specialty care and support a team-based approach to care rather than segmenting the patient according to a particular disease state.
- Set risk levels at an appropriate threshold for providers who are ready to take on risk.
- Account and give credit for start-up and ongoing investment costs related to APM participation.
- Provide participants with access to timely, actionable data.
- Allow for flexibility and reduce regulatory burdens to incentivize care transformation and enable innovative delivery models to emerge.
- Utilize appropriate performance evaluation methodologies that create an even playing field.
- Harmonize quality measure sets with those of other payers/models and not require overly burdensome reporting requirements.
- Incentivize creative and appropriate ways to engage beneficiaries.
- Provide transparency for key program calculations and processes used for evaluating participants.
- Reward providers with appropriate incentives commensurate with their work.
- Not penalize high performing providers by adding value-based payments to the APM benchmarks they are measured against.

**APMs should transition providers to risk-based arrangements over time and only through voluntary initiatives rather than forcing providers into risk before they are ready.**

The decision to take on risk is at the heart of an ACO's choice about which model to select and having to potentially pay millions of dollars to Medicare is simply not practical nor feasible for many organizations. Taking on large amounts of risk necessitates that ACOs have considerable financial backing. Many ACOs are unable to access investor capital and face many barriers to obtaining sizeable credit. Without large enough assets to secure loans, many physician owners are left having to personally guarantee debts and obligations. Basing risk on total cost of care creates situations where physicians could be responsible for repaying a substantial amount, if not all, of their Medicare income for a particular year. The challenges of taking on risk are often exacerbated for those in rural areas and safety-net providers, which care for some of the most vulnerable patient populations. Based on these realities, it is critical that APMs should transition providers to risk-based arrangements over time and only through voluntary initiatives rather than forcing providers into risk before they are ready.

**APMs must prioritize population health focused payment and delivery models and refrain from further segmenting care.**

Population health focused payment and delivery models, such as the ACO model, are just now gaining momentum and an evidence base to learn from. It is critical that we allow these models to realize their full potential. NAACOS supports the exploration of new payment models, which will ultimately benefit all who are working to reform health care delivery and payment models to better support patients and to contain costs while providing exceptional care. However, new payment reform efforts must work in tandem with existing models to protect the progress organizations such as ACOs have worked so hard to accomplish to

date. APMs must prioritize population health focused models and refrain from pitting population health models against other, more segmented approaches to reform.

**APMs must encourage the integration of primary care and specialist and encourage a team-based approach to care rather than segmenting the patient according to a particular disease state.**

Specialists play a key role in containing costs and coordinating a patient's care in the effort to focus on population health. It will be critical to work on including these specialists in population health focused models such as ACOs, rather than further isolating specialists with their own episodes. NAACOS has concerns that the current growth of specialty focused payment models may result in a proliferation of siloed, specialty-focused care models that are not integrated into population health focused care models. This has the potential to diminish the focus on population health and the entirety of a patient's care. Therefore, APMs must encourage the integration of primary care and specialty care and encourage a team-based approach to care rather than segmenting the patient according to a particular disease state.

**APMs must set risk levels at an appropriate threshold for providers who are ready to take on risk.**

For providers who choose to take on risk, risk levels must be set at a reasonable and appropriate level. APMs must be designed to incentivize ACOs to begin taking on risk in a manner that holds them accountable for cost and quality in an appropriate way, providing a glide path to assuming risk. Additionally, these participation options should be made widely available to ACOs of all sizes and structures so that participation is not restricted to a certain type of ACO or for a specific number of agreement periods.

**APM evaluations must give credit for start-up and ongoing investment costs related to APM participation.**

When evaluating APMs, the significant investments ACOs make in start-up and ongoing costs must be accounted for and included as part of the definition and calculation of risk. This investment—the cost of switching to a fundamentally different approach to patient care—is in and of itself a substantial risk. ACOs incur these costs with the goal of earning shared savings payments; therefore, ACOs consider and account for their investment costs as risk inherent in MSSP participation. These investments include start-up and operating costs to help fund critical ACO activities designed to improve beneficiary care, enhance care coordination, and reduce unnecessary spending and hospitalizations including those related to clinical and care management, health IT/population analytics/reporting, and ACO management and administration.

**APMs must provide participants with access to timely, actionable data.**

Developing care coordination processes and other care management strategies require intervention at the appropriate time. For this reason ACOs must have access to timely, transparent and actionable data that they can use to provide the right care to the right patient at the right time. Obtaining performance feedback on both quality and costs is critical to an ACO's success. The ultimate goal should be to provide this feedback in real time.

**APMs must allow for flexibility and reduce regulatory burdens to incentivize care transformation and enable innovative delivery models to emerge.**

Removing legal and regulatory barriers that inhibit providers from working together to provide better-coordinated, high quality care is of the utmost importance to ACOs. Waiving payment regulations like the Skilled Nursing Facility Three Day Rule and certain limits on the use of telehealth services for example, is essential so that ACOs can effectively coordinate care and ensure that it is provided in the right place at the right time. These waivers provide ACOs with valuable tools to increase quality and reduce unnecessary costs and should be available to advance the success of all ACOs.

**APMs must utilize appropriate performance evaluation methodologies that create an even playing field.**

It is critical that APMs use appropriate performance evaluation methodologies that result in fair assessments. For example, risk adjustment methodologies must account for adjustments in beneficiary health status and demographic changes. Not accounting for such changes in a patient population unfairly penalizes an ACO for something that is beyond their control and serves as a disincentive to participation in the program. Therefore, APMs must utilize fair and appropriate performance evaluation methodologies that create an even playing field among the model's participants as well as the performance thresholds participants are compared against. Further, following rigorous evaluation of the various approaches to critical program methodologies, such as risk adjustment, CMS should ensure an optimal methodology that is fairly applied across APMs.

**APMs must harmonize quality measure sets with those of other payers/models and not require overly burdensome reporting requirements.**

The increasing burden associated with reporting quality measures has the potential to detract from the actual provision of high quality care. APMs must harmonize quality measure sets to cut down on the administrative complexity created by each payer and model using their own unique quality measure set. Additionally, APMs must reduce the number of quality measures ACOs are evaluated on and focus only on those measures that represent a true impact on a patient's care. Lastly, quality measure reporting requirements should be simplified and streamlined to reduce the costs and burdens associated with reporting so that ACOs can instead use those resources to focus on actually providing high quality care to its patients.

**APMs must incentivize creative and appropriate ways to engage beneficiaries.**

While NAACOS supports the ability of patients to choose their health care provider, there are certain instances when this freedom of choice creates an insurmountable obstacle for ACOs trying to coordinate a patient's care and provide the highest quality care possible. Therefore, APMs should allow organizations to request patients obtain their healthcare services from an approved list of preferred clinicians and to provide beneficiaries incentives to do so. This will allow ACOs to direct patients to the most cost effective and high quality providers, thereby also resulting in cost savings for the ACO and Medicare.

**APMs must provide transparency for key program calculations and processes used for evaluating participants.**

It is critical that ACOs are aware of the methodologies and key program calculations used in evaluating their performance. These processes must be fully transparent and available to participants at all times. Further, advanced notice should be provided prior to any key changes in these methodologies. ACOs simply cannot be successful if they are evaluated using a moving target. What's more, these methodologies must be fully transparent so they are easily replicated allowing for the ACO to verify these findings.

**APMs must reward providers with appropriate incentives commensurate with their work.**

APMs must be rewarded for their hard work and the inherent risk they take on by engaging in the extremely difficult work of transforming care processes. APMs must reward providers with appropriate incentives that are commensurate with the amount of work required of the ACO. Specifically, ACOs should receive a sufficient proportion of the savings they are instrumental in generating and should be rewarded in other ways, such as through advanced investment opportunities or additional funding for initiatives including those related to achieving higher quality or continuing on the path to value-based care.

**APMs should not penalize high performing providers by adding value-based payments to the APM benchmarks they are measured against.**

It is critical that APMs explicitly exclude other value-based incentives earned by the entity from any benchmarks that will be used in measuring an ACO's performance. Including these payments as expenditures penalizes high performing providers and serves as a disincentive for participation. Further, it creates competing incentives and confusion for providers, especially if they are required to participate in programs separate from the ACO's core objective.