PIPC Partnership to Improve Patient Care

November 20, 2015

Dr. Sam R. Nussbaum, MD
Chair, APM Framework and Process Tracking (FPT) Workgroup
Health Care Payment and Learning Action Network

Re: Alternative Payment Model Framework Draft White Paper

Dear Dr. Nussbaum and APM FPT Workgroup Members:

The Partnership to Improve Patient Care (PIPC) is pleased to have this opportunity to comment on the Alternative Payment Model (APM) Framework Draft White Paper. Since its founding, PIPC has been at the forefront of patient-centeredness in comparative effectiveness research (CER) – both its generation at the Patient-Centered Outcomes Research Institute (PCORI), and its translation into patient care. Having driven the concept of patient-centeredness in the conduct of research, PIPC looks forward to bringing the patient voice to the discussion of how to advance patient-centered principles throughout an evolving health care system.

The U.S. has made significant progress in advancing patient-centeredness over the last several years. The progress we have made is the fruit of a movement that spans several decades, and PIPC is proud to have lent its voice to this effort. Advances in policy such as the authorization of the Patient-Centered Outcomes Research Institute (PCORI) in 2010 and Patient-Focused Drug Development at the Food and Drug Administration (FDA) highlight the recognition by policymakers that patients should not be in the back seat. Instead, patients should be driving research, and given the recognition that they are capable of translating patient-centered research into health care decision-making.

At the same time, much work remains to be done. While most health policy experts agree on the notion of developing a "patient-centered health care system," we do not yet have a delivery system that entirely incorporates or is modeled on delivering patient-centered health care. PIPC promotes policies that apply patient-centered principles throughout the health care system – from development of evidence (i.e. PCORI) to the design of new payment and delivery reforms (i.e. alternative payment models (APMs). We strive to raise awareness about the value of well-designed comparative clinical effectiveness research, the important role of continued medical innovation as part of the solution to cost and quality challenges in health care, and the importance of shared decision-making between patients and providers that empowers truly patients to play a more active role in their own healthcare decisions. PIPC members, representing a diverse, broad-based group of health care stakeholders, are dedicated to working together to promote giving a voice to patients, giving choice to patients, and advancing value for patients.

The Health Care Payment and Learning Action Network (LAN) provides an opportunity to advance a health system that meets the principles of patient-centeredness and therefore empowers and activates patients in their own care. While we appreciate the APM Framework

and Process Tracking Work Group's acknowledgement of this goal, we are concerned with the implicit assumption that payment models that place providers at financial risk are a sufficient condition to drive towards more patient-centered care.

In order for payment reforms to have the intended impact on improving patient care without creating barriers to access to care, safeguards must be in place to ensure that quality and patient engagement are not sacrificed on the altar of cost effectiveness, and that the care delivered is state-of-the-art and takes advantage of valued advances in science and technology. For this to occur, many foundational elements not explicitly referenced in the APM framework must be in place. First, new payment models must have the tools to appropriately risk adjust so that bundled, population-based or capitated payment models do not inappropriately restrict access to care for chronically ill and disabled patients. Second, quality measures must be developed and implemented that capture outcomes that matter to patients so that "quality" and "value" are based on patient needs, preferences and outcomes. Third, decision aids must exist and be used that provide patients with unbiased access to their treatment options and the impacts of those treatments on outcomes that matter to patients so that shared decision-making is meaningful. Lastly, a constant feedback loop must exist to identify in real time the impact of new payment models on access to care, particularly for vulnerable populations.

We would emphasize that achieving meaningful input from beneficiary stakeholders, particularly patients, people with disabilities, and their families, is a continuous process that requires targeted strategies. We believe such input from the beneficiaries whose care relies on getting this right will be vital to achieving the LAN's goals. Ultimately, the transition to value-based health care must look at value from the perspective of patients served by the system of care incentivized by new payment models and support providers to deliver the care patients' value. Accordingly, we offer our recommendations on the APM Framework White Paper and its approach to patient-centeredness.

Quality

PIPC agrees with the white paper's assessment that quality indicates that patients receive appropriate and timely care that is consistent with evidence-based guidelines and patient goals, and that results in positive patient outcomes. Yet, payment systems typically lack incentives to capture patient preferences and to demonstrate those preferences are driving care decisions. As was recommended by oncology patient groups in a roundtable recently convened by PIPC, quality and value to the patient requires three key steps. First, care planning should capture the preferences of patients and should be required for implementation in alternative payment models. Second, alternative payment models should demonstrate meaningful shared decision-making allowing patients to understand their condition, their preferences for treatment based on care planning, their treatment options, the benefits and risks associated with each treatment option, and their associated out-of-pocket costs. Third, quality measures should be developed and used to empower providers to engage in care planning and shared decision-making, so that providers are rewarded for identifying and achieving patient preferences. At the same time, it is important to prioritize the measures to which providers are held accountable so that they truly reflect

outcomes that matter patients and do not place undue administrative burdens on providers. Patients and providers should be at the forefront of this process.

Cost Effectiveness

We are concerned that "cost effectiveness" is considered a pillar for patient-centered care. While affordability is a serious concern for patients and the health system overall, the clinical effectiveness of a treatment option and its impact on certain factors related to quality of life will be the cornerstones for patient-centered care, not cost-effectiveness. The white paper does not clearly allow for an individualized assessment of treatment impact that is not necessarily based on treatment impact on "averages." Value is deeply personal, with some patients preferring or needing a treatment option that was not necessarily effective for the average patient, but perhaps being the most effective option for that person.

Patient Engagement

We are concerned with the terminology used in the white paper related to patient engagement as the "disparate and non-clinical" aspect of care. To the contrary, PIPC believes that patient engagement is an essential component of care and critical to achieving clinical outcomes. The language used in the white paper seems to indicate a more passive patient in the care process, though the language does capture the need to better inform patients. Patient engagement is required for the effective transition to a patient-centered health system, from governance of health systems to individual care decisions.

Patient engagement is critically needed at the level of governance to ensure that policies support these aims. Engagement begin early in the process of developing new policies and programs, particularly as they relate to new payment models, and should be measured to determine the use of patient input in the development of the final policy or product. For example, LAN workgroups should be primarily comprised of individual patients and/or patient groups and clinical experts. The LAN should seek input from patients on specific project activities, identifying the specific areas where patient input is most needed and directly soliciting feedback from impacted patient communities.

The LAN could lead by example to better engage patients in a process to identify the core components of a shared decision-making process required for alternative payment models, including the use of tools that allow patients to understand their condition, their preferences for treatment, and their treatment options, the benefits and risks associated with each treatment option, and their associated out-of-pocket costs. This includes a core standard of demonstrable patient engagement in the development and testing of shared decision-making tools utilized in alternative payment models so that they are assured to be meaningful. The LAN could also prioritize the creation of a targeted workgroup on measuring outcomes that matter to patients.

Changing the culture of our health care payment and delivery systems to value patient perspectives will require the same kind of commitment to patient engagement that has been

implemented by organizations such as the Patient-Centered Outcomes Research Institute (PCORI) where researchers are accountable for engaging patients as part of their contracts. In this process, the LAN should be consulting with patients and patient groups to identify a set of patient-centered criteria for engaging and empowering patients in their care. Otherwise, payment incentives could have the effect of driving patients to "one-size-fits-all" treatment options that are based on average assessments instead of promoting personalized care decisions.

Conclusion

PIPC is grateful for this opportunity to comment. We encourage you to review our white paper on Building a Patient-Centered Health System for insights on a patient-centered approach to developing alternative payment models and the foundation upon which they are built. In our work, we discuss the evolution of the patient-centeredness movement and the foundational and structural challenges that will be faced by alternative payment models. We are concerned about the pace at which alternative payment models are being promoted and expanded, potentially in the absence of appropriate risk adjusters, quality measures, decision aids, and feedback loops. We urge a strong focus on developing this foundation in order to thoughtfully advance alternative payment models that achieve outcomes that matter to patients.

In furtherance of this goal, PIPC provides the following broad recommendations for payment and delivery of healthcare:

- Provide a meaningful voice to patients. Policymakers should establish formalized mechanisms that provide a meaningful voice to patients throughout the healthcare system.
- Prioritize policies that promote patient-centeredness and ensure new payment and delivery models do not define success as simply meeting financial targets or promote a "one-size-fits all" approach to cost-containment.
- Catalyze the development and endorsement of meaningful quality measures and ensure they are appropriately incentivized in health systems. Policymakers should recognize the need to improve the patient-centered infrastructure for measuring and rewarding improved health outcomes. There are significant gaps in quality measurement that will require expanded support for measure development and endorsement.
- Foster informed choices from the range of clinical care options through shared decision-making, transparency of the incentives (financial and otherwise) that drive care decisions, and by empowering patients with accessible, understandable evidence.
- Support patient access to high quality individualized care.

Sincerely,

Tony Coelho