June 12, 2017

Alternative Payment Model Framework and Progress Tracking Work Group
CMS Alliance to Modernize Healthcare
The Mitre Corporation
7515 Colshire Drive
McLean, VA 22102-7539

**Re: Draft APM Framework Refresh White Paper**

Dear Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group:

Mental Health America and the undersigned organizations applaud the APM FPT Work Group for driving national payment reform to value over volume, and ensuring person-centeredness throughout. The undersigned hope to partner with the Health Care Payment and Learning Action Network to make the transition to Categories 3 and 4 a success.

The undersigned hope that the APM FPT Work Group will consider two additions to the framework, making the most of this refresh opportunity: (1) a new Category 5 for Net Present Value-based Payments, and (2) a place for community-level investments that promote health but may not change provider behaviors. Although the recommendations do not go into great detail about how the models should be constructed, it is essential that the implementation of these models maintain the careful person-centeredness and person-engagement that the APM FPT Work Group has advanced so thoughtfully.

1. **A new Category 5 for Net Present Value-based Payments**

The undersigned believe that risk-adjusted population-based payments with value-based incentives for efficiently using resources to optimize health is a crucial next step for health care in the United States. However, this still represents a partial transition to value – the final step will need to look at value beyond the present attribution period, and toward how present health system performance impacts health outcomes and health care utilization in coming years and even coming decades.

The undersigned encourage the APM FPT Work Group to include a fifth category of APM for net present value-based payments that include a long-term perspective on value in population-based payment models. The core issue is captured well in behavioral health – Category 4 payments may reward depression screening in adolescence and subsequent progress toward remission, but do nothing to reward (or may even disincentivize) intervention earlier in life to prevent that individual from ever screening positive for depression. Today, health promotion/prevention is captured predominantly through process measures (e.g. developmental screening for toddlers), which is not ideal as so many systems try to move toward outcome

measures. The cardiovascular risk reduction model, with its focus on calculating and mitigating risk ten years into the future, signals the beginnings of a possible positive shift.

APMs can begin to capture predicted future value by transitioning from "total cost of care" as a resource efficiency metric to "net present value of care," which would include total cost of care plus the expected value of reductions in future actuarial risk as predicted by health outcomes achieved during the past attribution period (divided by an appropriate discount rate). For example, a maternity care bundled payment model could allow obstetrics practices to share predicted savings to the child's future health care costs when they address perinatal risk factors, such as maternal stress, depression, or substance use, all of which are well correlated with future health care needs as the child grows up. While reductions in future actuarial risk is not a perfect indicator for life-course health promotion (dollar values may need to be assigned to certain adverse events to prevent perverse incentives in marginal cases), it provides a strong initial foundation that also complements efforts toward overall cost containment.

Health plan churn may presently undermine the value of forecasting into the future, but the rise of all-payer frameworks increases the likelihood of average reciprocity of benefits for health plans as they invest in prevention, and integrated Category 4C models may have high enough geographic penetration that individuals would churn less frequently. Predicting expected values based on present outcomes may also present a challenge initially, but a combination of findings from the empirical literature in prevention science and health care systems' existing administrative data can allow for some initial conservative estimates to support at least some preliminary models. Over time, growing health information exchanges will allow for more actuarially rigorous estimation of the expected value of health outcomes, overcoming past difficulties with valuing prevention.

True value-based payment should capture value in health outcomes and reduced health care utilization across the life-course. The undersigned hope that the APM FPT Work Group will consider designating a Category 5 for Net Present Value-based Payments as it charts to course for American health care transformation in the coming years.

**2. A place for community-level investments**

The undersigned agree that value-based payments should drive delivery. The undersigned encourage the APM FPT Work Group to also consider how community-level investments that promote the Triple Aim, but are not necessarily provider delivered, could be integrated into the framework. For example, a successful APM may incentivize clinical preventive interventions for obesity. In some cases though, an even more successful APM may incentivize a health system to invest in a playground and walkable spaces to encourage physical activity and prevent obesity at the community level. While presently there are few examples of these types of investments outside of community benefit, meaningful population health management models should include these types of investments when they are more effective than provider-delivered care. Category 4 payments would promote provider-level attention to social determinants of health and coordination with community-based organizations and health-related social services providers, but it is unlikely to incentivize the types of capital investments that might ultimately be most

health promoting and cost-saving. In many places, community-level investments will be essential for addressing social determinants of health and building a foundation from which community-based organizations and health-related social service providers can excel – a growing priority in recent years for CMS and NQF. Since the framework is focused on driving provider-level incentives, it is not clear where community-level investment incentives would fit, but it is important that they have a home in any vision for the future of health care in America.

**Conclusion**

The undersigned thank the APM FPT Work Group for its work in driving payment and delivery reform, and the opportunity to comment on this draft white paper. The undersigned hope that the Work Group will consider the two recommendations, and look forward to working with the Health Care Payment and Learning Action Network in the transition from volume to value. For further questions, please do not hesitate to contact Nathaniel Counts, J.D., Senior Policy Director of Mental Health America, at ncounts@mentalhealthamerica.net.

Sincerely,

Mental Health America

Alliance for Strong Families and Communities

Association for Ambulatory Behavioral Healthcare

American Association on Health and Disability

Campaign for Trauma-Informed Policy and Practice

CHADD (Children and Adults with ADD)

Child and Family Policy Center

Community Oriented Correctional Health Services

The Eating Disorders Coalition

Healthcare Leadership Council

Global Alliance for Behavioral Health and Social Justice

Kennedy Forum

National Alliance on Mental Illness

National Association of State Mental Health Program Directors

National Council on Alcoholism and Drug Dependence of Maryland

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