PBGH
PACIFIC BUSINESS GROUP ON HEALTH

575 Market St. Ste. 600
SAN FRANCISCO, CA 94105
PBGH.ORG

OFFICE 415.281.8660
FACSIMILE 415.520.0927

March 8, 2016

Dana Safran, ScD
Glenn Steele, Jr, MD, PhD
Population-Based Payment Workgroup
Health Care Payment Learning and Action Network
PaymentNetwork@MITRE.org

RE: Comments re PBP Financial Benchmarking Paper

Dear Drs. Safran and Steele:

Thank you for the opportunity to provide comments on the population-based payment (PBP) workgroup's recent paper on Financial Benchmarking. The Pacific Business Group on Health (PBGH) is a non-profit organization that leverages the strength of its 65 members—who collectively spend $40 billion a year purchasing health care services for more than 10 million Americans—to drive improvements in quality and affordability across the U.S. health system. A number of PBGH employers utilize PBP arrangements both directly with accountable care systems and indirectly through their medical carrier. Working with its member organizations, PBGH also manages the Employers Centers of Excellence Program, which uses a prospective, integrated hospital and physician bundled payment model for hip and knee replacement and spine surgery.

Our feedback today is informed by direct experience with alternative payment models. As the largest collective underwriter of American healthcare, public and private employers are increasingly interested in alternative payment methods like PBP that have the potential to increase value across the broader system in which we all purchase and receive care. The PBP workgroup's recommendations regarding financial benchmarking are important in promoting alignment among value-payment methodologies, but its tone and content seem one-sided relative to the perspective of providers. We strongly support the LAN's work, but believe that its approach to financial benchmarking tends to reinforce the status quo rather than achieve the goal implicit in the paper's title, "Accelerating and Aligning Population-Based Payment Models." Some general comments and observations include:

1) The paper assumes that the shift to PBP models is voluntary and that a generous initial baseline is required to entice voluntary participation. There are many instances of ACO-based models where organizational contracting with established health systems and provider organizations binds individual participating providers to the overall terms of the agreement. Recommendation 1a is misdirected in reinforcing a baseline of "provider-specific spending." "Local market forces" in a region that is highly consolidated may in fact set price points well above the actual cost of care. For example, a provider-sponsored health plan in Northern California has bid prices at nearly 30 percent below the existing cost structure offered through a blended health plan rate.
2) The paper assumes that current levels of payment, whether viewed nationally or regionally, are the correct starting point from which to base risk-sharing or incentive payments. Complacency in accepting current pricing levels as de facto benchmarks is insufficient to address purchaser and consumer concerns about affordability. Delivery system reforms that improve access and quality have the potential of lowering baseline costs. Similarly, market competition with transparency of

price position has been demonstrated to drive radical re-pricing of services. Rather than "favoring lower efficiency organizations" at the outset, we suggest that financial benchmarking should take into account the current level of efficiency and clinical performance of an organization and offer incentives that promote movement to greater efficiency, regardless of the starting point.

3) The absence of a time horizon for creating a blended national and regional benchmark attenuates existing incentives to maintain current fee-for-service payment structures that often remain the primary payment model under PBPs. PBPs need to create aligned incentives that accelerate innovation and care redesign rather than motivate deeper provider discounts at the margins.
4) Convergence in adjusted payments from public and private plans within a common payer segment may not be realistic. Market competition should be the driving force for convergence, such that high cost or inefficient providers are motivated to improve their performance. Purchasers are also concerned that current levels of public-private cost shift be institutionalized in baseline commercial ACO benchmarks at a time when ACA-driven coverage expansion should significantly reduce uncompensated care.
5) We concur with the LAN's recommendations on risk adjustment balance that rewards effective management of high cost populations and that risk adjustment should not be used to rationalize a lower level of performance expectations for organizations serving disadvantaged populations. We agree that utilization should not unduly influence risk score. Furthermore, payers should use utilization indicators such as the percentage of Emergency Department (ED) visits resulting in an admission, avoidable ED visits, and ambulatory care sensitive admissions to inform potential savings opportunity, rather than incorporating a high level of potentially inappropriate utilization as part of financial benchmarking. While concurrent risk adjustment may be used for retrospective adjudication of risk mix, we also believe that prospective population-based payments should reflect prospective risk estimation.

Below are additional comments and feedback on other sections of the paper:

Overview and Preamble

The purpose of "provide a blueprint that can help guide the technical work of establishing, updating, and rebasing financial benchmarks in PBP models" could be more clearly articulated at the beginning of the white paper. As with some of the other LAN papers, there is a tendency to elaborate on the committee process which obscures the desired goal and outcome.

Definitions

We applaud the LAN's approach to defining the Total Cost of Care to be broad and inclusive with respect to behavioral health and pharmaceutical costs, as well as recognizing the value of flexibility for provider organizations to invest in social services that may be critical to managing and improving health. However, we find that the definition for Financial Benchmark seems to extend beyond the concept of a target population-based spending level. The use of risk adjustment would be more appropriately reflected as a recommendation as opposed to being embedded in the Financial Benchmark definition. Additionally, a target may be established through negotiation or a bid process, as opposed to historical or geographic experience.

Principles

It is not clear how the stated principles are intended to be operationalized. We believe that the principles need to be considered from all stakeholder perspectives – purchasers, consumers, plans, and providers. For

example, a blanket statement about trust is insufficient absent the elements that would engender trust, such as transparency, aligned incentives and communication. We respectfully suggest that some component elements may be more appropriately framed as process recommendations. A stated target that "fairly rewards provider organizations" overlooks the expectation of potential savings to the purchaser and consumer. We understand that a collaborative process that seeks to distill a variety of far-reaching objectives into a cohesive set of principles can result in the combination of elements that are not fully connected. Under separate cover, we provide specific comments on the construction of the stated principles.

Several years ago, PBGH articulated a set of principles for ACOs, and subsequently updated in a toolkit jointly developed with Catalyst for Payment Reform. We believe that adapting some of these principles may provide directional guidance for achieving the implied objective of accelerating and aligning PBP models:

- Transparency – sharing information about clinical performance and financial arrangements is critical to performance accountability.
- Incentives – pay providers for quality, not quantity. Too often, incentives are not aligned such that the vast majority of payments underlying a PBP model are still based on fee-for-service rather than alternative payment structures.
- Affordability – beyond benchmarking based on historical cost, PBP models should take into account overall savings opportunities relative to a combination of national and regional benchmarks. Some high performing groups have gone beyond moderating existing trends to produce negative cost trends.
- Meaningful measurement – incent quality improvement that is outcomes-focused, patient-centered and enhance value.
- Competition – support a competitive marketplace.
- Infrastructure investment – support appropriate investment in health information technology for clinical decision support, clinical integration, information exchange among providers and with patients.

Thank you again for the opportunity to provide feedback to the PBP workgroup on these important methodological documents. We look forward to continuing to engage public and private purchasers in the workgroup's activities, and continue to strongly support the LAN's broader effort to increase value across the U.S. health system.

Please contact me should you require any additional information or clarification.

Sincerely,

David Lansky, PhD
President & CEO

Cc: Michael Chernew, PhD