July 1, 2016

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Health Care Payment Learning and Action Network
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Dear Drs. Safran and Steele:

Thank you for the opportunity to comment on the population-based payment (PBP) workgroup's recent paper on data sharing. The Pacific Business Group on Health (PBGH) is a coalition of large healthcare purchasers—both private employers and public agencies—who drive improvements in quality and affordability across the U.S. health system. Collectively, we spend over $40 billion a year purchasing health care services for more than 10 million Americans.

Increasing the transparency and free flow of data in the health system is foundational to many PBGH programs and a key priority for all of our members. Our organization administers the California Healthcare Performance Information System, one of the largest multi-payer claims databases in the country. We co-lead the Center for Healthcare Transparency, a non-profit, multi-stakeholder group seeking to make information on the relative cost and quality of healthcare services available to 50 percent of the U.S. population by 2020. Furthermore, several PBGH members have implemented direct contracts with providers that include total cost of care accountability and robust data sharing requirements.

We draw on this experience and preface detailed comments below with three overarching points for the PBP workgroup to consider. First, we encourage the group to revisit its decision to provide a set of general principles and ideal scenarios for data sharing arrangements without any practical road map for realizing its vision—the recommendations as currently written are insufficient to this task. While it is important to state what various actors "should" do, and note that they may have business reasons for moving slowly, it would be helpful for the paper to outline an architecture or structural approach to surmount these barriers. If current business agreements between payers and providers have generally not produced adequate data sharing arrangements in PBP models, what specific path and enforceable mechanisms does the workgroup endorse for getting there?

Second, while the paper makes clear the workgroup's belief that patients should be empowered by data sharing, it fails to include any meaningful discussion on how to ensure that this happens. In the current system, parties to a PBP contract—payer and provider—have little reason to show patients other providers who offer lower cost or higher quality, or to support community-level data sharing that might disadvantage them. To address this, we encourage the group to put forth actionable recommendations consistent with the broader LAN patient principles, viz., patients are entitled to comprehensive and longitudinal data about their care in a form that they can compile, control, and share with caregivers.

Finally, the workgroup makes several references to "health" throughout the framework paper, raising the important question of what we mean by health and what data ultimately needs to be publicly and privately

shared so that we can adequately evaluate it. The workgroup's implied focus on claims data is inadequate, given that claims contain no information about outcomes. A distinctive role for the LAN in this arena is to address value and how it is defined; a unique contribution from this workgroup could be to outline the complete set of data (e.g., patient-reported outcomes) needed to compute value, and a recommended path for ensuring that such data are available to all health system stakeholders.

Beyond these overarching issues, our more granular recommendations for improving the PBP data sharing whitepaper include:

1. **Purpose and scope of the white paper**
   - Two goals are stated: (1) real-time, comprehensive patient level data to inform clinical care; (2) improving the marketplace of healthcare purchasing based on cost and quality. While the optimal end state enables both of these things, the data sharing specifics of each of these are quite different. For example, one needs to be up-to-the-minute accurate, while the other can be over longer intervals. This confuses internal versus external data sharing functions.

2. **Data sharing principles**
   - Principle 1 is a straightforward observation that does not advance the workgroup's desire to "strike new ground."
   - Principle 2 can be misconstrued to suggest that the current FFS system can stay where it is. We recommend acknowledging that data sharing enhancements in PBP models should be leveraged to enhance data sharing in all other payment models (including FFS) to improve health, accountability, and efficiency.
   - Principle 3 focuses on the importance of multi-stakeholder relationships. It would be helpful for the workgroup to provide a more explicit set of expectations, roles, and rules for each stakeholder. Similarly, an exploration of the enforcement mechanisms available to operationalize this important principle would be valuable.
   - Principle 4 suggests that data use agreements should be put in place between providers and payers. While there is nothing intrinsically wrong with this, it seems to perpetuate a misaligned system when we should be looking for solutions that serve many entities. Some existing HIE standards address this, providing DUAs between providers, and for patients and providers.
   - Principle 5 is consistent with our belief that de-identified, population-level data should be treated as a public good. A key question for the workgroup to address is who will pay for this public good. Should it be supported the way other public goods are?
   - The Center for Healthcare Transparency is both misspelled and mischaracterized in Principle 6. HIEs, APIs and 3rd party vendors are presented as alternatives to CHT. In reality, CHT has HIEs as members, APIs are a technology channel not an "approach" to data sharing, and many RHICs use 3rd party vendors to aggregate data.

3. **Use cases for data sharing**
   - It would be helpful for the workgroup to reframe the use cases in terms of the originator and recipient, and the essential data types involved. Payers should be the source of cost and utilization information. Providers should be the sources of clinical information. Providers have—or should be investing in—clinical data and therefore should have much better clinical information than payers. Patient-reported data would ideally be collected through neutral a third party, but could also be collected by a payer or provider.

4. **Data sharing recommendations**

    - Provide more detail on what the approaches and policies suggested in Recommendation 1 actually are.
    - Identify an approach to address the problem of patient matching and mapping (e.g., a national patient identifier). Recommendation 2 does not speak to the challenge of—and resources required to manage—this controversial issue.
    - Recommendation 4 states that purchasers should ensure that payers provide the data they need to support value-based employee benefit decisions. While the general language describing the data sharing elements to include in a purchaser-payer agreement is instructive, provision of detailed model contract language in an appendix to the white paper would be an important step towards common standards and expectations.
    - Recommendation 5 should include a sample enforcement mechanism endorsed by the LAN PBP workgroup.

Finally, as we have mentioned to this and other LAN groups, members of the purchaser community would benefit tremendously from a concrete action guide outlining the steps they can take as private employers and public agencies to facilitate robust data sharing in population-based payment models. As they are currently written, the general principles and recommendations provided in the paper are not sufficiently actionable to be helpful to purchasers.

Thank you again for the opportunity to provide feedback to the PBP workgroup on this framework document. We look forward to continuing to engage public and private purchasers in the workgroup's activities, and continue to strongly support 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 and CEO