March 9, 2016

VIA ELECTRONIC MAIL

Population-Based Payment Work Group
Health Care Payment Learning and Action Network

Re: Comments on Draft Financial Benchmarking White Paper

Dear Chair Sir/Madam:

The Health Care Transformation Task Force ("HCTTF" or "Task Force")[1] commends the work of the Health Care Payment Learning and Action Network's ("LAN") Population-Based Payment Work Group ("Work Group") on its draft White Paper on Financial Benchmarking ("White Paper"). The Task Force appreciates the opportunity to provide comments to the Work Group, and looks forward to further collaboration to help facilitate widespread health care delivery transformation.

The HCTTF agrees with much of what is included in the White Paper. Thematically, we urge the White Paper's focus be sharpened to reflect what's best for patients, and not necessarily what's best for providers in particular situations. Providers at varying states of readiness/performance should be encouraged to improve themselves, regardless of where they are currently on the continuum toward population-based payments. If they are unable to improve, they should be not be protected by overly favorable benchmark policies.

Definitions

On the total cost of care definition, we seek clarification as to whether the patient payment portion is included. The Task Force believes it should be if it is not.

[1] The HCTTF is an emerging group of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry—including patients/consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs.

Our organizations aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

Key Principles

The Task Force agrees with and supports the four key principles. Regarding Principle 3, we urge attention to the need for transparency around benchmark calculations and the ability for audits and appeals of benchmarks to occur. Given how critical benchmarks are to overall ACO financial performance, a premium should be placed on ensuring they are correct and that participants have the ability to present for adjudication any concerns that may exist.

Recommendation 1: Establishing and Updating the Benchmark

The state of play of health care transformation reflects a wide variance of readiness and adoption among both payers and providers. We understand the premise that benchmarking practices should be designed in a way that encourages inefficient actors to become involved and take steps to provide better quality care at lower cost for better health. Conversely, those organizations that are unable or do not show desire to move in this direction should not be rewarded or protected from the consequences of their inaction.

A sound approach is to entice new entrants with a favorable benchmark methodology, while also rewarding high performers so they continue to be incentivized to stay the course and push transformation forward. However, there should not be a one-size-fits-all approach to benchmarks; flexibility and choice are better approaches.

The Task Force believes that both a historical and "community rating" model should be available, with all models being open source and replicable. The use of multiple years of performance data is preferred in setting benchmarks, if possible.

While the HCTTF prefers the concept of regional benchmarks, it is understandable that approach may be disfavored by some ACOs, at least initially. Because the overarching goals are APM adoption, retention, and improvement, available benchmark methodologies should help drive toward these goals. Thus, a transition to a regional benchmark from a historical benchmark is appropriate. The transition schedule need not be the same for all ACOs.

The White Paper repeatedly talks about the importance of convergence to a uniform benchmark, and the Task Force agrees. The Task Force believes that convergence can be accomplished through three different transition paths.

1. <u>Transitioning from ACO historical costs to regional benchmark</u>: Three paths

    a. Below regional benchmark at the end of the first contract
        i. 2nd contract: 50% (Historical Benchmark) / 50% (Regional Benchmark)
        ii. 3rd contract: 20% (Historical Benchmark) / 80% (Regional Benchmark)
        iii. 4th contract: 100% (Region)

    b. Above the regional benchmark at the end of the first contract
        i. 2nd contract: 80% (Historical Benchmark) / 20% (Regional Benchmark)
        ii. 3rd contract: 50% (Historical Benchmark) / 50% (Regional Benchmark)

iii. 4th contract: 20% (Historical Benchmark) / 80% (Regional Benchmark)
iv. 5th contract: 100% (Regional Benchmark)

c. Move straight to regional benchmark.

Generally, we are concerned about any approach that may cause a decrease in value due to failure to properly reward positive performance. Available models should be beneficial for historical high performers in addition to being enticing for low performers to engage in the model.

Recommendation 2: Risk Adjusting Regional and National Benchmarks

The White Paper recommends that risk-adjustment models should minimize the connection between utilization and risk score, because gaming is cited as a considerable challenge when distinguishing between the two. The White Paper indicates that increasing the lag time between when codes are collected and when adjustments are implemented may help to reduce gaming. The Task Force does not believe this is appropriate.

The purpose of risk adjustment is to make accurate comparisons in value between two different people or populations. To change an entire methodology due to the gaming concerns emanating from a small population seems unnecessarily drastic and makes measurement of value in health care more difficult and moves us away from our goal of value-driven health care. Instead, we urge an audit or oversight process be made available that investigates individual gaming concerns, with applicable penalties for any proven bad behavior.

The Task Force is concerned about the Work Group's commentary on the issue of risk adjusting for socio-economic status (SES). There is a significant amount of research being done on the appropriateness of SES risk adjusting, and we believe the Work Group's commentary does not accurately reflect the accepted thinking on the subject. While we agree it is premature to take a definitive position on the issue, there is more work supporting SES risk-adjusting than the Paper recognizes. We urge the Work Group to infuse greater balance on this topic in a final white paper to reflect greater objectivity.

Please contact HCTTF Executive Director, Jeff Micklos, at jeff.micklos@leavittpartners.com or (202) 774-1415 with any questions about this communication.

Sincerely,

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