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March 7, 2016

Health Care Payment Learning & Action Network
The MITRE Cooperation
7525 Colshire Drive
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Submitted via: HCPLAN Financial Benchmarking Comment Form

We appreciate the opportunity to provide feedback on the Healthcare Payment Learning & Action Network's Draft White Paper, "Accelerating and Aligning Population-Based Payment Models: Financial Benchmarking."

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation is a hub devoted to teaching, learning and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers. We have been active members of the LAN Consumer and Patient Affinity Group.

We offer the following comments on the draft White Paper:

Principles:

As a consumer health advocacy organization, we are concerned about the omission of consumers from the proposed key principles. For example, Principle 1 discusses the need for trust among payers, providers and purchasers, in order to manage population-based payment (PBP) models. We believe that this trust must extend to the consumers who are being served by these models. Our work, including recent work in the context of the dual eligible demonstration projects,[1] has confirmed that careful and deliberate engagement of consumers in the design, implementation and ongoing evaluation of new models of care is critical for building stronger consumer-centered policies and practices. This consumer voice provides valuable feedback that strengthens the delivery of care.

[1] Available at http://www.communitycatalyst.org/initiatives-and-issues/initiatives/voices-for-better-health/full-description.

Similarly, Principle 3 describes the need for payers to transparently communicate to providers the risk-sharing parameters involved in participating in a PBP model. However, there is no discussion of the similar need to communicate with consumers and the wide-ranging number of organizations that represent them. This is a critical omission, as consumers deserve to be informed about and given the ability to choose the payment arrangements that they are being enrolled in as a matter of principle. From a pragmatic perspective, transparency is a prerequisite for consumers to be able to provide input that improves care and detects unintended consequences of new payment models. Moreover, transparency is essential for creating the consumer engagement that can help accelerate the transition to models that incentivize person-centered care and patient-responsive delivery systems, as envisioned by the LAN.

Recommendations:

Under Recommendation 1, we are concerned about the conflation of the concept of financial success with "efficiency." Many factors contribute to an organization's "bottom line," not solely its efficiency or inefficiency. In particular, we note that an organization's ability to command high prices improves its financial standing. We are concerned that the overly simplistic paradigm laid out in the White Paper could lead to a scenario where organizations that are disadvantaged by factors such the high-need populations they serve, may be squeezed out not because they are inherently inefficient, but simply because they do not have the market clout to charge higher prices. We note that the use of historical benchmarks further aggravates this situation by "locking in" disparities in provider prices. We are similarly concerned that benchmarking based on historical payments presumes that the current structure of payments for different service types and different providers is fair.

We believe that the work group should give further consideration to mitigation of the potential impact on providers, particularly those serving vulnerable populations.

The White Paper also recommends driving convergence in rates within each payer segment, such as Medicare, Medicaid and private payers. These are very broad segments, with diverse and heterogeneous subpopulations within each segment. Within the Medicare Advantage population, analysis by CMS of its risk adjustment methodology demonstrated consistent under prediction of costs associated with community-dwelling full-benefit duals, resulting in underpayments to plans with higher proportions of dually eligible individuals.[2] As a result, CMS has recently proposed to change its risk adjustment methodology to account for the marked differences between full, partial and non-dual eligible Medicare beneficiaries. We believe that segments must be considered on a far more granular basis, in order to prevent creating perverse incentives in a PBP system for provider organizations to avoid enrolling these most vulnerable consumers.

Finally, on the issue of risk adjustment, we appreciate the challenge that the work group faces in attempting to strike a balance with respect to risk adjustment such that providers are neither unduly penalized nor let off the hook for poorer outcomes in their community. We agree that addressing disparities in quality of care and health is critically important. We

[2] CMS Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter. Available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2017.pdf .

would emphasize the need for payment structures to adequately reflect the difference in the amount of investment needed to address disparities. We note that providers serving underserved populations tend to be underresourced themselves, and the benchmarking strategy, as mentioned above, if not carefully applied, may lock in existing payment differences due to market power and case mix.

We believe that the work group should give consideration to specifically incentivize quality improvements for those populations, as a way to improve care for low-income or other disadvantaged populations.

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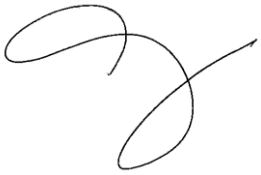
We appreciate the opportunity to comment. We ask that the work group consider making changes to its White Paper that emphasize the important role of consumers, particularly those that are vulnerable or low-income, at the center of health system transformation efforts.

Sincerely,



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