



FINANCIAL BENCHMARKING WHITE PAPER

Comment Response Document

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Introduction

The Guiding Committee of the Health Care Payment Learning and Action Network (LAN) convened the Population-Based Payment (PBP) Work Group to support the development, adoption, and success of payment models under which providers accept accountability for patient population across the full continuum of care. The Work Group was charged with developing recommendations on four priority issues for population-based payment models:

- Patient attribution;
- Financial benchmarking;
- Data sharing; and
- Performance measurement.

A White Paper was drafted on financial benchmarking, the method used to establish spending targets for provider organizations.

After the release of the draft Financial Benchmarking White Paper, a series of Listening Sessions were held to provide information on the preliminary recommendations and, more importantly, to hear from LAN participants, stakeholders committees, and the general public about their concerns and suggestions regarding the recommendations.

At the end of the four-week public comment period, 32 submissions were received comprising more than 100 pages of commentary, with 11 comments submitted by individuals and 21 submitted on behalf of organizations. Many types of stakeholders submitted comments, with 38 percent coming from providers, 17 percent from consumer and patient advocacy organizations, 8 percent from government agencies, 8 percent from employers/purchasers, and additional comments coming from consultants, associations, and professional organizations.

A number of changes were made to the White Paper in response to the public comment. Below, we have summarized the main themes that appeared in the comments received. We have also indicated our perspective on these comments, and, where appropriate, discussed how the comments were incorporated into the final version of the Financial Benchmarking White Paper.

It is the Work Group's hope that this document will be read in conjunction with the final version of the White Paper and that members of the community can use it to gain deeper insight into the thinking behind the White Paper's key findings

Failing Organizations

Many commenters expressed concerns with Principle 5, which stated in part that the goal of financial benchmarking is to allow failing organizations to fail. Commenters noted that there is a dearth of providers in certain geographic areas, especially rural areas, and that allowing these provider organizations to fail would create significant barriers to access for patients in these areas.

The Work Group shares these concerns. As discussed in the context of Principle 4, the Work Group maintains that "At worst, financial benchmarks should have no impact on quality and access..." The White Paper makes a similar point about taking care to avoid unintended and deleterious impacts on access when diminishing the lucrateness of fee-for-service payments in the context of the Assumption. We believe that some of the commenters' concerns may stem from the notion that allowing failing organizations to fail is an explicit *goal* of financial benchmarking in population-based payment models.

Accordingly, we have revised Principle 5 to state that allowing failing organizations to fail is a necessary *effect* of financial benchmarking in population-based payment models, but is not an explicit goal.

Although the Work Group believes that eliminating failing organizations is not the intent of financial benchmarking, we also believe that sustaining low-performing provider organizations is not the purpose of population-based payment models. As discussed in the context of Principle 5, some provider organizations will not be able to operate efficiently in advanced payment models because they are unable to implement delivery system innovations that provide high-value care. In such cases, and where access would not be unreasonably curtailed, the Work Group believes that allowing failing organizations to fail will benefit the health care system as a whole by eliminating potentially large sources of inefficiencies in care delivery.

Scope of Total Cost of Care (TCOC)

Several commenters recommended that certain services should be included when determining the scope of TCOC calculations. For example, commenters recommended that rehabilitation services and medical nutrition therapy should be included within the scope of TCOC. The Work Group agrees that these services likely benefit patients and that plans should consider including such services in benefits packages. The Work Group also maintains that an expansive set of services—ideally including pharmacy and behavioral health services—should be included in population-based payment models that cover the full continuum of care. Nevertheless, the Work Group does not believe it is fair for payers to include services in TCOC calculations for which providers cannot receive payments from payers, because doing so would artificially inflate benchmarks by including costs for which providers are not held accountable. Rather, as discussed in the definitions section of the Financial Benchmarking White Paper, the Work Group believes that the scope of TCOC should be bounded by the set of services a plan covers but also that providers should have maximum flexibility to spend payments in whichever way they think most effectively delivers high-quality, low-cost care. For example, if a provider organization believes that offering additional transportation or housing support is the most cost effective way to prevent chronic disease, then payers should allow them to do so. However, including these services in the scope of TCOC without holding provider organizations accountable for delivering them effectively would introducing unnecessary inefficiencies into the delivery system.

Technical Assistance for Providers

Several commenters noted that approaches to financial benchmarking are often quite complex, which limits providers' ability to understand and manage the financial risk associated with participation in population-based payment models. Accordingly, commenters recommended that steps should be taken to ensure that providers have the technical assistance needed to understand and operate under financial benchmarking arrangements.

The Work Group agrees with commenters on this point. We continue to maintain that provider understanding of financial benchmarking arrangements should not hinder the implementation of financial benchmarking approaches that fairly and effectively drive efficiencies in health care delivery. However, the Work Group also believes that payers are ultimately responsible for ensuring that providers have access to technical assistance programs that inform them about how benchmarks are set and for providing suggestions about how to best manage financial risk associated with population-based payment models. The discussion under Principle 3 in the Financial Benchmarking White Paper has been revised accordingly.

Variation in Regional Costs

Several commenters noted that the Work Group should draw greater attention to ways in which regional cost variation may impact the recommended methodology. Specifically, the Work Group was asked to explain how the recommended methodology account for the fact that some regions of the country (e.g., Miami) are more expensive than other (e.g., Omaha).

The Work Group agrees that it is crucial to adjust financial regional cost variation, and has revised the White Paper’s definition of “financial benchmark” to reflect this. At the same time, the Work Group stresses that adjustments for regional cost variation should not mask variations in the cost of care, particularly in high-cost regions.

Financial Benchmarks and Timing Considerations

Many commenters made suggestions regarding how to time critical milestones in the process used to update baselines. For example, some commenters recommended that payers should establish benchmarks before the period of performance in order to allow provider organizations sufficient lead time to establish goals, make adjustments, and implement monitoring programs. The Work Group agrees, and the White Paper has been revised to reflect this recommendation.

Other commenters recommended holding benchmarks constant for multiple years or to use a three-to-five year rolling average. The Work Group appreciates that such approaches would allow provider organizations more time to make the transition to population-based payment models and that this would likely boost participation. Nevertheless, we believe that such time frames and approaches would prolong the convergence process to an extent that is inconsistent with the imperative to rapidly contain health care spending while maintaining or improving quality.

Highly Desirable and Highly Undesirable Characteristics of Financial Benchmarks

Several commenters recommended adding explicit mention of characteristics that financial benchmarking should or should not possess. For example, commenters suggested that benchmarks:

- Should not create new financial barriers to needed care
- Should be based on transparency, aligned incentives, and communication
- Should ideally generate cost savings for purchasers and consumers
- Should not replicate inequities in health care and outcomes

The Work Group agrees with these recommendations and they have been included, where appropriate, in the final version of the White Paper.