Population-Based Payment Work Group
Teleconference

December 14, 2015

Public Summary

On December 14, 2015, the Population-Based Payment (PBP) Work Group of the Health Care Payment Learning & Action Network (LAN) met virtually to review draft recommendations and outstanding issues from the group's financial benchmarking and patient attribution sprints.

Financial Benchmarking Sprint:

Michael Chernew, Chair of the financial benchmarking sprint, presented areas of agreement and ongoing challenges in financial benchmarking "convergence," the process through which benchmarks across a care continuum (after adjusting for risk, input prices, and potentially, quality) start to converge into a single benchmark. Discussion centered on five points:

1. Convergence in benchmarks across organizations is needed because disparate payments are unfair and give inefficient organizations an advantage and no incentive to become more efficient.
2. Convergence to a single national rate is ideal, adjusted for input prices that vary greatly across the country, but convergence at a regional level is a priority.
3. Achieving convergence is constrained by several factors: Participation is voluntary, and that limits the ability to lower payments to inefficient organizations; the private sector may be constrained by market forces; and benchmarks need to be raised for efficient groups but also lowered for inefficient groups. Otherwise, total spending will rise.
4. Achieving convergence quickly will be difficult because current disparities, even in a single region, are wide. Imposing stringent rules could impede participation in PBP models.
5. Convergence can be achieved in two ways, either by imposing differential updates (lower payments for inefficient organizations) or imposing a blended rate (weighting national and regional rates differentially over time). The advantage of the first method is that it is easier to manage updates; the advantage of the second is it might be easier for risk adjustment.

A key follow-up discussion point was the need to maintain pressure on fee-for-service rates to make alternate payment models (APMs) more appealing, particularly in markets where providers have a high market readiness for APMs.

The Work Group also discussed risk adjusting the financial benchmarks, particularly as benchmarks converge to regional or national rates. It was noted that the "state of the art" of risk adjustment is likely to change over time, but a critical principle is that it should minimize the connection between utilization and risk. The group concluded that concurrent risk adjustment is not the preferable approach prospective risk adjustment is better, and combining outlier payments and risk adjustment is useful. The standard of success for risk adjustment should include how well it predicts spending at a population level, how well it fits for key subgroups, and whether or not it is "gameable"—that is, whether it can be manipulated to a plan's advantage. It was agreed that any variables that plans can manipulate should

be excluded. Finally, benchmarks should be adjusted for differences in socioeconomic status (SES), as failure to do so could lead plans to avoid patients in high-cost SES groups.

The sprint group's recommendations on financial benchmarking convergence and risk adjustment will be further developed in an upcoming white paper.

Patient Attribution Sprint:

Amy Nguyen Howell, Chair of the patient attribution sprint, led the Work Group through a discussion of her sprint's draft White Paper, providing consensus guidelines for effective patient attribution methodologies in PBP models. The White Paper will address the potential benefits to a patient being cared for by a provider in a PBP model, and the value of patient attribution to the patient and other stakeholders. The group discussed the following nine guidelines:

1. Start with the patient's choice. Patient selection of a provider is the preferred method for patient attribution.
2. Use a claims/encounter-based approach when patient attestation is not available. This alternative approach, based on historic insurance information about the patient's use of health care services during a defined look-back period, can be highly accurate and valid.
3. Provide transparent information to the patient about his or her attribution. Regardless of the attribution method used, transparency is key. Patients have a right to know which medical group they have been attributed to and how they were attributed. Providers, payers, or purchasers, all of whom have access to attribution information, can give patients this information.
4. Prioritize primary care clinicians in claims/encounter-based attribution. Attribution should start with tying patients to primary care, using evaluation and management codes for wellness care. Claims and encounter data can be a starting point for assigning accountability to a provider group for whole-person care.
5. Consider subspecialty providers if no primary care is evident. If an evaluation of claims data does not identify a primary care provider, look for visits with subspecialty providers. A patient who has not visited a primary care provider may be seeking services from a subspecialty provider who oversees all of their care needs. In the course of a year, patients being treated for diabetes or cancer, for instance, might seek care solely or predominantly from a subspecialist.
6. Define eligible providers at the beginning of the performance period. The definition should include eligible clinical specialties and provider type.
7. Generalize a national model for a commercial product. Commercial claims-based attribution does not need to vary by locality.
8. Further explore alignment among commercial, Medicare, and Medicaid populations. Although it seems possible to create uniformity for commercial populations, it is unclear if alignment is possible and even desirable between private and all public programs. The White Paper will examine the feasibility of alignment, allowing for some adjustments, as necessary. Outreach to five State Medicaid Directors will be conducted in the next month to learn more about state approaches to attribution.
9. Give providers updated information on enrolled patients. At the beginning of the performance period, providers should know which patients they are responsible for managing and the actual time period for managing them. Share updated lists of attributed patients with provider groups and/or delivery systems in a PBP model periodically, preferably monthly.

The group also discussed of the pros and cons of the two methods used for identifying attributed patients: prospective and retrospective.

Participants offered additional recommendations to consider for the next version of the White Paper, including adding in a section on Medicare attribution, providing a flexible range for the timeframe of "look-back" claims/encounter data, and avoiding the word "managed" in describing patient care within the PBP model.

Next Steps and Wrap-Up*:*

Anne Gauthier, LAN Project Leader, highlighted options for circulating these principles to the larger LAN community. In keeping with the LAN's mandate for transparency and inclusion, input on the work products of both sprints will be specifically sought from stakeholder communities.

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