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Financial Benchmarking: Weighing price, volume, and the voluntary nature of alternative payment models

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HCP LAN
Health Care Payment Learning & Action Network

PBP Work Group Priority Areas

Patient Attribution	Patient attribution identifies the patient-provider relationship and forms the basis for performance measurement reporting and payment in a PBP model.
Financial Benchmarking	Financial benchmarks are set to help providers and payers to manage resources, plan investments in delivery support infrastructure, and identify inefficiencies.
Data Sharing	Data sharing refers to the exchange of information between payers and providers to successfully manage total cost of care, quality and outcomes for a patient population.
Performance Measurement	PBP models require a measurement system through which providers and payers monitor performance, and performance is rewarded.

Financial Benchmarking

Principles

- The purpose of financial benchmarks in PBP models is to enable accountability, compare performance across sites and over time, and to establish a target that fairly rewards high performers.

- Payers should transparently communicate to providers the risk-sharing parameters involved in participating in a PBP model.

- Unexpected events will require collaborative responses from purchasers, payers and providers. In such cases, trust between payers and providers must already exist to update methodologies in a way that is financially responsible and fair for providers.

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Why Financial Benchmarking?

Financial benchmark's lead PBP models toward more high valued care

Setting financial benchmarks help to ensure that overall spending remains at a sustainable level

Using financial benchmarks to compare performance across provider organizations, helps to identify optimal spending levels

Financial benchmarks provide a foundation for providers to deliver high quality, cost effective, and person centered care

Financial benchmarks hold provider organizations accountable for delivering care efficiently

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Financial Benchmarking

Assumptions

- Participation in PBP models will likely be voluntary in the vast majority of circumstances, but participation in PBP models should be driven in part by decreasing demand for FFS-based alternatives.

- Successful approaches to financial benchmarking must simultaneously encourage participation while meeting financial and quality objectives.

- The goal of financial benchmarks is to enable 1) efficient provider organizations to succeed; 2) struggling organizations to improve; and 3) failing organizations to fail.

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Financial Benchmarking

Recommendations

1) Approaches to financial benchmarking should encourage participation in the early years of the model's progression, while driving convergence across providers at different starting points towards efficiency in the latter years.

   a) The initial baseline should be based on provider-specific spending, taking into account the provider organization's history and local market forces.
   b) Updates to the initial baseline should quickly drive convergence around local spending rates, with an eventual movement to regional and national rates in the medium to long term.
      - *That is initial baseline could start with org specific spending levels, but move to regional spending levels, with growth trends should converge to national over time*
   c) There are multiple pathways to convergence, but the end point is what matters.

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Financial Benchmarking

Recommendations

2) Risk adjustment must strike a fine balance, such that providers who serve disadvantaged populations are not unduly penalized, and disadvantaged populations do not receive substandard care.

   a) The state of the art of risk adjustment is likely to change over time, and it will be important to keep up with recent developments that improve the precision of risk-adjustment approaches.

   b) Risk adjustment models should minimize the connection between utilization and risk, in part by increasing the time lag between when variables are coded and when adjustments are applied.

Financial Benchmarking

Recommendations

c) Successful risk-adjustment models should accurately predict spending at the population and subpopulation, but it is not important for models to accurately predict spending at the individual level.

d) PBP models should not disrupt care for high-need populations, and risk adjusting for socioeconomic status (SES) may be one way to accomplish this. Nevertheless, SES adjustments should not be a mechanism for forgiving lower care for needy populations.

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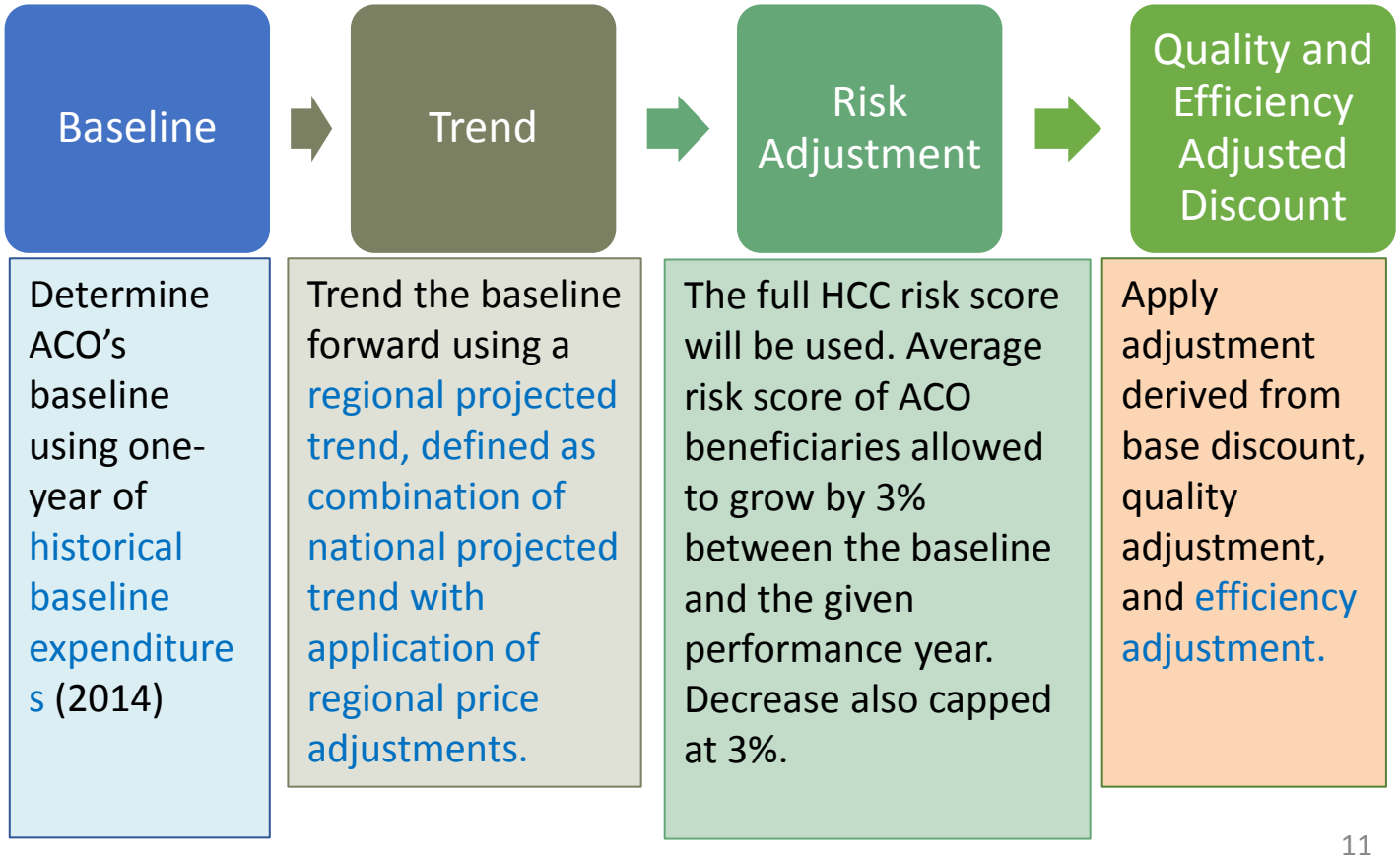
Financial Benchmarking in the Next Generation ACO Model

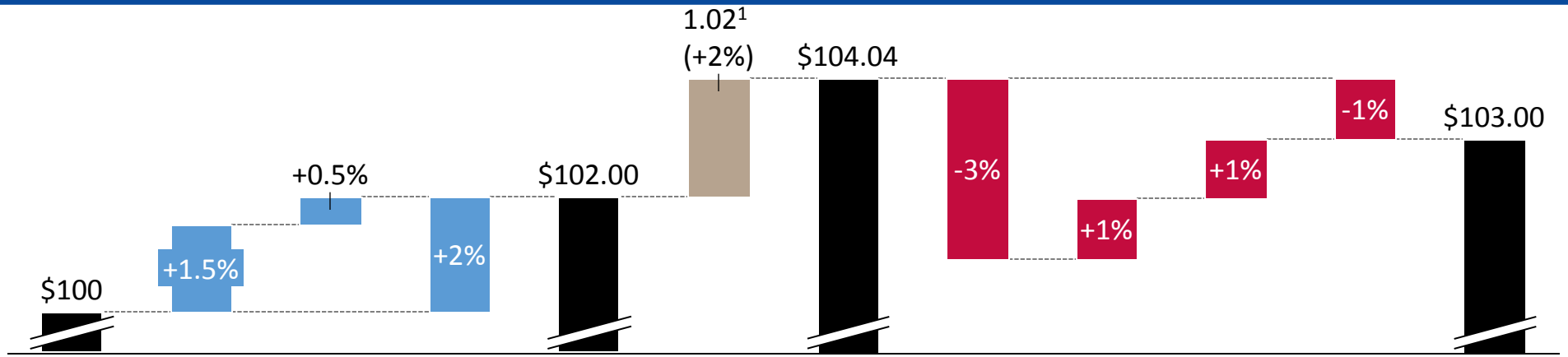
Overview of benchmark

The benchmark will be **prospectively set prior to the performance year** using the following four steps[1]:



1 Benchmark will be prospectively set with retrospective adjustments based on final risk adjustment and quality score information

Building from baseline to benchmark (graph)



Baseline expenditure: Run alignment in baseline year (2014) to determine ACO's historic expenditures

National projected trend: Projected trend from baseline year to performance year

Regional price adjustment: Change in regional price factors (e.g., AWI / GPCIs) relative to the nation

Total trend adjustment

Baseline, trended

Risk adjustment: Ratio of performance year to baseline year average risk score

Baseline, trended and risk adjusted

Base discount (always 3%)

Quality bonus (always +1% in PY1)

Efficiency adjustment (regional and national components, range of -1.5% to +1.5%)

Overall Quality and Efficiency Adjustment

Benchmark

Trend – set prospectively (i.e. does not change during/after course of performance year)[2]

Risk adjustment – not set prospectively (i.e. ratio not final until final risk scores known, after performance year)[3]

Quality and Efficiency Adjusted Discount – efficiency adjustments set prospectively, quality adjustments set mid-year[4]

1 In this example, 1.02 (equivalent to a +2% adjustment) is the ratio of the average re-normalized performance year risk score to the average re-normalized baseline year risk score (for instance, 1.0302 / 1.0100 = 1.02)

2 Exception to not changing during/after course of performance year in cases of unexpected utilization / price changes with a very large impact on ACO expenditures

3 CMS exploring options for providing interim information prior to the final risk scores being available

Projected Regional Trend

- **A projected regional trend will be calculated for each entitlement category** (Aged/Disabled and ESRD). It will be the product of:
  - A national projected FFS trend (expenditure percentage growth rate) for the entitlement category similar to that currently in calculation of the Medicare Advantage (MA) county ratebook; and,
  - A regional geographic adjustment factor (GAF) trend-adjustment that accounts for the impact of the performance-year Medicare geographic price factors on baseline expenditure (does not account for regional/local changes in utilization)
- **Trend defined as difference between two points of time**: baseline and performance year
- The projected regional trend will be set prior to the start of the performance year and will be applied to final settlement.
- Under limited circumstances, CMS would adjust the projected trend in response to unforeseeable events such as legislative actions that have a substantial impact on Medicare FFS expenditures.

Projected National FFS Expenditure Trend -- Overview

- The projected national FFS expenditure trend will be determined using a methodology similar to those used to calculate the MA county ratebook.[1]

- CMS uses a projected FFS United States Per Capita Cost (USPCC) in the calculation of the ratebook.[2]

- The FFS USPCC will be customized for the NGACO Model by applying adjustments to take into account differences between the FFS population as a whole, and the subset of those eligible to be aligned to NGACOs.

1 The methodology used by OACT to project the FFS USPCC can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf. An high level overview of this projection methodology is provided in a later slide.
2 For example, the 2016 projected FFS USPCC used in the MA benchmark calculation can be found in the 2016 MA Announcement (published April 6, 2015): https://www.cms.gov/Medicare/Health-

Projected National FFS Expenditure Trend – Methodology (1/2)

- At a high level, this projection methodology has two major parts: 1) projection FFS expenditure base, and 2) projected change in FFS expenditures.

1. Projection FFS expenditure base

- To establish a suitable base from which to project future FFS expenditures, the incurred payments for services provided must be constructed for the most recent period for which a reliable determination can be made.
- Attribute payments to providers based on dates of service, rather than payment dates;
- Try to eliminate nonrecurring effects of changes in regulations, legislation, or administration, and of any items affecting only the timing and flow of payments to providers.

1 See, e.g., https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf

Projected National FFS Expenditure Trend – Methodology (2/2)

2. Projected change in FFS Expenditures

- Part A (inpatient hospital, skilled nursing facility, home health agency, hospice)
- Part B (physician, durable medical equipment, hospital outpatient, clinical laboratory, and other)

➢ For example, projected change in FFS expenditures for inpatient hospital services are analyzed in five broad categories:

- Hospital input price index—the change in prices for goods and services purchased by the hospital.
- Unit input intensity allowance—an amount added to or subtracted from the input price index (generally called for in legislation) to yield the prospective payment update factor.
- Volume of services—the change in total output of units of service (as measured by covered hospital admissions).
- Case mix—the financial effect of changes in the average complexity of hospital admissions.
- Other sources—a residual category reflecting all other factors affecting hospital expenditure changes (such as enacted legislative changes).

- The changes in the input price index (less any intensity allowance specified in the law), units of service, and other sources are compounded to calculate the total change in expenditures for inpatient hospital services.

Regional Geographic Adjustment Factor (GAF) Trend Adjustment -- Overview

- Medicare FFS payments under most Medicare payment systems are adjusted to reflect the cost-of-doing-business in the local geographic area in which the provider operates.
  - Examples of these Geographic Adjustment Factors (GAFs) are the Medicare area wage index (AWI) and the geographic practice cost index (GPCI). These local geographic price adjustments are updated annually.

- The purpose of the GAF trend adjustment in the NGACO Model is to prevent the benchmark from being unfairly understated (or overstated) because of differences between the GAFs that Medicare used to calculate provider payments in the base-year (CY2014) and the performance-year.

- The GAF trend adjustment factor for a county is an estimate of the impact of the difference between the base-year Medicare GAFs and the performance year Medicare GAFs on base-year provider payments for services provided to reference beneficiaries residing in the county.

Calculation of the GAF Trend Adjustment (1/2)

- The GAF trend-adjustment for a county will be the ratio of:
  - The county PBPM expenditure calculated after adjusting base year claims to reflect the impact on provider payments of the geographic pricing factors that Medicare will use in the performance year; to,
  - The actual incurred county PBPM expenditure (reflecting the geographic pricing factors that Medicare used to calculate provider payments in the base year).[1]
- Calculated prospectively for alignment-eligible beneficiaries in each county in the base year without impact on the national FFS trend.
- Equal to the person-month weighted average of county GAF-trend adjustment factors, where the weights are the aligned beneficiary person months residing in each county.
- Requires that baseline claims be adjusted to reflect the estimated impact on baseline expenditures of the GAFs that CMS will apply when calculating provider payments in the performance year.
- Baseline claims will be adjusted using appropriately weighted performance year geographic pricing factors. For example:
  - The geographic price adjustment under the Inpatient Prospective Payment System (IPPS), the Area Wage Index (AWI), is weighted by the proportion of cost that is attributable to labor.
  - Under the Physician Fee Schedule, the three Geographic Practice Cost Indexes (GPCIs) are weighted by the corresponding relative value units.

1 The calculation of the GAF-trend adjustment will be normalized such that the trend adjustments neither increase nor decrease the total expenditure of the reference population. That is the adjusted claim amount for the reference population will equal the incurred claim amount.

Risk Adjustment

- Next Generation ACO benchmark is **cross-sectional**, which means that:
  - Alignment algorithm applied to baseline year, and **then separately** to performance year[1]
  - **Populations in these two time periods will overlap but be different** – some beneficiaries will be aligned in baseline year but not performance year, while some beneficiaries will be aligned in performance year but not baseline year (e.g., because of changes in utilization patterns, changes in provider/market landscape, etc.)
- Risk adjustment is meant to **adjust for the difference** between the baseline and performance-year populations[2]
- Use **CMS Hierarchical Condition Category (HCC) model** used to determine average risk score of baseline year population and average risk score of performance-year population[2]
- **Average risk scores will be "re-normalized" to the average risk score of the national population** (i.e. for the purposes of financial reconciliation, HCC risk scores are adjusted in any given year such that the average risk score nationally is 1)[3]
- Increase in average risk score **capped** at 3% cap. Decrease in HCC risk score will also be **capped** at 3%
- **Risk adjustment initially set prospectively, but retrospectively adjusted** for final reconciliation when "final risk scores" become available after the performance year[4]

2 The "baseline year population" and the "performance year population" are also referred to as the "baseline year panel" and the "performance panel" in certain Pioneer / Shared Savings Program documents – a panel here simply refers to a group of beneficiaries which may overlap with other panels

3 The "national population" here refers to the national population of beneficiaries eligible to be aligned to a Next Generation ACO

4 Note that HCC scores are based on diagnoses in claims for the year prior to the performance year. As an example, consider Performance Year 2 (2017). Performance year risk scores are based on prior-year claims (i.e. claims incurred in 2016). The HCC methodology does not allow for final calculation of these performance year risk scores are until early-to-mid 2018. The benchmark, however, will be prospectively set based on currently available information at the time, and CMS is exploring options for updating benchmark based on interim risk score information available prior to the final scores becoming available.

Quality- and Efficiency-Adjusted Discount

- The NGACO benchmark will be calculated by applying to the trended, risk-adjusted benchmark an efficiency- and quality-adjusted discount. The adjusted discount is the sum of four components:
  - A standard discount of 3.0%.
  - MINUS: A quality adjustment to the standard discount of up to +1.0%
  - MINUS: A regional efficiency adjustment of ±1.0%
  - MINUS: A national efficiency adjustment of ±0.5%
- The quality- and efficiency-adjusted discount for an NGACO thus can vary from 0.5 to 4.5% **(assuming a +1.0% quality adjustment for PY1, range in PY1 is from 0.5 to 3.5%)**
- A separate quality- and efficiency-adjusted discount will be calculated for Aged/Disabled and ESRD beneficiaries.
- The efficiency adjustments will be calculated separately for Aged/Disabled and ESRD beneficiaries and may differ. The same quality adjustment will apply to each entitlement category however.

Regional efficiency adjustment (1/2)

- The regional efficiency adjustment adds ±1.0% to the standard discount
- It is based on the ratio of:
  - The ACO's standardized baseline PBPM; to
  - The ACO's regional standardized baseline PBPM.
- Standardization controls for differences in:
  - The risk of the ACO's and region's beneficiaries
  - The GAFs that Medicare applies in the ACO's region
- The standard discount will be:
  - Decreased if the ACO baseline is lower than the regional baseline
  - Increased if the ACO baseline is higher than the regional baseline

National efficiency adjustment (1/2)

- The national efficiency adjustment adds ±1.0% to the standard discount
- It is based on the ratio of:
  - The ACO's standardized baseline PBPM; to
  - The national standardized baseline PBPM.
- Standardization controls for differences in:
  - The risk of the ACO's and all alignment-eligible (national) beneficiaries
  - The GAFs that Medicare applies in the ACO's region
- The standard discount will be:
  - Decreased if the ACO baseline is lower than the national baseline
  - Increased if the ACO baseline is higher than the national baseline

MSSP Proposed Rule

- Proposed changes for 2nd or subsequent agreement period beginning on or after January 1, 2017:
  - Adjusting rebased historical benchmark to reflect a percentage of the difference between the regional FFS expenditures in the ACO's regional service area and an ACO's historical expenditures.
  - Replacing national trend factor with regional trend factors for establishing rebased historical benchmarks;
  - Removing the adjustment to account for savings generated under the ACO's prior agreement period.
  - Updating benchmark each performance year using trends in regional FFS spending
  - Defining a region
    - ACO's regional service area would include any county where one or more assigned beneficiary resides
    - Include expenditures for all assignable FFS beneficiaries residing in those counties in calculating county FFS expenditures by enrollment type
    - Weight county-level FFS expenditures by the ACO's proportion of assigned beneficiaries in the county
- Proposing program-wide change to use only *assignable beneficiaries* instead of all FFS beneficiaries as the basis for program calculations using regional and national FFS expenditures

Table: Characteristics of Current and Proposed MSSP Benchmarking Approaches

Source of Methodology	Agreement Period	Historical Benchmark Trend factors (Trend BY1, BY2 to BY3)	Adjustment to the historical benchmark for regional FFS expenditures (percentage applied in calculating adjustment)	Adjustment to the historical benchmark for savings in prior agreement period?	Adjustment to the historical benchmark for ACO Participant List changes	Adjustment to historical benchmark for health status and demographic factors of performance year assigned beneficiaries	Update to historical benchmark for growth in FFS spending
Current Methodology	First	National	N/A	N/A	Calculated using benchmark year assignment based on the ACO's certified ACO Participant List for the performance year	Newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using demographic factors alone unless CMS-HCC risk scores result in a lower risk score	National
	Second and subsequent	National	N/A	Yes	Same as methodology for first agreement period	Same as methodology for first agreement period	National
Proposed Rebasing Methodology	Second (third for 2012/2013 starters)	Regional	Yes (35 percent)	No	ACO's rebased benchmark adjusted by expenditure ratio*	No change	Regional
	Third and subsequent (fourth and subsequent for 2012/2013 starters)	Regional	Yes (70 percent unless the Secretary determines a lower weight should be applied, as specified through future rulemaking)	No	Same as proposed methodology for second agreement period	No change	Regional

* Proposed adjustment to the historical benchmark for ACO Participant List changes using an expenditure ratio would be a program-wide change applicable to all ACOs including ACOs in their first agreement period. As part of the proposed rebasing methodology, the regional adjustment to the ACO's rebased historical benchmark would be recalculated based on the new ACO Participant List.

Questions to Consider

- **What are the relative contributions of variation in prices versus variation in utilization, to overall variation in total costs of care?**
- **If participation in an APM is voluntary, what is the relative attractiveness of *not* participating? That is, what forcing functions are available to payers in FFS?**
- **How much time are payers willing to give providers to adapt and "reset" to a convergence of expected prices and/or utilization?**