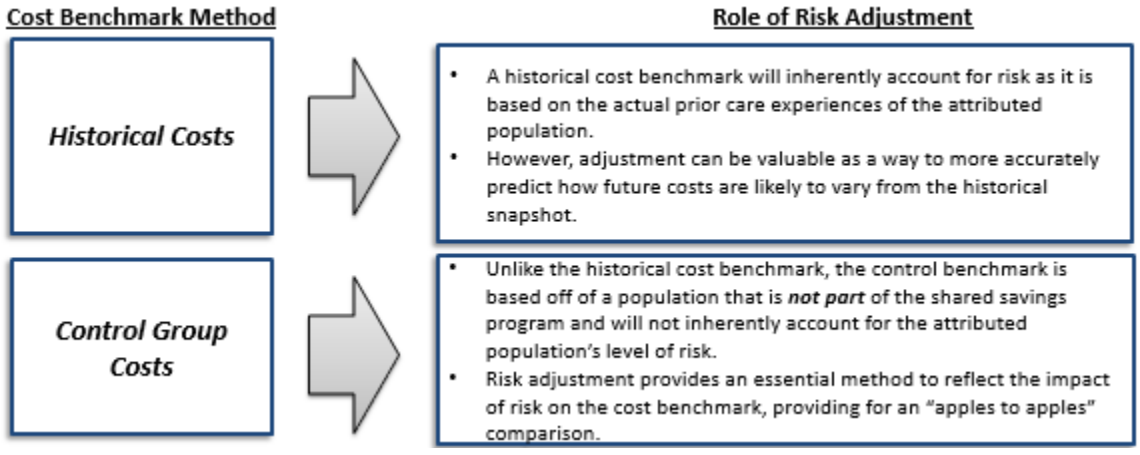
Cost Target Calculation

Background

To determine if an ACO achieves savings during a shared savings program contract period, the expected (or targeted) cost of caring for the population attributed to the ACO first needs to be defined. This is known as the cost benchmark. The determinants of the cost of a population include many factors, some of which allow for a level of predictability and others that do not. Some of the more predictable factors include: current diagnoses, age, socioeconomic status, and other social determinants of health (e.g., housing, access to transportation, etc.). Less predictable factors include: new and unexpected diagnoses, catastrophic events, and unpredictable general health trends (e.g., a bad flu season). In combination, all of these factors influence how complex and potentially costly a patient is to care for and should be considered when determining a cost benchmark. The choice of population used to set a benchmark, and the risk adjustment methodology used to adjust those costs, relate to the more predictable factors associated with cost benchmarking. The risk adjustment methodology adjusts future cost projections to account for the variation in resources required to care for different populations. The risk adjustment takes into consideration demographics and the diagnoses of the population to allow for an "apples to apples" comparison in costs between populations with different risk profiles. Additional contract features relate to the less predictable factors associated with benchmarking.

Payers generally use one of two data sources to establish a cost benchmark for a given population: historical costs or control group costs. A historic benchmark sets the expected costs of a population based on the past experience of that population. A control group benchmark uses a comparator population (e.g. all enrollees in a health plan throughout a broad regional area) to determine expected costs. Importantly, the historic benchmark inherently accounts for the clinical and cost profile of a given ACO's population, while the control group does not. For this reason, risk adjustment is an especially important dimension of a benchmarking method that relies upon a control group.



Another difference between these two methods is how accurately the benchmark reflects the utilization of a population that is desirable (i.e. represents best clinical practice). A historic benchmark utilizes the historical experience of an ACO's population, which may or may not represent best practice, whereas a control benchmark is based on performance against market-wide medians, targets, or trends. If a historic benchmark is used and historically the population has experienced unnecessary over-utilization, the benchmark will not account for excessive and unnecessary costs that a shared savings program

attempts to minimize. Over time this will be addressed as the cost benchmark is adjusted over the subsequent years, but getting to best practice may take longer than it would if the control group methodology were to be used. Regardless of which population is used to determine the cost, risk adjustment will also be necessary. Even when a historical benchmark is used, additional factors need to be considered, such as the increased age of the population or new diagnoses. CMS currently uses the historical cost methodology for MSSP and applies a risk adjustment factor (Bailit & Christine, 2011). The CMS risk adjustment takes into account acuity of diagnoses and basic demographics such as age, but does not account for any social determinants of health. In addition, as the CMS MSSPs function today, risk is adjusted annually for patient age and decreases in patient acuity are reflected to adjust cost benchmarks downward, but CMS does not adjust the benchmark upward if there is an increase in acuity (Gaus, 2015). In the healthcare market there are additional proprietary risk adjustment methodologies used by various commercial payers (Bailit, Huges, & Burns, Shared-Savings Payment Arrangements In Health Care: Six Case Studies, 2012). However, given their proprietary nature there is not an abundance of publicly available information and it is unclear which factors are adjusted for in their methodology.

To account for the less predictable factors that affect a population's cost of care, shared savings programs often include additional contract features to help minimize ACOs' financial risk. Common examples of these additional contract features and examples of payers that use them are outlined in the table below:

Additional Contract Feature	**Payers That Utilize**
Truncation of High Cost Claimants – exclusion of patients with costs above the a certain percentile (commonly 99th percentile)	• CMS • Vermont Medicaid Shared Savings Program
Exclusion of high cost procedures or services – plans will exclude high cost procedures such as transplant and/or less predictable services to such as behavioral health	• Commercial payers and CMS (Bailit, Huges, & Burns, Shared-Savings Payment Arrangements In Health Care: Six Case Studies, 2012)
Enhanced Per Member Per Month (PMPM) Payment for patients with chronic conditions – payment intended to support enhanced care management needs	• BCBS of Michigan (Share & Mason, 2012)
Socioeconomic payment adjustment factor – enhanced payment to account for non-health factors that impact the complexity of caring for an individual	• Providers are working with payers to develop in Oregon

Discussion

From the perspective of a provider, the greatest financial opportunity in a shared savings program can only be achieved if costs are effectively managed and quality targets are met. The cost benchmark chosen for the population of patients cared for through a shared savings contract plays a fundamental role in determining whether or not an ACO receives a financial reward for adequately controlling costs. A cost benchmark should provide an incentive to reduce medically unnecessary expenditures through better utilization management and attainment of a healthier population, without creating perverse

incentives to stint on necessary care or to avoid particularly complex patients in order to meet the defined cost targets. A cost benchmark that accurately reflects the expected cost of a population and is realistic with respect to the prior cost profile for the population will minimize any incentive for providers to stint on care or to avoid more complicated patients. An accurate and realistic cost benchmark will also likely incent providers to take on more complex patients. Complex patients have the greatest utilization management opportunity and therefore also represent the greatest savings opportunity. Clinically complex patients are likely already diagnosed with the illnesses that make them complex, which makes their costs more predictable. With the stated goals of the cost benchmark in mind, the following design considerations for setting a cost benchmark will be explored here: the basic methodology (data source) employed, how the benchmark is risk adjusted, and what additional contract features are included to account for less predictable risks.

A cost benchmark should promote appropriate cost management but should not set unattainable targets or incent under-service or patient selection. Both the historical and control group methodologies can be used to meet these goals, but each has distinct advantages with respect to the subjects of this report. A historical benchmark inherently accounts for year over year improvement. Providers are being measured against prior year performance for their own population, and so they are rewarded for improvement against their own performance.

Conversely, a control group methodology may pose challenges for an ACO whose population's historical costs far exceed the best practice or market average in a region. Such an ACO will likely not be able to drive their costs down to the benchmark in one year using clinically appropriate methods. In some cases the cause of an ACO's relatively high cost profile may be unnecessary over-utilization and selection of more expensive sites of care; in this case, a control group benchmark may be useful to stimulate a change in provider behavior. But in other cases an ACO's high cost profile may be due to complexities in its population that justifiably cause their care to be more costly than what risk-adjusted market-based benchmarks would suggest. If a control group benchmark is unrealistic it may generate incentives to stint on care or avoid patients with certain profiles in order to meet the cost target. To guard against that possibility, in instances where a control group methodology is utilized, it may help to reward providers for improving upon prior performance (as measured against a market-based benchmark) in addition to rewarding them for absolute performance against the benchmark in a given year.

> ***<u>Recommendation #1</u>: Rewarding providers for improving cost performance year over year will minimize pressure on historically lower performers to achieve a fixed cost benchmark that is unattainable using clinically appropriate cost management methods. In turn, this may reduce the risk of under-service and patient selection. Use of a historical benchmark provides an inherent incentive to improve; a control group benchmark does not. When payers utilize a control group cost benchmarking methodology, they should consider rewarding providers based on their degree of cost improvement over the prior year, in addition to their performance against the group.***

An inherent benefit of the control group methodology that is similarly absent in the historic methodology is the ability to account for any one-time unpredictable costs that can be incurred throughout the year. A bad flu season or the introduction of a new, expensive drug to the market can cause an unexpected spike in healthcare costs, which may or may not be localized to specific clinical

populations. Even though this is not inherent in the historic cost methodology, it could be incorporated as an adjustment method to achieve a similar effect.

> ***<u>Recommendation #2</u>: When a historical methodology is used to set a cost benchmark, a concurrent control group benchmark should also be calculated to evaluate the need to adjust for any systemic factors that substantially increased the cost of caring for the population – or a sub-population – beyond what was predicted for that year.***

Another important consideration related to cost targets, and one that is particularly relevant to this report's scope, is accounting for healthcare expenses that result from non-clinical complexities of certain patient populations. These types of complexities are generally referred to as social determinants of health and include factors such as socioeconomic status, cultural and linguistic barriers to obtaining care, and an individual's social support structure.

Traditional risk adjustment methodologies are diagnosis-based and do not directly account for non-clinical risks. For example, clinical evidence suggests that, on average, a patient who is diabetic will need a certain number of billable procedures or tests that are above and beyond what a healthy patient will need. There is sufficient evidence to estimate what the cost of providing this care should be. However, the costs incurred caring for patients who are more resource-intensive due to social determinants of health may be less predictable and also may not be billable on a fee for service basis.

In a shared savings program that uses a control group to establish cost benchmarks, an ACO that cares for a patient population with a relatively high prevalence of socioeconomic risk factors may find that, absent some supplemental non-clinical risk adjustment, the expected cost to care for its population does not accurately reflect the population's true cost. This may create some incentives to under-serve these populations or to select them out of provider panels. To the extent that socioeconomic factors in fact lead to clinical conditions that can be measured using a traditional risk-adjustment, this incentive is intrinsically limited. However, there may be populations for which resource-intensiveness is relatively high but for which clinical acuity is not – in which case a supplemental adjustment or method of compensating for this added cost should be employed.

Chronic disease management poses similar reimbursement challenges as social complexities and has demonstrated success with improving quality and lowering overall costs of care by providing a per member per month (PMPM) care management fee to care for patients with chronic disease. Among others, Blue Cross Blue Shield of Michigan used this approach in 2011 as part of a broader value based care initiative that was focused on managing the quality and costs of patients with chronic conditions and demonstrated success (Share & Mason, 2012), (CMS, 2015).

As with chronic disease management, providing adequate care to patients who face socioeconomic barriers will require a number of resources in the form of increased visit times, more robust education and potentially more proactive care management. The additional resources are often not reimbursable and represent an opportunity cost for the provider. Given the similarities from a resource perspective between managing chronic conditions and social complexities, using a PMPM approach to financially support providers who are caring for patients with social complexities could minimize the incentive to stint on care or to avoid patients who are socially complex. While there are parallels between chronic disease management and social complexities, payments in any form that reimburse for costs incurred due to socioeconomic barriers is relatively unchartered territory. Determining which socioeconomic

complexities are the most appropriate to address in this manner will likely require additional research over time through the monitoring of the shared savings program after its inception.

> ***<u>Recommendation #3</u>: Use of a PMPM payment should be considered for patients who have socioeconomic attributes that are demonstrated to increase resource-intensiveness of providing care but that are not well-captured by purely clinical risk adjustment methods.***

As value-based contracting becomes more prevalent, retrospective analysis of utilization and other trends can help to identify gaps in care for certain populations. This will provide the insight necessary to identify any populations that are not benefiting from existing risk adjustment methods and provide insight into how to adjust them going forward.

> ***<u>Recommendation #4</u>: In the long-term, data collected for under-service and patient selection monitoring purposes should be utilized to identify populations for which the current risk adjustment methodologies are not leading to improvements in equity and access, and should be adjusted accordingly using clinical or non-clinical factors.***

Amongst all populations there will be unpredictable and costly risks for which a risk adjustment or a supplemental PMPM cannot account. These types of risks are often referred to as catastrophic events and could pose a risk for under-service after the event occurs. This could be an accident (i.e. trauma) or a newly diagnosed medical condition that involves unusually high costs. To avoid any incentive for withholding care, and to create more predictable financial outcomes for providers, it is common to truncate high-cost claimants as a percentile of costs. Incorporating this as a shared savings contract feature will likely reduce any incentive a provider might have to stint on the care for a patient who experiences a catastrophic event.

> ***<u>Recommendation #5</u>: Truncating costs based on a percentile cutoff will eliminate any incentive to withhold required care after a catastrophic event in an effort to minimize overall costs, and will help to keep providers focused on managing the more predictable types of utilization that value-based contracts seek to improve.***

Summary of Recommendations

> ***<u>Recommendation #1</u>: Rewarding providers for improving cost performance year over year will minimize pressure on historically lower performers to achieve a fixed cost benchmark that is unattainable using clinically appropriate cost management methods. In turn, this may reduce the risk of under-service and patient selection. Use of a historical benchmark provides an inherent incentive to improve; a control group benchmark does not. When payers utilize a control group cost benchmarking methodology, they should consider rewarding providers based on their degree of cost improvement over the prior year, in addition to their performance against the group.***

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References

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