

OHHS Total Cost of Care (TCOC) Guidance for the AE Pilot Program

January 29, 2016

Definition

The total cost of care (TCOC) calculation is a fundamental element in any shared savings and/or risk arrangement. Most fundamentally it includes a historical baseline or benchmark cost of care specifically tied to an Accountable Entity's (AE) attributed population projected forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

Effective TCOC methodologies provide an incentive for AEs to invest in care management and other appropriate services to keep their attributed population well, in the hope that they will earn savings. Shared savings distributions must be scaled in light of comprehensive and well-defined quality and outcomes metrics.

TCOC Development and Approval

Medicaid Managed Care Organizations (MCOs) and AEs will establish TCOC calculation methodologies to serve as the basis of their shared savings and/or risk arrangements. These methodologies must be approved by OHHS.

OHHS will review the MCO's TCOC methodologies and reserves the right to ask for modifications before granting approval.¹ MCOs may submit details of their TCOC methodologies to OHHS for approval in advance of contracting with AEs.

Alternatively, if their TCOC methodology has not been approved in advance, then MCOs must submit details of their TCOC methodology to OHHS within 15 days of concluding contracts with AEs at the latest. If MCOs choose to utilize the post-contracting TCOC approval option, then their AE contracts must include appropriate language to account for the possibility of alterations to their TCOC methodology resulting from the OHHS approval process.

MCOs must submit applications for TCOC approval to OHHS in writing. Applications must demonstrate compliance with the requirements outlined in this guidance, and must provide comprehensive answers to all questions posed herein. Simple numerical examples may be helpful. OHHS's approval, denial, or requests for amendment will also be transmitted in writing, without

¹ In addition to this OHHS requirement, note that depending on circumstances transparency in such arrangements is specifically required in CFR42 §438.6 Contract requirements 438.6(g): Inspection and audit of financial records – Risk contracts must provide that the state agency and the Department may inspect and audit any financial records of the entity or its subcontractors. 438.6(h) Physician Incentive plans – MCO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210 of this chapter. 436.6(k) All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

unreasonable delay. Material amendments to TCOC methodology must be approved by OHHS in advance.

If an MCO utilizes a TCOC methodology that differs in any respect from the approved methodology, then OHHS reserves the right to calculate risk- and gain-share with the MCO as if the approved methodology had been utilized, and the MCO shall provide OHHS with all information necessary to make that calculation.

OHHS also reserves the right to review these methodologies on an annual basis. In future years, OHHS may consider working with the MCOs and AEs to develop a uniform TCOC methodology.

TCOC Methodology Goals

In reviewing proposed TCOC methodologies, OHHS will favor methodologies that, to the greatest extent possible:

1. Maximize the financial incentives for AEs to engage with higher cost patient populations, and to reduce health care spending in these populations through the provision of high-quality and coordinated care;
2. Minimize the financial incentives for AEs to “cherry pick,” i.e. to lower an AE’s TCOC through increased representation within an AE’s attributed population of patients who would be expected to be lower-cost even absent the AE’s approach to care coordination;
3. Minimize the financial incentives for AEs to lower costs through withholding, delaying, or restricting access to medically appropriate care or services;
4. Include adequate application of comprehensive quality and outcomes metrics before the calculation of any shared savings distribution;
5. Build baselines and performance year projections using reliable historical data and actuarially sound methodology that is specific to the attributed population of each AE and, when projecting forward to performance year, includes appropriate risk adjustment methodologies;
6. Adequately protect the solvency of AEs, MCOs, and the RI Medicaid program.

Considerations

- **Ensure that the methodology supports the goals of the AE program and the Reinventing Medicaid initiative**
- **Allow variation in pilot methodology**
Provide MCOs and AEs freedom and flexibility to develop own approaches, and build on current practices if available. Allow OHHS to review and evaluate different approaches, and potentially identify best practices.
- **Recognize (and limit where possible) challenges associated with a lack of uniformity**
May make it difficult for AEs to work towards a single set of performance goals. May make program evaluation difficult.
- **Allow OHHS and MCOs to work towards standardization** in future years if appropriate

TCOC Methodology: Required Elements

MCO TCOC arrangements with Accountable Entities must meet the following requirements:

1. Covered Services

TCOC methodologies shall include all costs associated with benefits and services that are included in OHHS's contract with MCOs for the performance year. Any excluded costs must be explicitly requested and pre-approved by EOHS, whether for baselining or for performance measurement purposes.

2. Historical Benchmarking

Baselines and performance year projections must use data that are specific to the attributed population of each AE. The methodology must describe how the baseline population is matched to the attributed population. Unless specifically approved by OHHS, risk adjustment shall not be applied while calculating an AE's historical baseline costs, though changes in an attributed population's risk profile may be considered when projecting historical costs forward into the performance year.

3. Performance Time Period

TCOC methodologies shall include a minimum 12-month performance period during which costs will be measured and compared to projections, and where quality and outcome metrics will be measured with scores impacting eligibility for shared savings distributions. The methodology must specify this performance period.

4. Cost Trend Assumptions

When projecting (or trending) historical costs forward into the performance year, TCOC methodologies shall appropriately account for trends in the medical component of capitation rates being paid to MCOs by OHHS. Unless otherwise approved by OHHS, trends assigned to TCOC baselines shall not exceed the final cumulative trends to the medical portion of rates contained in the OHHS data books for the appropriate product line, after consideration of all factors affecting the medical component of capitation rates. For the rate period of Jan. 1, 2016 through June 30, 2016, those trends can be found in the following tables of the following data books:

- Rite Care – Table 8
- Children with Special Healthcare Needs – Table 10²
- Rhody Health Partners – Table 11
- Rhody Health Options – Exhibit 11
- Medicaid Expansion – Table 3

5. Impact of Quality and Outcomes on Distributions

An appropriate comprehensive quality score factor must be applied to any shared savings pool to determine the actual amount of the pool eligible for distribution (e.g. a quality score of 75%

² The CSHN data book for this period contains two Table 10s. We refer to the Table 10 found at page 21, rather than the Table 10 found at page 17.

applied to a shared savings pool of \$100 = maximum pool of \$75). The methodology must specify the quality and outcome metrics that are considered in calculating shared savings distributions. Quality and outcome metrics must, to the greatest extent possible, be comprehensive and include the full range of Medicaid-funded care that AE-attributed patients will receive. Recognizing that this may not be possible in year 1, OHHS also prefers for MCOs to utilize measures identified by the Measure Alignment Workgroup of RI's State Innovation Model (SIM) project. The TCOC methodology must also specify the quality score factor – that is, how the metrics impact the calculation of shared savings distributions.

6. Exclusivity of Approved TCOC Methodologies

MCO TCOC arrangements shall supersede and be exclusive of any other TCOC-related shared savings arrangements with an AE or any of its constituent providers.

TCOC Application

MCO TCOC applications must demonstrate compliance with the TCOC requirements outlined above. Applications must also include detailed answers to the following:

1. Benchmark Time Period

Historical data from what time period is used to establish an AE's cost benchmark? How does the methodology account for attributed patients for whom no historical data is available?

2. Benchmark Data Source

What data sources are used to establish an AE's cost benchmark?

3. Risk Adjustment

What risk adjustment methodology is used to project an AE's cost benchmark forward into the performance year?

4. Risk Mitigation

What strategies or methodologies are used to truncate or exclude outlier costs to mitigate an AE's risk for catastrophically large costs?

5. Trend Projections

How is an AE's baseline cost projected forwarded into the performance year? What trend factors are used and how are those trend factors calculated? How are the trend factors appropriately linked to trends in capitation rates paid to MCOs by OHHS, as outlined in the appropriate OHHS rate development data book tables? How do the trend projections account for changes to the MCO in-plan benefit package between the baseline year(s) and performance year?

6. Mid-Year Changes

How does the TCOC calculation account for month-to-month changes in MCO enrollment and/or PCP assignment, whether during benchmark years or the performance year? How does the TCOC calculation account for month-to-month changes in the PCP roster of an AE, whether during benchmark years or the performance year?

7. Minimum Savings Rate

What is the minimum threshold rate of savings that must be achieved before an AE is eligible for shared savings distributions?

8. Quality and Outcome Metrics

What quality and outcome metrics are being used to measure AE performance? Please include National Quality Forum (NQF) numbers or other details allowing OHHS to identify each measure specifically. How are benchmarks or goals identified for each metric? How are those metrics applied to impact potential shared savings distributions? What efforts have been made (or will be made in the future) to utilize measures identified by the SIM Measure Alignment Workgroup?

9. Shared Savings Distribution Rate and Calculation

What portion of the eligible shared savings pool (after accounting for scaling based on quality and outcomes metrics) will be distributed to the AE?

10. Shared Savings Distribution Timing

At what time are shared savings distributions made to qualifying AEs? If distributions are made more than annually, please also describe any true-up processes.

11. Small Populations

Does the TCOC model differ when an AE's attributed populations is relatively small? If so, how? And at what population size thresholds do these differences attach? If the population threshold is something other than 5,000 lives, then please explain why this threshold is the appropriate one.

Appendices:

1. Prior EOHHS TCOC Guidance as described in the AE Application

Appendix 1: Prior TCOC Guidance as included in the AE Pilot Application

Total Cost of Care Calculation and Quality Score

The total cost of care calculation (TCOC) is a fundamental element in any shared savings and/or risk arrangement and requires careful analysis. Most fundamentally it will include a baseline or benchmark cost of care projected forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

Any savings observed must be in light of defined quality metrics to help ensure that any cost savings that are realized are due to improved care and outcomes rather than denial of care. EOHHS will require that any agreement with an MCO will provide that an appropriate quality score factor be applied to any shared savings pool to determine the actual amount of the pool eligible for distribution (e.g. a quality score of 75% applied to a shared savings pool of \$100 = maximum pool of \$75).

The specific terms of the savings and risk transfer between the MCO and the AE are at the discretion of the contracting parties. Note that shared savings, shared risk and full risk models are all potential constructs for these arrangements. EOHHS does not intend to stipulate the terms of these arrangements but does reserve the right to review and approve them.³

CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. For ease of reference links to relevant State Medicaid Director Letters are provided below:

- www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf
- www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf

Links for the Medicare Shared Savings Program final rule and a CMS Factsheet are also provided:

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf
- The Shared Savings Program final rule can be downloaded at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf> on the Government Printing Office (GPO) website

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