



8/16/17

Comments regarding OHHS Total Cost of Care Guidance

BVCHC commends OHHS's efforts to better define total cost of care. Recognizing the challenge of small populations and a better defined calculation for quality metrics are helpful. We also appreciate the movement towards standardization, making it easier to manage contract with multiple MCOs. Allowing AE's to adjust for prior year savings is helpful to the lower cost providers. We do, however, have some areas which we feel could be improved and they are as follows:

- The model for calculation is complicated and not all information is available to the AE's. We would request that MCO's be required to provide more detailed data on a monthly basis so AE's can know the progress for shared savings each month. NHPRI does not share actual cost data making it difficult to know progress to date.
- More detail is needed on how patients will be assigned to each AE. If major changes are made to the current model, it could destabilize the AE's ability to continue.
- Inclusion of additional payments such as CTC, incentive and FQHC transition funds are a barrier to participation for the following reasons:
 - CTC payments were focused on specific deliverables for PCMH efforts and helped to offset the flat capitation payments since 2009. The capitation payments, which were adjusted for inflation by 2.9% in 2009, would have increased the PMPM by 23% since 2009. The 4.00 PMPM for the CTC payments are far less than an adjusted capitation rate.
 - Incentive payments- The funds paid for incentive in 2017 had specific requirements to expend funds for additional infrastructure. These have been one time funds that have varied over time. The infrastructure is building systems or staff to increase the ability to manage the care over time. These incentive funds are not necessarily related to the savings generated in the year being measured. If OHHS wants AE's to succeed, these funds should not be included in the TCOC calculation.
 - FQHC transition payments- FQHC transition payments are mandated by Congress for the scope of additional services provided that are not required by other non-FQHC AE's. The comparison of TCOC between AE's will not be relevant if the costs are included. Additionally, the process to reconcile the transition visit model to the attribution model would require a complicated process.

- BVCHC continues to disagree with the 60/30/10 weighting factor. This weighting factor makes it more difficult for lower cost providers to attain shared savings. Medicare has had to adjust their model with the Next Generation ACO as so many low cost providers were dropping out of the program. The model shouldn't be a disincentive to the providers saving the most money. BVCHC is a strong advocate for using regional benchmarks rather than measuring against prior year performance. This allows shared savings for the higher performers.
- More detail is needed on how the historical base will be calculated in the first year if an AE signs on with a new MCO.
- BVCHC continues to be concerned that the model will not allow for enough upside savings to build adequate reserves to take on risk. We would advocate for some of the infrastructure payments to be used for reserves.

BVCHC feels we have invested in the staffing and infrastructure to allow for shared savings to be generated year 1. We look forward to a TCOC model that will help generate the funding to pay for the ongoing costs of those investments, and allow us to continue to build capacity to meet the growing patient's needs.