

OHHS Total Cost of Care (TCOC) Guidance

Overview and Considerations

Overall Program Approach

Challenges

Nationally recognized Medicaid Managed Care program

Limitations (*in RI & nationally*)

- Fee based (vs. value based)
- Does not generally focus on health outcomes,
- Limited emphasis on Population Health
- Opportunity to better meet the needs of those with complex health needs & exacerbating social determinants.



Siloed, fragmented care, with high readmissions and missed opportunities for intervention

Approach: Three Pillars

1. Certify Accountable Entities

Define expectations for system transformation

2. APM Guidance

Require transition from fee based to value based payment model (today's discussion)

3. HSTP Incentive Funds Support Infrastructure Development

Goal: System Transformation

More effectively meet the real life needs of individuals and their families.

- “Break through” the financing and delivery system disconnects
- Build partnerships across payment systems, delivery systems and medical/social support systems
- Align financial incentives

TCOC Methodology Considerations

- ❖ Significant pilot development effort, and progress by all parties
- ❖ Budget challenge
- ❖ Charting a new course -- limited (and emerging) national lessons

=>. Any TCOC method selected must

- be trusted by all parties
- demonstrate integrity, clarity, transparency

Key Sources

- Learnings from the Pilot
- CMS Medicare ACO Program
- OHIC APM requirements
- Expert Advisors: Michael Bailitt, CHCS
- CHCS Learning Collaborative Participation
- Other States: VT, CT, NY, Others

TCOC Methodology Goals

Overall Goal:

Ensure that the TCOC Methodology Supports Meaningful Performance Measurement

1. A Sustainable Business Model, that is fiscally responsible for all participating parties
2. Specifically recognize and address challenge of small populations, random variation
3. Incorporate quality metrics related to increased access and improved member outcomes (*under development*)
4. Establish a progression to “meaningful AE risk”, linked to development of required AE certification standards/capabilities and financial capacity
5. Increase standardization while still allowing some innovation and flexibility

For Discussion: Additional Considerations?

1. Sustainable Business Model

Goal

Create shared savings opportunity for AEs, within specified limits, that encourages new business models & shared responsibility while remaining fiscally responsible

Premise

Over time, this approach should pay back with higher savings, as AEs build capacity/infrastructure and change practices/protocols to accomplish cost reductions

Approach: Consistent with recent refinements to CMS ACO models

1. Allowance for Retained Savings

- Allow upward adjustment to TCOC target for prior year savings
- AE share of prior year savings can be retained (included in the base TCOC)
- Capped adjustment (Max per AE @ 2% of the unadjusted spending target)

2. Historical Adjustment

- Allow adjustment to the TCOC target for AEs with below average historical costs
- Adjustment based on percentage TCOC fell below MCO average spending
- Historical performance must be risk adjusted, after FQHC reconciliation payment
- Up Only. No adjustment for high-cost AEs
- Cap adjustment (2% of the unadjusted spending target per AE)
- Over time, may shift to up and down adjustment

2. Addressing Random Variation/Small Populations

Goal

Account for statistical uncertainty due to random variation in utilization & spending in small populations

Approach

Applying a shared savings adjustment factor, defined by AE attributed population size.

- Adjust the AE's shared savings (loss) pool proportionately by the probability of true savings = $1 - \text{Pr}$ (achieving shared savings as a result of chance).
- The proportion of savings for which an AE is eligible shall be adjusted along a sliding scale by AE size, based on the parameters below.
- *Note: Consistent with CMS philosophy but different approach*

Shared Savings/Loss Adjustment Factor Parameters

| Shared Savings/Loss Adjustment Factor Parameters by AE Size and Savings Rate | | | | Probability of Achieving Shared Savings/Loss as a Result of Chance* | | | |
|--|--------------------|-----------------------|--------------------|---|---------------|----------------|----------------|
| Savings % | Small AE (5-9,999) | Medium AE (10-19,999) | Large AE (20,000+) | Savings % | 5,000 members | 10,000 members | 20,000 members |
| 1% | 73% | 79% | 89% | 1% | 27% | 21% | 11% |
| 2% | 82% | 92% | 97% | 2% | 18% | 8% | 3% |
| 3% | 91% | 97% | 99% | 3% | 9% | 3% | 1% |
| 4% | 95% | 99% | 100% | 4% | 5% | 1% | 0% |
| 5% | 98% | 100% | 100% | 5% | 2% | 0% | 0% |
| 6% | 99% | 100% | 100% | 6% | 1% | 0% | 0% |

4. Establish a progression to “Meaningful” AE risk

- Required progression to downside shared risk within three years of program participation
- Progression to risk linked to development of required AE certification standards/capabilities and financial capacity
- AEs assuming downside risk may be eligible for a higher share of Shared Savings Pool
- EOHHHS has defined “meaningful risk” based on learnings from other states, OHIC requirements and federal MACRA rules, as follows:

| | Marginal Risk AE Share of Losses | Loss Cap Maximum Shared Loss Pool | Total Potential Risk |
|------------|---|---|---|
| Definition | The percentage of any Shared Loss Pool for which the AEs are financially responsible. | The maximum percentage loss over Targeted Expenditures for which the AEs are financially responsible. | The maximum potential loss for which the AEs are financially responsible. |
| Year 1 | 0% | NA | 0% |
| Year 2 | 0% | NA | 0% |
| Year 3 | At least 15% of any Shared Loss Pool | At least 2% No more than 5% | 15% x 2% x Adjustment Factor (82% to 97%) = 22% to 23% |
| Year 4 | At least 30% of any Shared Loss Pool | At least 2% No more than 10% | 30% x 2% x Adjustment Factor (82% to 97%) = 25% to 26% |
| Year 5 | At least 50% of any Shared Loss Pool | At least 2% No more than 10% | 50% x 2% x Adjustment Factor (82% to 97%) = 28% to 1.0% |

4. Accelerated Risk Opportunity

Accelerated Schedule to Shared Risk

Should an MCO and AE wish to share risk on a more accelerated schedule, the MCO and AE should submit written documentation to EOHHS, including:

- the draft contractual financial terms between the parties;
- a statement of why the AE is qualified to assume greater risk than that outlined above, including infrastructure to manage clinical risk, established record of meeting quality metrics
- documentation of secured funds necessary to meet the maximum financial obligation that the AE could potentially incur under the terms of the proposed agreement.

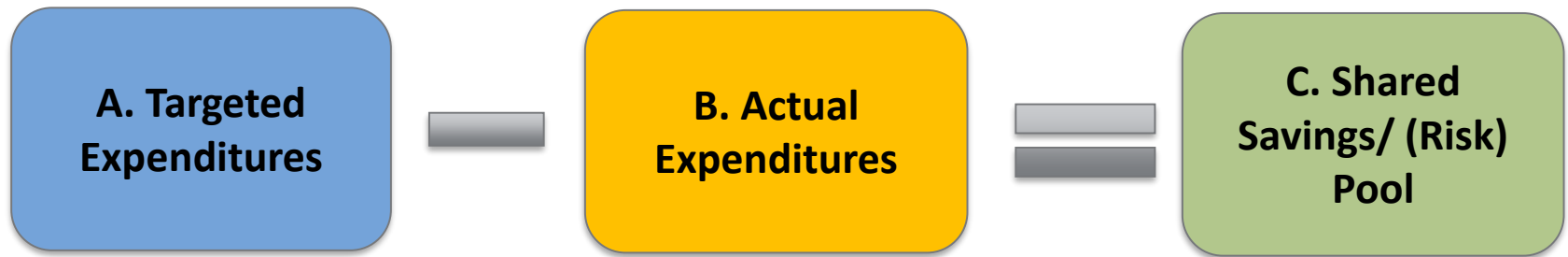
Following review, EOHHS will decide whether the arrangement may proceed

Total Potential Risk Greater than 10% of Expected Expenditures

Additionally, if an AE enters into an arrangement that provides for shared losses with a total potential risk that equals or exceeds 10% of expected expenditures:

- the AE must meet all of the financial reserve and risk-based capital requirements required of a Managed Care Organization, with oversight by DBR.
- EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three (3) months of claims.

5. Increasing Standardization while allowing flexibility



Required Elements

1. Defining a Historical Base
2. Required Adjustments to the Historical Base
3. Targeted Expenditures for the Performance Period
4. Actual Expenditures for the Performance Period
5. Shared Savings/(Loss) Pool Calculation
6. AE Share of Shared Savings/(Loss) Pool
7. Required Progression to Risk

Next Steps

Goal:

Certified AEs in qualified APM arrangements with participating MCOs by Jan, 2017

HSTP Incentive Funds: Initial milestones met and payment distributed: Q1 2017

Immediate Next Steps (August)

- DRAFT APM Guidance to CMS
- DRAFT AE Application distributed for feedback
- Additional draft guidance distributed for feedback (HSTP Incentive Program, Attribution)

Backup: Details on Required TCOC Elements

- A. Targeted Expenditures: Defining and Adjusting Historical Base
- B. Actual Expenditures for the Performance Period
- C. Shared Savings/(Loss) Pool Calculations

A. Targeted Expenditures: Defining and Adjusting Historical Base

| Element | Considerations |
|---|---|
| AE Specific Historical Cost | <ul style="list-style-type: none"> • Number of years of historical cost data • Weighting by year |
| Covered Services | <p>Exclusions:</p> <ul style="list-style-type: none"> • Services in stop-loss provisions in OHHS's contract with MCOs (e.g., organ transplant) • HSTP incentive payments • Prior risk-sharing reconciliation amounts |
| Claims Caps | <p>How to limit outlier costs in historical base</p> <ul style="list-style-type: none"> • Annualized spending threshold per member • AE responsible for 10% of costs above threshold |
| Risk Adjustment | <p>How to adjust for changes in the risk profile of attributed population over the base years</p> <ul style="list-style-type: none"> • Rate cell based adjustments; or • Risk adjustment software |
| Cost Trend Assumptions | <ul style="list-style-type: none"> • Use trends from medical component of capitation rates being paid to MCOs by OHHS • By Cap Cell, By Year |
| Adjustment for Prior Year Savings | <p>Allow upward adjustment to TCOC target for prior year savings</p> <ul style="list-style-type: none"> • AE's share of prior year savings may be retained • Cap adjustment (ie. 2% of the unadjusted spending target) |
| Adjustment for Historically Low-Cost AEs | <p>Allow upward adjustment to the TCOC target for AEs with below average historical costs</p> <ul style="list-style-type: none"> • Up Only. No adjustment for high-cost AEs • Adjustment based on percentage TCOC fell below MCO average spending – risk adjusted, after FQHC reconciliation payments • Cap adjustment? (ie. 2% of the unadjusted spending target) |

B. Actual Expenditures for the Performance Period

| Element | Considerations |
|--|--|
| Calculating Actual Expenditures | Actual expenditures for the performance period to be calculated using the same covered service and claims cap conventions used to generate the historical base *See: (1) Defining a Historical Base, Covered Services and Claims Caps |

C. Shared Savings/(Loss) Pool Calculations

| Element | Considerations |
|---|--|
| Small Sample Size Adjustments for Random Variation | Account for the effect of random variation in utilization and spending in small populations <ul style="list-style-type: none">Define adjustments to the Shared Savings Pool by AE population size based on the probability of achieving shared savings as a result of chance? (SEE backup) |
| Impact of Quality and Outcomes | <ul style="list-style-type: none">Under development |
| Maximum Allowable Shared Savings (Loss) Pool | A cap is applied to the shared savings pool (x% of Target Expenditures) <ul style="list-style-type: none">Increased cap for AEs taking downside riskIs the loss cap need not match savings cap |
| AE Share of Savings/(Loss) Pool | Maximum share of savings/(loss) are AEs eligible for <ul style="list-style-type: none">AEs taking downside risk eligible for an increased share of savings |