Total Cost of Care Shared Savings Incentive

Overview and Purpose

The Payment Transformation model allows providers more flexibility to care for their patients by providing them an up-front monthly payment for all attributed patients, as opposed to a per-service or per-visit payment. A new total cost of care (TCOC) shared savings incentive is available to PCPs and POs participating in Payment Transformation.

PCPs and POs who manage the rate of growth of all costs incurred by their patients – and therefore generate savings against an expected cost trend – can share in these savings.

TCOC is an essential feature of the new payment model for the following reasons:

- To encourage and reward PCPs and their POs who provide high-quality, patient-centered care as efficiently as possible, working together to manage costs and coordinate care (i.e., to minimize things like preventable hospital admissions and ER utilization), and

- To ensure that under the new global payment methodology, there is no perverse incentive to unnecessarily shift care out of primary care settings to higher cost settings (such as to hospitals).

Importantly, TCOC will be measured and scored at the PO level. While PCPs will receive information through Cozeva about the TCOC of their individual panels, TCOC must be measured and scored at the PO level. This is because any one individual PCP does not have enough attributed patients to statistically protect against one large adverse event significantly impacting that PCP’s cost trend/performance for the entire measurement period.

A PO will be eligible for TCOC shared savings if the cost growth for the PO’s attributed members grows less than the shared savings target trend in the current measurement period from the prior measurement period for that PO. Each year, the fixed shared savings target trend will be based on the State of Hawaii’s annual GDP growth rate plus 2%. The target trend will be specified in the Payment Transformation Guide.

Notably, a PO can successfully earn TCOC shared savings if it manages its own rate of growth against a fixed target growth rate (e.g., 4%). POs will not compete against other POs in the network to achieve shared savings.

---

1 In 2015, Hawaii’s real GDP grew 2.3 percent according to the U.S. Department of Commerce’s Bureau of Economic Analysis (Published on 9/28/16 and accessible here: https://www.bea.gov/regional/bearfacts/pdf.cfm?fips=15000&areatype=STATE&geotype=3).
Of the savings beneath the shared savings target trend, the PO will receive 40%. HMSA strongly recommends that the PO distribute at least 50% of any earned savings to providers. The PO is only eligible to receive the shared savings bonus if the PO meets a specified quality threshold. In 2017, the quality threshold is specified as the PO earning at least 50% of the total max potential performance (quality) payments for the PCP performance measures for the measurement year, across all lines of business combined.

All TCOC calculations will be risk-adjusted to reflect variations in patient’s clinical profiles.

Defining TCOC

Costs

TCOC is defined as all costs incurred in the health system by a patient, regardless of provider. This includes costs for all primary care, specialty, hospital/facility, and ancillary services. HMSA will identify these costs by looking at all reimbursed claims for these services.

Costs for two key services are currently excluded from TCOC: behavioral health services and prescription drugs that are not a medical benefit. Behavioral health services are excluded to encourage provision and/or referral for these services without concern about cost.

TCOC also includes all non-claims costs associated with members attributed to the PO. The following non-claims based costs will also be included in a PO’s TCOC calculation:

- PCP’s PT PMPM payments;
- Fees (PCMH PCP, PO, ACO, HMO, etc.), if any;
- PCP & PO patient management fees;
- Quality payments (PCP, PO, hospital, etc.);
- Payments to HMSA vendors.

Additional information about TCOC cost calculations, including a list of excluded behavioral health services and codes, are specified in the PT Guide, Appendix G.

Members (“eligible population”)

Patients who meet all of the criteria below will be included in the TCOC calculation for a PO:

- Be a member of an HMSA commercial plan (this includes all HMO and PPO plans except for those listed in the exclusion list below);
- Be attributed to any PCP within the PO as of the last month of the performance period (e.g. December 2017).
- Be in both base and performance periods

Patients who are currently excluded from TCOC are:

- All QUEST Integration plan members;
- All Akamai Advantage (Medicare Advantage) plan members;
- All Federal Employee Plan (FEP) members;
- All Fed87 Plan members;
- All HMO Children’s Plan members;
- Members of another health plan operating under a license with the Blue Cross Blue Shield Association and entitled to benefits under the Blue Card Program.

Calculating TCOC
To calculate a PO’s TCOC, HMSA will use the following methodology:

A. Calculate the PO’s TCOC PMPM Baseline

1. Identify the eligible population for the PO. The cohort will include all eligible patients attributed to the PO’s PCPs as of the last month in the performance period.

2. Calculate the PO’s unadjusted (non-risk adjusted) TCOC as a per-member per-month (PMPM) figure using the following formula:

   
   \[
   \frac{(\text{Total claims reimbursements for qualified claims for eligible population (dollars)})}{(\text{Total member months for eligible population})} = \text{PO unadjusted TCOC PMPM}
   \]

   Qualified claims for the cohort will include all reimbursed claims except for those related to behavioral health services and prescription drugs.

   The unadjusted PMPM calculated in this step is based on claims-based reimbursement only.

3. Calculate the PO’s risk-adjusted TCOC PMPM. It is critical to risk-adjust each PO’s TCOC PMPM to account for changes in the clinical complexity of each PO’s panel.

   Each PO’s panel will be risk adjusted based on claims-based data for their eligible population. Because we know that TCOC of members varies with age, gender and morbidity, risk adjustment allows us to estimate how POs compare if they had the same member composition. Risk adjustment accounts for systematically measurable sources of risk: individual age, gender and morbidity (illness burden). HMSA uses Optum’s Episode Risk Grouper (ERG) methodology for the member morbidity calculation.

   While the risk adjustment methodology is fully explained in the PT Guide, Appendix G, in general, risk adjustment allows HMSA to calculate an expected TCOC PMPM based on the risk factors of the PO’s patients. Thus, if a PO has a patient panel that is more clinically complex (has higher illness burden) than the network average, the PO’s TCOC will be adjusted to account for the expected complexity of care – and expected associated costs - for those patients.
4. **Calculate non-claims based costs as a PMPM for the PO.** The following non-claims based costs will also be included in a PO’s TCOC calculation:

- PCP’s PT PMPM payments;
- Fees (PCMH PCP, PO, ACO, HMO, etc.), if any;
- PCP & PO patient management fees;
- Quality payments (PCP, PO, hospital, etc.);
- Payments to HMSA vendors.

5. **Calculate the PO’s TCOC by adding the risk-adjusted TCOC PMPM (step 3) and the non-claims based PMPM (step 4).**

B. **Calculate the PO’s TCOC for the performance period.** Repeat all steps outlined in A using data for the performance period.

C. **Determine if the PO earns TCOC shared savings.** If the PO’s TCOC PMPM is below the target shared savings trend and the PO meets the quality threshold, the PO will earn TCOC shared savings for the measurement period.

   1. Calculate the PO’s TCOC rate of growth:

   \[
   \frac{\text{(PO's performance period TCOC PMPM} - \text{PO's baseline TCOC PMPM)}}{\text{PO's baseline TCOC PMPM}} = \text{PO TCOC rate of growth}
   \]

   2. Compare the rate of growth against the target trend for shared savings. If the PO’s rate of growth is less than the target trend, the PO earns shared savings. If the PO’s rate of growth is equal to or higher than the target trend, the PO does not earn shared savings.

   3. Determine the amount of shared savings earned by calculating the difference between the PO’s rate of growth and the target trend. For example, if the PO’s TCOC rate of growth was 2% and the target trend is 4%, the PO is eligible to receive 40%\(^2\) of the difference between the 2% (actual) and the 4% (target). The PO’s shared savings is calculated using the following formula:

   \[
   \text{PO baseline TCOC PMPM} \times (\text{Target TCOC trend} - \text{PO TCOC rate of growth}) \times 40\% \times \text{attributed member months} = \text{shared savings}
   \]

\(^2\) PO’s receive 40% of any savings, with the remainder of the savings accruing to employer groups and other payers (who fund HMSA’s quality programs) and HMSA. A substantial portion of HMSA’s share is reserved for other providers (i.e. specialists) who may also be eligible for TCOC shared savings in future years.
An example: If the PO’s baseline TCOC was $200 PMPM and the target trend was 4%, to earn shared savings, the PO would need to keep their TCOC PMPM below $208. If the PO’s TCOC increased 2% from baseline to $204, the PO’s total savings would be $4 ($208 - $204) x the PO’s attributed member months for the measurement period. The PO’s shared savings would be 40% of this total.

Distribution of Shared Savings

HMSA will score and distribute any TCOC shared savings earned by June of the following year. The shared savings will be distributed to the PO. HMSA strongly recommends that the PO distribute at least 50% of any earned shared savings to its providers. Each PO must determine how to distribute any shared savings to PCPs. For instance, a PO may opt to distribute any earnings based on providers’ panel size and/or risk, quality performance, or other performance or engagement metrics. If a PO would like HMSA to distribute shared savings to individual PCPs, the PO must specify the methodology and amounts.