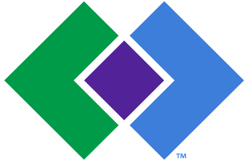

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Consideration for TCOC ✓

Medicaid and Medicare products

Background

The Total Cost of Care (TCOC) and Resource Use measures were endorsed by the National Quality Forum (NQF) for a commercial population; however, with modifications, they could be used for Medicare or Medicaid populations. These modifications would need to be made on the methodological constructs of the measures and each would need to be tested independently within the Medicare and Medicaid populations to ensure they produce reliable and valid measures. While we tackle these constructs separately to highlight the considerations needed, the impact of these constructs are inter-related and also need to be assessed for reliability and validity in totality within the Medicare and Medicaid populations. Based on the evaluation of these constructs and the need to tailor the measure for each population, we strongly recommend that results must be segmented by payer. Segmentation, or stratification, divides a population into meaningful categories, such as payer type (e.g. commercial, Medicaid, and Medicare) to ensure reporting and measurement are accurate, relevant, and actionable for all stakeholders.

Constructs of the measures:

- Services covered
- Risk assessment
- Member attribution
- Total cost truncation threshold
- Minimum enrollment length
- Resource assessment

Adjustments to the criteria for consideration, within the commercial NQF-endorsed measures

Services Included

Commercial, Medicare, and Medicaid products often differ significantly in their coverage of certain large buckets of services (e.g. behavioral health, pharmacy). If these types of service covered are not similar among these populations, the results must be segmented so that results are comparable and accurate within the population.

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Risk Assessment

Risk adjusters are designed to assign expected resource consumption to a person with a particular set of conditions and/or procedures based on a study population. Each risk adjuster emphasizes certain conditions or combinations of conditions depending on the underlying population. Since the commercial, Medicare and Medicaid have vastly different condition profiles, it is necessary to segment these populations as combined risk assessment becomes less accurate as the relative population differences become too great for any risk adjuster to accurately assess risk, resulting in a lower R^2. Furthermore, some risk adjusters do not adequately assess particular segments of the population because they are not the main drivers of cost for that population. For example, Hierarchical Condition Categories (HCCs) utilize conditions to assess risk on approximately 20-30% of the commercial population while the remaining population only receive an age and gender score.

Attribution

Commercial, Medicare, and Medicaid products have varying provider or network selection criteria. Some have no selection requirement (open access), whereas others require identification of a primary care provider in which all care is coordinated with varying levels of adherence requirements (ACO or closed network). If a provider or geographic region's cost assessment is being performed, understanding the member provider relationship is of vital importance to understanding the underlying cost drivers (e.g., provider performance vs. network design).

If the unit of analysis is per capita spend, rather than member assignment or attribution to a provider group, attribution is not necessary.

Truncation

High cost members are not removed, rather they are truncated to a pre-determined level to hold providers accountable for all their members care, without having a single member unduly impact their performance. All risk adjusters become less effective (lower R^2) in explaining members costs when they exceed certain thresholds of spend. Since reliability and validity are essential in provider measurement, an acceptable balance must be struck between spend and the level of reliability and validity needed for accurate measurement. For practical purposes the goal is to hold providers accountable for the health care, rather than the insurance risk of a high cost patient.

Finding this balance is not consistent across the commercial, Medicare, and Medicaid populations, as evidenced in the variation in resource use and per unit cost across these products. In addition to per unit cost variation, utilization patterns across these products need to be set individually to appropriately set a truncation limit. For example, a commercial member who consumes $125,000 of services at a high per unit cost consumes far fewer resources than a Medicare member who consumes $125,000. Since the truncation limit must be aligned with risk assessment, a single truncation level across all products would produce ineffective risk assessment (lower R^2) and cost profiling.

Enrollment Length

Enrollment length is essential for accurate risk assessment; the more information used in the risk assessment, the more accurate the predictive power (higher R^2). While commercial populations are fairly consistent in their enrollment, state Medicaid programs are considerably different in enrollment requirements, and persistency of enrollment for individuals. An additional confounder for benchmarking Medicaid is coverage criteria and benefits vary significantly state to state. Looking at the Minnesota Medicaid programs, there is a significant difference in average enrollment length from the commercial population.

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Resource Use - TCRRVs

TCRRVs should be calibrated by product. Each type of payer's population consumes different amounts of resources by place of service, and those places of service each have varying payment rates. If a single resource use scale is applied across payers, price and resource use results will be misleading, as the number of dollars consumed by place of service will not be aligned with the resources.

Price by Place of Service Variation across Payers

The payment rates for commercial populations are considerably different than Medicare, and using the same TCRRV system would confound price opportunities based on a provider's payer mix. In essence the payer mix itself, would generate high or low price.

TCRRVs are calibrated within place of service based on CMS weights (DRG, APC, RVU). However, when calibrating across places of service it is important to consider the varying payment rates by place of service for each payer. This is important as the number of resources assigned to each place of service, should generate the same price relativity as the payment rates by payer (i.e., spend/TCRRVs = spend / CMS weight)

Conclusion

In summary, the Total Cost of Care (TCOC) and Resource Use measures were endorsed by the National Quality Forum (NQF) for a commercial population; however, with modifications, they could be used for Medicare or Medicaid populations.

While these constructs are outlined individually to highlight the considerations needed within each, the reality is they work in an inter-related fashion in their impact on results. As such, they need to be assessed for reliability and validity in totality.

Based on the evaluation of these constructs and the need to tailor the measure for each population, results must be segmented by payer for usability purposes by stakeholders. The need to segment was also the finding of the National Quality Forum (NQF) Cost and Resource Use Steering Committee that was charged with evaluating harmonization of the HealthPartners-endorsed Resource Use measure and the related CMS measure*.

**National Quality Forum Cost and Resource Use Harmonization discussion with HealthPartners and the Centers for Medicare and Medicaid "Payment-Standardized Total Per Capita Cost Measure for Medicare Fee-for-Service Beneficiaries (#2165).*
May 9, 2013. Day 2 Transcript, starting on page 115 through page 169.

http://www.qualityforum.org/Calendar/2013/05/Cost_and_Resource_Use_Measures--Steering_Committee_In-Person_Meeting_-_2013-05-08.aspx