Total Cost of Care (TCOC) Workgroup

April 24, 2019

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions & Updates
- Y1 MPA (PY18)
  - Y1 Preliminary Results
- Y2 MPA (PY19)
  - MPA Operations
  - Data Sharing and Reporting Release
  - Regional Approaches to Addressing TCOC
- Y3 MPA (PY20)
  - Quality Brainstorm
  - TCOC "General Ledger" Discussion
  - Benchmarking Update
  - Attribution Discussion and General Process Improvement Discussion

Updates

- Stakeholder Innovation Group – Idea Intake
- https://www.mhaonline.org/transforming-health-care/tracking-our-all-payer-experiment/stakeholder-innovation-group

Y1 MPA (PY18)

- Preliminary MPA Year 1 Results

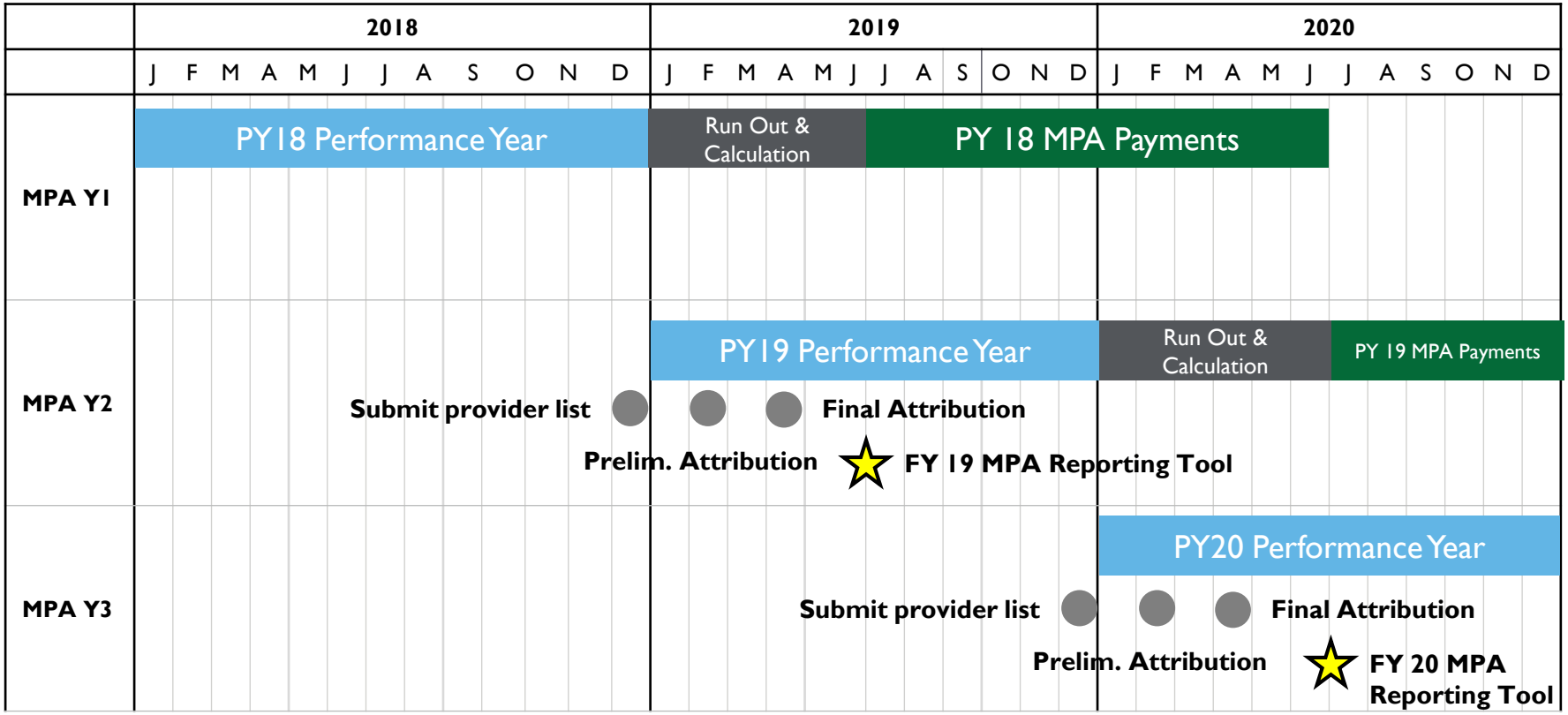
Y1 MPA Implementation

Steps Moving Forward:

- HSCRC calculates the MPA and shares results with hospitals in early May 2019
- HSCRC tells CMS what percentage adjustment to make to hospitals' Medicare payments
  - The Y1 MPA will include an offset to preserve the Medicare Savings Run Rate and keep the MPA revenue neutral
- Expected July 1, CMS implements adjustment with the Medicare Administrative Contractor (MAC)
- *Note: the MPA does not go into rates, does not affect hospitals' GBR, and is not reflected in rate orders*

MPA Timing: Understanding Performance Year, Scoring, and Payments

"Traditional MPA" Timing (does not include ECIP or MPA-Efficiency Component for simplicity)



Y2 MPA (PY19)

- MPA Operations
  - MPA Operations
  - Data Sharing and Reporting Release
  - Addressing Regional TCOC

MPA Information Submission and Review Timeline

Estimated Timing	Action
December 2018	• Hospital submitted provider lists
January 2019	• Performance year begins
February 2019	• Preliminary attribution shared with hospitals
March 2019	• 4 week review period
April 2019	• HSCRC reruns final attribution algorithm for implementation and shares results with hospitals • *Voluntary:* Hospitals wanting to be treated as a combination under the MPA submit a joint request to HSCRC
June 2019	• Hospitals attest to care coordination agreements for referral relationship attributed providers. • MPA Reporting Tool Released
Late Summer	• Additional attested referral relationships accepted • MPA Reporting tool is updated with attested referral relationship provider data

Empowering Hospitals to Manage TCOC: Current State of Available CCLF Data and Tools

- Hospitals will be able to receive individually identifiable data
  - Expand touch attribution to all Maryland hospitals (not just CRP)
  - Share PHI data for select MPA attributed patients
  - Non-PHI data will still be available for all MPA patients

Population	Tool	Hospital-Type
Non-PHI Data		
TCOC Data for MPA Attributed Beneficiaries	MPA Monitoring Tool	All Maryland Hospitals
PHI Data		
PHI Data for Beneficiaries Who Have Been to the Hospital (Touch Attribution)	MADE Reporting Tool	CRP Hospitals

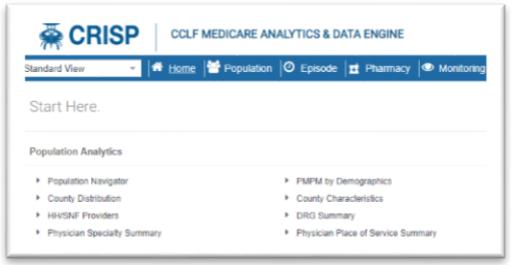
CRISP – CCLF Reporting Tools

Aggregated Data Reporting

Medicare Performance Assessment (MPA) Reporting Tool

Primary Uses:
- TCOC Monitoring
- Aggregate Clinical Analysis
- Peer comparison and opportunity analysis

Patient-Level Data Reporting



Medicare Analytics and Date Engine (MADE) Tool

Primary Uses:
- Patient Level Clinical Analysis
- Targeting of Clinical Interventions

CCLF Patient Populations through Attribution

- Hospitals have access to Medicare FFS beneficiary data/reports through two attribution methodologies.

Touch Attribution

In Short (Beneficiary Driven):
- Medicare claims data are available for Medicare FFS beneficiaries that have received services at a hospital

Population:
- Medicare FFS Beneficiaries receiving services at a given hospital
- PHI data available in MADE

Medicare Performance Adjustment (MPA) Attribution

In Short (Provider Driven):
- Medicare claims data are available for Medicare FFS beneficiaries attributed to hospitals through the MPA

Population:
- Beneficiaries who are attributed to MDPCP, ACO, or Referral Providers with a Care Coordination Agreement will have PHI data available in MADE
- Beneficiaries who are attributed to Referral Providers without a Care Coordination Agreement or through Geographic will have non-PHI data available in the MPA Monitoring Tool

Future State of Available CCLF Data and Tools

Population	Requirements
Non-PHI Data (available through the MPA Monitoring Tool)	
MPA Attribution: TCOC Data for MPA Attributed Beneficiaries	No Requirements
MPA Attribution: Referral w/o Care Coordination Agreement	No Requirements
MPA Attribution: Geography	No Requirements
PHI Data (available through the MADE Tool)	
Touch Attribution: PHI Data for Beneficiaries Seen at Hospital	No Requirements
MPA Attribution: MDPCP Attributed Beneficiaries	CTO Association Agreement
MPA Attribution: ACO Attributed Beneficiaries	CMS ACP Participation Agreement, ACO List
MPA Attribution: Employed Attributed Beneficiaries	Employment Contract, NPI List
MPA Attribution: Referral w Care Coordination Agreement Attributed Beneficiaries	Care Coordination Agreement

Updated Attribution Lists and Care Coordination Attestation

- To view patient-level data through MADE for "referral" linkage providers, hospitals must attest to a care coordination agreement between the hospital and the provider
  - ACO-like, MDPCP, and employment steps are already covered
- HSCRC will be providing updated attribution lists shortly with a column where hospitals can attest to a care coordination agreement
  - Worksheet will pre-fill attestations for existing care agreements for clinicians in the ACO-like, MDPCP, and employment steps
- In order to access patient-level data when reports become available, attestations must be received by **June 1.**
  - Anticipate additional attestation opportunities throughout the year

Care Coordination Agreement requirements: Hospitals are responsible for determining what is necessary in a care coordination agreement to meet requirements of data sharing under HIPAA

- Updated lists will also include a tab for geographic attribution

Addressing Regional TCOC

For discussion:

- The HSCRC is interested in understanding how hospitals may partner together to reduce regional TCOC and improve population health
- What additional policies, program, or incentives may be beneficial to encourage multi-hospital collaboration to address regional costs and improve quality?
- What are the current barriers to addressing TCOC on a regional level?

Y3 MPA (PY20)

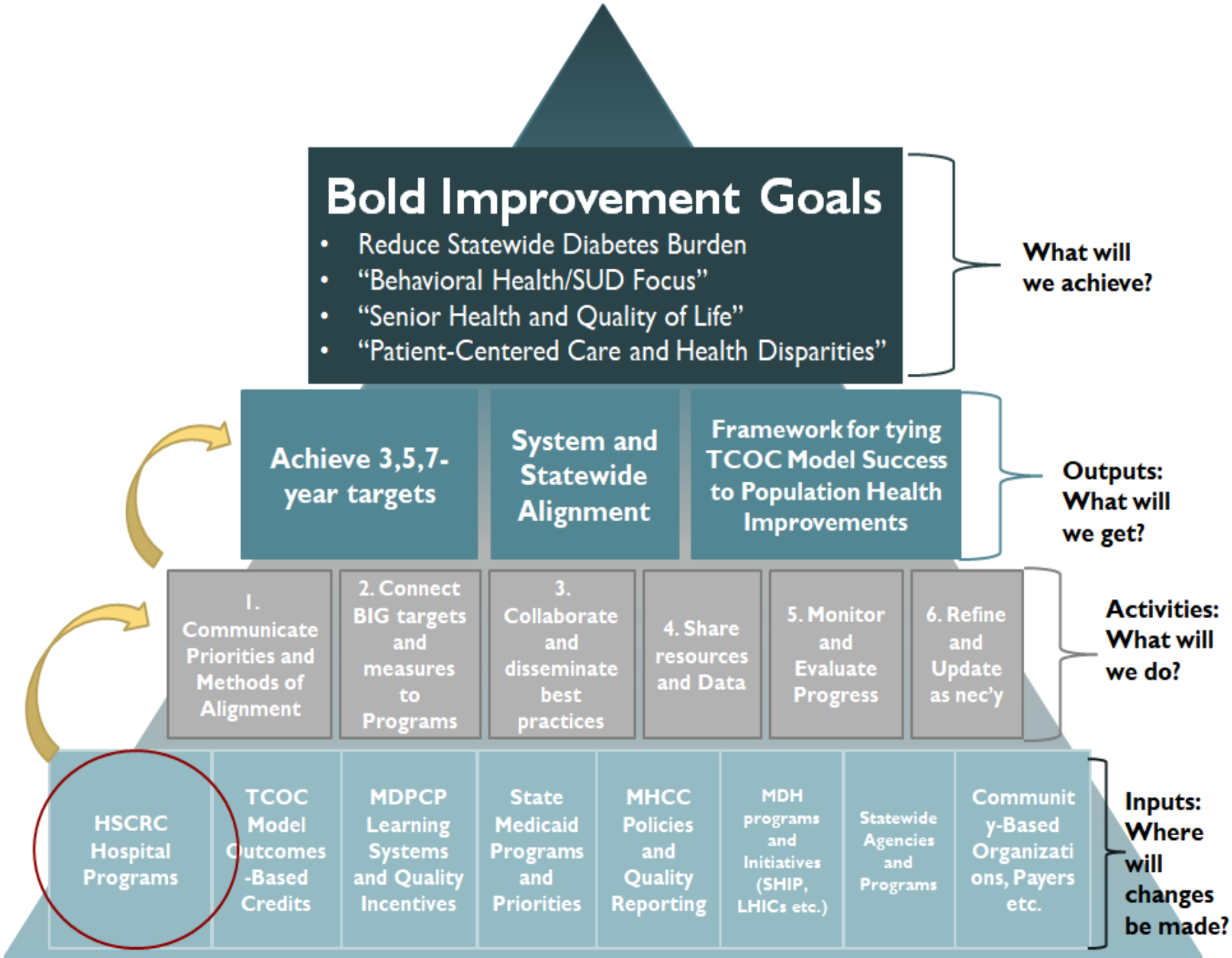
- Quality Brainstorm
- TCOC "General Ledger" Discussion
- Benchmarking Update
- Attribution Discussion and General Process Improvement Discussion

MPA Quality Adjustment

- Rationale
  - Payments under an Advanced APM model must have at least some portion at risk for quality
  - Because the MPA connects the hospital model to the physicians for MACRA purposes, the MPA must include a quality adjustment
- Other requirements
  - Must be aligned with measures in the Merit-Based Incentive Payment System (MIPS) to the extent possible
- Required to include, at minimum:
  - Adjustments from Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Conditions (MHAC)

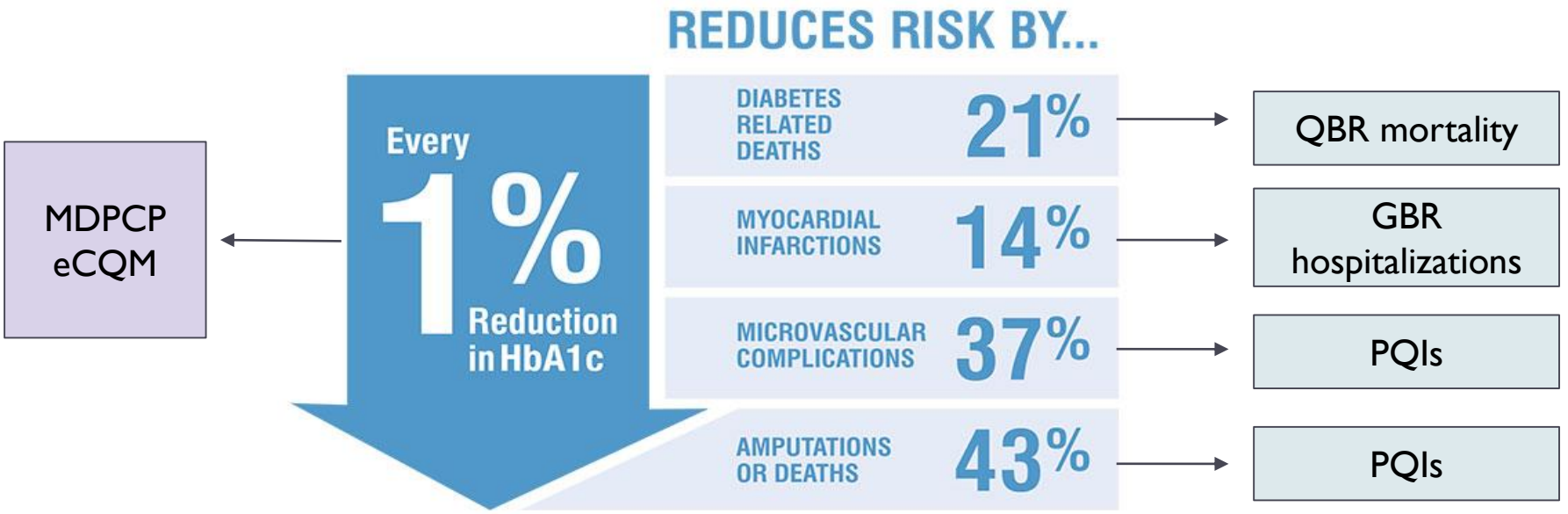
MPA Quality Adjustment – Y3

- For Y3 MPA Policy, considering new measures
  - Opportunity to utilize Medicare claims data and other data sources to capture quality of care not possible in case-mix data
- As always, use validated measures whenever possible
- New measures should be aligned with TCOC goals (BIGs)
  - Total Cost of Care Model requires a focus on population health improvement for all Marylanders
  - Bold Improvement Goals (BIGs) are intended to align community health, provider systems, and other facets of the State's health ecosystem to improve population health and achieve success under the TCOC Model


Bold Improvement Goals
• Reduce Statewide Diabetes Burden
• "Behavioral Health/SUD Focus"
• "Senior Health and Quality of Life"
• "Patient-Centered Care and Health Disparities"
What will we achieve?
Achieve 3,5,7-year targets
System and Statewide Alignment
Framework for tying TCOC Model Success to Population Health Improvements
Outputs: What will we get?
1. Communicate Priorities and Methods of Alignment
2. Connect BIG targets and measures to Programs
3. Collaborate and disseminate best practices
4. Share resources and Data
5. Monitor and Evaluate Progress
6. Refine and Update as nec'y
Activities: What will we do?
HSCRC Hospital Programs
TCOC Model Outcomes-Based Credits
MDPCP Learning Systems and Quality Incentives
State Medicaid Programs and Priorities
MHCC Policies and Quality Reporting
MDH programs and Initiatives (SHIP, LHICs etc.)
Statewide Agencies and Programs
Community-Based Organizations, Payers etc.
Inputs: Where will changes be made?

Example: Diabetes Burden

- Proposed outcomes-based credit for diabetes incidence (prevention)
- Both MDPCP and hospitals assessed on diabetes measures (management)
- State believes that collaboration between public health, providers, consumers, and hospitals can lead to better health and outcomes



Existing diabetes-specific measures in payment programs

	Outcome Based Credit	GBR	Medicaid	MDPCP	Hospital P4P	MPA
Population at risk	**x**		**x**	**x**		
BMI Assessment and weight counseling			x	x (PY2)		
Diabetes Incidence	x					
Population with Diabetes		**x**	**x**	**x**	**x**	
Eye Exam			x			
HbA1c Testing			x			
Medical Attention for Nephropathy			x			
HbA1c Control			x	x		
Diabetes Admissions (PQI)		x		x*	x	
ED visits				x		
Readmissions		x		x*	x	

* Measure is included in larger MDPCP utilization measures, but not called out specifically

Year 3 MPA Quality Adjustment

- Should be designed to align with BIGs, but at what level?
  - As additional BIGs are developed, may want to add related measures to MPA quality

Example measures

Diabetes Prevention (aligns with outcomes-based credit)	**Diabetes Management (aligns with GBR and MDPCP)**	**Diabetes Utilization (aligns with GBR and MDPCP)**
BMI Screening & follow up	Eye & foot exams	PQIs
Diabetes Screening	HbA1C Testing/Control	Readmissions
Well-visits for at risk adults	Nephropathy	Hospitalizations
DPP enrollment	Follow-up after hospitalization	ED visits

Open questions:
- Should this work be under the TCOC WG or performance measurement WG?
- Aligning with diabetes prevention or management measures under the MPA?
- Measures that are already implemented in our programs or new unique measures that align with existing measures?
- What measures do we think hospitals and their ambulatory partners have influence on?

Decision may be made in Juy TCOC WG

TCOC “General Ledger” Discussion

Proposal for offsetting MDPCP Care Management Fees

- Medicare TCOC Savings Run Rate must increase to $300 million by CY 2023, with annual hard targets in the interim
- Care Management Fees (CMF) from the Maryland Primary Care Program (MDPCP) will add approximately $60 million of Medicare spending in CY 2019
  - In June 2018, the Commission approved a resolution saying "hospitals should not be held financially responsible for losses resulting from the payment of MDPCP Care Management Fees by the federal government during the initial years of the program"
  - At the same time,
    - The Commission has told payers that hospitals would not get credit for certain other policies (e.g., Public Payer Differential)
    - Hospital-owned CTOs and practices are receiving MDPCP CMF

Policy Changes Not Credited to Hospitals

The State of Maryland and CMMI have made changes affecting hospital payments as well as the negotiated required TCOC Run Rate relative to national growth.
These include:

- Increase in the Public Payer Differential to 7.7 percent, from 6.0 percent
- All-payer reduction in Medicaid Deficit Assessment:
  - $30M in FY 2019
  - $25M in FY 2020+
- As an offset for inclusion of MDPCP in the savings test, Federal government agreed to the following adjustments to the State's advantage:
  - Eased the short-term TCOC targets building up to $300M target
  - Allowed half of any TCOC savings beyond the TCOC target for CY 19 and 20 to be credited to the following year's run rate

Five-Year State Responsibility for MDPCP Spending, Assuming No MDPCP ROI and excluding changes in Run Rate Requirement*

Program or Policy	2019	2020	2021	2022	2023
MDPCP	**63**	**95**	**111**	**123**	**130**
LESS: 0% ROI on TCOC	No impact included for this view				
LESS: CMF to hosp CTOs	(15)	(20)	(21)	(22)	(23)
LESS: CMF & CPCP to hospitals' drs	(8)	(17)	(25)	(30)	(32)
MDPCP not paid to hosps	**40**	**58**	**65**	**71**	**75**
Differential increase	(20)	(40)	(40)	(40)	(40)
Medicaid Deficit Assessment	(10)	(20)	(30)	(40)	(50)
Reduced Run Rate when MDPCP included	No impact for this view				
Subtotal: Policy offsets	**(30)**	**(60)**	**(70)**	**(80)**	**(90)**
Total: State responsibility	**10**	**(2)**	**(5)**	**(9)**	**(15)**

*Items on this schedule are estimates based on currently available data and HSCRC assumptions

Take-Home Points: Accounting for State Responsibility for CY 2019 MDPCP Costs

- The State resolved that hospitals should not be responsible for losses resulting from the payment of MDPCP Care Management Fees during the initial years
- On the flip side, hospitals should also not get credit for certain policies that improve our TCOC savings rate
- A full accounting of State policies not credited to hospitals more than offset CY 2019 and future MDPCP non-hospital spend
- Since additional dollars not necessary from hospitals to hit Medicare TCOC target, no action recommended at this time.
- Traditional MPA scoring will not be adjusted for any of these factors. The state will track the impact.

Handling of Rate Adjustments in Calculating MPA and CRP adjustments

- In addition to MDPCP and the differential change there are a number of other changes that will influence a hospital's performance on the MPA or in programs like ECIP:
  - Bonuses and Penalties for prior MPA or CRP performance
  - Capital funding through the update factor
  - Quality rewards/penalties from HSCRC all-payer programs
  - Deregulatory and other unusual rate setting adjustments

- For MPA Y1 we are not adjusting for any of these factors, we will need to determine the approach for Y2 and beyond.

Handling of Rate Adjustments in Calculating MPA and CRP adjustments

- HSCRC's bias is to make no adjustments:
  - Greater simplicity
  - Don't start down the slippery slope
  - Some items will not be material
  - MPA is measured on an attributed basis but the adjustments are on a hospital basis which complicates the calculation but also dilutes the impact of any one facility (i.e. a hospital's MPA results are impacted not just on their performance but by any hospital who treats their attributed beneficiaries).
- HSCRC would propose to:
  - Monitor the impact at a high level
  - To the extent material, consider adjustments effecting this and other policies in the future.

Benchmarking Update

Update on Benchmarking

- Expect to release cost comparisons with some drill down in mid-May in time for review prior to May TCOC meeting
- Initial comparison will compare:
  - Hospital Attributed Beneficiary Results to
  - Benchmark generated by blending county level benchmarks based on distribution of attributed beneficiaries
  - e.g. if GBMC attributed beneficiaries are 70% Baltimore County and 30% Baltimore City, GBMC's MPA attributed TCOC performance would be compared to a 70:30 blend of the benchmark groups for those two jurisdictions
- Working on process to adjust benchmark results to better match specific demographics of hospital's attributed beneficiaries (based on zip code distribution of attributed beneficiaries)

Update on Benchmarking

Let us know if you have feedback on the benchmark groups or MPA attainment approach reviewed in prior meetings!

Y3 Attribution Improvements and Other MPA Enhancements

Attribution Improvements and Other Enhancements for Y3 (Laura)

- Suggestions received during review period
  - Add Physician Assistants as eligible PCPs in referral pattern
  - Attribute patients to specialists when majority of care is with specialists, versus a PCP they may only see once
- Open to suggestions for Y3 enhancements if there is strong support for changes
  - HSCRC preference to keep attribution stable if possible
- HSCRC working with MHA and partner hospitals to develop an MPA "Manual" to provide additional guidance, FAQs, and other help in the future

Next meeting:
May 29, 2019

Future meetings

- TCOC Work Group meetings
  - May 29
  - July 31
  - September
- HSCRC Commission meetings
  - May 8
  - June 12

Appendix 1:
Y3 MPA Options for Incorporating Attainment

Policy questions on reflecting Attainment in MPA formula for Year 3

- How? Simplest approach is to adjust hospitals' TCOC Benchmark based on Attainment
  - Current TCOC Benchmark is previous year TCOC per capita increased by national growth minus 0.33%
- Which hospitals should qualify for the Attainment adjustment?
- What is the appropriate size of the Attainment adjustment?

Attainment adjustment: Potential policy rationales and trade-offs

- Lower the bar for MPA improvement for hospitals already at low TCOC per capita
  - Arguably harder for these hospitals to improve TCOC
  - However, State's financial tests are improvement only, with no accounting for attainment
  - Hospitals with lowest TCOC could have benchmark equal to national growth
- Raise the bar for improvement MPA for hospitals with high TCOC per capita
  - Arguably easier for these hospitals to improve TCOC
  - However, State's financial tests are improvement only, with no accounting for attainment

Proposed Adjustment to MPA target based on benchmark performance

- A hospital's Traditional MPA target would be set based on how its adjusted performance versus its peer group compares to Maryland's overall performance (assumes Maryland will be more expensive on a blended basis).
- Example columns assume:
  - Maryland is 8% above the nation (1.08)

Hospital Performance vs Benchmark	MPA Traditional Target will be National Growth – X%,	Example Range of Values
2% points or more above Maryland Level	– 0.66%	Greater than 1.10
Between 2% points above Maryland Level and 2% points below Peer Benchmark	– 0.33%	Between 1.10 and 0.98
2% points or more below Peer Benchmark	– 0.00%	Less than 0.98

Potential considerations:

- Make targets more / less challenging
- Make middle tier linear to avoid "cliffs"
- Should we add additional "tiers" of attainment performance or more differentiated growth targets between tiers

See next slide for specific calculations

Proposed Adjustment to MPA target based on benchmark performance

1. Calculate each hospital's Adjusted-County Benchmark and Benchmark Level
   - Adjusted-County Benchmark is the straight average of its peer counties per capita TCOC performance adapted to a hospital's specific population as discussed in the benchmarking section.
   - Benchmark Level is the ratio of the hospital's per capita TCOC to the Adjusted County Benchmark stated as a ratio to 1.0

2. Establish the overall Maryland comparison to the nation based on the blend of the county performance (Maryland Benchmark Level):
   - County benchmarks are calculated (no hospital adjustment)
   - The resulting difference is aggregated to the state level using the relative number of MC FFS beneficiaries in each county
   - The result is stated as a ratio to 1.0

3. Hospital MPA Traditional Component targets are set by comparing its Benchmark Level to the Maryland Benchmark Level and 1.0 (average peer group performance)
   1. Above the Maryland Benchmark Level plus 2% points: National Growth – 0.66
   2. Between the Maryland Benchmark Level plus 2% points and 0.98: National Growth – 0.33
   3. Below the 0.98: National Growth