Total Cost of Care (TCOC) Workgroup

May 29, 2019

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions & Updates
- Y1 MPA (PY18) Swan Song
  - Y1 Results Distribution
  - Thank you to Kam Knab
- Y2 MPA (PY19)
  - Update on attribution assignment and results
  - Reporting Status
- Y3 MPA (PY20)
  - Development Timeline
  - Potential Attribution Changes
  - Other Potential Policy Changes
  - First-pass Churn Review
- Analysis of 2013 to 2018 Savings

Y1 MPA (PY18) Swan Song

- Y1 Results Distribution

MPA Results, Year 1

- MPA results released, see recap on next slide
- Net ~$5.9 M earnings,
- HSCRC removed revenue neutrality based on lack of clarity around the process (may be revisited as part of MPA efficiency component recommendation)
- Medicare payments will be changed 7/1/19 on an incurred basis. MPA Adjustment is applied to Medicare payment, does not change charges.
- Final adjustment is the hospital specific factor, amounts will not be retrospectively reconciled to targeted dollars.

Year 1 Results by System/Facility

Adventist	($121,285)
Holy Cross	($317,318)
Hopkins	$1,973,547
Lifebridge	$1,077,666
MedStar	$2,310,976
UMM	$930,049
Meritus Medical Center	$359,344
Frederick Memorial	($285,973)
Mercy Medical Center	($519,254)
Saint Agnes Hospital	($64,240)
Bon Secours	($113,223)
Garrett County	($77,688)
Peninsula Regional	$636,843

Anne Arundel Medical Center	$208,875
Western MD Health System	$184,614
Union of Cecil	($160,843)
Calvert Memorial	($234,483)
Greater Baltimore Medical Center	($262,243)
McCready	$8,000
Doctors' Community Hospital	$366,545
Fort Washington	$3,776
Atlantic General	$66,064
Total	5,969,751

Dollars values are shown for reference, value is applied as a % adjustment as shown in data release, amounts will not be reconciled to these dollars.

Calculation Example – Carroll County

Line	Calculation	Value
Carroll Target	CY17 PBPY x (1+Target %)	$12,252
MPA Impact before Quality and Thresholds	(Carroll Target - Carroll CY18 Actual)/Carroll Target	2.38%
Total Quality Adjustment	RRIP + MHAC Adjustment	-0.26%
MPA Impact before Thresholds	MPA Impact before Quality x (1+Total Quality Adjustment)	2.37%
MPA Impact after Threshold	Max of 2.0% either direction (3% in Y2)	2.00%
MPA Adjustment	MPA Impact x (0.5% / 2.0%), (1% and 3% in Year 2)	0.50%
MPA Reference Dollars	MPA Adjustment x Hospital CY18 FFS Payments for Maryland Residents	$430,289
Hospital Specific MPA Factor	**1 + MPA Reference Dollars/Hospital CY18 FFS Payments**	**1.00477**

Inputs	
CY17 Total MPA Attributed PBPY	$11,869
CY18 Total MPA Attributed PBPY	$11,960
RY20 RRIP revenue adjustment*	-0.48%
RY20 MHAC revenue adjustment*	0.22%
Hospital CY18 FFS Payments for Maryland Residents	$86,057,894
Hospital CY18 FFS Payments	$90,132,404
National Growth %	3.56%
Target % (National - 0.33%)	3.23%

*Quality adjustment is derived by adding together a facilities MHAC and RRIP adjustment calculated as of 4/26/2019

Y2 MPA (PY19)

- Attribution Recap and Status
- Reporting Update

Year 2 Attribution Recap and Status

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-May 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	• *Voluntary:* Hospitals attest to care coordination agreements for referral relationship attributed providers. • Test Version of MPA Reporting Tool Released
Summer	• Additional attested referral relationships accepted • MPA Reporting tool final, MADE is updated with attested referral relationship provider data

Updated Attribution Lists and Care Coordination Attestation

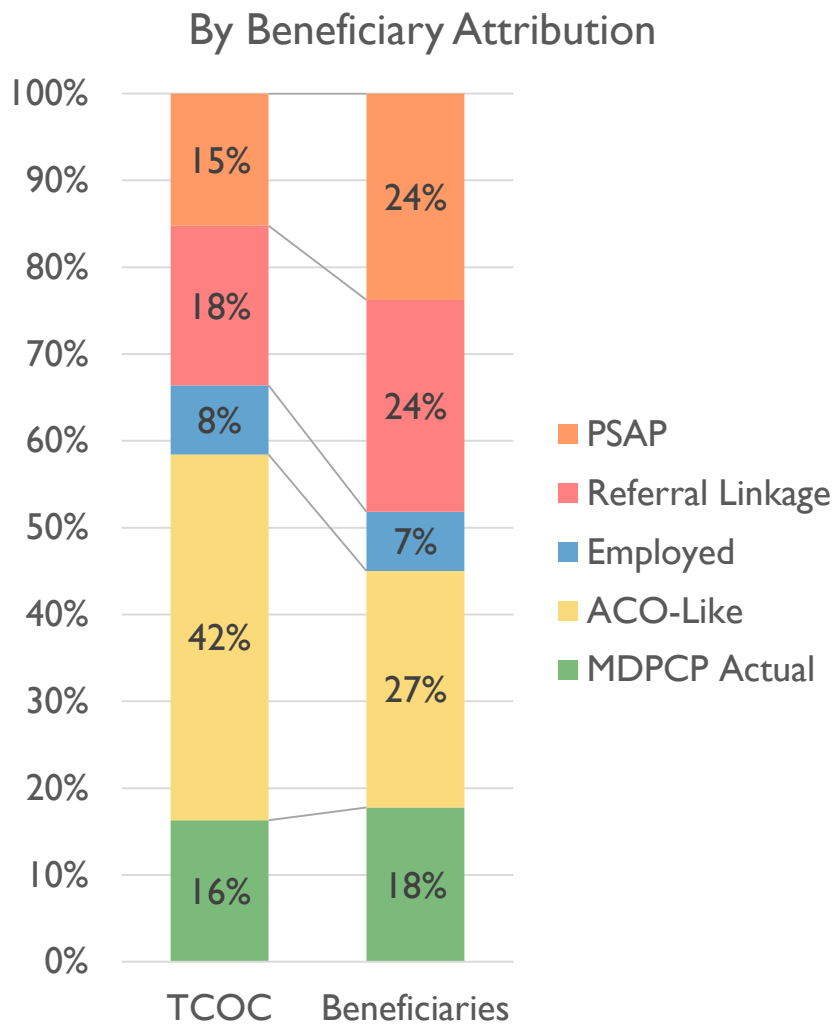
- To view patient-level data through MADE for "referral" linkage providers, hospitals must attest to a care coordination agreement between the hospital and the provider
  - ACO-like, MDPCP, and employment steps are already covered
- HSCRC provided attribution lists with a column where hospitals can attest to a care coordination agreement
  - Worksheet pre-filled 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 15.**
  - Anticipate additional attestation opportunities throughout the year

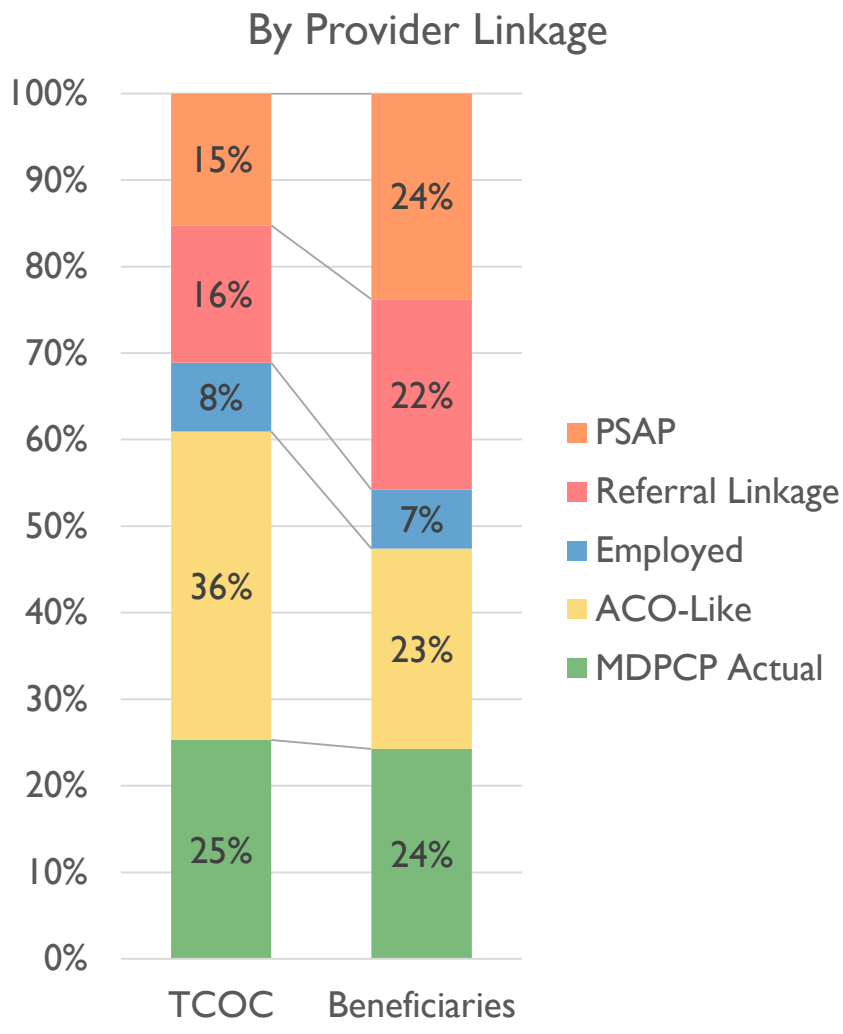
Care Coordination Agreement requirements: Hospitals are responsible for determining what is necessary in a care coordination agreement to meet requirements of data sharing under HIPAA

Recap of Y2 Attribution approach

- HSCRC developed an MPA "Manual" to provide additional guidance, FAQs, and other help in the future
- Will continue to update with clarifications and answers
- Available on the website

Summary of Y2 attribution





Reporting Update

Update on CMS Data Quality

- CCLF Issue: CCLF data was not aligning with CCW
  1. CMS agreed to adjust CCLF cohort to better match CCW
     - Received new file May 6th
     - Preliminary validation shows that the file is much closer to CCW than previously. MPA reporting released 5/24 reflects this newest data.
     - HSCRC is still doing some final validation but believes the data is substantially correct but may have one more update
  2. HSCRC determined that using newer data sets to refresh 2017 data was causing larger variations from CCW. Will be changing process to stop updating older periods as soon as 3 months run out is complete

Year 2: 2019 Changes Overview

- Separate CRISP tool with 2019 MPA attribution methodology including 2019 and 2018 data
  - Risk adjusted dollars will be available as a separate metric. Key tabs such as 1 and 1A will default to the risk adjusted value.
  - Detail reporting will include all dollars. Dollars excluded due to winsorizing will be extracted from CCW at a hospitals level and shown as part of the overall reconciliation between CCLF and CCW.
  - CPCP payments under MDPCP that are included in MPA scoring will be summarized at a hospital level and added as part of the reconciliation with CCW. Data will not be available below the hospital level.
  - Differential change to be adjusted out at a claim level. MPA reports will not reflect differential impact.

Year 2: Illustration of New Reconciling Items

Extract from MPA Report 1A-1

1A-1 High Lvl by Facility | 1A-2 High Lvl Comparison

Incurred Through: Start 1/1/2017 — Incurred Through: 7/31/2018 — 1/1/2017

Monthly Medicare Paid per Captia	YTD Prior Year	YTD Current Year
ACO Like Per Capita	$1,076.09	$1,050.25
MD PCP Like Per Capita	$1,146.21	$1,148.84
PSAP Per Capita	$584.53	$576.87
Total CCLF Per Capita	$965.53	$997.40
% Change CCLF Total		3.30%
Adjusted CCLF Per Capita	$1,002.64	$1,034.85
% Change Total		3.21%

Total Cost	YTD Prior Year	YTD Current Year
ACO Like Costs	$1,535.9M	$1,652.1M
MD PCP Like Costs	$2,584.4M	$2,856.1M
PSAP Costs	$867.1M	$630.5M
Total CCLF Costs	$4,987.5M	$5,138.7M
Suppressed Substance Abuse Costs	$172.5M	$171.9M
Partial Year MA Beneficiary Costs	$63.8M	$55.0M
Adjusted Total CCLF Costs	$5,223.8M	$5,365.6M

MPA CCLF will exclude differential at a claim level. Adjustment will not be in MADE.

Amounts before reconciling items tie to detail reporting in Sandbox and most other tabs.

Winsorized exclusions and CPCP will be added as reconciling items so they are not reflected in the detail:

- Backing winsorized values out at a detail level undermines the integrity of the detail data and creates considerable complexity
- CPCP data doesn't exist at a detail claim level.
- The differential adjustment may also be handled here.

Amounts after reconciling items support final trend that, with other corrections, should align more closely to CCW scorekeeping numbers.

Patient Level Detail for MPA Attributed Benes in MADE

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

- MHA/HSCRC developing further guidance on care coordination agreement. Facilities will have at least two opportunities to submit a list of agreements in place (June 15 and ?).
- Challenges with tracking terminated relationships will likely result in additional administrative requirements in order to remove PHI for beneficiaries no longer covered by one of these relationships.

Year 2: 2019 MPA New Module

- Population Analytics Module (previously "Quality" module)
  - Diabetes care profile by attributed facility
  - PQI per capita reporting by attributed facility (subset of broader PQI reporting being provided by HSCRC quality team). Oversight rests with the Performance Measurement Workgroup.

Y2 Report Release Dates and Training

- MPA Reporting and beneficiary level detail in MADE
  - Test release June 14th, one month of CY19 data
    - Tentative Training - Week of June 17th
    - RAC and RAC Subcommittee and others upon request
  - Full release July 12th, two months of CY19 data
    - Tentative Training - July 16th
    - All Existing Users

- Population analytic modules likely one month behind
- Data release in MADE may be delayed a month due to resolution of HIPAA issues related to identifying termination of treatment relationships.

Year 2: Diabetes Population Profile

- Goals: Use MPA attribution and CCLF claims data to:
  1. Describe cost and nature of care being delivered to attributed beneficiaries who have the CCW flag for diabetes
  2. Identify potential areas of focus for concentrated efforts in this cohort

- Claims data is not sufficiently robust to point to specific gaps in care or measure quality at a patient level and that is not the objective of this module.

Year 2: Overall Care Profile - Diabetes

Target Selection Box:
Select One or More MPA Attributed Facilities

Comp Selection Box:
Select One or More MPA Attributed Facilities or State

Note:
Diabetes flag based on the CMS chronic condition warehouse definition

	PY Calendar Year			CY YTD		
	Comp Group	Target Facility(ies)	Variation Indicator	Comp Group	Target Facility(ies)	Variation Indicator
Measures Related to All Attributed Benes						
Claim for DPP per K						
% of Attributed Benes w. Diabetes Flag						
Measures Related to Attributed Benes with Diabetes CCW Flag						
Average # of Diabetes Flagged Benes						
30 day readmission rate						
30 day readmissions per k						
PQI 93 per k						
ED Vists per K						
IP Days per K						
Per Capita Cost						
Per Capita Cost by Care Setting:						
IP						
ED						
.						
Etc.						

DPP = Diabetes Prevention Program (derived from claims)
The denominator is the count of hospital's all attributed beneficiaries

Benes with diabetes / All attributed beneficiaries

Values based on number of beneficiaries with diabetes

Definitions TBD

Y3 MPA (PY20)

Development Timeline

Potential Attribution Changes

Other Potential Policy Changes

First-pass Churn Review

Tentative Y3 Timeline

- Today:
  - Review analysis of savings from 2013 to 2018
  - Introduce potential attribution and other policy changes
  - Introduce churn analysis
- July meeting:
  - Revisit draft MPA Efficiency Component Recommendation (submit draft in the September Commission Meeting)
  - Review further churn analysis
  - Update on Attainment/Benchmarking (delayed due to normalization process)
  - Gather input on Y3 attribution/policy changes
- September meeting:
  - Review outline of draft Y3 MPA Policy (submit draft in October Commission meeting)
  - Review benchmarking data
- October meeting:
  - Review feedback on draft policy and discuss changes for final policy

Summary Diagram of MPA Y2 Attribution

Goal: Develop an attribution algorithm that accurately captures the beneficiary-to-provider and provider-to-hospital relationships.

Step:

01 **Beneficiary Attribution**

1A. MDPCP-Actual | *1B. ACO-Like* | *1C. PCP-Like*

02 **Provider-to-Hospital Linkage**

2A. MDPCP Provider to CTO Hospital | *2B. ACO Provider to ACO Hospital* | *2C. Employment Linkage* | *2D. Referral Pattern Linkage*

03 **Remaining Beneficiary Geographic Attribution**

Beneficiary-to-provider attribution

Step 01

Beneficiary-to-Provider Attribution

1A. MDPCP-Actual *1B. ACO-Like* *1C. PCP-Like*

Goal: Link beneficiaries to providers based on provision of primary care services.

Hierarchy: Beneficiary attribution based on hierarchy of:

- 1A. Maryland Primary Care Program (MD-PCP)-actual
- 1B. ACO-like
- 1C. PCP-like (formerly MDPCP-like)

Rationale:

- Keeps care management relationships at the forefront
- MDPCP-actual represents the most tightly defined patient relationship between beneficiaries and PCPs
- Each step broadens the definition of primary care provider (including certain specialists) to minimize the number of beneficiaries attributed based on geography

Provider-to-Hospital Linkage

Step 02

Provider-to-Hospital Linkage

2A. MDPCP Provider to CTO Hospital	*2B. ACO Provider to ACO Hospital*	*2C. Employment Linkage*	*2D. Referral Pattern Linkage*

Goal: Link providers and their attributed beneficiaries to a hospital using existing relationships.

Hierarchy: Provider Linkage based on hierarchy of:

- 2A. Participation with hospital-affiliated CTO
- 2B. Participation with a hospital-affiliated ACO
- 2C. Employment (voluntary)
- 2D. Referral patterns

Note: MDPCP practices that are not associated with a Hospital CTO will be grouped together for linkage in Step 2B – 2D.

Rationale

- Keeps care management relationships at the forefront
- MDPCP-actual with hospital-affiliated CTO represents the most tightly defined patient relationship between beneficiaries, PCPs and hospitals
- Allows for different organizational relationships between providers and hospitals

Remaining Beneficiary Geographic Attribution

Step 03

Remaining Beneficiary Geographic Attribution

Goal: Link remaining beneficiaries to hospitals based on geography.

Hierarchy: Beneficiary linkage to hospital based on:

- PSA-Plus (PSAP): Geography (zip code where beneficiary resides)
  - Hospitals' Primary Service Areas (PSAs) under GBR Agreement
  - Additional areas based on plurality of utilization and driving time

Rationale:

Ensures that all beneficiaries are attributed to a hospital for purposes of accountability.

Attribution Improvement Ideas

- Open to suggestions for Y3 enhancements if there is strong support for changes
  - HSCRC preference to keep attribution categories stable if possible
  - Changes most doable in the PCP-like/referral pattern/employment part of the attribution
- Considerations raised during the review period
  - Providers working with more than one hospital
  - General eligible specialty concerns
    - Specialists working as PCPs
    - Urgent care providers
  - PCP-like beneficiary attribution logic – Referral Linkage and Employment
    - Provider inclusion/exclusion criteria
    - Eligible specialties

Providers working with more than one hospital

Potential Scenario
Provider participates in Hospital A's ACO but also works occasionally in an independent primary care office where his/her patients primarily go to Hospital B

- MPA Y1:
  - Separately attributed the ACO patients to Hospital A and the referral patients to Hospital B.
  - Strong response from stakeholders that it was confusing and impractical to have multiple hospitals linked with the same provider.
- MPA Y2:
  - In response to concerns from Y1, Y2 MPA attribution required a single provider to single hospital link
  - All beneficiaries attributed to that provider were linked with Hospital A (ACO hospital)
- Is this something the workgroup would like to revisit?

Eligible specialty questions

- What if patients see a specialist for the bulk of their care but sees a PCP maybe once every other year?
  - By design, the algorithm intends to attribute patients to traditional PCPs whenever possible.
    - If the patient had no PCP care, we would expect the patient to be attributed to the specialist
  - Is this an issue for workgroup members?
- Should urgent care providers be included?
  - Should we try to exclude these providers from the PCP-like part of the algorithm?
  - If yes, how can we identify these providers?

PCP-like beneficiary attribution referral linkage criteria

- Beneficiary attribution to PCPs determined beneficiaries' use of primary care services as *originally* proposed in the Maryland Primary Care Program (MDPCP)
  - Different than what subsequently was used in actual MDPC
  - The goal of these criteria was to ensure that we were capturing actual PCPs
- Beneficiaries are attributed to NPIs based on the plurality of that beneficiary's office visits AND providers who met the following criteria:
  - Billed at least 25 total office visits by attributed Maryland beneficiaries in the same performance period.
  - Primary care services >= 60% of total costs performed by provider during in most recent 12 months, excluding hospital and ED costs.
- **Do we want to keep all of these restrictions?**

PCP-like Eligible Specialties

- Beneficiaries are attributed to Traditional Primary Care Providers first and, if that is not possible, then to Specialist Primary Care Providers.
  - Traditional Primary Care Providers: Internal Medicine; General Practice; Geriatric Medicine; Family Practice; Pediatric Medicine; Nurse Practitioner; or Obstetrics/Gynecology.
  - Specialist Primary Care Providers: Cardiology; Gastroenterology; Psychiatry; Pulmonary Disease; Hematology/Oncology; or Nephrology.
- Should we add Physician Assistant to the list?
  - Pro: PAs may see significant numbers of patients and are included in the MDPCP-actual and ACO-like attribution already
  - Cons: Cannot distinguish between surgical and medical physician assistants in claims
- Should we keep all of the specialists?
  - In particular, nephrologists have particularly high TCOC per capita and are concentrated in particular areas of the state
  - If we excluded them from the list, these patients would likely default to geography instead.

Employment vs. Referral Linkage

- In the attribution, employed providers did not have those same criteria as referral linkage providers.
- Should attribution to employed providers and referral linkage providers use the same criteria and specialties?
- Providing employment information is currently voluntary - should we require employment submission to increase consistency?

Other Potential Policy Changes for Year 3

- Increase significance by increasing 1% bonus/penalty cap
- Change/increase quality adjustment
  - Add new measures to quality adjustment, e.g. follow-up after hospitalization and diabetes related measures
  - Increase significance of quality adjustment
  - Current quality adjustment increases or decreases, on a percentage basis, bonus/penalty by the amount the sum of the RRIP and MHAC adjustment (potentially from +2% to -4% but most facilities in the middle).
- Attainment (as discussed previously)

Proposed Approach to Adjustments in Y3

- Include all MDPCP fees
  - Will be in both base and performance in Y3
  - For Y2 only CPCP fees are included because they are an offset to a change in the claims payments but there are no fees in the base period.

- Differential change excluded for first half of Y3, starting 7/1/20 it will be in both base and performance

- No other adjustments (for changes in GBR, ECIP savings, deficit assessment, etc.)

2013 to 2018 Savings Drivers

Slides to be added for Meeting

Next meeting:
July 31, 2019
(June Cancelled)

Future meetings

- TCOC Work Group meetings (invites to be sent)
  - June meeting will be cancelled
  - July 31
  - September 25
  - October 30
- HSCRC Commission meetings
  - June 12

Appendix: Quality Background

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

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?