Total Cost of Care (TCOC) Workgroup

July 31, 2019

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions & Updates
- Y2 MPA (PY19)
  - PHI Sharing Process Update
  - Changing to use CCLF for MPA Traditional Scoring
- MPA Framework
- Y3 MPA (PY20)
  - Potential MPA Y3 Policy Changes
  - Potential Attribution Changes
  - Churn Analysis
  - 2013-18 Inpatient Admits and Unit Costs for IP, MD vs. national

Updates

- MATT development
- MPA Training

Y2 MPA (PY19)

- PHI Sharing Process Update
- Changing Scorekeeping to CCLF

PHI Sharing Updates

- The table below shows the termination and addition events along with the notification requirement for each
- Notice of an event is due to the HSCRC at hscrc.tcoc@maryland.gov upon the event, and should be delivered no later than the next occurring 25th of the month following the date of the event

Event Type	Relevant Attribution Tier	Event	Notification Requirement
Termination	ACO	Termination of an ACO or the ACO's relationship with a hospital (applicable only to those hospitals attributing beneficiaries based on an ACO relationship).	Notify HSCRC of the hospital(s) associated with the termination.
Termination	Employed Provider	Termination of a provider's employment by a hospital for a provider on the employed provider list given to the HSCRC as part of MPA attribution.	Notify the HSCRC of the NPIs of any terminated providers and the related hospital. If the hospital did not give the HSCRC an employed provider list, this requirement is not relevant.
Termination	Referral	Termination of a previously signed care coordination agreement between a hospital and a provider or provider group.	Notify the HSCRC of the NPIs of any terminated providers and the related hospital.
Termination	MDPCP	Termination of a group's participation in MDPCP where the group is associated with a hospital's CTO.	None required. The HSCRC will derive MDPCP information from data received from CMS.
Addition	Referral	Signing of an HIPAA-compliant care coordination agreement between a hospital and a provider or provider group.	Notify the HSCRC of the NPIs of any added providers and the related hospital and submit an updated signed attestation noting the change

CCLF vs CCW

- HSCRC has been working to reconcile CCW and CCLF
- At an aggregate level, adjusted amounts are very close

2018 Comparison PBPY	CCW	Adjusted CCLF*	% Diff.
2018 as Performance Year (Y1)	$12,367	$12,357	-0.08%
2018 as Base Year (Y2)	$12,355	$12,338	-0.14%

  - 2017 will always be slightly off as CMS did not correct older data. 2019 should work similarly to 2018
- However at a hospital level we will continue to see differences, particularly for small hospitals
  - Attribution differs slightly due to substance abuse
  - Other noise in data

*CCLF adjusted for known reconciling items, e.g. SAMSHA

Y1 Comparison Pro Forma

- HSCRC recalculated Y1 payments using CCLF data
  - Due to issues in 2017, differences appear larger than they would really have been
  - Overall payment went from ~$5M to ~$6M
    - Increase is volatility outcome not a bias upwards
    - 16 hospitals had no change – those outside corridor
    - 15 hospitals changed but payment remained in the same direction – absolute average change of ~120k
    - 5 hospitals changed direction, primarily small hospitals close to the target – absolute average ~220k
  - HSCRC is recommending switching to using CCLF for scorekeeping in Y2
    - Totals are the same, impact on individual hospitals is not significant
    - Better for hospitals to score on the data that they can access

Proposed Approach

Current:

Raw CCW PBPY

- Winsorized Claims

+ CPCP

Total PBPY

apply Risk Score (CCW)

Risk Adjusted PBPY

Proposed:

Raw CCLF PBPY

- Winsorized Claims

+ CPCP

+ Substance Abuse from CCW

Total PBPY

Apply Risk Score (CCLF)

Risk Adjusted PBPY

If we move forward MPA reporting will need to be revised in the coming months.

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Review of Draft Recommendation: MPA Framework

New MPA-EC Terminology

- The MPA Efficiency Component (MPA-EC) will now be renamed the MPA Framework with two payment options:
  - The MPA Reconciliation Component (MPA-RC): to be used to encourage Care Transformation Initiatives
  - The MPA Savings Component (MPA-SC): to be used to help the State achieve its savings benchmarks

- The original Medicare Performance Adjustment (MPA) will be referred to as the Traditional MPA

The MPA Framework has two primary functions

- Medicare Individual Hospital Payment and Offset
  - Payments for quantifiable Medicare TCOC reductions through Care Transformation (e.g. ECIP payments)
  - Offset of savings payments to individual hospital for care transformation across all hospitals to maintain net savings and incent participation
  - No offset to Traditional MPA

- Medicare Savings Statewide Cut
  - If needed to achieve $300 million Medicare savings by CY 2023
  - We are not implementing a cut for the first half of CY20

Importance of MPA Framework for Care Transformation

- HSCRC has invested significant resources in infrastructure grants related to care transformation
- Hospitals that have reduced utilization have retained significant amounts of revenue that is available for investment in care transformation
- Success under the model will require successful care transformation, not just rate adjustment
- The State has not systematically assessed care transformation and the effect it has had on the delivery system and we need to begin assessing savings and appropriately rewarding hospitals in order to justify investments

Care Transformation Initiative Proposals

- Hospitals may propose CTI by submitting:
  - A description of the Care Redesign Interventions
  - A claims based intervention trigger
- HSCRC staff will develop a reconciliation payment for those initiative based on the identified population
- HSCRC Staff have developed a form for hospitals to submit their CTI proposals to HSCRC
  - HSCRC staff will meet with hospital staff and provide technical assistance to hospitals submitting a proposal
  - Questions and submissions to:

    hscrc.care-transformation@maryland.gov
- HSCRC staff will address all of the hospitals' proposals

Overview of the CTI savings calculations

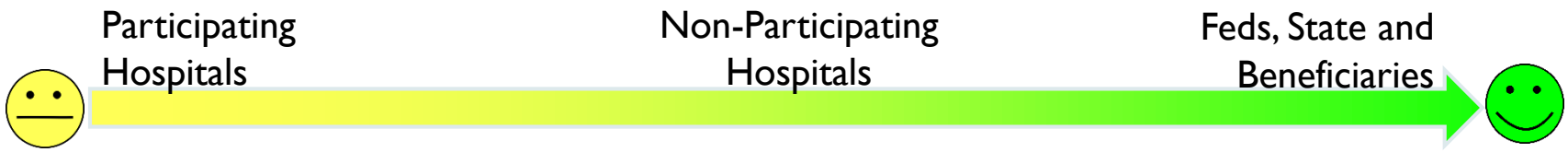
- The hospital's CTI must include the following information:
  - A description of the Care Redesign Interventions
  - A claims based method to "identify" the intervention population
- HSCRC staff will be discussing the Care Transformation Initiatives at a subgroup meeting on August 12th
  - The subgroup meeting will cover the approach that will be used to identify the intervention population
  - The methodology to calculate the savings produced by the hospital's CTI
  - The timing and process for evaluating CTIs
- All TCOC and Payment Models workgroup members are invited

MPA Framework

Using the MPA Framework to Achieve Savings and Reward Care Transformation

Example:
Under All-Payer Model (2014-2018)

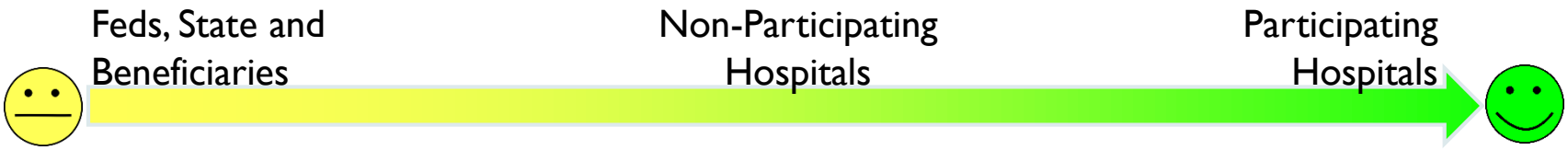
10 hospitals implemented a strategy in CY18 to save $7 million in Medicare post-acute spending, improve quality, and reduce hospital readmissions



Example: Under TCOC Model w. MPA Framework for payback but no offset (2019-)

- New: 10 hospitals generate $7 M in post-acute savings and receive $6M in Care Transformation payments
- Under MPA-RC policy, ECIP* and other Care Transformation Initiatives will return close to 100% of savings to the responsible hospital to maximize the benefit of participation

Post-acute Care Transformation savings achieved	$7M
Reward payments to participating hospitals	($6M)
Net Savings to Medicare	**$1M**

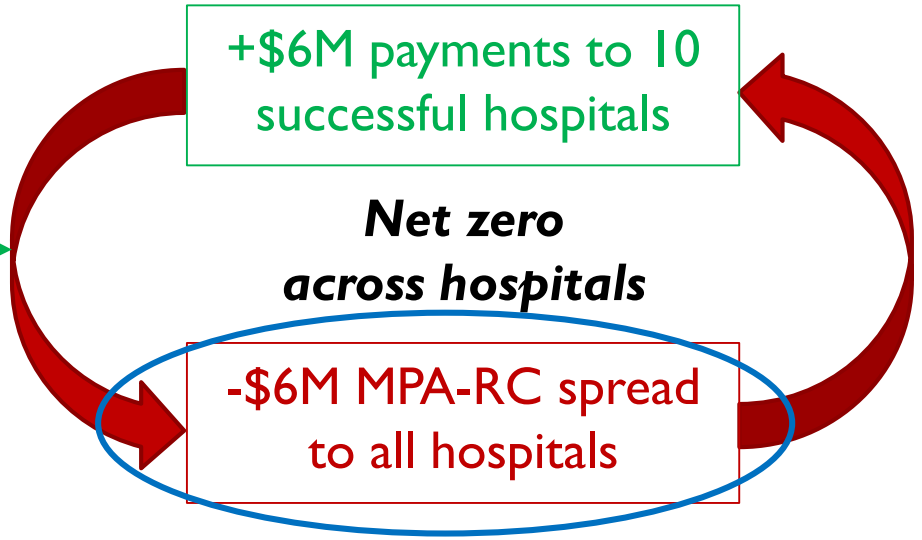


*EC recommendation will include a change to ECIP to return 100% of savings to a hospital if they meet a 3% savings threshold
** Some hospitals may not achieve 3%, therefore, residual savings are accrued to the program

Example: Under TCOC Model w. MPA Framework for payback **and offset** (2019-)

- 10 hospitals generate $7 M in post-acute savings and receive $6M in Care Transformation payments
- New: Care Transformation payments are offset across all hospitals in proportion to their share of MC spending

Post-acute Care Transformation savings achieved	$7M
Reward payments to participating hospitals	($6M)
Offset of reward payment	$6M
Net Savings to Medicare	**$7M**

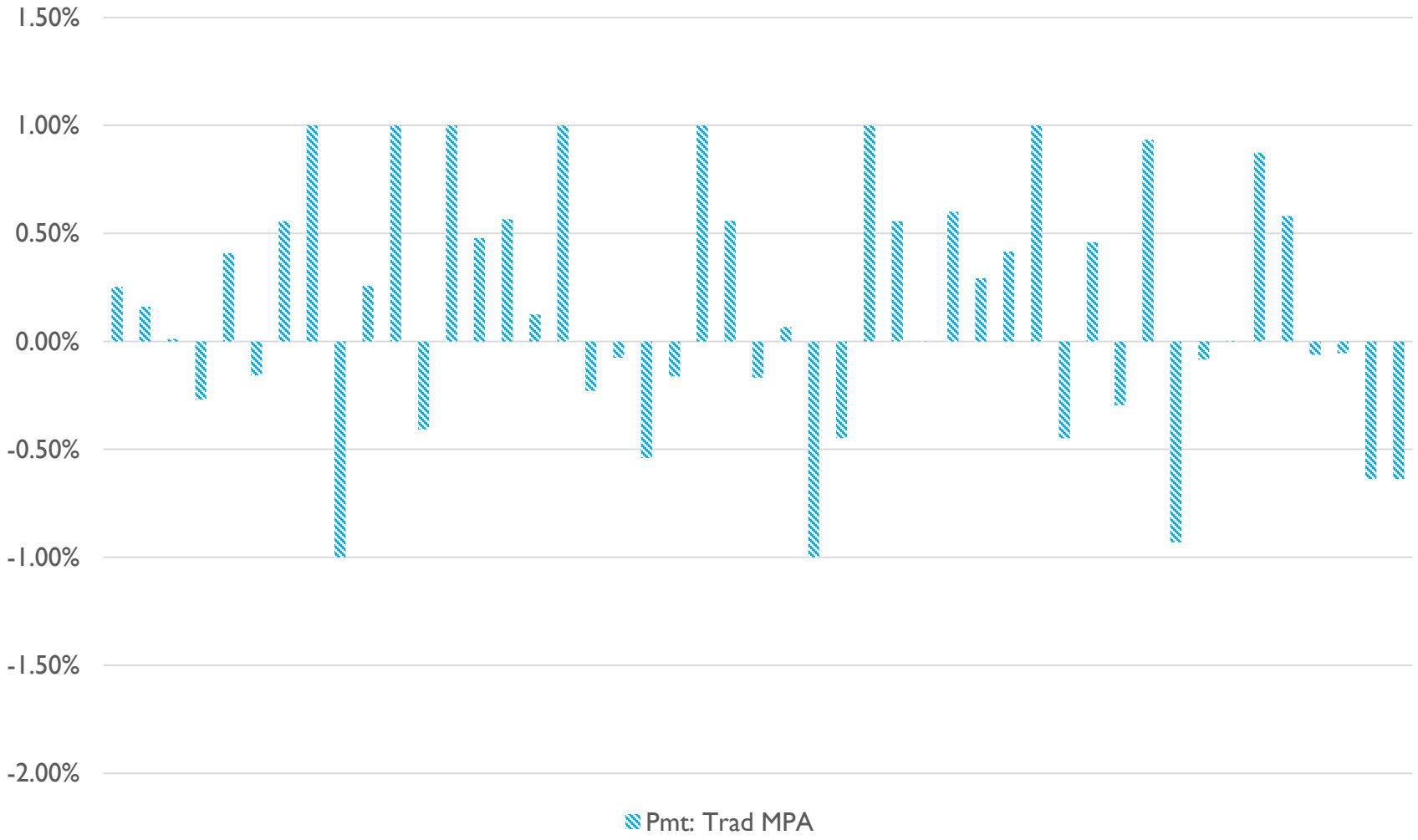


MPA Framework in Action

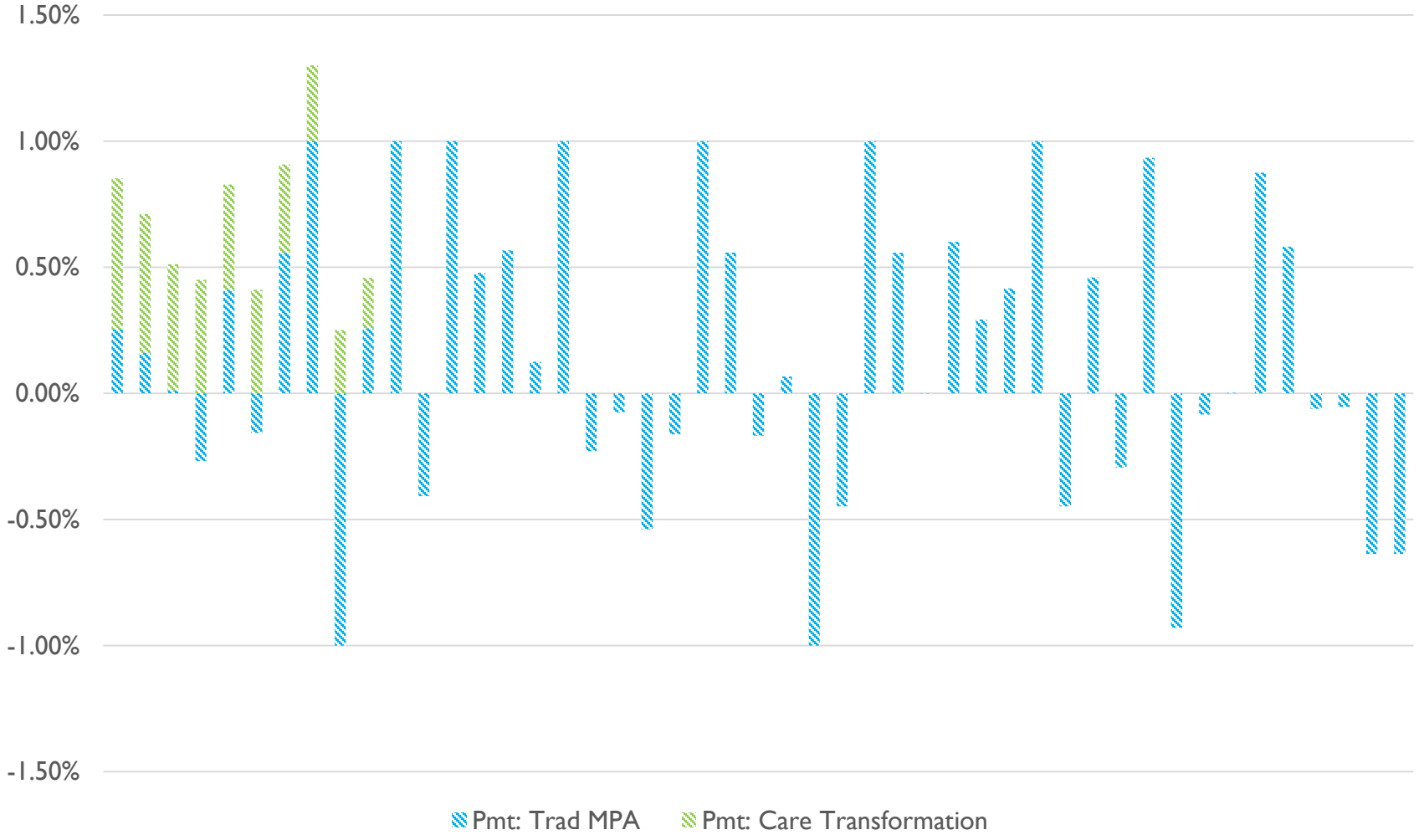
Example: Statewide

- Step 1: Traditional MPA Individual Hospital Payments
  - Assume net totals +$10M
- Step 2: Care Transformation Individual Hospital Payments
  - Assume totals +$6M
- Step 3: Offset Care Transformation payments with Medicare Statewide Savings Cut of $6M (-0.1%)
  - Ensures Care Transformation does not cause state to backslide on Medicare TCOC

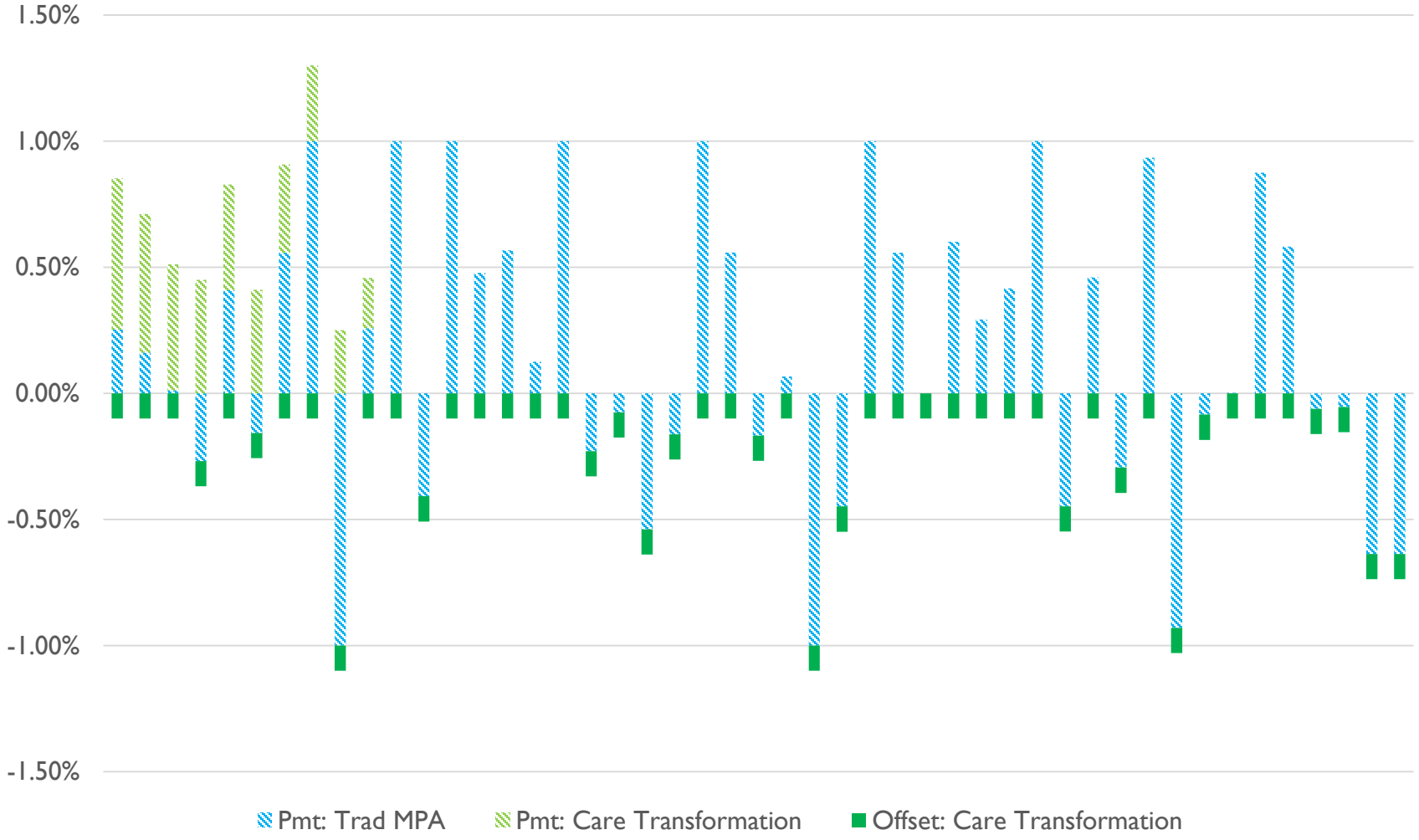
Step 1: Individual hospital Medicare payments for Traditional MPA (e.g., net +$10M)



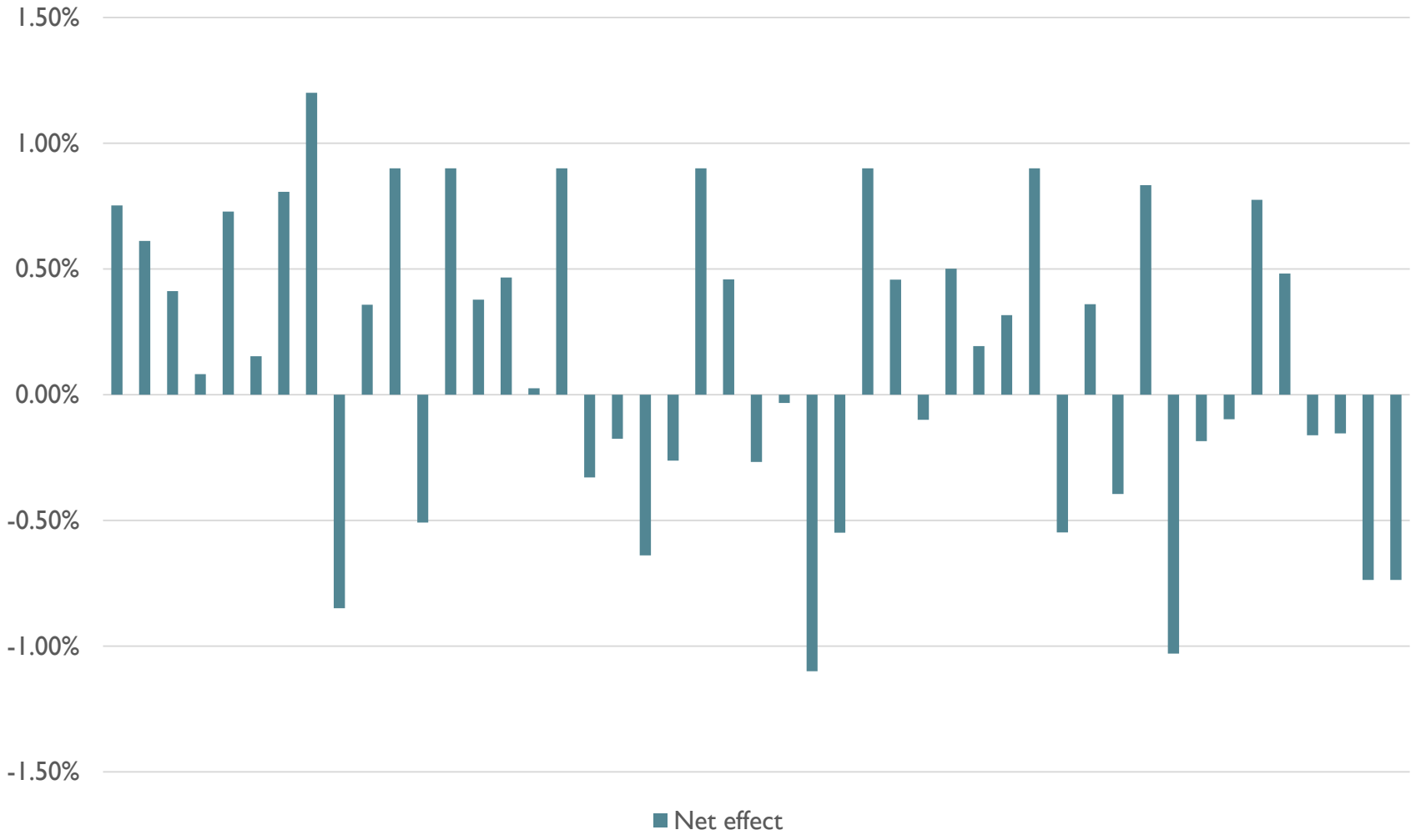
Step 2: Individual hospital Medicare payments for Care Transformation (e.g., +$6M to 10 hospitals)



Step 3: Statewide hospital Medicare offset for Care Transformation (e.g., -$6M = -0.1% statewide)



Example: Net effect on each hospital



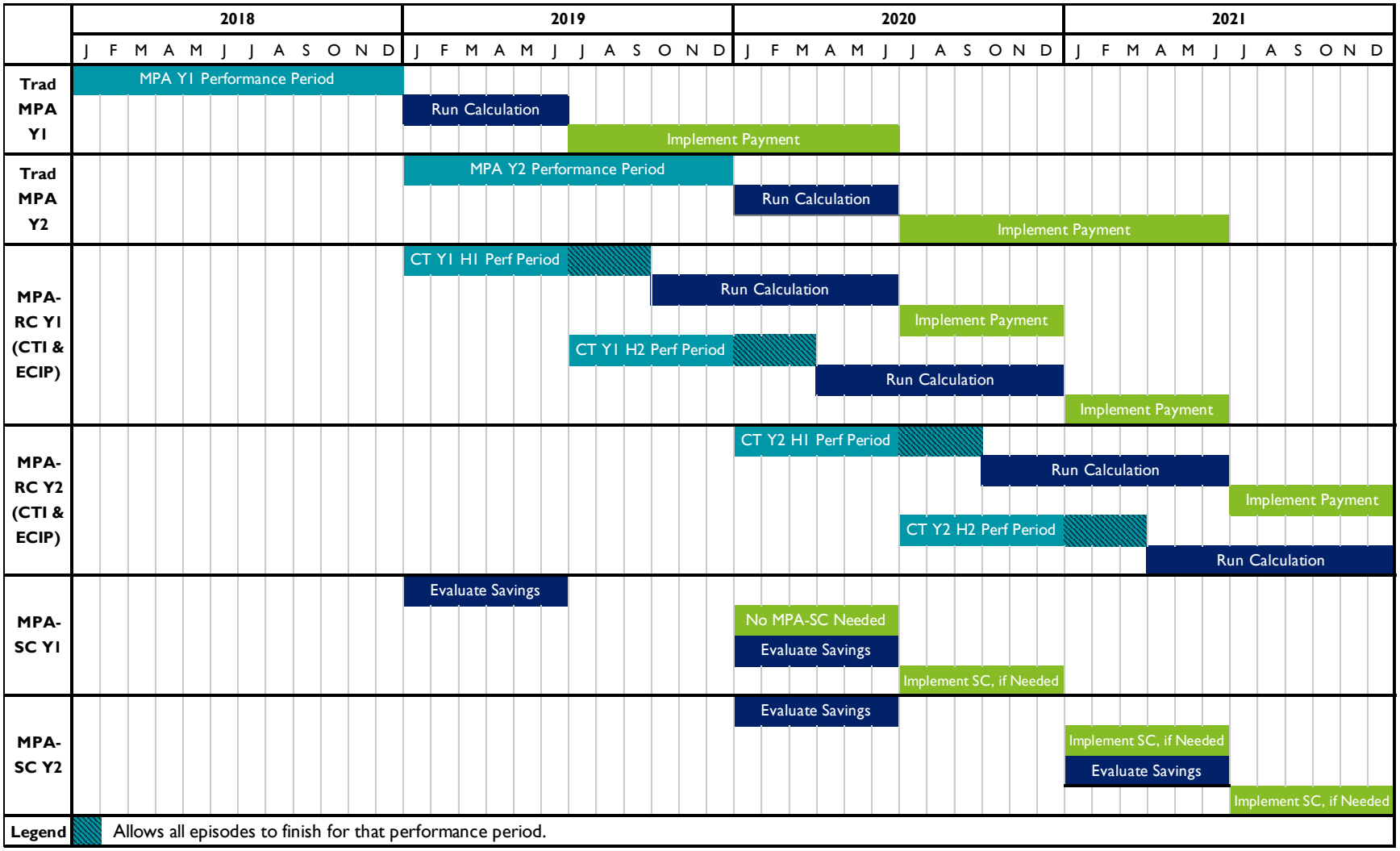
MPA Framework

Summary and Timeline

MPA Framework to Achieve Savings (Statewide Cut)

- The amount in any year is determined by the Commission based on end points goals and the run rate
- Intent is to create the tool, but not currently putting it to use
- Its use will depend on the situation, such as where the state is against the TCOC savings run rate, and would be prospectively determined based upon hospital share and applied to hospitals' Medicare payments
- **No MPA-SC will be applied to hospitals' Medicare payments for January to June 2020. There will be another assessment for the second half of the year in early 2020, but application of the MPA-SC is not anticipated. This will continue to be evaluated in future years**
- **If cut is deemed necessary a formal proposal to the Commission would be reviewed**

Timing for MPA built around other policies to provide hospitals' budget predictability



MPA Framework

Draft Recommendations

Draft Recommendation: MPA Framework

1. MPA-RC will be used to reward hospitals for Care Transformation savings (at up to 100% of savings) with reward payments offset across all hospitals.
2. Commission staff will continue to work with hospitals, providers, and other partners to develop Care Transformation Initiatives (CTIs). Qualifying CTIs will be made available to all hospitals to accelerate delivery system reform and encourage the sharing of best practices.
3. The Update Factor will be set to ensure that hospitals' Medicare payments do not exceed the Medicare total cost of care (TCOC) Guardrail, thereby constraining the growth of hospital costs for all payers in the system. The MPA-SC will be set to prospectively attain additional incremental savings necessary to achieve the $300 million Medicare savings target by CY 2023, if needed.

Draft Recommendation: MPA Framework (cont.)

4. There will be no MPA-SC adjustment to hospital rates effective January 1, 2020 due to the total cost of care savings achieved through CY 2018.
5. Commission staff will adjust other Commission policies to reflect its approach to achieving required Medicare Savings through the MPA-SC. Staff have removed the "savings cushion" from the Update Factor policy in RY2020 and will not include it in future years. Staff will also change ECIP to return 100% of savings to a hospital if they meet a 3% savings threshold.

Y3 MPA (PY20)

- Other Potential Policy Changes
- Potential Attribution Changes
- Churn Analysis
- 2013-18 Inpatient Admits and Unit Costs for IP, MD vs. national

Tentative Y3 Timeline

- Today:
  - Revisit draft MPA Framework Recommendation (submit draft in the September Commission Meeting)
  - Review further churn analysis
  - Gather input on Y3 attribution/policy changes
- Late August:
  - No meeting, but we will be sending out the Y3 MPA Framework Recommendation for your review and comments
  - Release update on benchmarking
- 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

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 (see appendix slides)

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.)

Y3 Potential Attribution Ideas

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
- Staff plans to focus on:
  - Employment approach: groups & attribution logic
  - Referral-linkage: eligible provider logic
- Other considerations raised during the review period
  - Providers working with more than one hospital
  - General eligible specialty concerns
    - Specialists working as PCPs
    - Urgent care providers

Employment Considerations for Y3

Employed Group approach

- Consider attributing beneficiaries to groups of employed providers (similar to ACO-like logic)
  - Beneficiaries would be attributed to the group of providers with the plurality of primary care services, and then to a specific provider in the group
  - Termination events would be at the group level
- Employed group approach follow-up questions
  - How do we define a 'group'? - TIN, Org NPI, Size/location limitations?, etc.
  - What about providers in more than 1 group?

Referral linkage considerations for Y3

- Can we allow for provider groups in referral linkage so termination events can be at the group-level also?
  - Likely not – who is the correct person to attest to non-hospital affiliated provider groups?
  - No comprehensive source of practices other than what is in MDPCP and what hospitals provide to us through submission

Review of Y2 Referral linkage approach

- 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 MDPCP
  - Goal: 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 office visits by attributed Maryland beneficiaries
  - Primary care services >= 60% of provider's total billed costs in most recent 12 months, excluding hospital and ED costs.

- Has led to some inconsistency among providers being included in one year and not a subsequent year
- Some providers are attributed very few beneficiaries

Re-examine Referral linkage for Y3

- Test removing 60% primary care (PC) services restriction
- Test adding 5 minimum beneficiary attribution criteria

Option #	% PC Services	Min Attrib. Bene.	Total Benes.	Total Providers	Avg benes. per provider
1 Current	60% services	None	167,726	4,015	42
2	None	None	205,876	7,668	27
3	60% services	5	164,516	1,388	119
4	None	5	198,447	3,960	50

- 60% requirement appears to have been effective in excluding specialists with small numbers of attributed beneficiaries
- However, 5 minimum beneficiary attribution criteria is equally as effective and results in more attributed beneficiaries.

60% requirement impact on # attributed beneficiaries by specialty

	60% require.	No 60% require.	% increase
INTERNAL MEDICINE	93,944	110,583	17.7%
FAMILY PRACTICE	44,475	49,305	10.9%
UNKNOWN	6,520	9,018	38.3%
NURSE PRACTITIONER	5,408	7,236	33.8%
PSYCHIATRY	5,299	6,712	26.7%
CARDIOLOGY	3,607	4,869	35.0%
OB/BYN	3,134	4,794	53.0%
GENERAL PRACTICE	2,112	2,894	37.0%
GERIATRIC MED	1,590	1,899	19.4%
PULMONARY	467	881	88.9%
GASTROENTEROLOGY	354	3,758	960.8%
PEDIATRIC MEDICINE	275	416	51.2%
OTHER	191	558	192.9%
HOSPITALIST	190	887	366.6%
NEPHROLOGY	77	1,016	1213.1%
MEDICAL ONCOLOGY	32	286	787.8%
HEMATOLOGY/ONC	16	766	4713.1%
TOTAL	**167,691**	**205,876**	**22.8%**

Churn Analysis

See Stand Alone Excel

Next meeting:
September 25, 2019

Future meetings

- TCOC Work Group meetings
  - September 25
  - October 30
  - December 4
- HSCRC Commission meetings
  - September 11

Appendix – Attainment Approach

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"
- Add additional "tiers" of attainment performance or more differentiated growth targets between tiers