FY 2018 Payment Model Work Group Update

April 12, 2017

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Work Group Update:

- Meeting with Payment Model Work Group to discuss:
  - Update Factor for FY 2018 including:
    - Drug Allocation
      - Drug Cost Inflation for All Hospitals
      - 0.10% added to volume adjustment – prospective adj. for new outpatient infusion and chemotherapy drugs (50% of est.)
      - 0.10% earmarked for new outpatient infusion and chemotherapy drugs (50% of actual volume growth)
  - FY 2018 UCC Policy (small change of -.13% between FY15 & FY16)
  - Waiting on President's Budget Projections, IPPS, and Global Insights
    - Global Insights December 2016 (Q4) figure 2.76%, but final Q1 figures have been lower than Q4 for last several years

Summary of Medicare Performance Adjustment (MPA)

Formerly Value-Based Modifier (VBM)

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Medicare Performance Adjustment (MPA)

- **What is it?**
  - A scaled adjustment for each hospital based on its performance relative to a Medicare Total Cost of Care (TCOC) benchmark

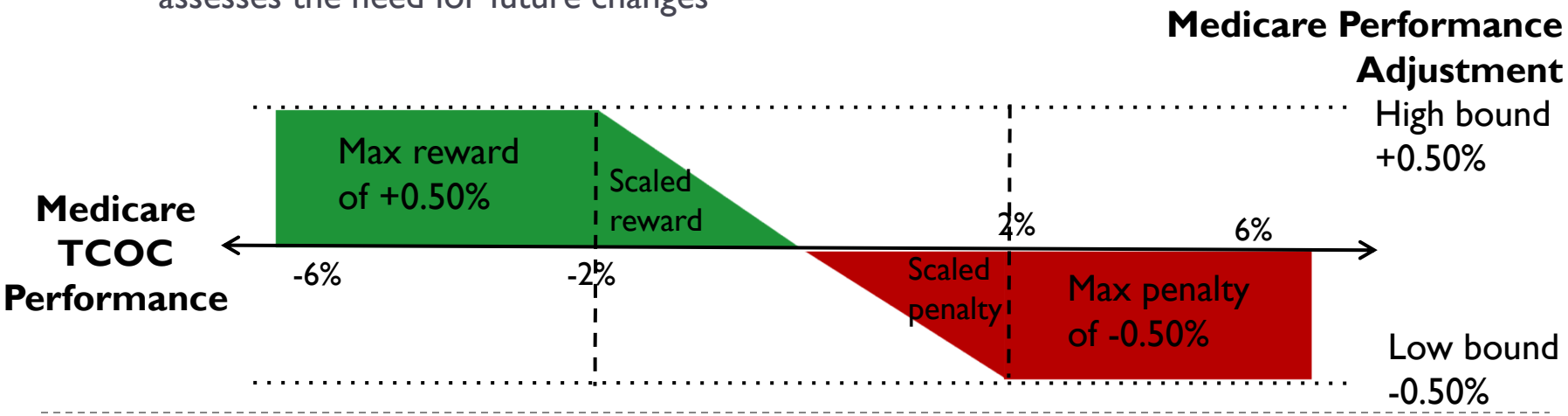
- **Objectives**
  - Allow Maryland to step progressively toward developing the systems and mechanisms to control TCOC, by increasing hospital-specific responsibility for Medicare TCOC (Part A & B) over time
  - Provide a vehicle that links non-hospital costs to the All-Payer Model, allowing participating clinicians to be eligible for bonuses under MACRA

MPA: Design Process

- **Initial staff and stakeholder discussions** (including Advisory Council)
  - Discussed high-level concept
- **Progression Plan** – Key Element
  - Summarized discussions to date under "Key Element 1b: Implement local accountability for population health and Medicare TCOC through the geographic value-based incentive"
- **TCOC Workgroup**
  - Working on MPA conceptual details
- **Other ongoing discussions** with staff, stakeholders, experts, including Mathematica, LD Consulting, Aditi Sen, PhD
  - Preparing materials for TCOC workgroup and vetting concepts

MPA: Current Design Concept

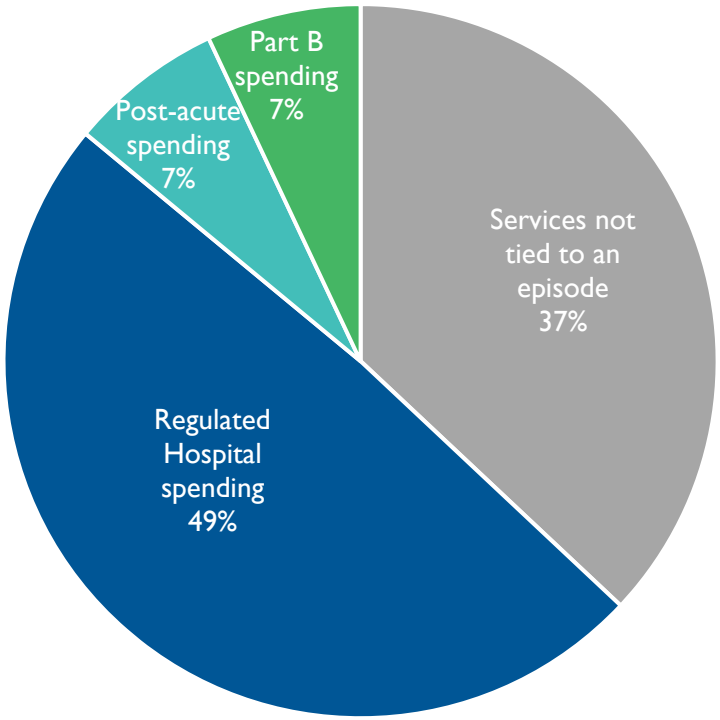
- Based on a hospital's performance on the Medicare TCOC measure, the hospital will receive a scaled bonus or penalty
  - Function similarly to adjustments under the HSCRC's quality programs
  - Be a part of the revenue at-risk for quality programs (redistribution among programs)
  - NOTE: Not an insurance model
- Scaling approach includes a narrow band to share statewide performance and minimize volatility risk
- MPA will be applied to Medicare hospital spending, starting at 0.5% Medicare revenue at-risk (which translates to approx. 0.2% of hospital all-payer spending)
  - First payment adjustment in July 2019
  - Increase to 1.0% Medicare revenue at-risk, perhaps more moving forward, as HSCRC assesses the need for future changes



MPA: Potential Options for Calculation of Hospital-level TCOC

- **A) Geographic Approach**
  - TCOC for Medicare beneficiaries living within a Hospital's geography.
  - PSAs cover ~90% of Maryland Medicare TCOC
- **B) Episode Approach**
  - TCOC for Medicare beneficiaries during and following a hospital encounter for a specified amount of time (i.e. 30 days)
  - Covers ~2/3 of Maryland Medicare TCOC with episodes alone
- **C) Attribution Approach**
  - Assignment based on Medicare beneficiary utilization and residence

Example of Episode Approach: Approx. share of Medicare TCOC included in hospital episodes with 30 days post-acute



Source: Draft analysis by HSCRC of 2015 Medicare FFS claims

MPA: Next Steps

- Receive federal, stakeholder, and HSCRC input on State's proposed concepts to date, including:
  - MACRA qualification
  - Level of revenue at risk, progression
  - TCOC linkage design
- Prepare MPA for Medicare TCOC so it is in place by January 1, 2018
  - Current focus is on the start-up Year 1 (Performance Year 2018, Adjustment Rate Year 2020)
  - MPA calculations modified in future years based on lessons learned and delivery system's increasing sophistication

Tentative Timeline for MPA Analytics and Policy

Date	Topic/Action
April 26, 2017 TCOC Work Group	More in-depth analyses of TCOC potential measures and modeling, including geographic areas besides current PSAs
May 28, 2017 TCOC Work Group	Potential benchmarking methodology (plus follow-up on TCOC measure refinement)
June 28, 2017 TCOC Work Group	Potential financial responsibility and rewards (plus follow-up on benchmark and TCOC refinements)
Additional TCOC WG meetings?	Other follow-ups and outstanding issues
July 2017 – Sept 2017	Continue technical revisions of potential VBM policy with stakeholders
October 2017	Staff drafts RY 2020 VBM Policy
November 2017	Draft RY 2020 VBM Policy presented to Commission
December 2017	Commission votes on Final RY 2020 VBM Policy
Jan 1, 2018	Performance Period for RY 2020 Value-Based Modifier begins

Monitoring Maryland Performance
Medicare Fee-for-Service (FFS)

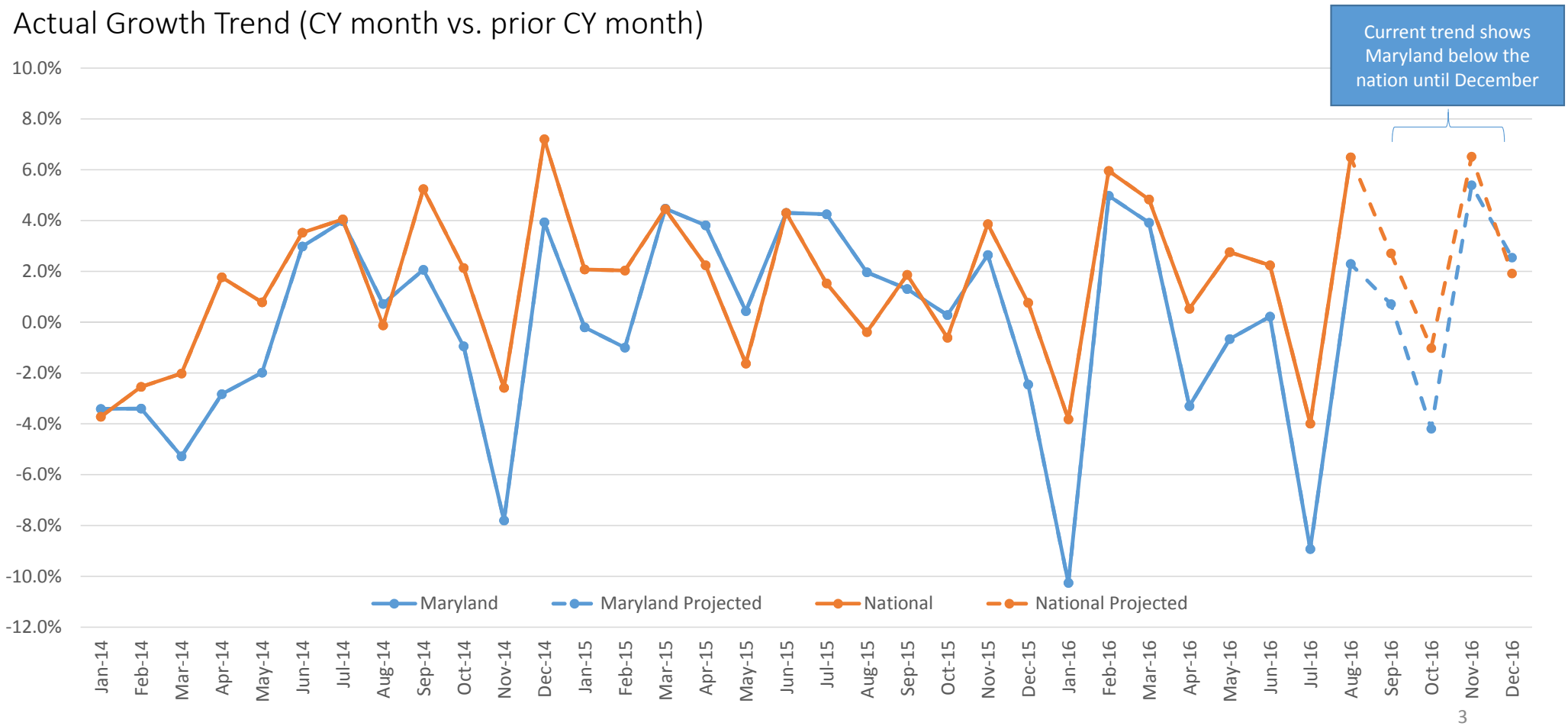
Data thru December 2016 – Claims paid through February
Source: CMMI Monthly Data Set

Disclaimer:

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

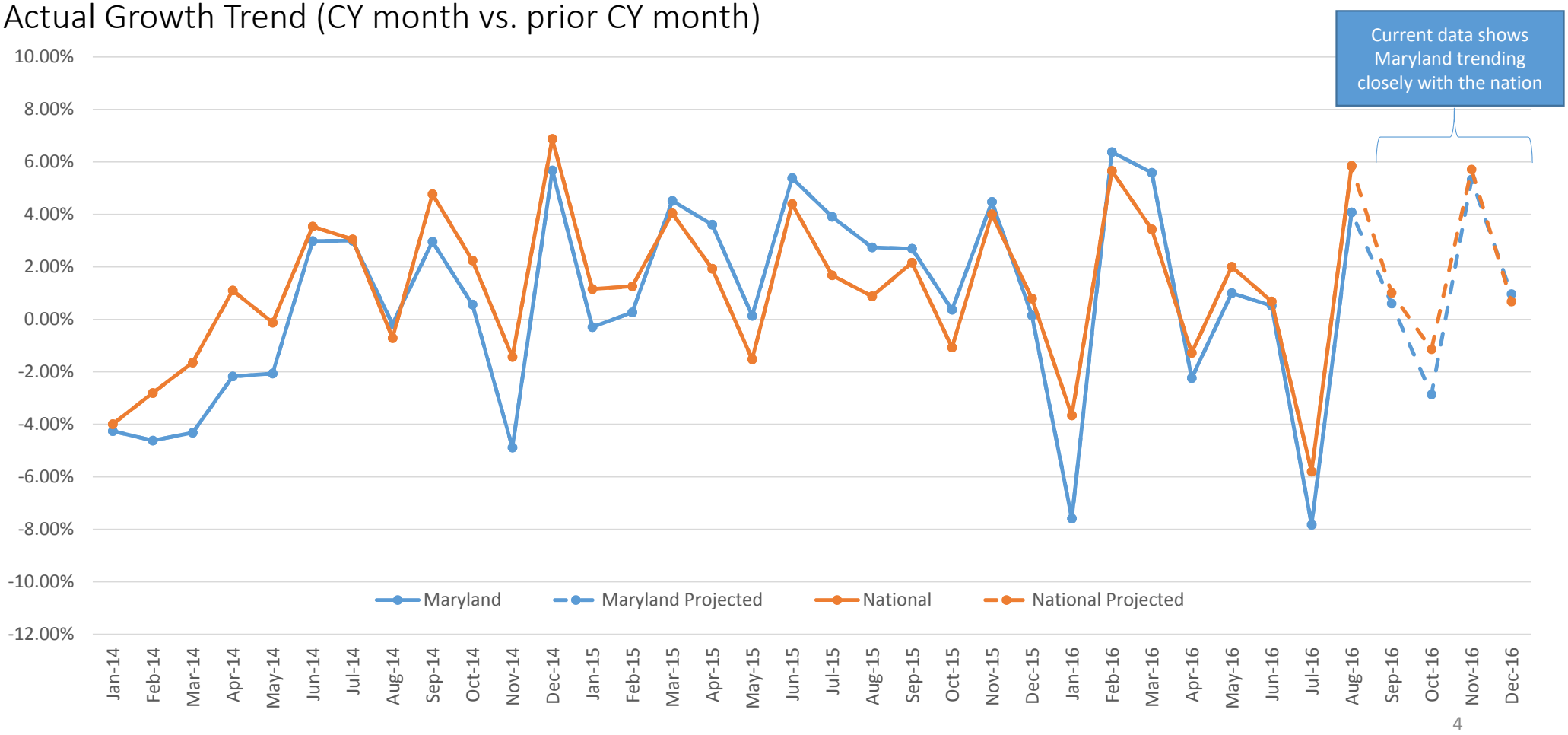
Medicare Hospital Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



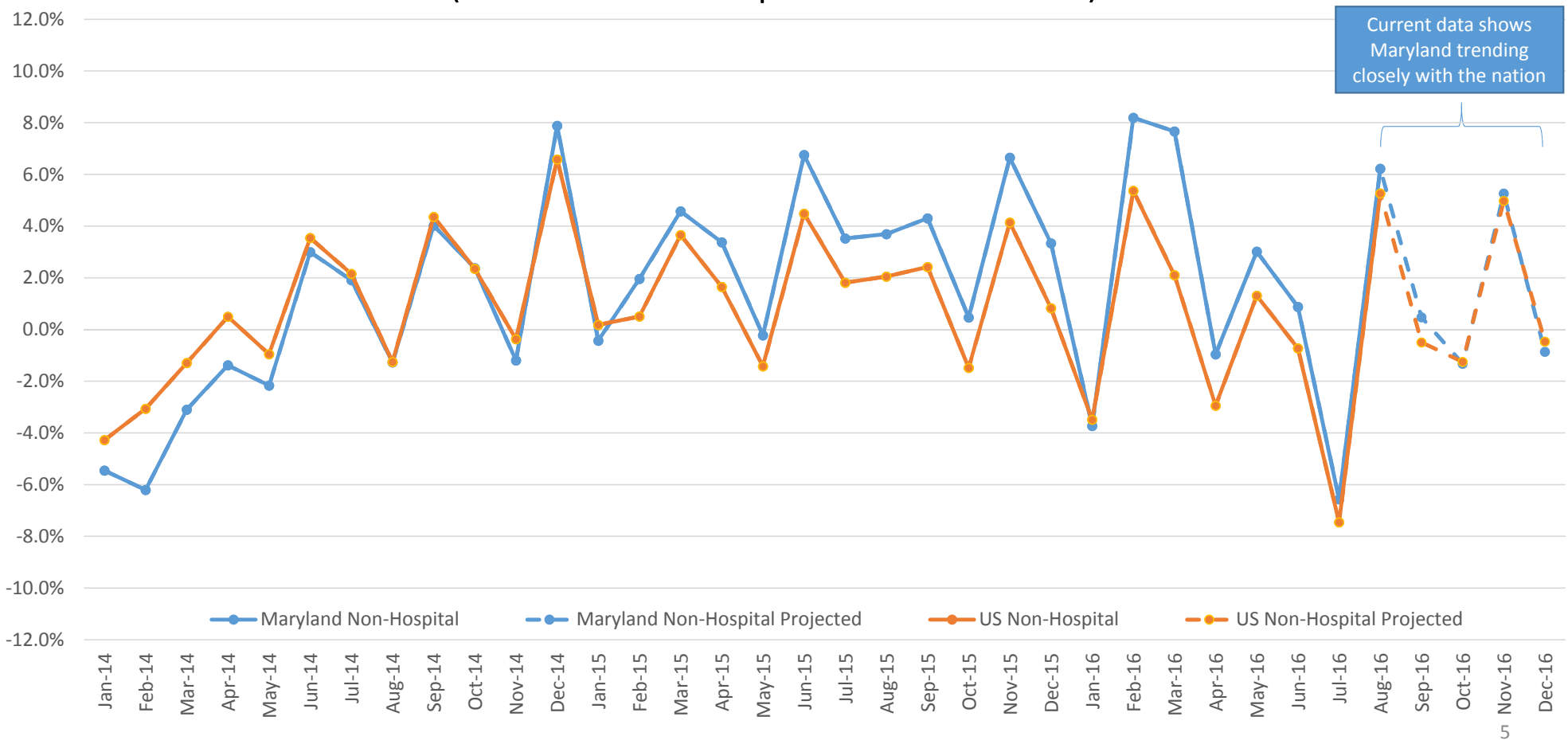
Medicare Total Cost of Care per Capita

Actual Growth Trend (CY month vs. prior CY month)



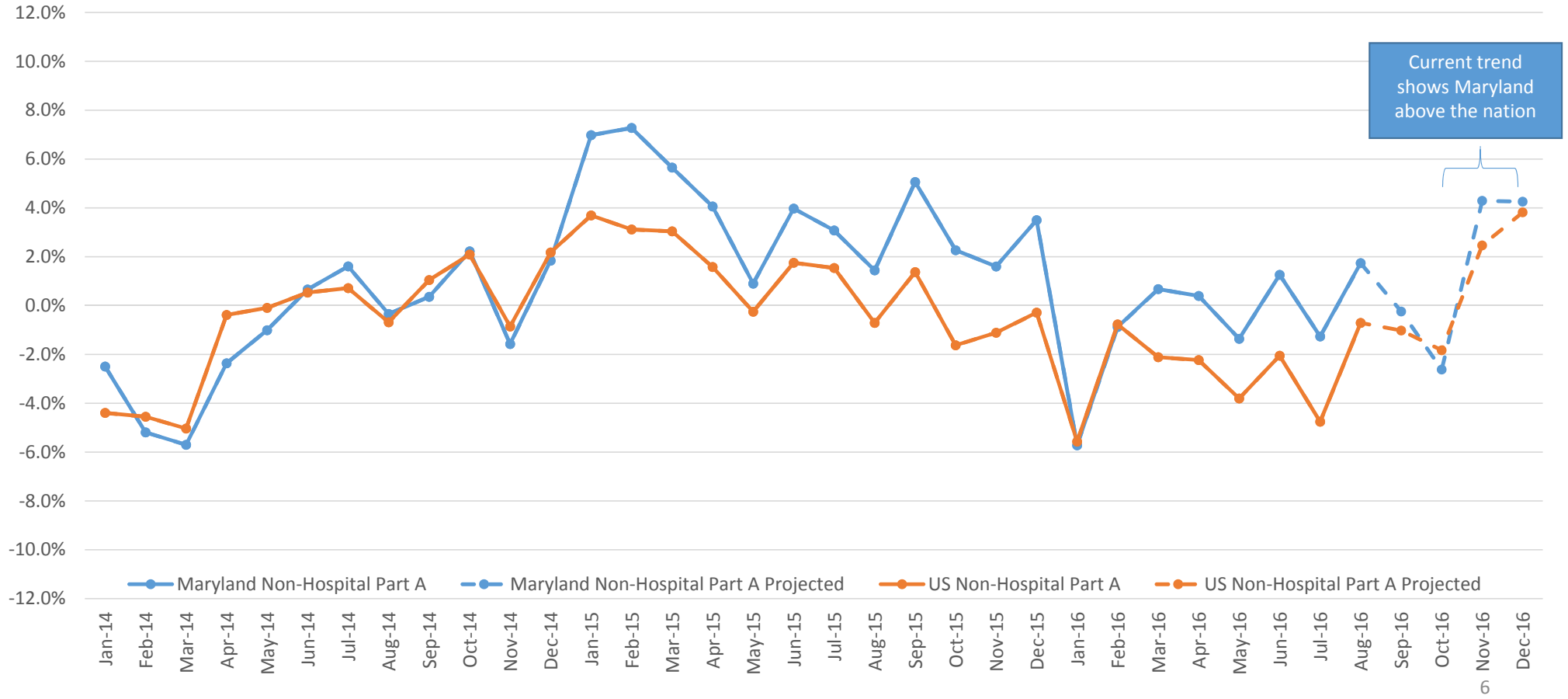
Medicare Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



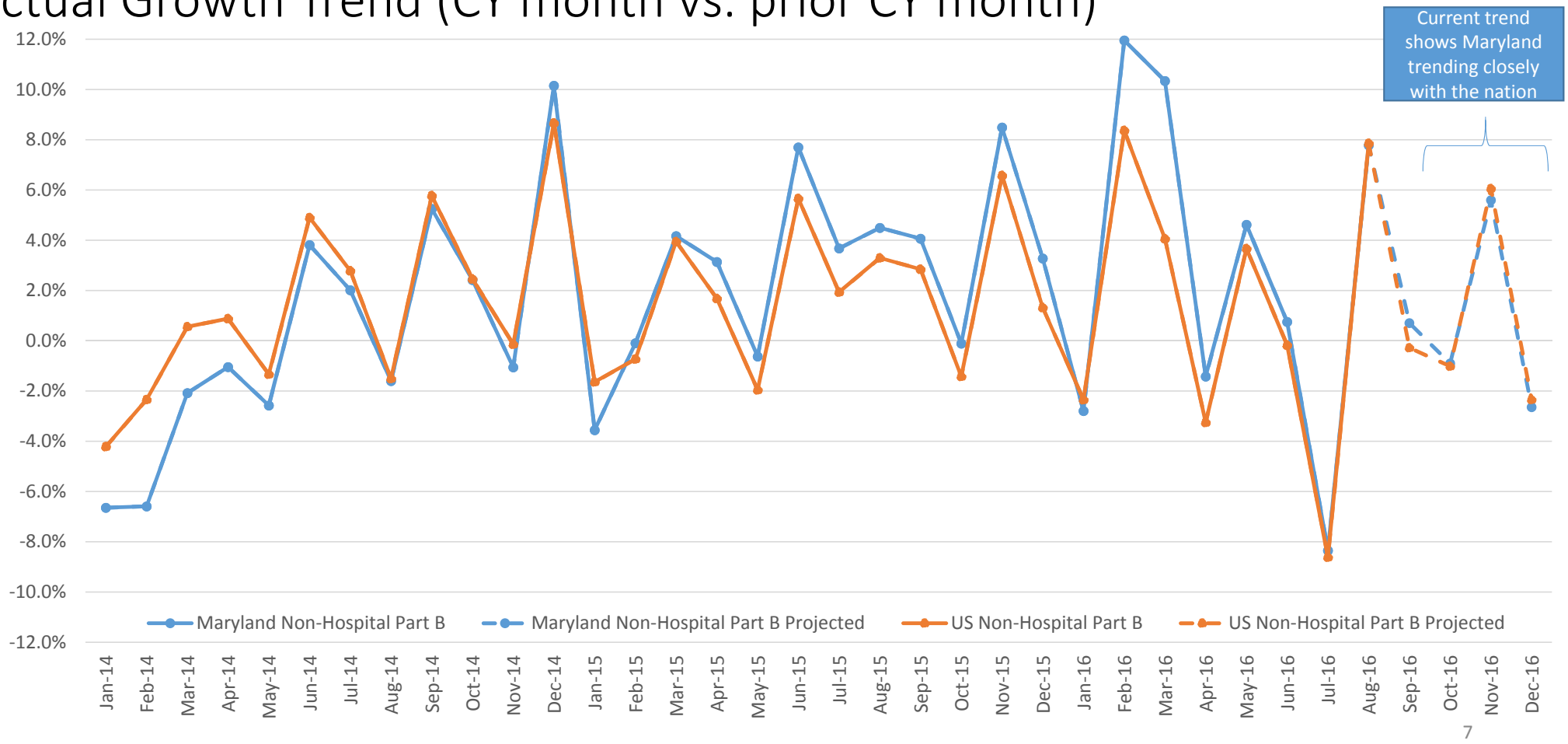
Medicare Non-Hospital Part A Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



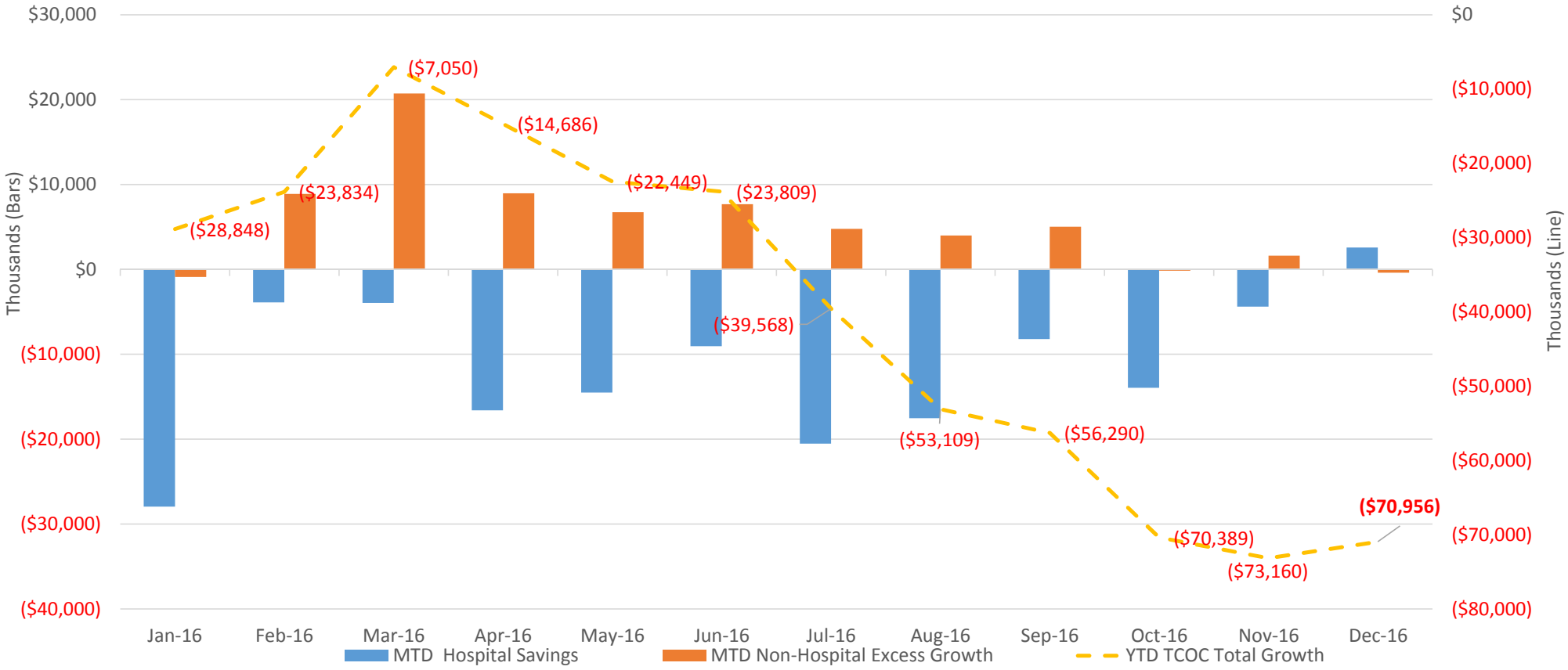
Medicare Non-Hospital Part B Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



Medicare Hospital & Non-Hospital Growth

(with completion) CY 2016



Monitoring Maryland Performance Financial Data

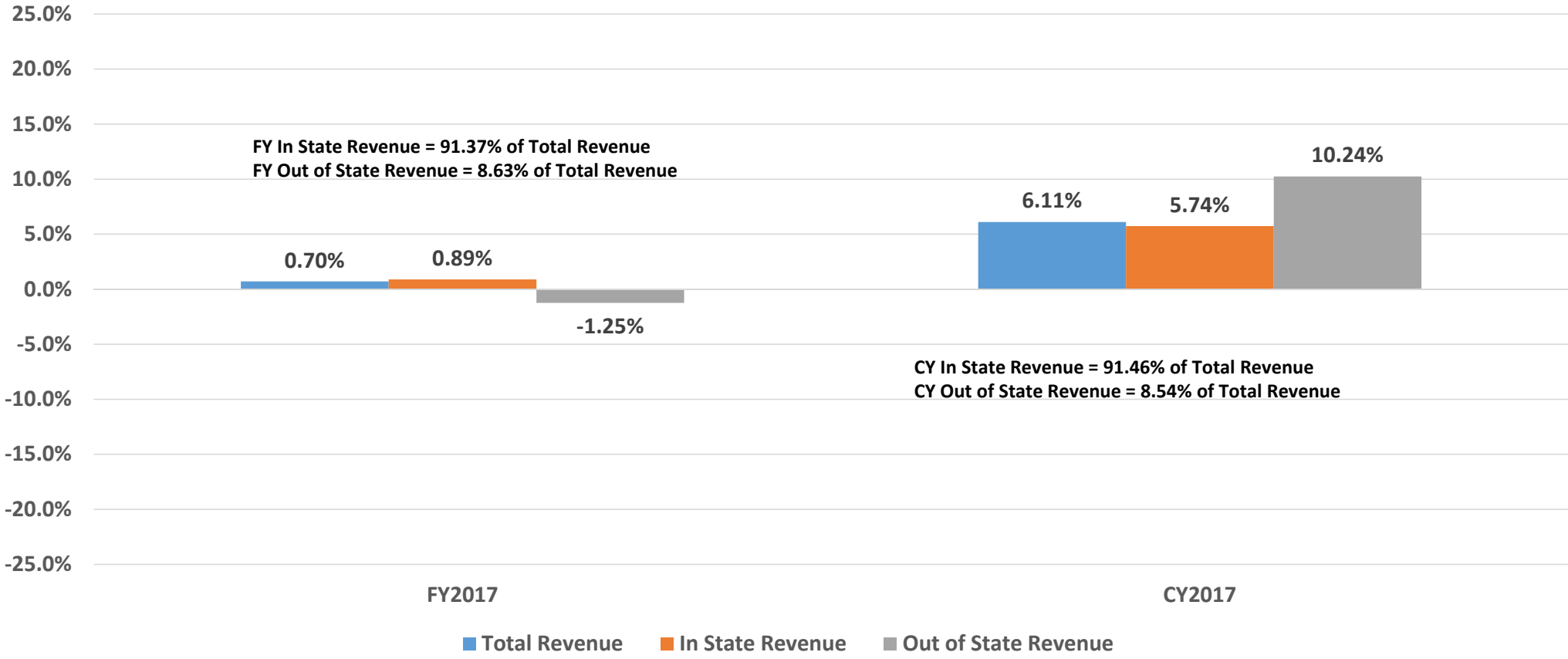
Year to Date through February 2017

Source: Hospital Monthly Volume and Revenue and Financial Statement Data

Run: April 2017

Gross All Payer Revenue Growth

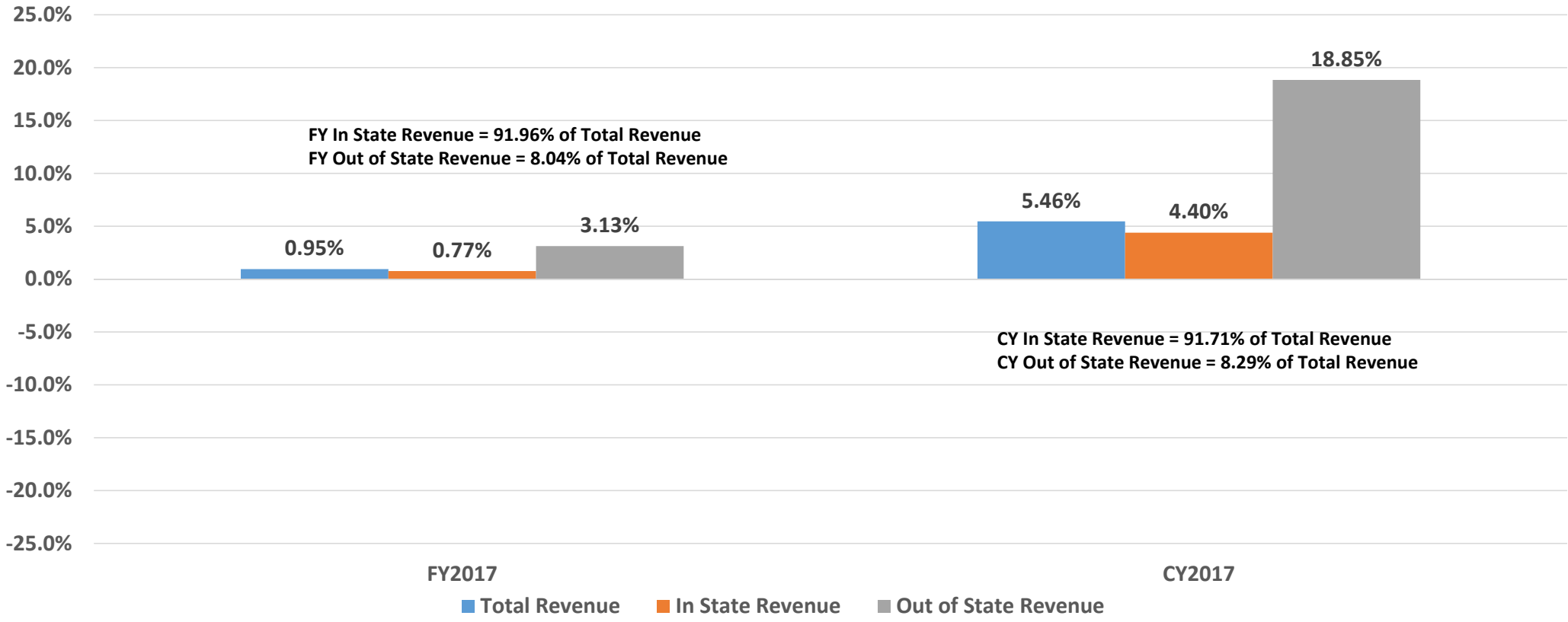
FY 2017 YTD (Jul 2016-Feb 2017 over Jul 2015-Feb 2016) and CY 2017 YTD (Jan-Feb 2017 over Jan-Feb 2016)



The State's Fiscal Year begins July 1

Gross Medicare Fee for Service Revenue Growth

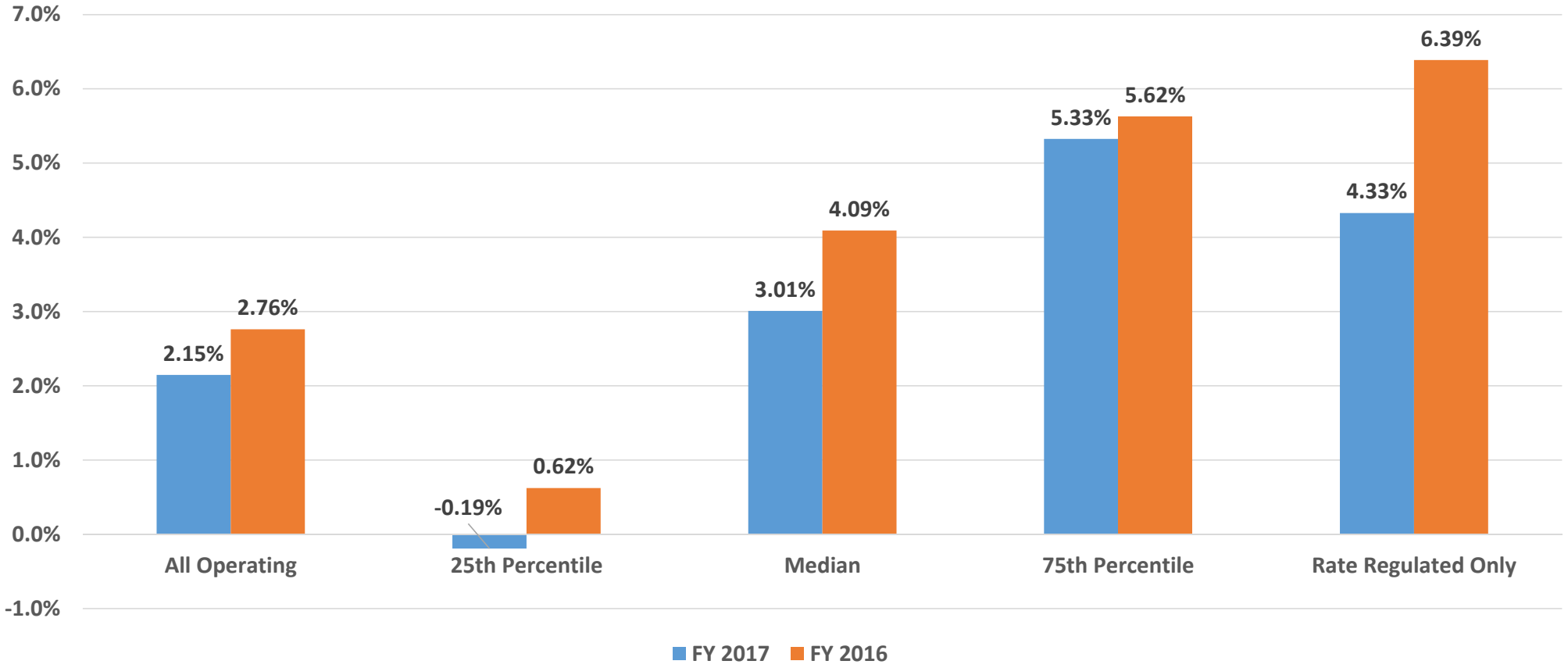
FY 2017 YTD (Jul 2016 - Feb 2017 over Jul-Feb 2015) and CY 2016 YTD (Jan-Feb 2017 over Jan-Feb 2016)



The State's Fiscal Year begins July 1

Operating Profits

FY 2017 YTD (Jul 2016-Feb 2017) Compared to Same Period in FY 2016 (Jul 2015 - Feb 2016)



FY 2017 YTD unaudited hospital operating profits to date show a 0.61 percentage point decrease in total profits compared to the same period in FY 2016. Rate regulated profits have decreased by 2.06 percentage points compared to the same period in FY 2016.

Monitoring Maryland Performance
Quality Data

April 2017 Commission Meeting Update

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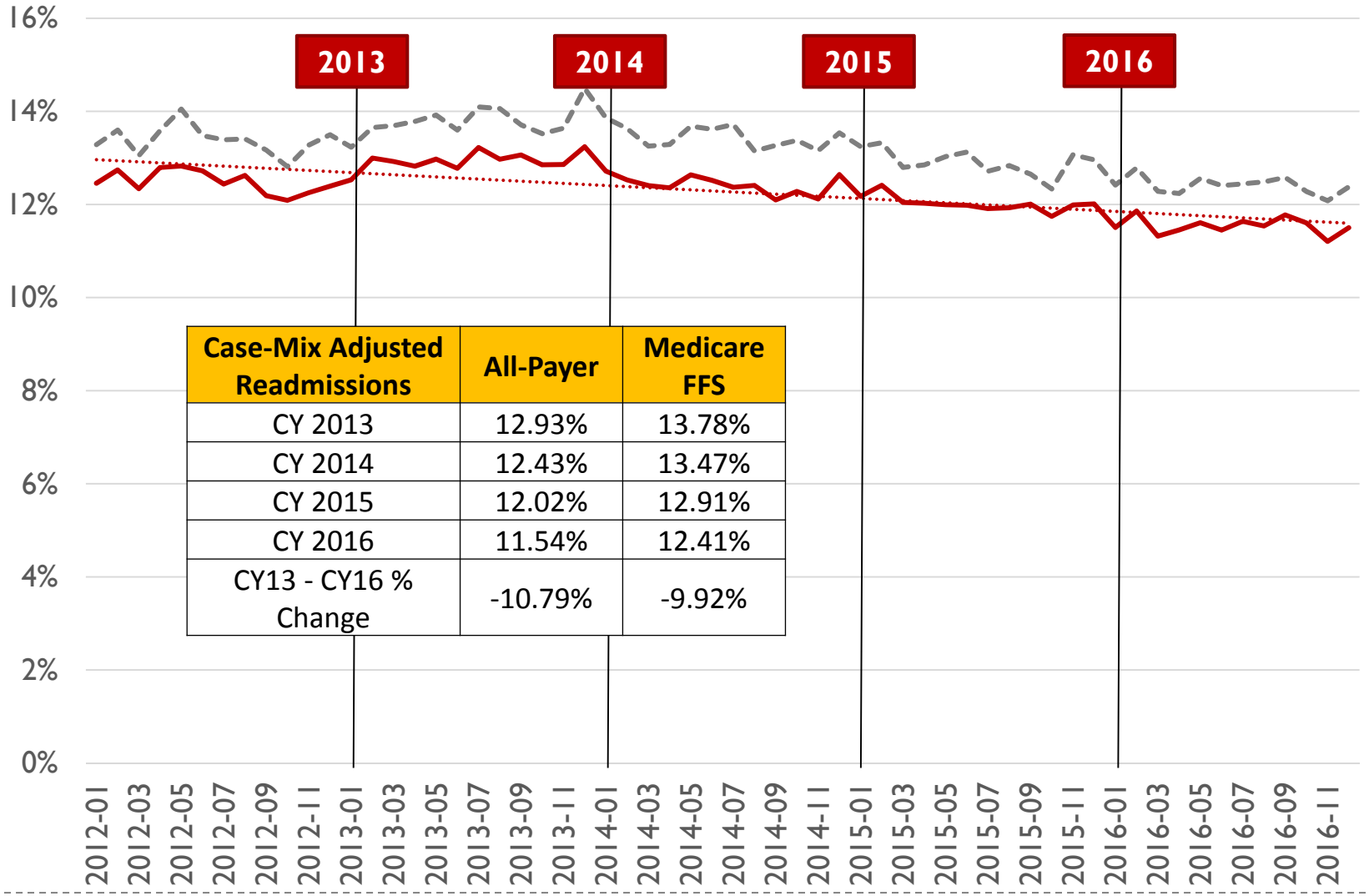
Readmission Reduction Analysis

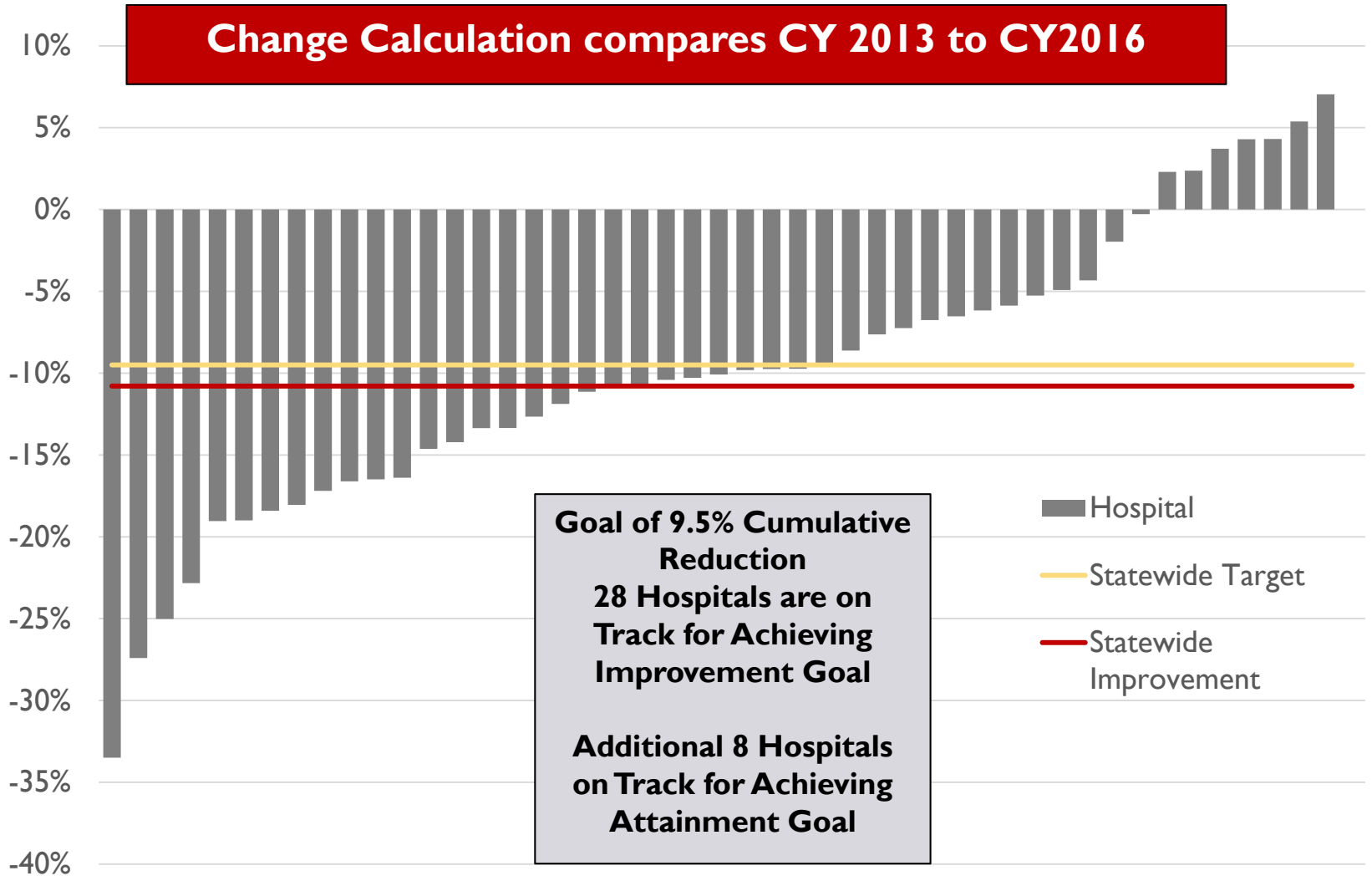
Monthly Case-Mix Adjusted Readmission Rates



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
CY 2013	12.93%	13.78%
CY 2014	12.43%	13.47%
CY 2015	12.02%	12.91%
CY 2016	11.54%	12.41%
CY13 - CY16 % Change	-10.79%	-9.92%

Note: Based on final data for January 2012 – December 2016

Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital



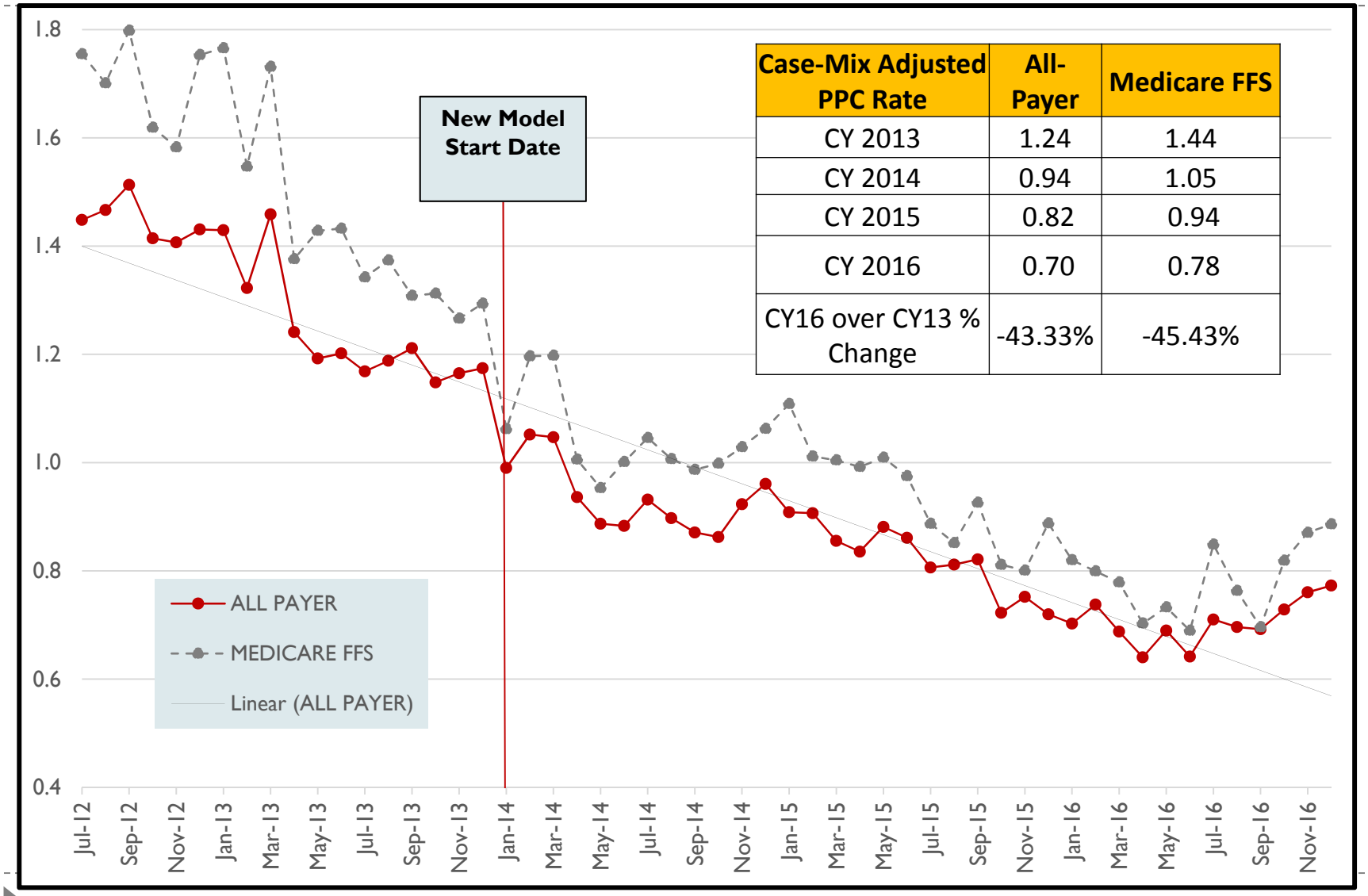
Note: Based on final data for January 2012 – December 2016.

Medicare Readmission All-Payer Model Test

Will be discussed in DRAFT RRIP

MHAC PPC Reduction Update

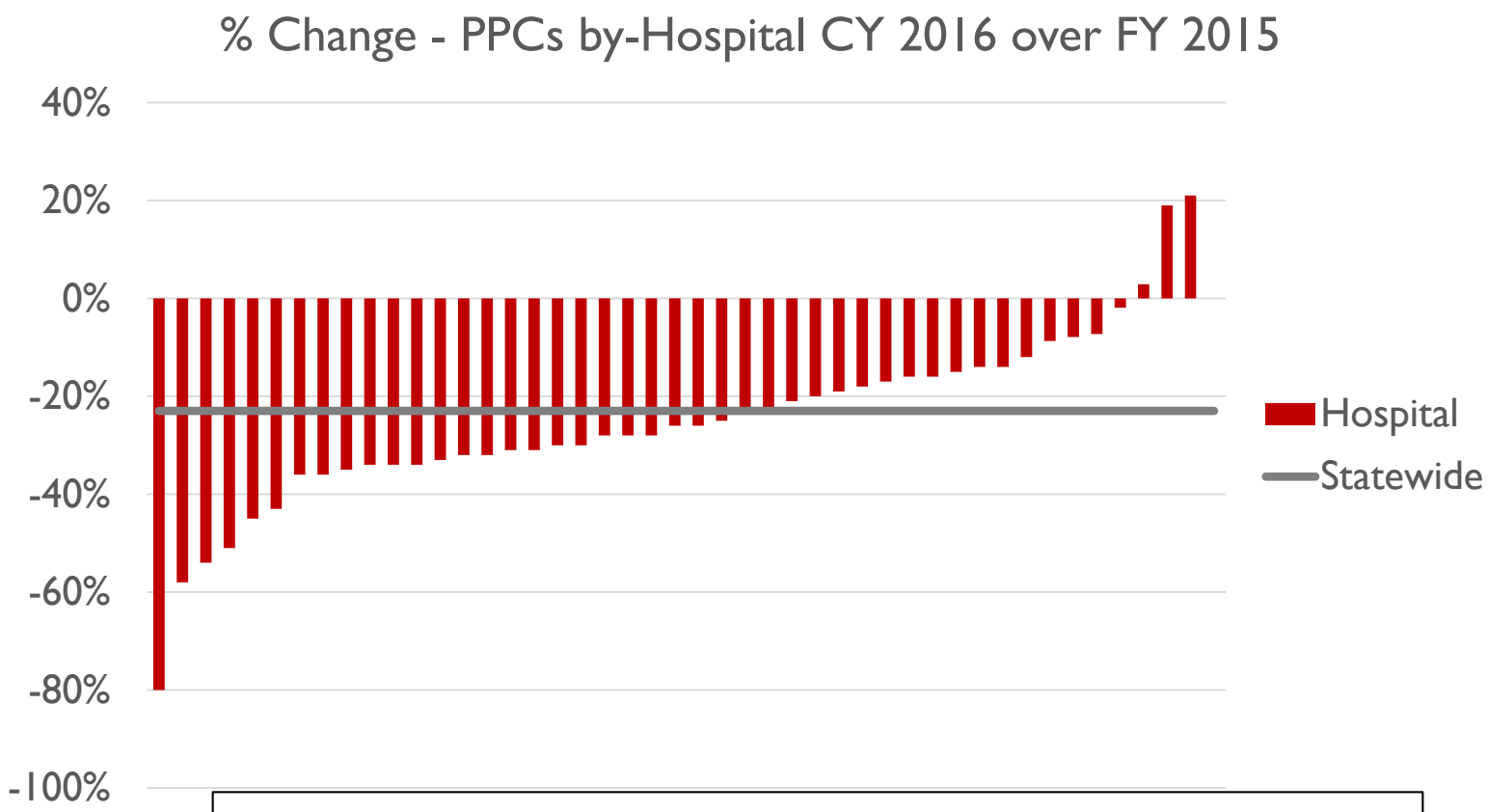
Monthly Case-Mix Adjusted PPC Rates



Case-Mix Adjusted PPC Rate	All-Payer	Medicare FFS
CY 2013	1.24	1.44
CY 2014	0.94	1.05
CY 2015	0.82	0.94
CY 2016	0.70	0.78
CY16 over CY13 % Change	-43.33%	-45.43%

Note: Based on final MHAC Program data for January 2012 – December 2016

Change in All-Payer Case-Mix Adjusted PPC Rates YTD by Hospital



Notes:
Based on final data for July 2013 – December 2016.
Percent change is comparing FY 2015 to CY 2016.
Excludes McCready Hospital due to small sample size.

RRIP RY 2019 DRAFT Policy

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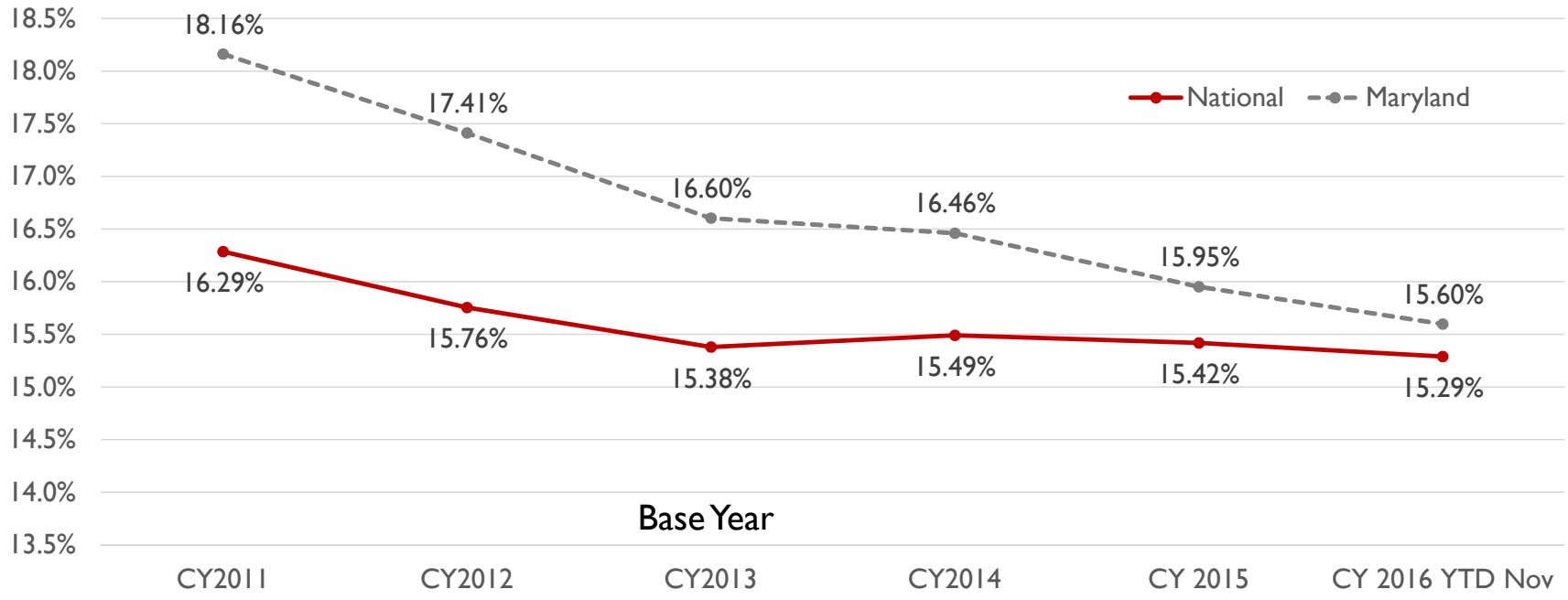
Medicare Test: At or below National Medicare Readmission Rate by CY 2018

Maryland is reducing readmission rate faster than the nation.
Maryland reduced the gap from 1.22 percentage points in the base year to 0.31 percentage points in CY 2016.
Our target for the gap for CY 2016 was 0.49 percentage point difference.



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RRIP proposal for RY 2019

- Continue to measure hospitals on the better of improvement or attainment
  - Use RY 2018 methodology to calculate updated Attainment Target
  - Continue to adjust readmission rate using Out-of-State readmission ratios calculated from Medicare data
- Update the policy to calculate improvement CY 2016 to CY 2017
  - Annual target ensures base and performance run under ICD-10
  - Add this improvement to CY 2013 to CY 2016 improvement (i.e., RY 2018 improvement) to calculate a **modified cumulative improvement rate**

Steps for Calculating Improvement Target

- Estimate National Medicare FFS Improvement for CY 2017 and CY 2018
  - Modeled 0.80% (actual CY 2015 to CY 2016 improvement), 1%, and 1.5%
- Calculate necessary Maryland Medicare FFS readmission rate to correspond with projected National Medicare readmission rate
  - CY 2017 target gap between MD and Nation is 0.16 percentage points
- Convert Maryland unadjusted Medicare FFS improvement to a case-mix adjusted All-Payer improvement
  - Multiple methods for this conversion were tested; with 1% national improvement trend these methods resulted in case-mix adjusted all-payer improvement targets ranging from 3.3% to 7.1%.

For purposes of draft recommendation, a 4% annual improvement target was modeled. This annual target was added to the actual statewide CY 2013 to CY 2016 improvement to get a 15% modified cumulative improvement target.

RY 2019 Proposed Revenue Adjustment Scales

Improvement Scale

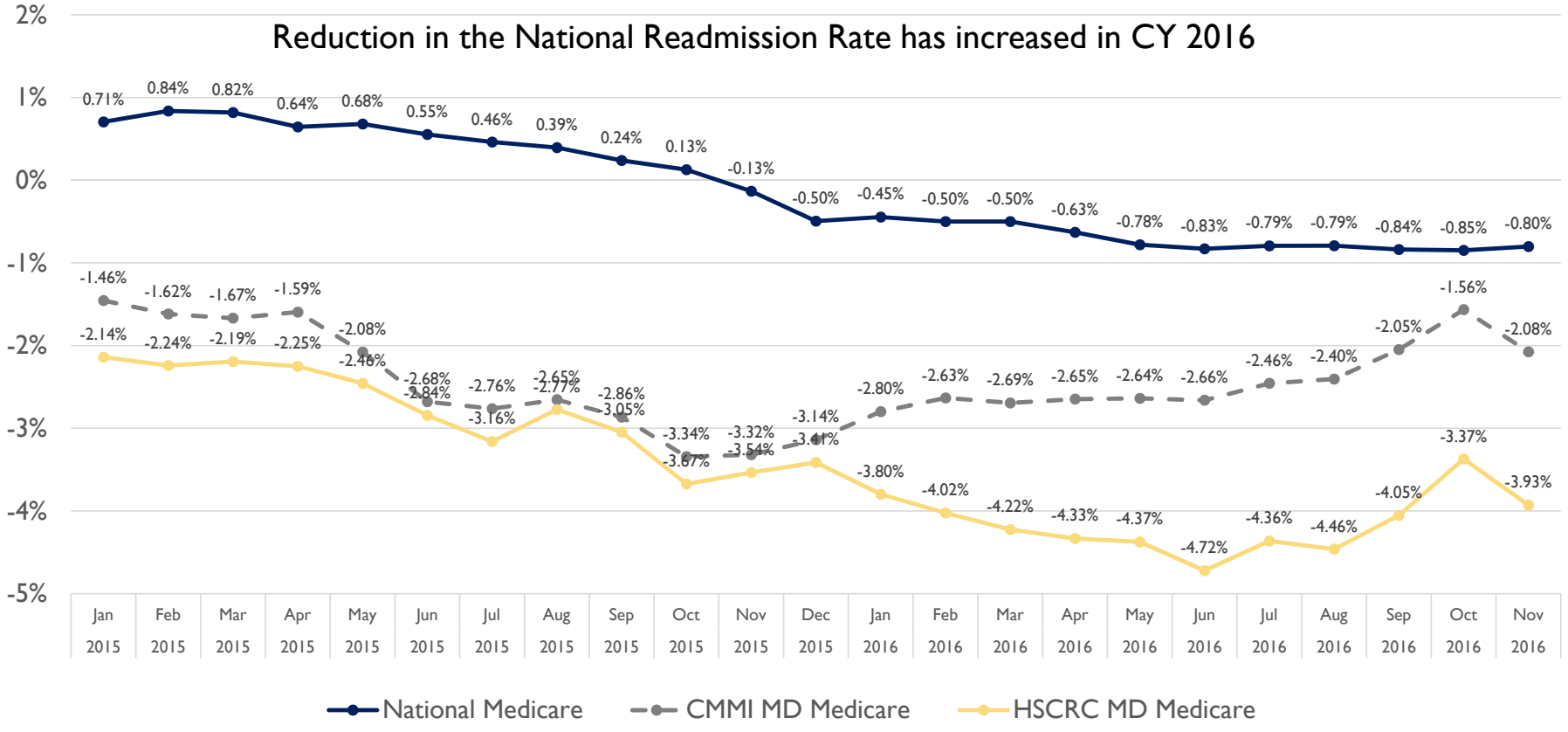
All Payer Readmission Rate Change CY13-CY17	Over/Under Target	RRIP % Inpatient Revenue Payment Adjustment
A	B	C
Better Improvement		1.0%
-25.5%	-10.5%	1.0%
-20.3%	-5.3%	0.5%
-15.0%	0.0%	0.0%
-9.7%	5.3%	-0.5%
-4.5%	10.5%	-1.0%
0.8%	15.8%	-1.5%
6.0%	21.0%	-2.0%
Worse Improvement		-2.0%

Attainment Scale

All Payer Readmission Rate CY17	Over/Above Target From Target	RRIP % Inpatient Revenue Payment Adjustment
A	B	C
LOWER Readmission Rate		1.0%
9.92%	-0.9%	1.0%
10.38%	-0.5%	0.5%
10.83%	0.0%	0.0%
11.29%	0.5%	-0.5%
11.74%	0.9%	-1.0%
12.20%	1.4%	-1.5%
12.65%	1.8%	-2.0%

Maximum rewards are set at the 10th percentile of performance for RY 2018, and maximum penalties are linearly scaled based on max reward and reward/penalty cut point

Cumulative Readmission Rate Change by Rolling 12 Months (year over year): Maryland vs Nation



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Draft Recommendations for RY 2019 RRIP Policy

- The RRIP policy should continue to be set for **all-payers**.
- Hospital performance should continue to be measured as the **better of attainment or improvement**.
- Due to ICD-10, RRIP should have a **one-year improvement target (CY 2017 over CY 2016)**, and will add this one-year improvement to the achieved improvement CY 2016 over CY 2013, to create a **modified cumulative improvement target.**
- The attainment benchmark should be set at **10.83 percent***.
- The reduction benchmark for CY 2017 readmissions should be **-4.0% percent*** from CY 2016 readmission rates.

*Improvement and Attainment Targets calculated using latest model data; subject to change in Final Policy.

GBR Infrastructure Investment – FY 2016

4/12/2016

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Overview

- Intent of these monies is to accelerate the development of **care coordination**.
- Commission required that hospitals report on all new population health investments for FY 2016.
- Reports were reviewed by a committee of **HSCRC** and **DHMH** staff.

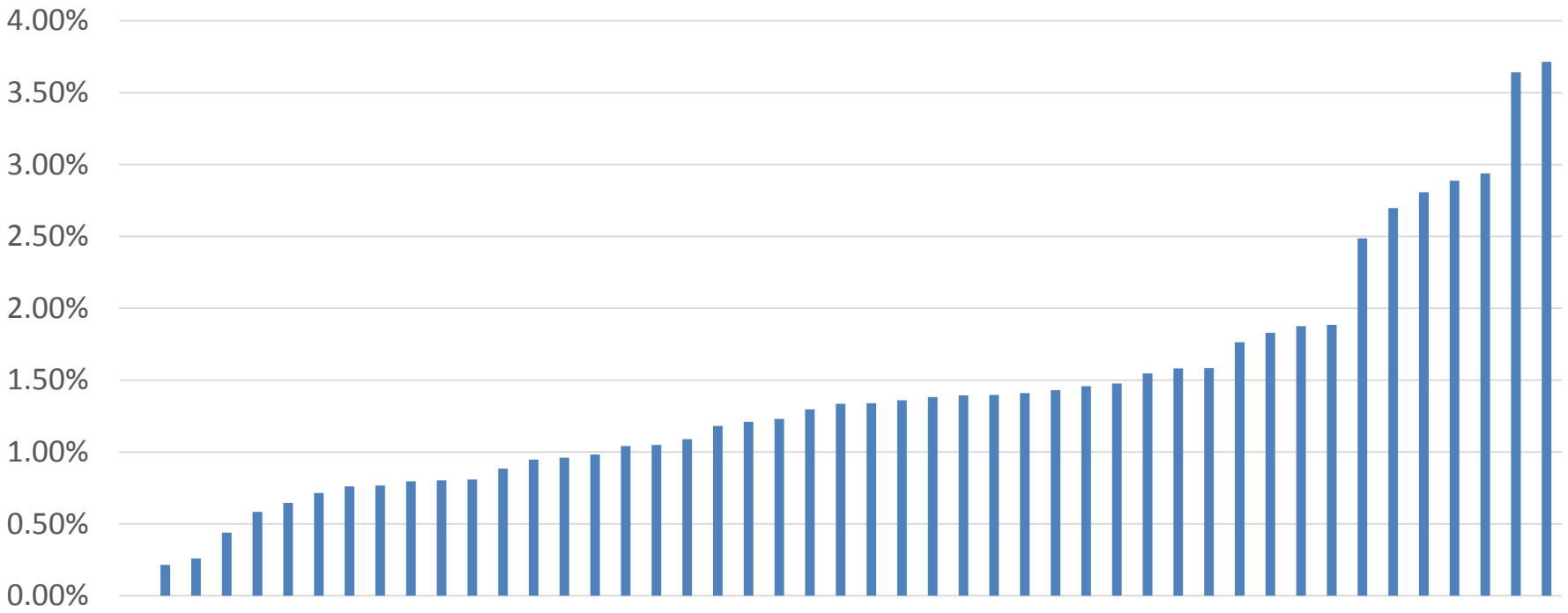
GBR Infrastructure Reports – A Snapshot

- To date, HSCRC has received reports from 46 hospitals, detailing over 700 infrastructure investments made during FY 2016.
- The individual infrastructure investment reports are posted on the Commission's website at the following link: http://www.hscrc.maryland.gov/plans.cfm
- Infrastructure Spending:
  - Total Reported: total reported minus grant or other funds
  - Moderate Estimate: partially discounts investments that represented ongoing hospital expenditures or unclear investments; wholly discounts non-germane investments

Investment Spending	All Hospitals	GBR Only*
Total Investments	$199 M	$163 M
Moderate Estimate	$144 M	$120 M

*For comparison purposes, the estimated amount of money put into GBR hospital rates in FY 2016 was approximately $146 M

% of FY 2016 GBR Invested in Infrastructure



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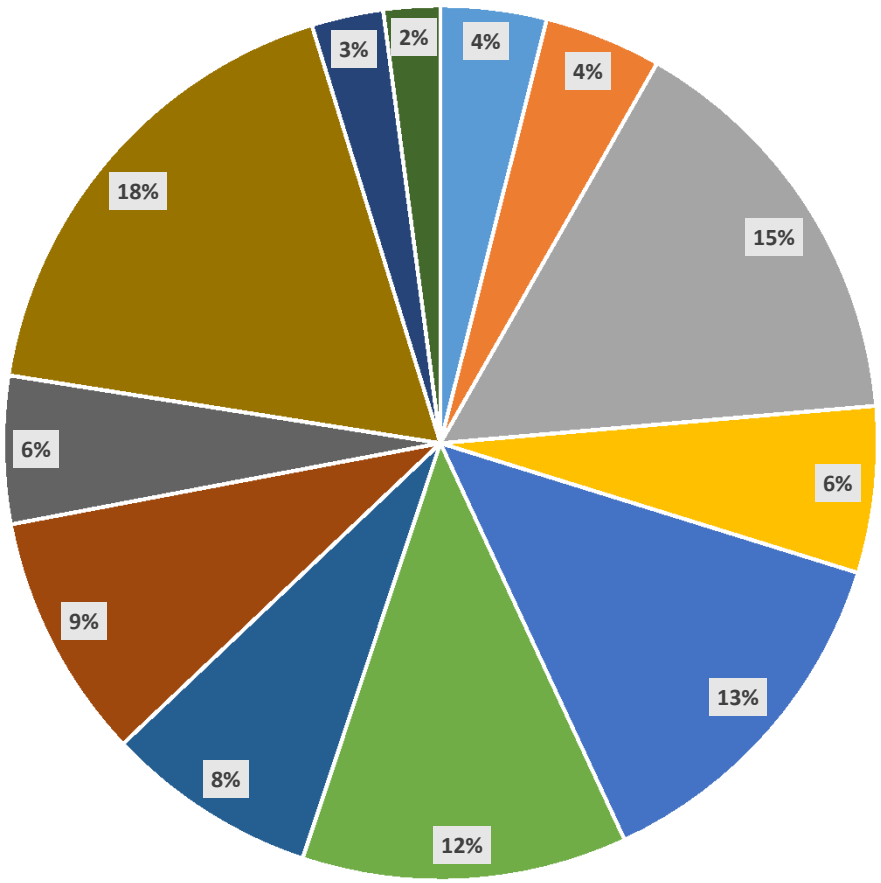
FY 2016 Reporting Template - Categories

- HSCRC worked with stakeholders to update the reporting template to include standardized investment categories with agreed-upon definitions.

- Categories refined with definitions
  1. ACO, PCMH, or formal Shared Savings Program
  2. Additional Physicians in Unregulated Space
  3. **Community-based Care Coordination**
  4. Consumer Education and Engagement
  5. **Disease Management (for Chronic Diseases)**
  6. Hospital Case Management
  7. IT, Data, and Data Analysis
  8. Patient Education
  9. **Post-Discharge and Transitional Care**
  10. Social Services
  11. Telemonitoring/Telemedicine
  12. Other

Count of Investments by Category (N=715)



- ACO, PCMH, or formal Shared Savings Program
- Additional Physicians in Unregulated Space
- Community-Based Care Coordination
- Consumer Education and Engagement
- Disease Management (for Chronic Diseases)
- Hospital Case Management
- IT, Data, and Data Analysis
- Other
- Patient Education
- Post-Discharge and Transitional Care
- Social Services
- Telemonitoring/Telemedicine

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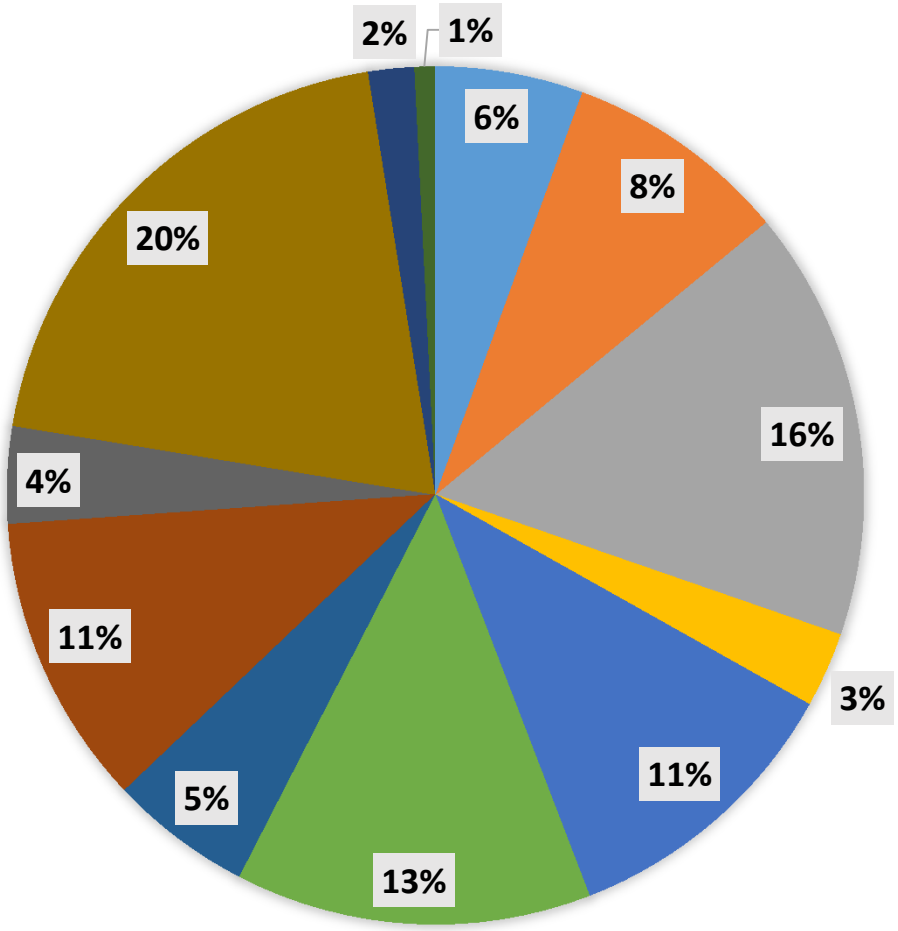
Investments $ by Category



- ACO, PCMH, or formal Shared Savings Program
- Additional Physicians in Unregulated Space
- Community-Based Care Coordination
- Consumer Education and Engagement
- Disease Management (for Chronic Diseases)
- Hospital Case Management
- IT, Data, and Data Analysis
- Other
- Patient Education
- Post-Discharge and Transitional Care
- Social Services
- Telemonitoring/Telemedicine

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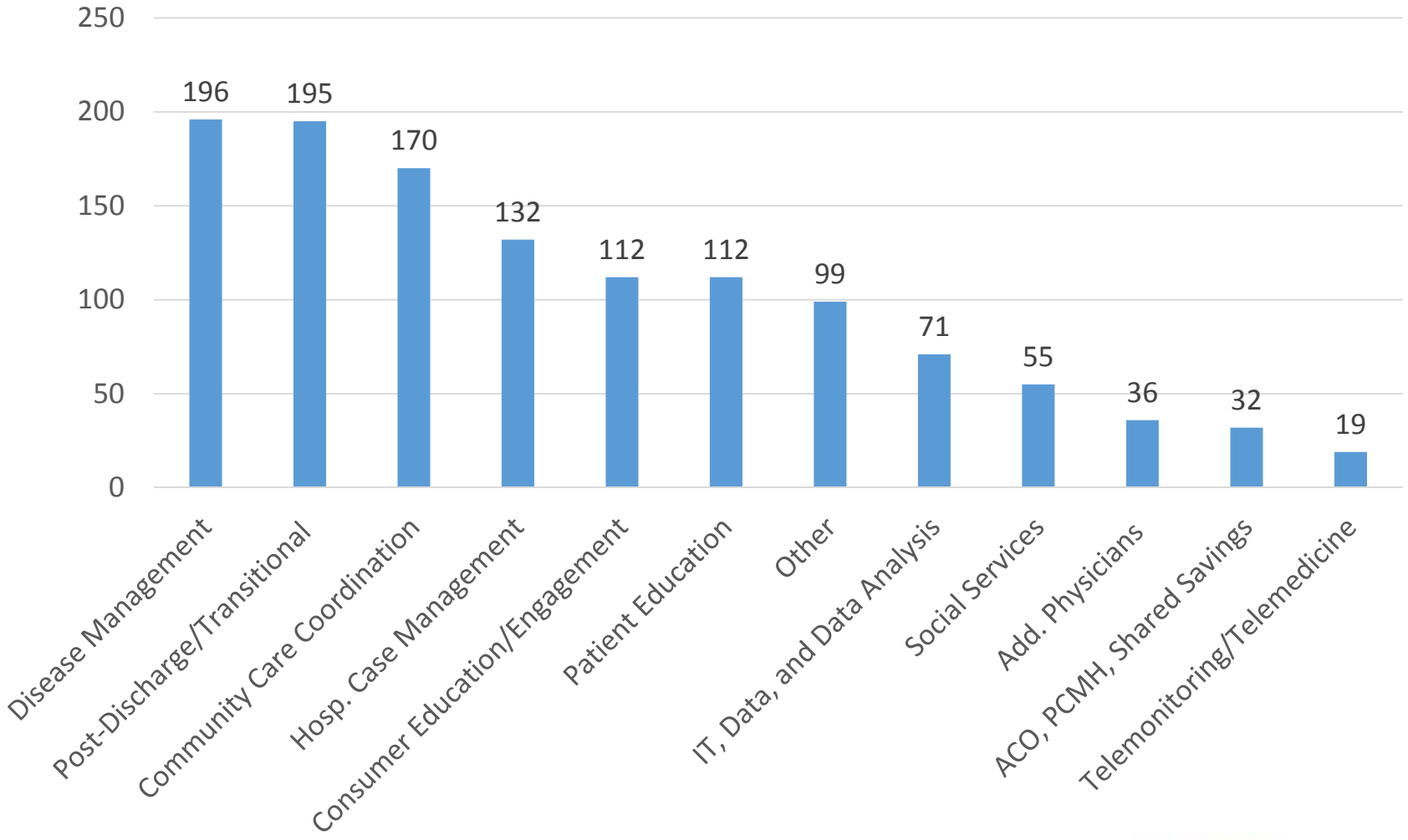
Categories (Hospitals could add up to 3)



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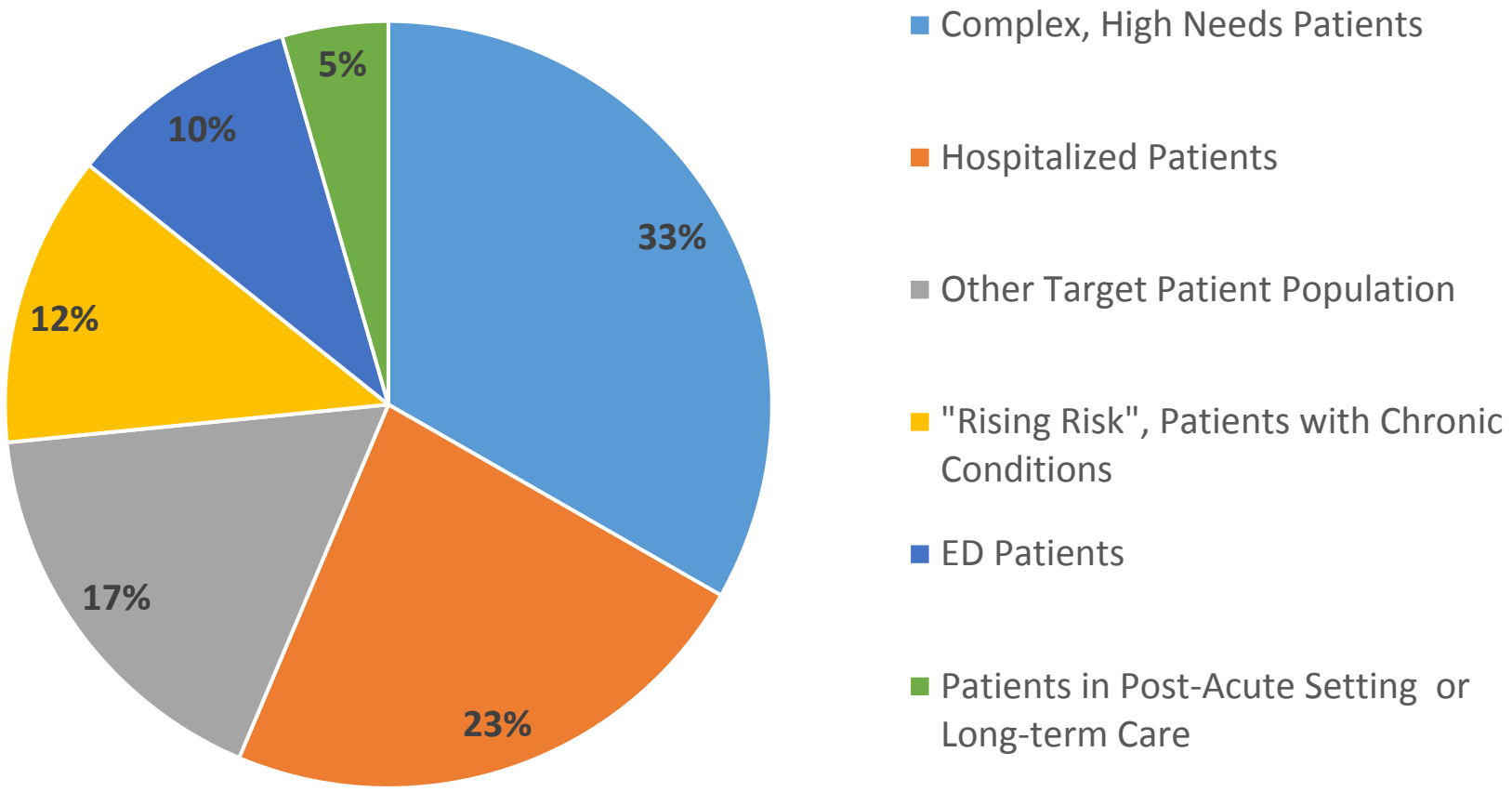
Target Populations



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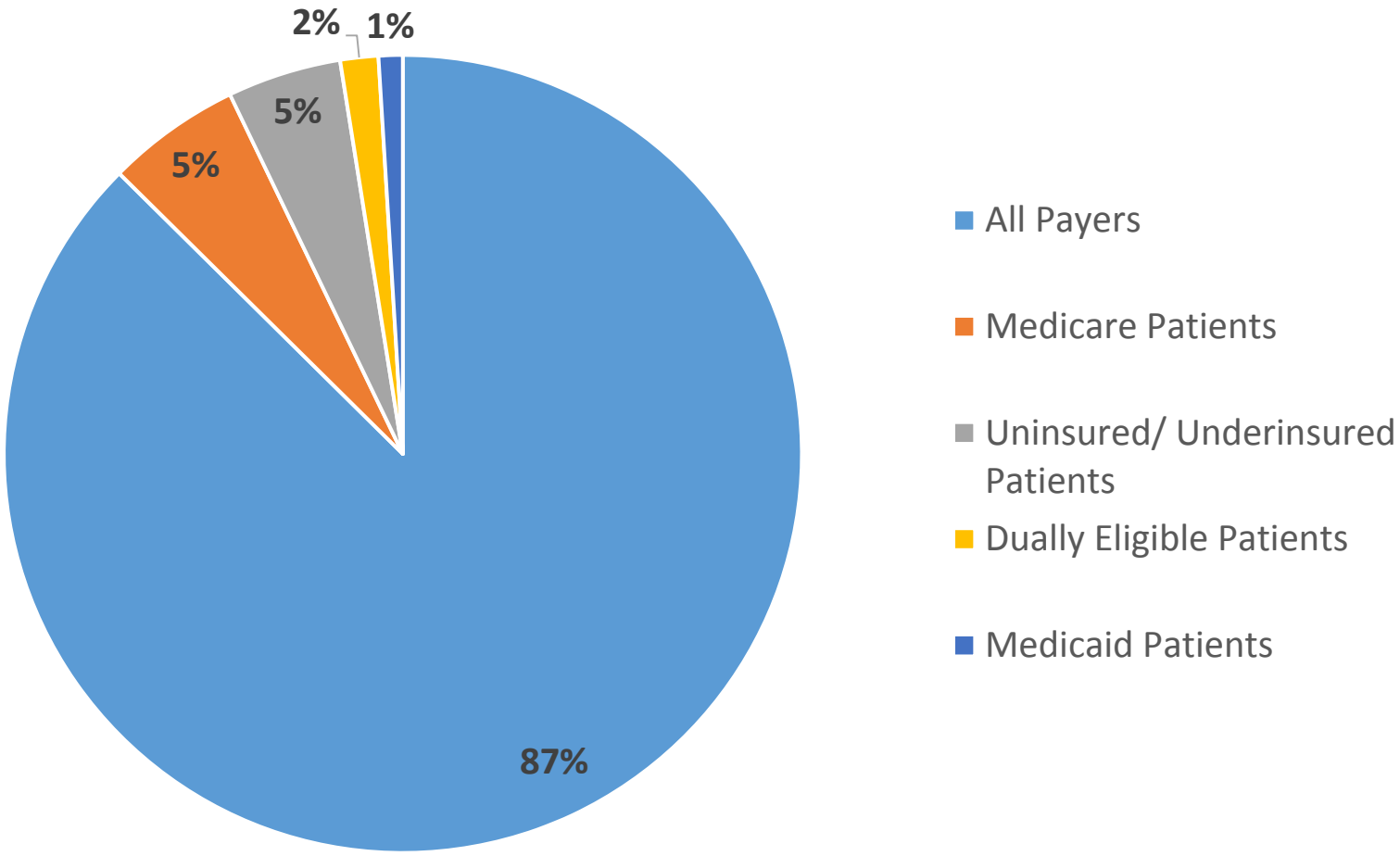
Target Payer



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FTEs working on GBR Infrastructure

- ~2,300 FTEs across all hospitals
- Representing ~2.7% of total FTEs (via Financial Reports)

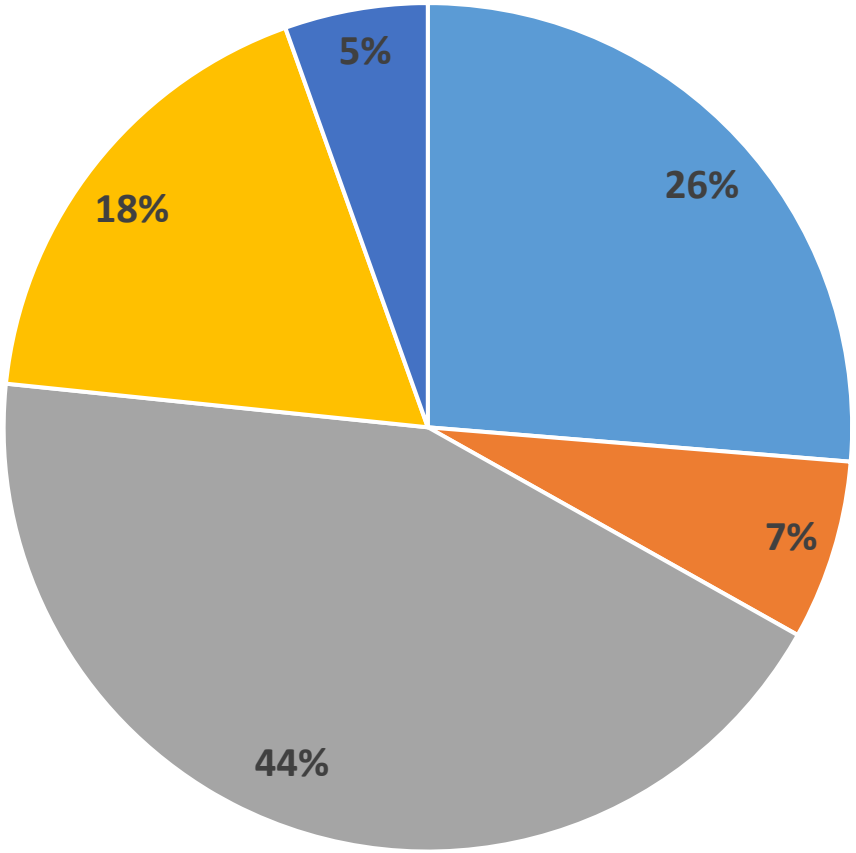
FTE Type	Numbers of FTEs	% of Total FTE
IT Staff	33.6	1.43%
Data Analyst	51.9	2.21%
Physician - Specialty Care	62.3	2.65%
Community Health Worker	66.7	2.83%
Hospital Management	97.4	4.14%
Physician - Primary Care	108.9	4.63%
Advanced Practitioner (Nurse Practitioner, Physician Assistant, etc)	121.9	5.18%
Physician - Hospital-based	122.3	5.19%
Social Worker	158.3	6.73%
RN	656.2	27.87%
Other	874.7	37.15%
Total FTEs	2354.3	

Partner Analysis

Clinical Partners (Most Relevant)	# of Investments	% of Investments
Owned by hospital/health system	285	39.86%
None	143	20.00%
Partially or wholly independent	110	15.38%
Other	83	11.61%
Long-term Care Facilities and Skilled Nursing Facilities	46	6.43%
Community-based Care Managers	32	4.48%
Retail Pharmacies	16	2.24%

Non-Clinical Partners (Most Relevant)	# of Investments	% of Investments
None	271	37.90%
CRISP	146	20.42%
Other	94	13.15%
Organizations that provide Social Services	74	10.35%
Local Health Departments	58	8.11%
Departments of Aging	29	4.06%
Faith-based Community Organizations	21	2.94%
Local Health Improvement Coalitions (LHICs)	15	2.10%
Schools	7	0.98%

Impact on TCOC



- Impact on non-hospital services is unclear at this time.
- Likely decrease non-hospital services.
- Likely increase non-hospital services.
- No impact on amount of non-hospital services likely.
- Did not Answer

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Care Coordination and Focus Investments

- Care Coordination Investments represented:

	Care Coordination Investments		% of All GBR Investments
Total Care Coordination Investments Reported	$	43,574,497	21.65%
Moderate Care Coordination Investments Reported	$	38,713,848	26.05%
Total # of Care Coordination Investments		170	23.78%

- Focus Investments (Community-based Care Coordination; Disease Management; Post-Discharge and Transitional Care) represented:

	Care Coordination Investments		% of All GBR Investments
Total Focus Investments Reported	$	94,983,210	47.18%
Moderate Focus Investments Reported	$	80,099,662	53.89%
Total # of Focus Investments		332	46.43%

Process Metrics

- Each investment's process metric was evaluated on the following scale:
  - 0 – Did not provide a process metric
  - 1 – Provided a process metric
  - 2 – Process metric rationale is valid
  - 3 – Presented a goal without data
  - 4 – Presented data toward this goal
  - 5 – Is on track to meet this goal (or is progressing toward this goal)

Focus Investments

Scale #	% of Investments
0	15.96%
1	11.75%
2	8.43%
3	6.93%
4	8.13%
5	48.80%

All Investments

Scale #	% of Investments
0	20.56%
1	13.29%
2	11.47%
3	6.85%
4	8.81%
5	39.02%

Examples of Metrics

- PCP Appointments scheduled for High-Risk patients before discharge
- Number of patients receiving home or bedside delivery of prescriptions
- Reduce High-Utilizer Visits
- HbA1c levels in OP diabetics
- Reduction in Readmissions from SNFs
- Pre- and Post- Assessments of Patient Education Programs
- Monitoring of HEDIS measures for Hypertension and Diabetes
- % of Behavioral Health Social Worker Evaluations leading to a referral

FY 2017 GBR Infrastructure Reporting

- HSCRC is considering suspending the GBR investment reporting for FY 2017
  - Allows hospitals to focus on care redesign reporting this year
  - In future years GBR reporting and care redesign reporting can be streamlined
  - Evaluate strategic plans or other options

FY17: Focus on Care Coordination

CRISP will support Maryland hospitals this year, with an aim of helping them all do these four things, to collectively improve care coordination:

1. **Flag Patient Care Management Relationships:** Notify CRISP for each patient who is enrolled/dis-enrolled in a care management program, including contact information for the patient, care coordinator, and primary care provider.

2. **Share Care Planning Data**: Whenever care management information appropriate for sharing is created or updated for a participating patient, send a copy of the information to CRISP.

3. **Use In-Context Alerts:** Create an “alert mechanism” in your hospital EHR so your clinicians know when a person who is in care management has shown up, with easy access to the full data.

4. **Use CRISP Reports:** Incorporate CRISP reports and compiled data into the work of the population health team. (For patient identification and performance measurement.)

This approach should align with broader interventions and programs in place to support the high need / complex patients

Positive Trends through FY17

Care Coordination Measures – High-needs Medicare FFS Beneficiaries

Measure 1: Known primary care provider or care manager

Beneficiaries	Total	w/PCP		w/CM		w/both	
4/10/2017	18,831	12,201	64.79%	3,170	16.83%	2,803	14.89%
3/7/2017	18,837	11,467	60.87%	2,801	14.87%	2,440	12.95%
2/10/2017	18,856	10,967	58.16%	2,594	13.76%	2,258	11.97%
1/6/2017	18,681	10,099	54.06%	1,804	9.66%	1,624	8.69%
12/13/2016	18,729	9,799	52.32%	798	4.26%	653	3.49%
12/7/2016	18,752	9,139	48.74%	463	2.47%	241	1.29%
11/29/2016	21,509	10,427	48.48%	499	2.32%	254	1.18%
11/4/2016	21,849	10,379	47.50%	468	2.14%	239	1.09%
9/27/2016	21,644	9,453	43.67%	172	0.79%		

Measure 2: Shared care alert or care plan

Beneficiaries	Total	w/CareAlert		w/CarePlan		w/either	
4/10/2017	18,831	1,114	5.92%	443	2.35%	1,554	8.25%
3/7/2017	18,837	937	4.97%	420	2.23%	1,354	7.19%
2/10/2017	18,856	652	3.46%	360	1.91%	1,011	5.36%
1/6/2017	18,681	536	2.87%	319	1.71%	854	4.57%
12/13/2016	18,729	506	2.70%	276	1.47%	781	4.17%
12/7/2016	18,752	508	2.71%	277	1.48%	784	4.18%
11/29/2016	21,509	410	1.91%	248	1.15%	658	3.06%
11/4/2016	21,849	394	1.80%	231	1.06%	625	2.86%
9/27/2016	21,644	244	1.13%	157	0.73%	401	1.85%

Committee and Stakeholder Roles

- Temporary ad hoc Care Redesign Committee established to advise CRISP board of directors on HCIP and CCIP implementation
- Members are Adam Kane (CRISP board exec comm), Carmela Coyle (MHA), Gene Ransom (MedChi)
- Committee will provide input on permanent care redesign governance structure

PROVIDER COMMUNITY	CRISP *Administrator*	HSCRC *State Regulator*	CMS *Federal Regulator*
CARE REDESIGN COMMITTEE *As the representative of industry, the Committee provides implementation recommendations to CRISP and policy-related recommendations to HSCRC.*			Approve terms of Care Redesign Programs and ensure program integrity.
• Establish and implement Care Redesign Programs.	• Communication and consulting hub. • CCIP administration and coordination. • HCIP administration and coordination. • Analytic support, including data collection and reporting. • Budget development.	• Set and interpret policy. • Develop methodology for total cost of care. • Approve incentive payment. methodology. • Review and resolve disputes. • Coordinate with statewide regulatory activities. • Funding source and approval.	

Procurement of Administrative Functions

- 3/15 CRISP released HCIP Administrator RFP
- Object is to hire a partner to implement day-to-day operation of HCIP
- Bidder proposals were due 4/10
- Evaluation committee considering bids for the entire scope of work and for discrete components
- Preferred vendor to be identified by 4/28
- CCIP administrative function managed in-house

Comprehensive Medicare Data

- As part of care redesign, CMS will provide comprehensive Medicare Part A, B, and D data to HSCRC for purposes of program oversight and quality management
- For care management purposes, each hospital will have access to comprehensive data for patients with an inpatient stay within 3 years
- CRISP is working with CMS on a process to become a data custodian for hospitals
- CRISP has a plan in place to roll out an analytics platform for state, hospitals when data arrives.