Total Cost of Care Workgroup

March 1, 2017

HSCRC
Health Services Cost Review Commission

Agenda

- Updates on initiatives with CMS
  - Care Redesign Programs (HCIP and CCIP)
  - Concept Paper on Value-Based Modifier (VBM) to CMS, based on paper sent to TCOC Work Group on 2/17
- Describe possible scaling of VBM to align with other HSCRC payment adjustments (e.g., MHAC)
- Primary goal for today's meeting:
  - Discuss policy/technical issues that need addressed for VBM and to guide analyses for future meetings

VBM Timing

- Current expectation is for Medicare TCOC VBM to be in place by January 1, 2018
  - Thus, a final recommendation from HSCRC commissioners would be required by December 2017 Commission meeting
  - Draft recommendation is needed by November 2017 Commission meeting
- The VBM could be modified in future years
  - Current focus is on the start-up Year 1 (2018)
  - The structure of VBM in 2019+ may be modified based on Phase 2 of the All-Payer Model, lessons learned in 2018, etc.
  - Increase amount of revenue at risk over time, consistent with other policies (e.g., readmissions, MHAC, QBR)

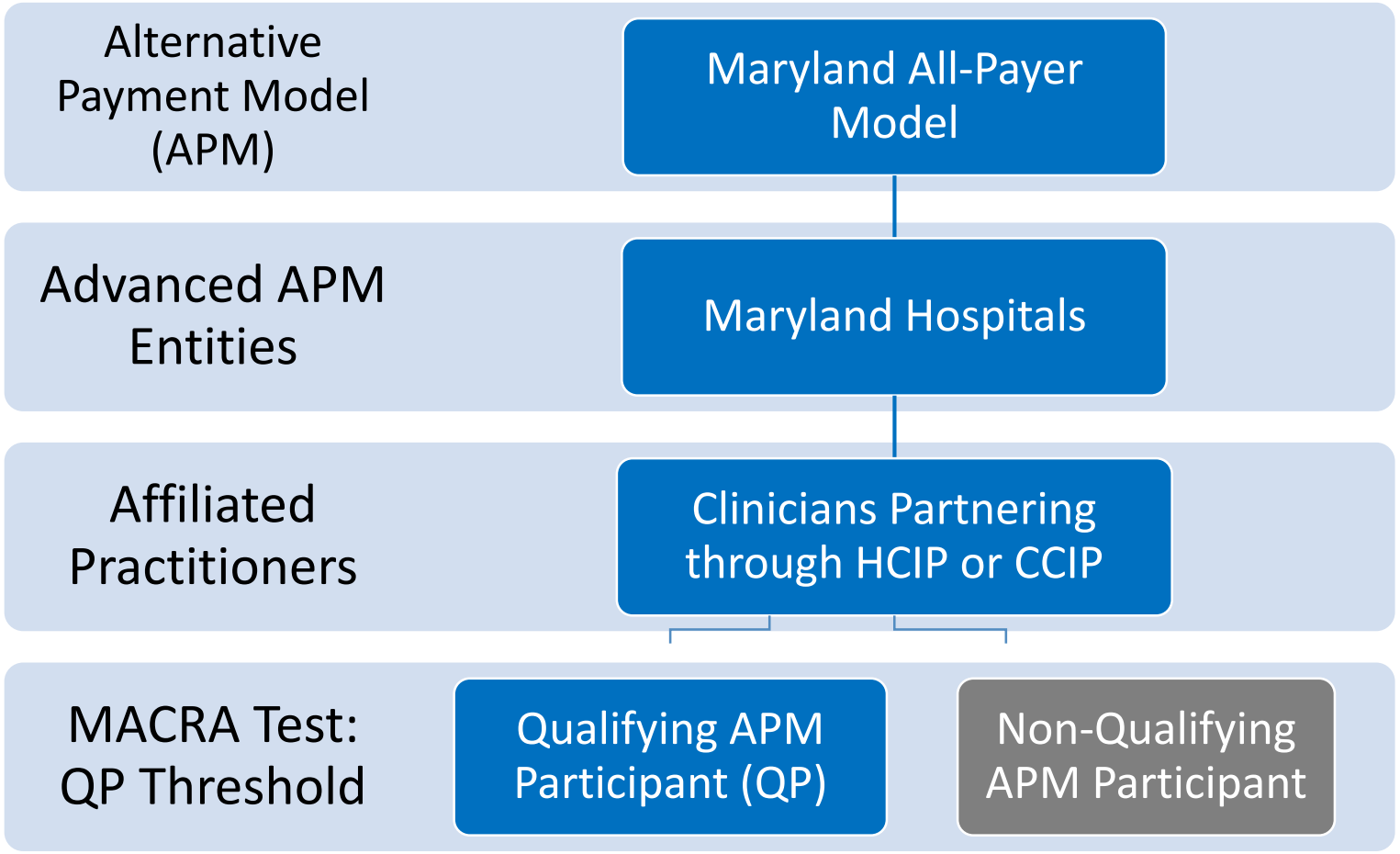
Update on Care Redesign Amendment Programs (HCIP and CCIP)

Update on VBM Concept Paper for CMS

Overview of VBM Concept Paper

- Seeking CMS determination that:
  - Maryland hospitals are Advanced APM Entities; and
  - Clinicians participating in Care Redesign Programs (HCIP, CCIP) are eligible to be Qualifying APM Participants (QPs) based on % of Medicare beneficiaries or revenue from Maryland residents (potentially also including PSAs in other states)
- Emphasis that Medicare financial responsibility is already borne by Maryland hospitals
  - Hospital-specific GBR
  - Statewide TCOC
- Illustrates how VBM is designed to further satisfy federal MACRA requirements — by placing hospital revenue at risk similar to other quality programs, based on a hospital-specific measure of Medicare TCOC
  - Consistent with Progression Plan

Proposed MACRA framework for MD



Eligible clinicians for 2017 defined as physicians, nurse practitioners, physician assistants, certified nurse specialists, and CRNA

Maryland's Proposed QP Threshold Approach

- Under MACRA, two threshold tests for QPs:
  - Patient-count threshold: % of a clinician's "attribution-eligible Medicare beneficiaries" who are under Advanced APM Entity
    - 20% in 2017 or 2018, 35% in 2019 or 2020, and 50% thereafter
  - Payment-amount threshold: % of a clinician's Part B payments for beneficiaries who are under Advanced APM Entity
    - 25% in 2017 or 2018, 50% in 2019 or 2020, and 75% thereafter
- Proposed for Maryland:

$$\%\ Patient = \frac{Clinician's\ Beneficiaries\ Residing\ in\ Maryland}{Clinician's\ Total\ Beneficiary\ Count}$$

$$\%\ Payment = \frac{Clinician's\ Part\ B\ Payments\ for\ Beneficiaries\ Residing\ in\ Maryland}{Clinician's\ Total\ Part\ B\ Payments}$$

Concept Paper Largely Based on Summary from Last TCOC Work Group Meeting (sent 2/17)

- Changes based on feedback from TCOC Work Group
  - Emphasizes hospital financial risk on statewide TCOC
  - Provides examples in Concept Paper of revenue at risk under VBM
  - Provides examples for measuring hospital-specific TCOC
- Shows a sample VBM based on scaling, consistent with other HSCRC policies
- Technical issues need to be resolved before implementing a VBM

Option for Scaling VBM Payment Structure

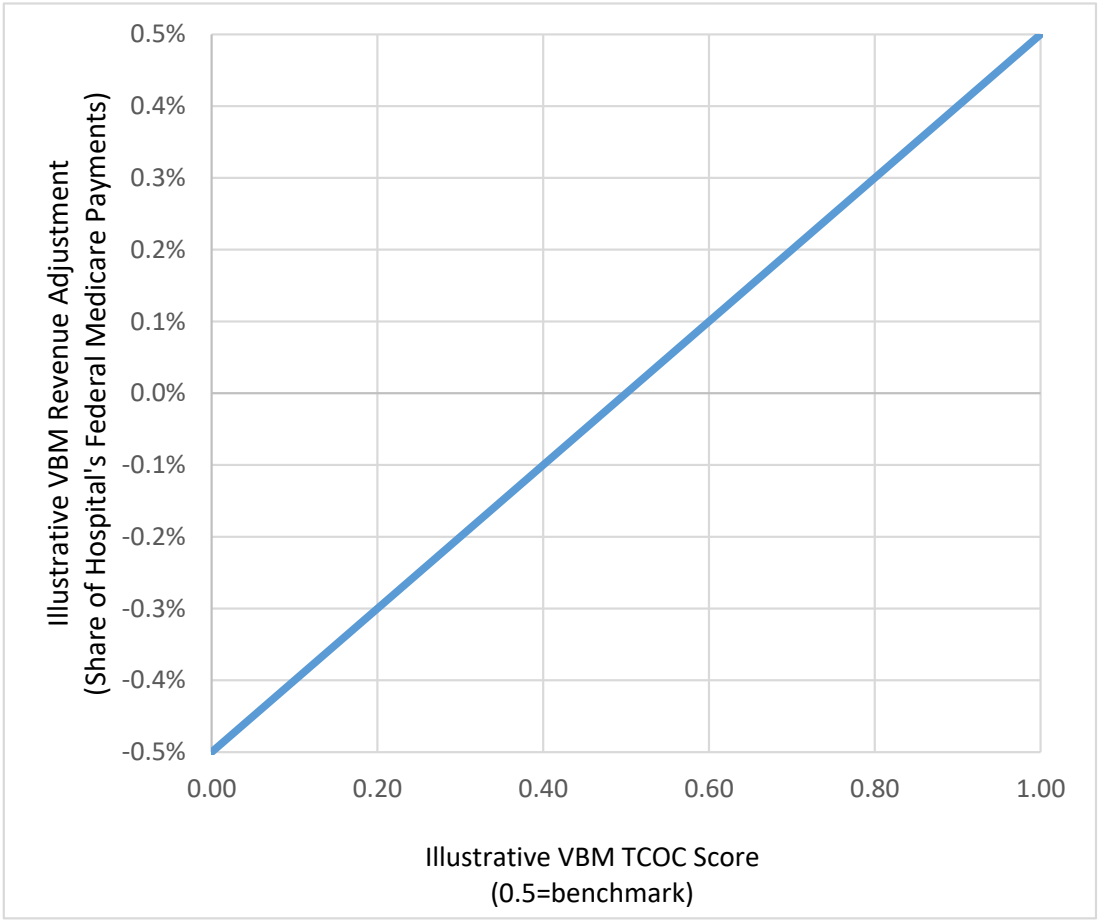
Option for Hospital-specific VBM Scaling Structure

- VBM could use a scaling approach, like other HSCRC programs, such as the Maryland Hospital Acquired Conditions (MHAC) program.
- Each hospital's TCOC performance relative to its benchmark could be transformed to a 0-1 scale.
- Hypothetical, illustrative example:
  - Hospital TCOC benchmark = 0.5
  - Score = 0 (max penalty) if TCOC is ≥3% **above** benchmark
  - Score = 1 (max reward) if TCOC is ≥3% **below** benchmark
  - Illustrative max penalty/reward = 0.5% of Medicare hospital revenue

Hypothetical Illustration under a Potential Value-Based Modifier (VBM)

Based on Hospital Scores on Medicare Total Cost of Care (TCOC), with Maximum Penalty and Reward of 0.5% of a Hospital's Medicare Federal Payments

TCOC Score	VBM Revenue Adjustment
0.00	**-0.50%**
0.05	-0.45%
0.10	-0.40%
0.15	-0.35%
0.20	-0.30%
0.25	-0.25%
0.30	-0.20%
0.35	-0.15%
0.40	-0.10%
0.45	-0.05%
0.50	0.00%
0.55	0.05%
0.60	0.10%
0.65	0.15%
0.70	0.20%
0.75	0.25%
0.80	0.30%
0.85	0.35%
0.90	0.40%
0.95	0.45%
1.00	**0.50%**



Policy and Technical Issues for Work Group Consideration

Overarching Questions to Guide Work

1. How to measure hospital-specific Medicare TCOC?
2. How to set benchmarks for assessing performance on hospital-specific Medicare TCOC?
3. How much in financial responsibility (and rewards) should hospitals face for that TCOC performance?
4. How does the VBM interact with other HSCRC payment policies, and do they need adjusting?

How to Measure Hospital-specific Medicare TCOC?

- Issues to consider in a potential measure:
  - How much hospital spending is appropriately captured?
    - How does the method affect hospitals with overlapping geography?
    - How does the method deal with the costs from patients receiving the majority of care at a hospital outside of their residential geography?
  - How much non-hospital spending is appropriately captured?
  - How to handle costs from beneficiaries who do not see a hospital?
  - Is there (and should there be) a denominator? Otherwise, how to handle growth in population or episodes?
  - How does the method handle out-of-state beneficiaries?

Exclusions and Adjustments

- Are there reasonable exclusions from the TCOC attachment to a hospital, such as burn cases, transplants, and quaternary care?
- How to handle population differences (e.g., risk adjustment)?

How to set benchmarks for assessing TCOC performance?

- Once the method is set for attaching TCOC, how should the benchmark for performance be set?
  - What is the comparison group?
    - For example, compared to national performance, relative to other Maryland hospital performance, relative to own hospital performance, etc.
  - What is the comparison timing methodology?
    - For example, year-over-year performance, cumulative, compared to a base year, etc.
- Once a benchmark is set, how is success measured (for example, based on attainment or improvement)?
- What adjustments are needed?

How much responsibility/reward for TCOC performance under VBM?

- What is the maximum revenue at risk that hospitals should face under the VBM in Year 1?
- Should hospitals also have the potential for financial bonuses? If so:
  - Should they be symmetrical with financial penalties?
  - Should they be revenue-neutral on a statewide basis?
  - Should there be other conditions for receiving bonuses (e.g., hospital participation in Care Redesign Programs)?

How does the VBM interact with other HSCRC payment policies?

- How would the VBM be incorporated into the existing suite of Maryland hospitals' value-based payment?
- Do other payment policies need to change in response to the implementation of the VBM?

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