maryland
health services
cost review commission

Maryland Health Services Cost Review Commission

Steering Committee Meeting

September 11, 2020

Agenda

- Administrative Updates
- CTI Methodology Update
- MDPCP & Primary Care CTI Policy
- New COVID-19 CTI proposal

Key Dates

- Preliminary baseline data will be available by the first week of October.
- HSCRC is delaying the final CTI intake template submissions until **October 23** in order to allow hospitals more time to review that baseline period data.
  - Hospitals should submit an intake template for all CTIs they wish to participate in.
  - Hospitals are not limited to intake templates that they had previously submitted.
  - HSCRC will review the intake templates and may request modifications or clarifications based on our review of the intake templates.
  - Hospitals that do not submit an intake template by October 23 will not be eligible to participate.
- Some hospitals have requested special modifications to the existing intake templates. HSCRC will allow **previously requested** modifications to be submitted after October 23 as HSCRC finalizes the operations.

Requested Modifications

- Modifications to Care Transitions CTI:
  - Care Transitions for MDPCP attributed beneficiaries
  - Care Transitions for patients that have a touch with a particular NPI
  - Care Transitions for patients that are discharged to a particular SNF
  - Care Transitions for ESRD population*
- Modification to the Primary Care CTI:
  - Medicare beneficiaries with 2 or more visits to a primary care doctor (from NPI list) in the 12 months prior to the performance period.
  - Medicare beneficiaries with 1 or more visits to a primary care doctor (from NPI list) in the 18 months prior to the performance period.

*HSCRC will follow-up with interested hospitals to discuss issues with regard to this submission.

Follow-up Discussion Regarding CRISP Integration

During the last CT Steering Committee, CRISP presented on the integration that is possible between CTI and the encounter notification system.

- The Encounter Notification Service (ENS).allows hospitals and physicians to see patient care management information at the point of care.
- ENS allows users to submit a roster (panel) of their patients via a manual spreadsheet or automated interface.
  - The available data include: the Care Program; the Care Manager; Care Manager Contact Information.
  - These fields display at point of care and can serve as an alert for other providers seeing the patient that they are enrolled in a CTI cohort (or other care management program).
- HSCRC would like to ensure that CTI attribution is known at the point of care. This would physicians and hospitals to know whether the beneficiary is currently in an CTI Episode.

CTI Methodology Update

Risk-Adjustment for CTI

Comparison of Different Risk Adjustment Models

- Beneficiaries will be risk adjusted using the APR-DRGs weights and/or the beneficiaries HCC score.
  - A beneficiary with a risk adjustment score of 1.10 would have a target price that is 10% higher than an average beneficiary.
  - The risk adjustment is based on the average risk score of all beneficiaries in the hospital's CTI.
- Hospitals will receive two risk scores:
  - A “preliminary risk score” that is based on the risk score during the baseline period.
  - A “final risk score” that is based on the risk score during the performance periods.
  - Participants should recognize that their final target price will not be known until the end of the year when the final risk scores are known.

Risk-Adjustment Analysis

Considerations for the CTI population

The relationship between risk scores and cost is likely one-to-one, e.g. a 0.01 increase in the HCC correlates with 1 percent increase in total cost of care. However, the relationship may be non-linear for some CTI population.

Therefore, our actuaries analyzed:

1. Whether there are structural breaks in the relationship between APR-DRG / HCC and the total cost of care.
2. Whether there are non-linear relationships between the APR-DRG / HCC score and the total cost of care.
3. Whether there are interactions between the APR-DRG & HCC score.

If there are any unusual relationships, the HSCRC will adjust the final risk score.

Risk-Adjustment Validation

Initial Assessment of the Care Transitions Risk-Adjustment

HSCRC assessed the effectiveness of the risk adjustment methodology by examining "winners and losers" in the baseline period. A perfect risk adjustment would have two characteristics:

1. Half of hospitals would be above and half of hospitals would be below the risk adjusted target price in the baseline period; and
2. The absolute error between historical performance and the target price would be low.

The straightforward risk-adjustment process using APR-DRG and HCC works well for the initial CTI thematic areas.

- 49.7% of episodes were above the risk adjusted target price; 50.3% were below the risk adjusted target price.
- The net deviation from the target price by hospital was 0.1%.

Minimum Savings Rate

Overview and Approach

- CTIs should only reward hospitals that achieve statistically meaningful savings and should not reward hospitals that benefit only from statistical variation. Therefore:
  - HSCRC will exclude CTIs that have fewer than 30 episodes. These episodes are not large enough to accurately measure the TCOC savings.
  - For all other CTI, HSCRC will set a minimum savings rate (MSR) that is based on the number of CTI episodes that the hospital participates in.
- HSCRC calculated the MSR for CTI episode using an actuarial analysis.
  - Our actuaries calculated the MSR based on the mean and standard deviation of the CTIs.
  - The MSR set to at the 85% critical value for the CTI.
  - Monte Carlo cross-validation was used to validate the MSR using historical data.

PRELIMINARY: Minimum Savings Rate

MSR decreases as the number of CTI episodes increases

- The MSR will be set based on the number of CTI episodes that the hospital is participating in.
  - The number of episodes will be summed across ALL CTI thematic areas.
  - E.g. HSCRC will count the number of Care Transition episodes, Palliative Care episodes, etc. when determining the MSR.
- Some CTI Thematic Areas may have a separate MSR if the variation in their episodes is substantially different.
- Note that we HSCRC is considering that panel-based CTI require a separate MSR.

Number of CTI Episodes	Minimum Savings Rate
< 30	n/a
31 - 150	10.0%
151 – 250	6.0%
251 – 350	5.0%
351 - 750	4.0%
751 – 3500	2.5%
3500+	1.5%

Example of the Minimum Savings Rate

The MSR is a threshold and not a discount

Hospital A beats the MSR	
Number of CTI Episodes	450
Minimum Savings Rate	4%
Aggregate Benchmark	$10 million
Threshold	$400k
TCOC Performance	$9.5 million
Savings	$500k
MPA Payment	**$500k**

Hospital B does not beat the MSR	
Number of CTI Episodes	450
Minimum Savings Rate	4%
Aggregate Benchmark	$10 million
Threshold	$400k
TCOC Performance	$9.7 million
Savings	$300k
MPA Payment	**$0**

Overview of Current CTI Submissions

Preliminary Submissions for the CTI

- Initial submissions (across all Thematic Areas) cover 120k episodes and $2.3 billion in TCOC.
- The size of the initial CTI submissions varies substantially.
  - HSCRC has been working with hospitals to revise their submissions.
  - Please reach out to hscrc.care-transformation@maryland.gov with any questions.
- Final intake template submissions will be due in October 2020.

Care Transitions Episode Count			
Episode Threshold	*Too Low <30 Episodes*	*High MSR 30 - 150 Episodes*	*Sufficient > 150 Episodes*
# Hospitals	2 Hospitals	12 Hospitals	23 Hospitals

Revenue at Risk Under CTIs

Preliminary Submissions for the Care Transitions Thematic Area

- The Hospital's Revenue at Risk is equal to their share of statewide hospital revenues x statewide CTI Savings.
  - Ex. If statewide savings is $100 mil and the hospital's share of revenue is 10% then their revenue at risk is $10 mil.
  - Reminder: The hospital can earn positive CTI payments. Their revenue at risk is only $10 mil. if they do not participate in the CTI and/or they do not achieve any savings.
- The hospitals "real" revenue at risk is based on the difference between their savings and the average savings by hospital.

		Average Savings Rate				
		0.50%	1.00%	1.50%	2.00%	2.50%
Dollars under the CTI	$5 Billion	$25 Million	$50 Million	$75 Million	$100 Million	$125 Million
	$4 Billion	$20 Million	$40 Million	$60 Million	$80 Million	$100 Million
	$3 Billion	$15 Million	$30 Million	$45 Million	$60 Million	$75 Million
	$2 Billion	$10 Million	$20 Million	$30 Million	$40 Million	$50 Million
	$1 Billion	$5 Million	$10 Million	$15 Million	$20 Million	$25 Million

MDPCP & CTI

Increased TCOC Accountability for Hospital-Owned Practices

- The Maryland Primary Care Program (MPDCP) involves a substantial investment of care management fees but does not include accountability for reducing the TCOC of their attributed beneficiaries.
  - The Commission directed staff to develop options for increasing the practices.
  - HSCRC staff intend to recommend encouraging hospitals to participate in the CTI.
  - This policy will be included in the draft MPA Recommendation in October.
- Under this policy, hospitals that do not participate in a primary care CTI will be subject to an MPA penalty that is equal to the care management fees that the hospital or its practices receive.

MDPCP & CTI Operational Timeline

1. By October 23, Hospitals will submit their CTI proposals.
   - This should include the NPI that hospitals intend to use for participation in MDPCP.
   - For operational reasons (CMS screening, additions or withdrawals, etc.) this list may differ from the actual MDPCP participation list.
2. By mid-November, HSCRC will send a letter to hospitals that choose not to participate in a primary care CTI asking for the NPI of their affiliated practices.
   - Hospitals should indicate all NPIs without who they have an employment relationship with.
   - Submissions of the NPI lists will use a similar process as the MATT tool for the MPA.
3. In July of 2021, HSCRC will apply the MPA adjustment equal to the amount of the care management fees received by those Practices.
   - HSCRC will inform hospitals of the calculated CMF penalty in May of 2021.
   - The penalty amount will be based on the primary 6 months of care management fees.

Care Management Fee Penalty Amounts

	Hospital Owned CTO	Independent or No CTO
Hospital Owned Practice	The penalty is equal to the full care management fees.	The penalty is equal to the full care management fees.
Independent Practice	The penalty is equal to the CTO portion of the care management fees.	Not applicable.

Primary Care CTI Attribution

- The panel-based primary care CTI requires that the hospitals submit a list of NPIs. HSCRC then uses the NPI list to attribute beneficiaries.
  - Beneficiaries are attributed to the hospital if that hospital's NPIs provided the plurality of the beneficiaries' primary care E&M claims. The actual attribution algorithm is HSCRC's referral attribution and not CMMI's MDPCP attribution.
  - Beneficiary lists will not match up perfectly. Measurement for the CTI will be based on the HSCRC attribution.
- The hospital should submit their 2021 MDPCP NPIs. These NPIs will be used to create the baseline period panel and the performance period panel.
  - The NPIs will be required to be in both the baseline period and the performance period.
  - HSCRC will exclude NPIs that do not have claims in the baseline period.
- Beneficiaries will be attributed to the CTI by January 1 2021.
  - The hospital will receive the list of attributed beneficiaries and this attribution will be frozen for the duration of the performance period except for beneficiaries that meet an exclusion condition (blood clotting, COVID, etc.).
  - This differs from the actual MDPCP attribution lists.

CTI Savings Calculation

- The target price for the primary care-based CTI by multiplying the total cost of care per capita by the inflation factors for each setting of care.
  - The target price will be based on the beneficiaries who are attributed to the hospital in the baseline period.
  - This is different from the “same store” analysis that compares the attributed beneficiaries to themselves in a prior year.
- HSCRC will calculate the savings for the CTI by comparing the TCOC per beneficiary in baseline period and the performance period.
  - Per capital savings are equal to difference between the target price and the TCOC per beneficiary during the period.
  - Aggregate savings will be multiplied by the number of beneficiaries in the performance period panel.

Other CTI Policies Related to MDPCP

- The MDPCP policy is not intended to change other aspects of the CTI policy.
  - Hospitals can filter the MDPCP population if they would like to be measured on a subset of the attributed population.
  - However, some changes may be necessary.
- A hospital may choose to hierarchy their CTIs in order to ensure sufficient participation in other CTIs.
  - The hospitals will have the option of deciding which CTI has the first claim on a beneficiary. We will extend this option to primary care panels.
  - For example, a hospital that wants to prioritize care transitions over primary care would be allowed to count a beneficiary under care transitions, removing them from the primary care CTI.
- HSCRC intends to allow overlaps between two different hospitals CTI to the greatest extant practicable.
  - HSCRC will definitively indicate which overlaps are allowed in December after analyzing the final baseline data.
  - For overlaps that are not allowed, HSCRC will discuss individually with the hospitals.

New COVID-19 CTI Proposal

Proposed Intervention Description

Hospitals have begun to submit additional CTI proposals for development over the next year. The first submission focusses on COVID treatment. Interventions include:

- Telehealth program designed to provide virtual care for a wide range of services, settings, and types of care.
- Supports Emergency Department (ED) to rapidly screen, triage, and provide patient disposition.
- Implemented prior to COVID-19 crisis; has been particularly helpful for manage surge capacity and keep EDs free for higher acuity patients.
- These intervention were implemented prior to COVID-19 crisis and has been particularly helpful during COVID-19 to manage surge capacity and keep EDs free for higher acuity patients.

Proposed CTI Episode Trigger

The CTI Episode Trigger Requires three components:

1. An Emergency Department Virtual E&M Claim
2. Emergency Department Visit
3. A Hospital Admission

Discussion Questions:

- What Medicare codes should be used to identify an ED Virtual E&M claim?
- Which of these criteria should be required and which should be optional?

Population Filtering Conditions

	Age	Geographic Service Area	Number of Chronic Conditions	Prior Hospitalization / ED utilization	Episode Length
Criteria Options	Hospitals determine the age range their intervention targets	Hospitals may provide a list of 5-digit zip-codes	• Indicate a number of chronic conditions (CCs) • Hospital may provide a list of CCs • Option to indicate primary diagnosis ICD-10 codes	• Prior IP stays OR ED visits OR observation visits AND/OR • Time window for how recent that utilization was	• Hospitals may submit an episode length of: 30, 60, 90, 120, 150, or 180 days
Default if Criteria is not Specified	All Medicare beneficiaries (65+)	Use no geographic restriction	Any condition and no threshold of chronic conditions	No requirement on prior utilization	30 days

Next steps for COVID Teletriage

COVID-19 Teletriage

1. If interested in this CTI, hospitals should submit a high-level document to HSCRC summarizing:
    1. Intake process or flowchart for teletriage (i.e. patient comes to ED, virtual teletriage conducted in special rooms for teletriage, etc) and
    2. Proposal for identifying virtual teletriage visits in Medicare FFS claims
    3. *Please submit by next Friday, September 18*
2. HSCRC staff will create CTI population definitions and triggering criteria based on submissions from hospitals (step 1) and input from the SC
    1. Final population definitions and trigger criteria will be shared at the next CT SC meeting
3. Once the population definitions have been finalized, hospitals will be given the opportunity to indicate whether they want to participate

Next Steps

Next Steps

- Upcoming CT Steering Committee Meetings:
  1. October Care Transformation Steering Committee – will focus on MDPCP CTI and other final operational issues.
  2. November Care Transitions Steering Committee – will focus on the final minimum savings rates for CTIs.
  3. December Care Transitions Steering Committee – will focus on finalize overlaps policies.
- We will continue to develop the COVID teletraige and other CTI proposals.
- In January, we will begin to discuss methodological changes that can address NPI churn and moving way from a baseline period comparison for some panel-based CTIs.