



Care Transformation Initiatives (CTI) Subgroup

August 20, 2019

Agenda

- ▶ **Background & Rationale for the CTI Policy**
 - ▶ Justification for “Investments” in Care Transformation
 - ▶ CTI & ROI Introduction
- ▶ **Methodology to Calculate CTI Savings**
 - ▶ Identify the Population
 - ▶ CTI Algorithm
- ▶ **Policy Overview**
 - ▶ Reconciliation Payments with the MPA Framework
 - ▶ Reporting & Transparency
- ▶ **Timeline & Process**
 - ▶ Rolling Acceptance of CTI Proposals
 - ▶ Prioritization with the Care Transformation Steering Committee

Background & Rationale

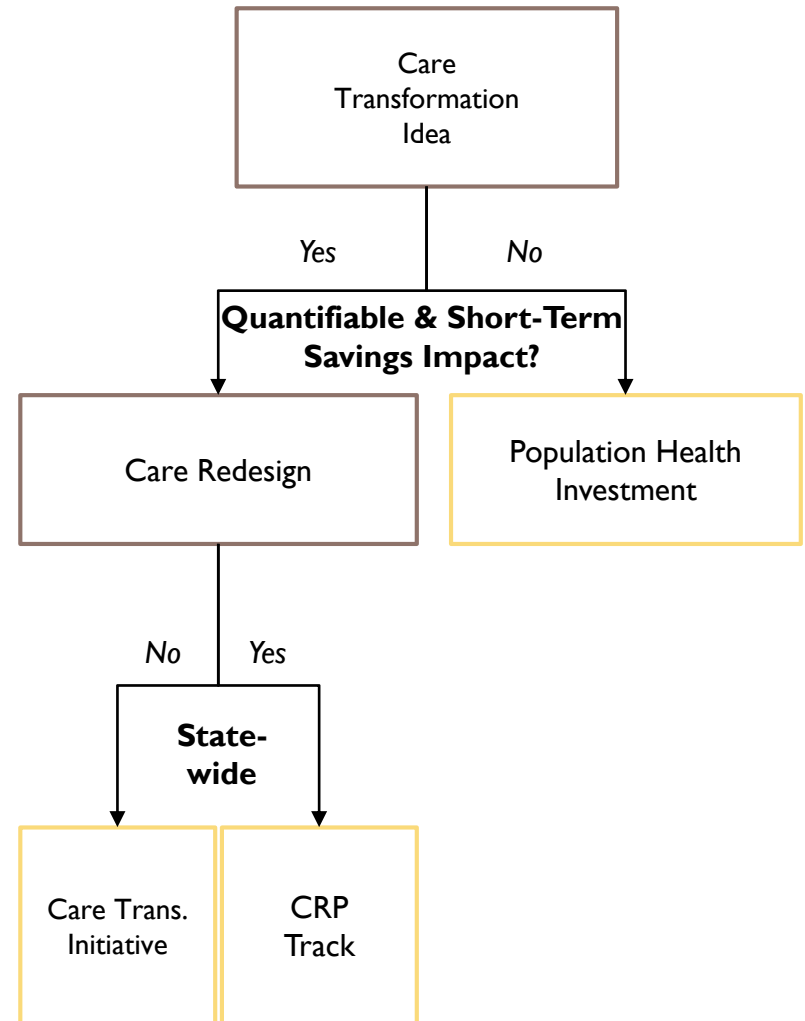


Care Transformation Initiatives Process

- ▶ A Care Transformation Initiative (CTI) is any initiative undertaken by a hospital or group of hospitals to reduce the total cost of care (TCOC) of a defined population
 1. Currently, this only includes the Medicare fee-for-service population. HSCRC Staff will include other payers as data becomes available
 2. Initiatives that cannot identify specific beneficiaries who are the target of the initiative will be classified as “population health” investments
- ▶ HSCRC is inviting hospitals to submit their CTIs so that Staff can assess their impact on TCOC and return those savings to the hospital

“Care Transformation” vs “Population Health”

- ▶ The CTI framework will likely not be able to accommodate population health investments. But...
 - ▶ Population health investments are very important
 - ▶ HSCRC Staff will continue to develop other approaches to include population health
- ▶ HSCRC staff are starting with CTI because...
 - ▶ CTIs are necessary (although not sufficient)
 - ▶ CTIs are ‘easier’ and within hospital’s traditional purview



Rationale for the CTI Process

- ▶ Hospitals should capture the returns from the interventions that they perform
 - ▶ Under currently policy, a hospital does not capture non-hospital savings they produce and the savings from avoided hospitalizations are diffuse across many hospitals
 - ▶ The CTI reconciliation payments will ensure that the hospital which produces the savings receives the rewards from those savings
- ▶ Hospitals **individual** level of effort is not well understood by the Commission or Staff
 - ▶ The CTI process will create an inventory of each hospital's level of effort and success at reducing TCOC
 - ▶ Understanding the savings produced through CTI has been a consideration in setting the Update Factor
- ▶ Staff is concerned about “free riders” that have not invested in care transformation but benefit from other hospital's success
 - ▶ The level of effort has implications for revenue distribution (e.g. retained revenue)

Future Work

- ▶ The CTI Process will assess the TCOC savings associated with an intervention. This is the “R” in ROI
 - ▶ Next steps will include accounting for the “I” in those interventions
- ▶ The CTI framework does not account for all Population Health Investments
 - ▶ Future work will develop a process that credits hospitals with their population health interventions as well
- ▶ The CTI can only be assessed when there is data available to track the population. Medicare data is available but other payers are missing
 - ▶ Future work will incorporate other payers into a similar framework

Methodology to Calculate CTI Savings

Identifying the Population

Identifying the Population

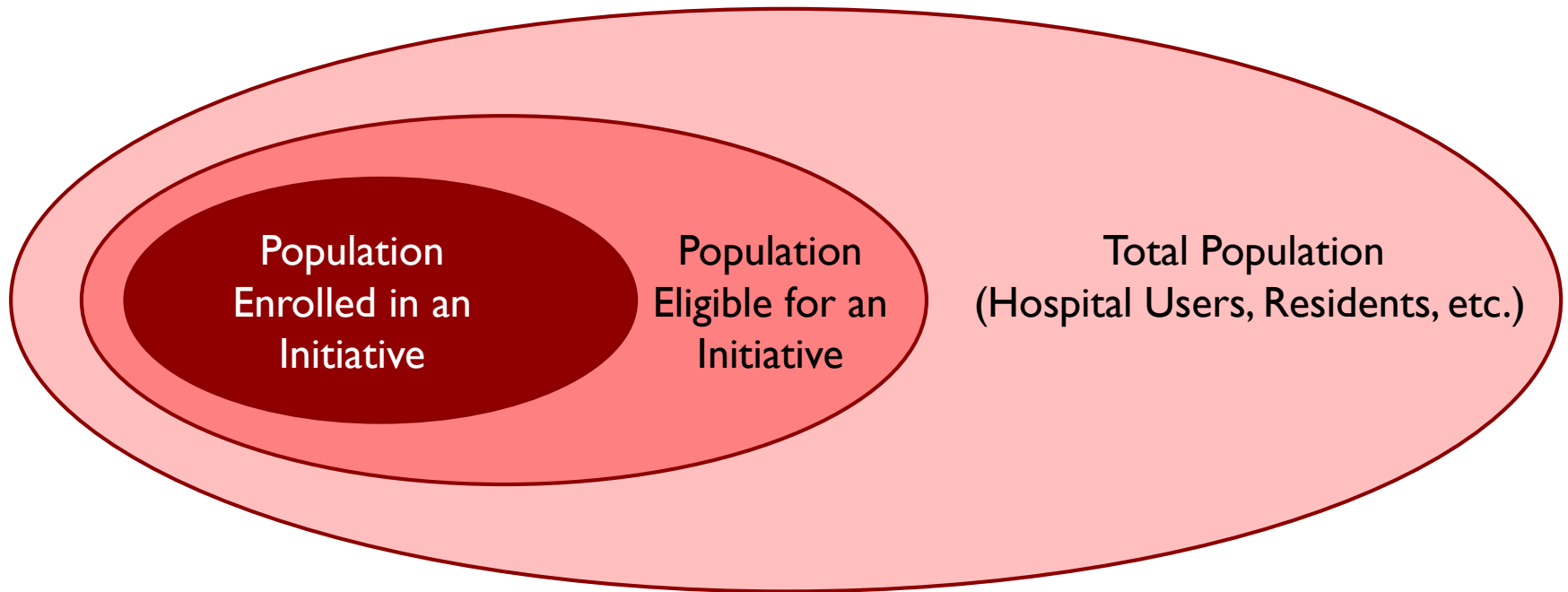
- ▶ The hospital must indicate which Medicare beneficiaries are eligible to participate in the intervention
- ▶ The trigger must be identifiable in claims data but may include **any** combination of:
 - ▶ Receipt of procedure(s) (e.g. hospitalization or count of ED visits)
 - ▶ Condition (chronic condition, primary diagnosis code, or DRG)
 - ▶ Geographic residency (by zip code or county)
 - ▶ Receipt of services from an indicated provider (CCN, TIN, NPI, or type of provider/specialty of supplier)
 - ▶ Other claims-based data as necessary

General Approach

- ▶ **Step 1: Choose the eligible population**
 - ▶ Identify beneficiaries who could benefit from the intervention (e.g. diabetic beneficiaries for a diabetes intervention)
 - ▶ Trigger based on the diagnosis of a condition (ICD principal diagnosis, chronic condition flag, etc.) or if beneficiary receives a certain procedure (IV-antibiotics, etc.)
- ▶ **Step 2: Restrict the population to those **most likely** to be impacted by the intervention**
 - ▶ Identify which eligible beneficiaries could have received the intervention from the hospital
 - ▶ Trigger based on a touch with the hospital or an associated provider
- ▶ **Step 3: Choose the intervention window**
 - ▶ The window could be 15, 30, 60, 90, 180, etc. days
 - ▶ All costs during the window (regardless of setting of care) are included
- ▶ The **final trigger** is a combination of the eligible population and those who may have been impacted by the intervention

Population Used for Assessing the CTI

- ▶ The CTI savings will be measured on the population that is eligible for the CTI, not based on who is actually enrolled in the initiative
 - ▶ The population eligible for an intervention is likely larger than the population actually enrolled
 - ▶ Hospitals should try to identify claims-based eligible criteria that get as close to the actual enrolled population as possible



Clarification: Intent-to-Treat Estimations Only

- ▶ Intent-to-Treat analysis is based on whether the beneficiary is in a group eligible for an intervention and not those who actually **receive** the intervention
- ▶ HSCRC Staff will use an Intent-to-Treat analysis in order to avoid methodological issues:
 - ▶ Selection bias
 - ▶ Regression to the mean
 - ▶ Intervention attrition
 - ▶ Etc.
- ▶ There are also policy and operational reasons to use an Intent-to-Treat analysis
 - ▶ Interventions with large effects on a small population should be compared to interventions with a small effect on a large population
 - ▶ HSCRC Staff lacks EMR data to determine if a beneficiary is enrolled in an intervention
 - ▶ This will encourage hospitals to maximize the size of their interventions

Example #1: ECIP

- ▶ ECIP is currently a Care Redesign Program and pays hospitals an episode-based payment for post-acute care costs
- ▶ Step 1: Identify the eligible population
 - ▶ Any patient with one of 23 conditions (hospitals may choose)
- ▶ Step 2: Restrict the population
 - ▶ Patients only become eligible when they are discharged from the participating hospital
- ▶ Step 3: The intervention window is 90 days
- ▶ **The Trigger** is anyone discharged from the participating hospital with one of the 23 conditions

Example #2: Palliative Care Interventions

- ▶ Hospitals have palliative care programs for seriously ill patients. Interventions begin after a non-claims-based assessment
- ▶ **Step 1: Identify the eligible population**
 - ▶ EXAMPLE: Any patient over 85+ years of age with 3+ chronic conditions
 - ▶ This is the population who **is eligible** to receive the intervention, not those who do receive the intervention
- ▶ **Step 2: Restrict the population**
 - ▶ The interventions are given by providers identifiable by their NPI
- ▶ **Step 3: The intervention window is 60 days**
- ▶ **The Trigger** is anyone 85+ years of age with 3+ chronic conditions and a claim associated with the palliative care team

Example #3: Mobile Integrated Health

- ▶ A hospital deploys a community-based team to provide home visits for patients that have called 911 six or more times
- ▶ **Step 1: Identify the eligible population**
 - ▶ 911 calls are not identifiable in the claims data
 - ▶ BUT ambulance transport is identifiable
 - ▶ For example: Find the overlap between six or more 911 calls and three or more ambulance transports
- ▶ **Step 2: Restrict the population**
 - ▶ Anyone living in the service area of the hospital's EMS program
- ▶ **Step 3: The intervention window is 180 days from the third ambulance transport**
- ▶ **The Trigger** is anyone who has three or more ambulance transports and lives in the hospital's EMS service area

Methodology to Calculate CTI Savings

CTI Algorithm

Overview of the Methodology

CTI savings will be assessed via a three-step algorithm

1. Calculate a **Target Price** using Baseline Beneficiary Per Member Per Month \$ (PBPM) and an Inflation Factor
2. Calculate a **Performance Period PBPM** by measuring TCOC for the population cohort
3. Calculate a **Reconciliation Payment** by comparing the Performance Period Per Member Per Month \$ to the Target Price

	Baseline Period	Performance Period	Reconciliation Payments
Baseline Population	<div style="border: 1px solid black; padding: 5px;"> <div style="background-color: #c00000; color: white; padding: 2px; display: inline-block; border-radius: 5px;">Step 1</div> Baseline Period PBPM x Inflation = Target Price </div>		<div style="border: 1px solid black; padding: 5px;"> <div style="background-color: #c00000; color: white; padding: 2px; display: inline-block; border-radius: 5px;">Step 3</div> Target Price – Performance Period PBPM x Number of Benes = Reconciliation Payment </div>
Intervention Population	<div style="border: 1px solid black; padding: 5px;"> <div style="background-color: #c00000; color: white; padding: 2px; display: inline-block; border-radius: 5px;">Step 2</div> Performance Period PBPM </div>		

Step 1: Baseline Costs

1. Identify the “Baseline Population”
 - ▶ The baseline population is the cohort that met trigger condition in the baseline year
 - ▶ The baseline year is the year prior to the intervention going live or the most recent data available
2. Calculate the total cost of care for the baseline population
 - ▶ The baseline costs are the **average per beneficiary per month costs**, e.g. divide the total cost of care for the baseline population by the number of beneficiaries
 - ▶ Costs are measured over the intervention window (e.g. 15, 30, 60, 180 days etc.)

Step 1 (cont.): Inflation Factor and Risk Adjustment

- ▶ **The baseline costs will be multiplied by an inflation factor to calculate current year dollars for the Target Price**
 - ▶ The inflation factors will be equal to the Medicare FFS update factor for each setting of care except for the hospital setting
 - ▶ The hospital setting will use the HSCRC's update factor as the inflation factor
- ▶ **Casemix / risk adjustment will also be applied as needed**
 - ▶ For interventions beginning in the hospital, HSCRC Staff will use the casemix index
 - ▶ For intervention that are initiated outside of the hospital, HSCRC Staff will use the HCC score

Step 2&3: Reconciliation Calculation

1. Identify the “Intervention Population” (e.g. the cohort that met the trigger condition in the Performance Period)
2. Calculate the “Performance Period PBPM”
 - ▶ Determine the Performance Period PBPM cost of the Intervention Population (e.g. divide the total cost of care for the baseline population by the number of beneficiaries)
 - ▶ The same time window will be used for both the baseline and intervention periods
3. Calculate the TCOC Savings
 - ▶ Subtract the Performance Period PBPM from the Target Price and multiply by the number of beneficiaries
 - ▶ The aggregate Reconciliation Payments will be made through the MPA-RC (more details provided in later slides)

Option: Inclusion of Hospital Costs

- ▶ To date, HSCRC has excluded hospital costs from Care Redesign Program savings (ECIP) because that revenue is retained under the GBR
- ▶ Under the CTI process, the HSCRC Staff will include savings produced by avoided hospital costs
 - ▶ This will fully reflect the effect of an intervention
 - ▶ This will also allow a hospital to capture savings when they reduce utilization at another hospital
- ▶ Including hospital costs introduces issues that will need to be addressed...
 - ▶ Hospital costs will require special inflation factors
 - ▶ “Double payment” for the avoided hospitalizations

Disclaimer: HSCRC Adjustments

- ▶ HSCRC reserves the right to modify the reconciliation calculations in two ways:
 1. In the event that a target population is small, the HSCRC may require a hospital to meet a savings threshold before making a reconciliation payment
 2. If the baseline period PBPM no longer appears to be a valid counterfactual, then the HSCRC may make adjustments to the baseline
- ▶ Any adjustment to the reconciliation payment methodology will be made **prospectively** and vetted with the industry

Example #1: ECIP

- ▶ **Baseline Costs:** calculate the PBPM costs of patients discharged from the hospital for one of the 23 chronic conditions in 2018
 - ▶ Calculate the historical costs separately for all 23 episodes
 - ▶ Apply SOI risk adjustment
- ▶ **Target Price:** calculate by multiplying the Baseline Costs by an Update Factor
 - ▶ Use the update factors for Medicare fee-schedules (PFS, SNF PPS, etc.)
 - ▶ Only post-acute care costs are included so no hospital adjustments are necessary (these could be included in the future)
- ▶ **Hospital's Reconciliation Payments:** calculate by comparing the Performance Year Costs to the Target Price
 - ▶ Calculate the PBPM costs of patients discharged from the hospital for one of the 23 chronic conditions in 2019
 - ▶ Calculate the difference between the Performance Period PBPM costs and the Target Price
 - ▶ Multiply by the number of beneficiaries to get the final Reconciliation Payment amount

Example #2: Frequent ED Utilizers

- ▶ **Baseline Costs:** calculate the PBPM costs of patients with 3+ ED visits in 2018 who have received a service at the hospital
 - ▶ Apply SOI risk adjustment
- ▶ **Target Price:** calculate by multiplying the Baseline Costs by an Update Factor
 - ▶ Use the update factors for Medicare fee-schedules (PFS, SNF PPS, etc.)
 - ▶ Update hospital costs by the HSCRC update factor
- ▶ **Hospital's Reconciliation Payments:** calculate by comparing the Performance Year Costs to the Target Price
 - ▶ Calculate the PBPM costs of patients with 3+ ED visits in 2019 who have received a service at the hospital
 - ▶ Calculate the difference between the Performance Period PBPM costs and the Target Price
 - ▶ Multiply by the number of beneficiaries to get the final Reconciliation Payment amount

Policy Overview:
Medicare Performance Adjustment Reconciliation
Component (MPA-RC)

Reconciliation Payments for CTI

- ▶ **HSCRC Staff will allow hospitals to identify CTIs that should receive Reconciliation Payments**
 - ▶ As part of this process, HSCRC Staff will quantify the TCOC savings that each CTI produces
 - ▶ The hospital will receive 100% of the savings that are produced by the hospital's CTI
- ▶ **The savings will be paid to the hospital through an MPA “Reconciliation Component” (MPA-RC)**
 - ▶ The hospital's MPA adjustment will be increased by an amount equal to the TCOC savings divided by their Medicare revenue
 - ▶ Medicare will increase the paid amount on the hospital's charges over the following year

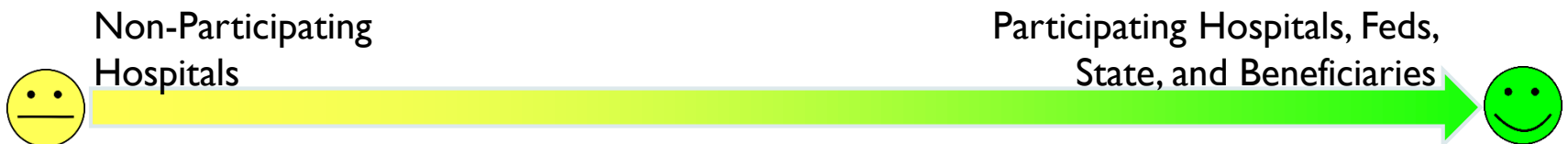
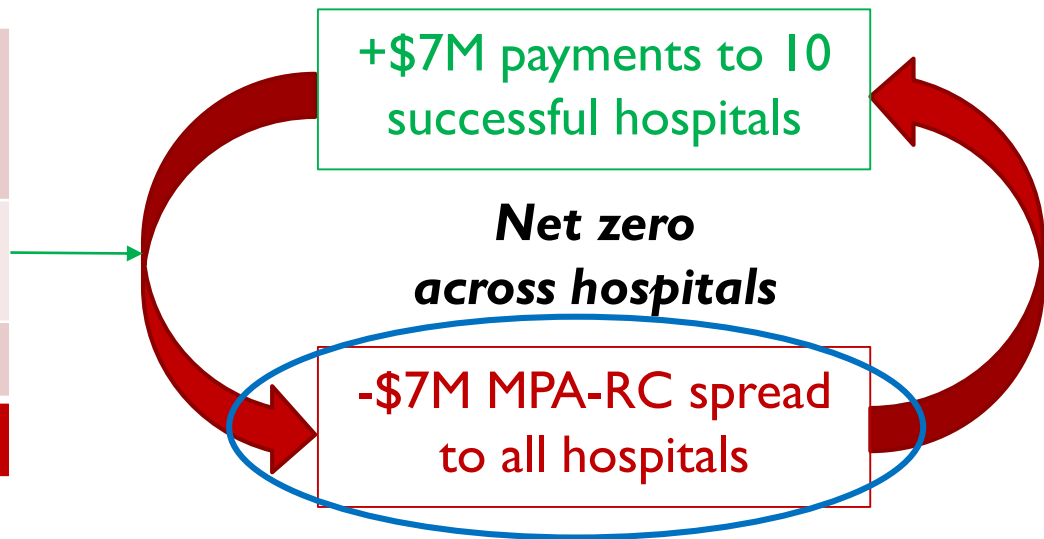
Net Neutral Offset for Care Transformation

- ▶ The savings produced by the CTI and paid to hospitals through “Reconciliation Payments” will be made in a net neutral manner
 - ▶ Any positive Reconciliation Payment to an individual hospital will be offset by a statewide MPA cut
 - ▶ The offset will be allocated based on the hospital’s share of statewide Medicare revenues
- ▶ The net neutral offset is intended to discourage “free riders”
 - ▶ Costs of CTIs will be born by hospitals that are not participating or are not successful
 - ▶ HSCRC Staff are committed to revisiting the need for an offset in the future if revenue equity issues have been addressed

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

- 10 hospitals generate \$7M in savings and receive \$7M in Reconciliation Payments
- Reconciliation Payments are offset across all hospitals in proportion to their share of statewide Medicare spending

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



Future Policy Work

- ▶ The CTI process may overlap with other policies currently in existence. Future policy work may be needed to address issues such as...
 - ▶ A CTI that avoids hospitalizations at another hospital and therefore creates retained revenue for that hospital
 - ▶ The MPA attribution and the CTI target populations will not perfectly overlap
- ▶ Staff propose to discuss these issues in further workgroups. In the interim, some payments may be duplicated by the CTI process
 - ▶ The expected magnitude of the payments is small early on
 - ▶ Magnifying the incentives will encourage participation

Reporting & Transparency



Reporting on CTI Performance

- ▶ HSCRC/CRISP are developing a tool that will report hospital's CTI performance
- ▶ The tool will show:
 - ▶ The number beneficiaries that meet the trigger condition
 - ▶ PBPM costs of the Baseline Population and the Target Price
 - ▶ PBPM costs of the Intervention Population
 - ▶ Data will be updated on a monthly basis to allow hospitals to see their performance in real-time
 - ▶ The tool will **possibly** show statewide aggregate savings in real-time
- ▶ The development of the CTI tool will be user-tested with the CT Steering Committee and CRISP's RAC

Savings Calculation

- ▶ **The savings amount for the Reconciliation Payments will be calculated from the CTI tool**
 - ▶ No additional reporting will be required from hospitals
 - ▶ Hold for applause
- ▶ **Savings will be calculated relative to a consistent base-period**
 - ▶ This will allow hospitals to earn savings on interventions that take time to become effective
 - ▶ The base period would only be updated in the future if the compounded inflation factors become unreliable
- ▶ **Savings will be calculated on either a semi-annual or annual performance period**

Options for Timing

- ▶ Staff are considering two timing options for making calculations and payments:
 1. Semi-annual performance periods (Jan-June with payments the following July; and July-Dec with payments the following Jan)
 2. Annual performance periods (July-June) with payments made in July
- ▶ Final payment amounts would be known 1-2 months before their effective date
- ▶ Semi-annual payment adjustments will make the reward occur closer to the beginning of the intervention but would create a payment adjustment mid-year
 - ▶ Staff would like input from the industry on their preferred option

Timeline & Process



Now Accepting Submissions for a January 1st Start

- ▶ **Hospitals may submit their CTI proposals at anytime**
 - ▶ Hospitals should submit their CTI to HSCRC.care-transformation@maryland.gov
 - ▶ HSCRC Staff will reach out to provide technical assistance on the CTI submissions
- ▶ **HSCRC will build a CTI Reconciliation Payment for all proposals that have a valid trigger**
- ▶ **However, the Care Transformation Steering Committee will prioritize which proposals are developed first**
 - ▶ Proposals prioritized based on the number of hospitals conducting similar CTI proposals
 - ▶ This is intended to maximize all hospitals' opportunity to participate in CTI

CTI Review Process

Meeting #1:

- Share tracker of initiatives with Committee (with number of hospitals per CTI Area)
- Ask hospitals to present their proposals with the Steering Committee
- Ask for Committee consensus on which we should prioritize for future meetings

Meeting #2:

- HSCRC will present an initial approach to identifying the savings
- Gather feedback on the initial approach

Meeting #3:

HSCRC presents initial population & costs estimates for agreed CTI priority areas



MPA Reconciliation
Payment to Hospital



Start Date for New CTI Initiatives

- ▶ Prior to starting a CTI, HSCRC Staff and the industry will need to
 - ▶ Identify the baseline population
 - ▶ Set the target price
- ▶ The CTI will start at the next semi-annual performance period (either January 1st or July 1st)
- ▶ The first Reconciliation Payment will be made 1 year after the end of the CTI performance period to allow for...
 - ▶ A 6-month episode completion
 - ▶ A 3-month claims runout
 - ▶ A 3-month calculation and verification period

Next Care Transformation Steering
Committee Meeting:
September 6th

