maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting (CTI Focused)

October 30, 2024

Agenda

- VBCI Tool Update
- Care Transformation Initiatives
  - Overview & Methodology
  - Comment Letter Recap
  - Areas of Change/Potential Change
    - Stop-Gain Analysis
    - Improvement Only Considerations in the CTI Offset
  - PY2 Results
- Next Steps & Upcoming Meetings

VCBI Tool Update

Value Based Care Insights (VBCI) Released 10/22/2024

- The Milliman MedInsight® VBCI Tool supports hospitals in evaluating total cost and utilization trends across their Medicare beneficiaries using claims (CCLF) data.
- Using Milliman's Well Managed benchmark based on National Medicare data and a State of Maryland benchmark to identify savings opportunities, VBCI provides hospitals and the state actionable insights for reducing total cost of care.
- VBCI offers several dashboards with seamless drill throughs from high-level summary data to patient-level details. Users can explore a series of detailed reports filtering across such measures as utilization and cost by service category, potentially avoidable services, and post-acute care.
- Access to VBCI is through the HIE Portal for credentialed users: https://portal.crisphealth.org
- Please reach out to CRS Support at VBCI-support@crisphealth.org with any questions.

Overview and Methodology

Overview of the Care Transformation Initiatives (CTI)

- Since early in the All-Payer Model, the HSCRC attempted to develop ‘alignment programs’ which encourage hospitals to partner with non-hospital providers to reduce TCOC.
- These early programs did not work for a variety of reasons:
  - There was a disconnect between hospital’s clinical efforts and programs developed by the HSCRC.
  - Hospitals had to earn substantial savings before they receive a reward and it is costly for hospitals to manage TCOC effectively.
  - Thus the ROI for participation was highly uncertain.
- The CTI program overcomes these problems by:
  - Allowing hospitals to define their own populations to focus on.
  - Providing all hospitals with ‘first dollar’ savings.
  - Distributing savings in a net neutral manner, so hospitals that do not participate (or do not make a successful effort) in care transformation are penalized.

Recap of CTI Methodology

- CTI are grouped into “thematic areas” which share a common attribution methodology and parameters that hospitals can use to select their population.
  - For example: in the Care Transitions Thematic Area beneficiaries are attributed to the hospital where they are discharged from. The hospital can limit the CTI population based on DRGs, chronic conditions, number of prior hospitalizations, etc.
  - There are five thematic areas: Care Transitions, Palliative Care, Primary Care, Geographic, and ED Care.
  - Hospital Outpatient Services (HOPD) added for PY4.
- Each CTI has a target price that is based on the TCOC of the beneficiaries attributed to the CTI in the baseline period.
  - Baseline period costs are updated for inflation and risk adjusted.
  - This compares hospitals to their own historical performance. In other words, this is an improvement only program.
  - Baseline periods can be set back as far as FY17 to try and recognize early adopters.
- Hospitals earn savings if their performance period costs are less than the target price.
  - Hospitals earn 100% of the savings they achieve that exceed a Minimum Savings Rate. This ensures that all payments are made for savings that are statistically significant.
  - All shared savings payments are offset on a statewide basis. Hospitals that are less successful in the CTI will pay for the savings of those hospitals that were successful in the CTI.
  - This ensures that Medicare continues to benefit from care transformation and also that hospitals which are not engaged in successful care transformation pay their fair share of meeting the statewide savings target.
- See https://www.crisphealth.org/learning-system/cti/ for more information

Recap of Calculation of Final Savings Amounts and Offsets

- Only positive savings are considered
- To be counted savings must meet a minimum savings threshold (MSR)
  - MSR is hospital specific and depends on the nature of the CTI and total episode volume
  - Hospitals are assigned separate MSRs for episode- and panel-based CTIs
  - Multiple similar CTIs can be combined to attain a lower MSR
  - If MSR is met, all savings are credited from first dollar
- Total positive savings are aggregated, and each hospital gets:

  \+ Hospital specific savings

  \- Hospital share of CTI statewide savings

  (hospital % of Medicare spending x statewide CTI savings)

  < *[Starting with FY23 Results]* Hospital impact limited to 2.5% of Medicare Spending (before redistribution of excess offset)

Comment Letter Recap

CTI Comment Letters Recap

Adventist:

- Suggests incorporating NCBP into CTI savings calculations.
- Suggests aligning CTI TCOC savings calculations with the Model TCOC savings test.
- FY24 - Suggests reversing the “tax” or offset immediately to redeploy excess CY24 savings & suggests to alternatively reverse rate order correction.
- FY25 – Modify CTI policy to include attainment provision similar to MPA targets & distribute tax or offset based on relative opportunity to generate Medicare savings calculated by Medicare FFS benchmarking.
- Supports Stop Gain of 10%

MHA:

- Suggests to continuing advocating for CTI buy-out methodology.
- Supports stop-loss provision with a standardized methodology to determine appropriate level.
- Concerned stop-gain limit could diminish incentives for maximum TCOC reductions.
- Requests consideration whether the offset methodology should account for equity considerations.

UMMS:

- Suggests limiting CTI policy changes during active and enrolled performance years.
- Supports a stop-gain mechanism but stresses it should 1) not aggressively dilute participation incentives & 2) be implemented before enrollment period.
- Suggests scaling stop-gain to county benchmarks and attainment in TCOC and suggests they should mimic CMMI policies.
- Does not support further reducing the Medicare revenue stop-loss threshold of 2.5%.
- Does not support scaling statewide savings pool for TCOC attainment - Suggests considering changing the CTI policy to not be revenue neutral.

CTI Areas of Change/Potential Change

CTI Areas of Change/Potential Change

Items with confirmed change/no change for this year

- For FY26 Pre-2022 baseline periods will no longer be available for new CTIs
  - Existing ones are grandfathered in
- Utilize a panel-based measurement approach rather than intent to treat
  - Intent to treat is the gold standard and is used in CMS programs
- Need for a coding intensity adjustment
  - Analytics shared in prior meeting show coding intensity is not the driver of savings
- Change the way CTI results translate into hospital rewards/penalties
  - No change to 2.5% of spending stop loss cap

Items for further discussion

- Institute a stop gain
- Revisit the “improvement only” nature of CTIs in the offset to better recognize regional differences

Stop-Gain Analysis

Stop-Gain Analysis

Research Question: What would be the financial implications of various stop-gain designs for CTI participants and the HSCRC?

- A stop-gain is a threshold of savings beyond which participants do not receive additional financial reward
- Examples of episode-based CMS payment models with a stop-gain:
  - Comprehensive Care for Joint Replacement (CJR)
  - Bundled Payments for Care Improvement Advanced (BPCIA)
  - Oncology Care Model (OCM)

20% stop-gain

Stop-Gain Analysis

Potential characteristics and pros/cons of an implemented stop-gain:

Level of Assessment	Pros	Cons
Apply stop-gain to individual CTIs	Targets outlier savings at the CTI level directly	May unduly penalize small, focused CTIs where large savings are feasible
Apply stop-gain across all CTIs at the participant level	Addresses outlier savings while allowing large savings to accrue	May not appropriately address risk of outlier savings

Amount of Stop-Gain	Pros	Cons
Stop-gain as a flat percentage of savings	Simplicity/equal application for all CTIs and participants	Does not account for variation (e.g., size) across CTIs
Stop-gain that varies by minimum savings rate (MSR)	Flexibility to account for variation by CTI and participant	Complexity

Stop-Gain Analysis

Proposed approach: a ***hybrid*** stop-gain assessed at the CTI level

- For each CTI, the stop-gain would be the larger between:
  - a flat ***10%*** savings rate or
  - ***3 times the CTI's pre-determined minimum savings rate (MSR)***

- ***Goal:*** to prevent the HSCRC from paying for outlier savings that occurred due to chance without unduly limiting rewards for participants that achieved large savings for a very targeted initiative.

Stop-Gain Analysis

- A hybrid CTI-level stop-gain allows for variation by CTI and participants while achieving reduced savings payouts to outliers of distribution
  - Would have reduced PY2 total savings paid out by $23 million (~12% of total savings)
- Next Steps: HSCRC will share a worksheet with detail by CTI as a follow up to the meeting. Spreadsheet will compare proposed approach to a flat 10% stop-gain.

Improvement Only Considerations in the CTI Offset

CTI Offset Background

- Under CTIs all scored savings that are paid out are offset by reducing payments to hospitals by an equal amount on a pro rata basis based on Medicare FFS spending.
- Savings net of the offset are limited to 2.5% of Medicare FFS payments with all eliminated savings shared back across all facilities in proportion to Medicare FFS payments.
- Offset was intended to:
  - Provide value for hospitals generating care transformation savings while maintaining savings to CMS
  - Prevent a free rider syndrome by "taxing" hospitals that choose not to participate in care redesign or are ineffective
  - Incent participation in care redesign by encouraging participation through limited downside risk and minimizing administrative barriers
- In addition to CTI payments hospitals benefit from CTI initiatives that reduce hospital utilization via the GBR (some of which accrues to hospitals other than the CTI owner)

But some stakeholders have raised a concern that the offset and the improvement only nature of the CTIs offset disproportionally "taxes" hospitals with lower opportunity.

“Improvement Only” Elements of CTIs

- Hospitals are measured on their ability to beat their own history. Performance against best practices or statewide averages is not considered.
  - Simple to measure
  - Incents participation by facilities with the greatest ability to deliver savings (connecting savings to an independent benchmark discourages participation by facilities who are below benchmark although they may have the most opportunity to create savings for the system).
- Offset is distributed across hospitals based on the Medicare FFS spending at the hospital
  - Was selected for simplicity
  - Reflects the size and financial wherewithal of the organization as well as being a reasonable proxy for “responsibility”
  - There is some correlation with opportunity - Medicare FFS Hospital spending is a component of opportunity
- Stop Loss is a flat 2.5% for all hospitals regardless of starting position.
- Combination of design elements mean hospitals in better performing TCOC areas have less opportunity to generate savings but experience roughly equivalent downside risk
  - HSCRC analysis has shown there is considerable variation in opportunity across the State.
  - Fixed cost intensive health system investment tends to be less fluid than population growth

Improvement Versus Attainment in the Traditional MPA

- The traditional MPA recognizes the varying level of opportunities. Requiring no savings below national trend from the lowest 20% TCOC areas and 1% improvement from the highest 20% (with others phased in between those limits)
  - This recognizes that higher cost areas can not instantly reduce costs to match others but holds them to a higher standard over time.
  - Lower cost hospitals are still held to matching national trend and can not loses sight of TCOC management
- HSCRC quality policies evolve over time in how they assess hospital performance generally focusing on the better of improvement or attainment. The CMS VBP also assesses performance based on the better of improvement and attainment.

Proposed Approach - Overview

- Staff believe introducing an attainment element to CTIs would increase fairness under the policy and that the easiest way is to adjust the offset distribution rather than changing CTI scoring.
  - Could be done by changing the offset methodology and the stop loss.
  - Or by just changing the stop loss
- Based on comment letters and other discussion Staff identified the following considerations in implementing an attainment component to CTIs:
  - Maintain the incentive for all hospitals to pursue care transformation, recognizing that in no area is the delivery system perfect
  - Ensure any method considers equity
  - Implement any approach prospectively so hospitals can make their decisions with the policy in mind (therefore first complete implementation would be for CTI Year Y5 (FY2026, with payment in FY2028)
  - Keep CTI policy aligned with other policies and maintain simplicity to the degree feasible.

Proposed Approach 1 – Adjustment Method

1. Effective with CTI Y5, instead of only considering hospital FFS spending in distributing the offset also consider the hospital's position under the HSCRC Medicare FFS TCOC benchmarking which reflects their total opportunity when compared to the nation.
2. To maintain simplicity, utilize the same 5 buckets as MPA for CTI.
3. Blend this approach with the current approach as shown on the **next slide**.

Buckets and adjustment level could mirror MPA:

TCOC Quintile Used in TCOC	MPA Savings Requirement (amount by target trend is lowered)	Proposed CTI Offset per $ of MC FFS Spending (using CTI Y2 results as an example)
1 (lowest TCOC)	0.00%	$0.0000
2	-0.25%	$0.0214
3	-0.50%	$0.0429
4	-0.75%	$0.0643
5 (highest TCOC)	-1.00%	$0.0857

Calculation of Proposed Offset: Middle tier is set at the average amount needed to offset all CTI savings (amount currently applied to all hospitals)[1]. Other tiers are then set in the same relationship as the MPA savings tiers. Values would change each year as middle tier is always reset to average value needed to reach full offset.

1. As quintiles are set by hospital not by spending not all quintiles have the same amount of spending as a result the calculation shown will not perfectly offset the savings, therefore all amounts would be proportionally raised or lowered to bring the total offset back to the total savings. Amounts on next slide are shown after this adjustment.

Proposed Approach 1 – Blend with Current Method

Blend the proposed approach with the current approach to maintain some CTI tax on all hospitals

- Staff wishes to retain a strong incentive to participate in CTIs
- While TCOC benchmarking is adjusted for demographics the ease of achieving all savings opportunities is not equal.

TCOC Quintile Used in TCOC	Current CTI Offset per $ of MC FFS Spending	Proposed CTI Offset per $ of MC FFS Spending w. True Up[1] (using CTI Y2 results as an example)	75/25 Split Current/New	50/50 Split Current/New	25/75 Split Current/New
1 (lowest TCOC)	$0.0429	$0.0000	$0.0322	$0.0214	$0.0107
2	$0.0429	$0.0209	$0.0374	$0.0319	$0.0264
3	$0.0429	$0.0417	$0.0426	$0.0423	$0.0420
4	$0.0429	$0.0626	$0.0478	$0.0527	$0.0577
5 (highest TCOC)	$0.0429	$0.0835	$0.0530	$0.0632	$0.0733

1. As quintiles are set by hospital not by spending not all quintiles have the same amount of spending as a result the base calculation will not perfectly offset the savings. Therefore, all amounts have been proportionally lowered to bring the total offset back to the total savings. . This results in different amounts from the prior slide and different Tier 3 amount than the current offset.

Proposed Approach 1 – Adjust Stop Loss

- In order to avoid diluting the impact of the change in the offset it would also be necessary to adjust the flat stop loss
- Stop loss could be adjusted using the same approach as the offset – blend of current flat stop loss with a stop loss tiered into the 5 quintiles

TCOC Quintile Used in TCOC	Current Flat Stop Loss	Stop Loss using Qunitile Logic (Middle = Average, Low = 0, High = 2x Middle)	75/25 Split Current/New	50/50 Split Current/New	25/75 Split Current/New
1 (lowest TCOC)	2.50%	0.00%	1.88%	1.25%	0.63%
2	2.50%	1.25%	2.19%	1.88%	1.56%
3	2.50%	2.50%	2.50%	2.50%	2.50%
4	2.50%	3.75%	2.81%	3.13%	3.44%
5 (highest TCOC)	2.50%	5.00%	3.13%	3.75%	4.38%

Proposed Approach 2 – Adjust Only Stop Loss

- Changing the offset as described will be complex, the tiering in the offset will change based on the savings each year.
- A simpler approach is to just adjust the stop loss to recognize differential opportunity – the same process could be used to set the stop loss. Amounts above the stop loss would still be shared back across all institutions.

TCOC Quintile Used in TCOC	Current Flat Stop Loss	Stop Loss using Quintile Logic (Middle = Average, Low = 0, High = 2x Middle)	75/25 Split Current/New	50/50 Split Current/New	25/75 Split Current/New
1 (lowest TCOC)	2.50%	0.00%	1.88%	1.25%	0.63%
2	2.50%	1.25%	2.19%	1.88%	1.56%
3	2.50%	2.50%	2.50%	2.50%	2.50%
4	2.50%	3.75%	2.81%	3.13%	3.44%
5 (highest TCOC)	2.50%	5.00%	3.13%	3.75%	4.38%

Comparison of Impact on Final Savings

- Data based on Y2 outcomes
- 50:50 scenario used in both approaches

TCOC Quintile Used in TCOC	Scored Savings (before offset and stop loss)	Payments Net of Offset and Stop Loss – As is	Payments Net of Offset and Stop Loss – Approach 1	Payments Net of Offset and Stop Loss – Approach 2
	$ in Millions (% of hospital MC FFS Spend)			
1 (lowest TCOC)	$31.3 (3.9%)	-$0.8 (-0.1%)	$12.8 (1.6%)	$4.6 (0.6%)
2	$60.8 (9.4%)	$32.1 (5.0%)	$38.3 (5.9%)	$32.4 (5.0%)
3	$47.0 (3.8%)	-$5.6 (-0.4%)	-$5.9 (-0.5%)	-$6.5 (-0.5%)
4	$39.9 (3.3%)	-$11.9 (-1.0%)	-$22.1 (-1.8%)	-$15.0 (-1.2%)
5 (highest TCOC)	$15.5 (2.4%)	-$13.9 (-2.1%)	-$23.1 (-3.5%)	-$15.4 (-2.3%)

Offset, after stop loss, is worth approximately 4.3%

Offset, after stop loss, ranges from 2.3% to 5.9%

Offset, after stop loss, ranges from 3.3% to 4.7%

Areas for Discussion

- Should an adjustment to recognize attainment within the CTI approach be made?
- If yes, are the proposed approaches reasonable solutions
- Within these approaches:
  - Should the greater impact of the offset+stop loss approach (#1) be pursued versus the simpler stop loss only approach (#2)
  - Within either approach is the 50:50 blend of improvement (non-tiered calculation) and attainment (tiered calculation) appropriate?
- Should the approach be implemented retroactively (for CT Y2 and 3) on a one-sided basis given savings above target.
- HSCRC will share an excel spreadsheet showing all of the options.

PY2 (FY 2023) Results

PY2 Savings – Key Takeaways

- All hospitals participated in the CTI program in PY2.
- Across all care transformation programs (CTI, ECIP, EQIP) nearly 40% of the State's Medicare population was attributed to a care transformation program in CY2023.
- During PY2, CTI's generated ~$195M in savings. This represents a 51% increase from PY1.
  - Net redistribution was $82M as compared to $56M in PY1.
- In PY1 there were 260K episodes and 305K in PY2, representing a 17% increase.

Overview of CTI Results – PY1

Thematic Area	Number of CTI	Avg. Episodes Initiated	Number Exceeding Target Price	Percent Exceeding Target Price	Number Exceeding MSR	Percent Exceeding MSR	Average Savings
Care Transitions	55	498	36	65%	28	51%	1.6%
Palliative Care	5	173	3	60%	3	60%	2.9%
Primary Care	23	7,946	14	61%	11	48%	2.2%
Geographic	10	3,095	5	50%	5	50%	3.2%
ED	14	1,287	8	57%	7	50%	1.0%
Total	107	2,430	66	62%	54	50%	1.9%

Overview of CTI Results- PY2

Thematic Area	Number of CTI	Avg. Episodes Initiated	Number Exceeding Target Price	Percent Exceeding Target Price	Number Exceeding MSR	Percent Exceeding MSR	Average Savings
Care Transitions	48	660	33	69%	26	54%	3.6%
Palliative Care	6	303	3	50%	3	50%	-3.8%
Primary Care	27	6,921	15	56%	11	41%	2.0%
Geographic	10	7,846	6	60%	5	50%	5.3%
ED	8	801	5	63%	5	63%	5.1%
Total	99	3,083	62	63%	50	51%	3.0%

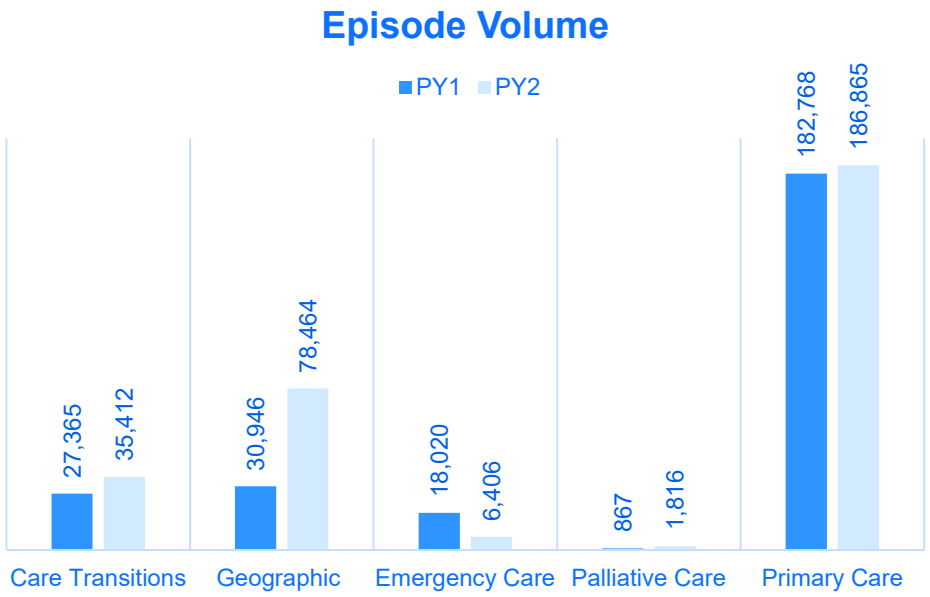
Average Savings – P1 & P2

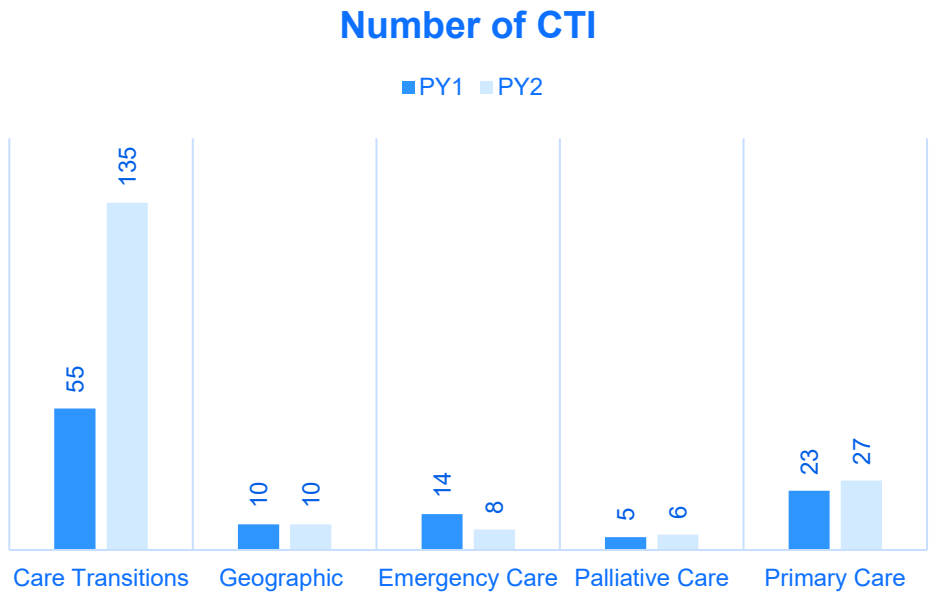
- All thematic areas saw an increase in average savings except for palliative care and primary care.
- ED increased by ~4% contributing to a total average savings increase from PY1 to PY2 of 1%.

Thematic Area	PY1 Average Savings	PY2 Average Savings
Care Transitions	1.6%	3.6%
Palliative Care	2.9%	-3.8%
Primary Care	2.2%	2.0%
Geographic	3.2%	5.3%
ED	1.0%	5.1%
Total	1.9%	3.0%

PY2 Volume Changes

- Growth in number of CTIs occurred primarily within the Care Transitions thematic area
- Geographic thematic area had a YoY increase in volume of 154% and Palliative care had a YoY of 109%.
- The only category to see a decrease during PY2 was Emergency Care with -64%.





What's next?

- Is it helpful to conduct further discussion regarding PY1 and PY2 as a larger group?

Next Steps

TCOC Workplan for Upcoming Months

- Upcoming TCOC Workgroup Dates (Dates have changed)
  - November 20, 2024 (8-9:30AM)
  - December Meeting Cancelled
  - January 22, 2025 (8-10AM)
  - 2025 Meeting Dates (Tentative) posted on TCOC Workgroup Webpage
- Future meetings topics:
  - November - Finalized MPA recommendation changes
  - November - Continue benchmarking discussion
  - January - AHEAD All-Payer financial targets discussion (Medicaid, Commercial, Primary Care Investment)
  - January - Update on savings drivers through June 2024
  - May add additional meetings specific to benchmarking

Thank You
Next Meeting November 20, 8-9:30 am