maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

September 18, 2024

Agenda

- Update on CTI Hospital Outpatient Department (HOPD) Services Thematic Area
- 2025 MPA/CTI Priorities Based on Comment Letters and other feedback
  - Care Transformation Initiatives
  - Medicare Performance Adjustment
- Advancing Innovation in Maryland (AIM)
- Next Steps

Update on HOPD Services Thematic Area

- New for current performance year
- Risk Adjustment
  - Will use HCC risk adjustment only
  - APR-DRGs are not relevant.
  - HSCRC considered using EAPGs but initial testing did not show increased explanatory power versus just HCC while adding complexity
- HSCRC is reviewing how this thematic area will fit into the minimum savings threshold waterfall

Recap of CTIs and Potential Changes for 2025

Recap of CTI Methodology

- Hospitals can design their own population target based on the parameters within each Thematic Area. Each Thematic Are provides a menu of selection options.
  - 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.
  - New thematic area for FY2025: Hospital Outpatient Services
- 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 in time to 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.
  - Bonuses and penalties are applied via MPA Reconciliation Component.
  - This ensures that Medicare continues to benefit from care transformation and 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

CTI Areas of Change/Potential Change

- For FY26 Pre-2022 baseline periods will no longer be available for new CTIs
  - Existing ones are grandfathered in
- Provide additional forum for discussion of CTI policies and procedures
  - Reinstitute the CTI steering committee for a temporary window?
- Utilize a panel-based measurement approach rather than intent to treat
  - Intent to treat is the gold standard and is used in CMS programs
- Change the way CTI results translate into hospital rewards/penalties
  - Institute a stop gain
  - Revise the 2.5% stop loss
  - Revisit the “improvement only” nature of CTIs in the offset to better recognize regional differences
  - Separate discussion to follow
- Need for a coding intensity adjustment
  - Is CTI performance a function of coding intensity drift?
  - Separate presentation to follow

Background - 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)

Potential Changes

- Revise Stop Loss
  - 2.5% threshold was based on Y1 results, far more hospitals hit the threshold in Y2.
  - Stop loss threshold limits opportunity for successful hospitals
- Institute a Stop Gain
  - Large number of hospitals hitting stop loss in Y2 was a function of small number of hospitals scoring very high gains
  - Institute a stop gain of X%? 10%?
    - High enough to maintain incentives while protecting against “windfall” scoring that might be a function of luck rather than program intervention
    - HSCRC reviewed CMS program, stop gains are more typically 20%+ but this is purely episodic based programs were higher savings rates would be expected.
- Adjust Dollars subject to the offset
  - Exclude innovation spending
  - Improvement Only Concerns
    - CTI rewards improvement against a hospital’s own baseline. Hospitals in lower cost area have less opportunity.
    - CTI Offset is in proportion to total Medicare spend and therefore does not recognize the varying opportunity. If region A has 3% opportunity and region B has 6% then Region A has 33% of the upside but bears close to 50% of the risk.
    - MPA targets are tiered to recognize these gaps, a change would make CTIs more conceptually equivalent.
    - Revise offset calculation:
      - Distribute offset based on relatively opportunity under HSCRC MC FFS benchmarking. Region A would bear only 33% of the offset as they have only 33% of the opportunity (assuming region A and B are equal in size)
      - Blend the existing calculation with an opportunity-based calculation as described in the prior bullet

Correlation between Coding Intensity (Risk Scores) and Episode Savings

Coding Intensity and Earned Shared Savings

Research Question: Is coding intensity driving success with shared savings?

If coding intensity was driving success, we would expect to see that:

- Changes in risk score and target price are positively correlated with earning shared savings against the adjusted target price (the target price after updating for changes in risk scores)
- Changes in risk score and target price are uncorrelated (or positively correlated) with earning shared savings against the baseline target price (the target price calculated using baseline risk scores)
    - If patients are not more complex over time (i.e., the baseline risk scores are still correct), then cost reductions should lead participants to be beat their baseline target price
        - If coding intensity increases, and practices do not make real efforts to reduce costs, then practices should still earn shared savings roughly 50 percent of the time (based on baseline target prices) due to chance fluctuations

Changes in Risk Score and Target Price are Uncorrelated with Earned Shared Savings Against Adjusted Target Price

- For example, across all CTIs, a 1.0 percent change in risk score is correlated with a <0.1 percentage point change in the probability of earning shared savings against the adjusted target price (p=0.943).

Change in the Probability of Earning Shared Savings Against Adjusted Target Price

Independent Variable	All CTIs	Small CTIs	Large CTIs	CTI 03-05	CTI 01-02
One percent change in risk score	-0.0	0.0	-0.1	-0.3	0.0
p-value	*0.943*	*0.918*	*0.800*	*0.660*	*0.921*
One percent change in target price	0.1	0.0	0.7	1.1	0.0
p-value	*0.822*	*0.924*	*0.335*	*0.477*	*0.929*

Notes: All estimates are reported in percentage point terms
Small = < 200 Episodes; *Large* = 200+ episodes
CTI 03-05: Not triggered by inpatient discharge; *CTI 01-02*: Triggered by inpatient discharge

Changes in Risk Score and Target Price are Negatively Correlated with Earned Shared Savings Against Baseline Target Prices

- For example, across all CTIs, a 1.0 percent increase in risk score is correlated with a 1.5 percentage point reduction in the probability of earning shared savings against the baseline target price ($p<0.001$).

Change in the Probability of Earning Shared Savings Against Baseline Target Price

Independent Variable	All CTIs	Small CTIs	Large CTIs	CTI 03-05	CTI 01-02
One percent change in risk score	-1.5	-1.2	-2.1	-2.4	-1.2
p-value	*< 0.001*	*< 0.001*	*< 0.001*	*< 0.001*	*< 0.001*
One percent change in target price	-1.5	-1.1	-3.3	-4.8	-1.2
p-value	*< 0.001*	*0.002*	*< 0.001*	*< 0.001*	*< 0.001*

Notes: All estimates are reported in percentage point terms
Small = < 200 Episodes; *Large* = 200+ episodes
CTI 03-05: Not triggered by inpatient discharge; *CTI 01-02*: Triggered by inpatient discharge

Analyzing Outliers

CTIs in the top five percent in terms of change in target price, and those in the top five percent in terms of change in risk scores, both had:

- Overall rate of earning shared savings: 56%
- Overall rate of earning shared savings versus baseline target price: 11%
    - Shared savings against baseline target prices should occur at least 50% of the time, on average, if increases in risk score don't reflect true increases in patient complexity

Conclusion

- Evidence is consistent with target price changes caused by increased patient complexity rather than increases in coding intensity
  - True among high- and low-volume CTIs, CTIs with and without inpatient triggers, and CTIs with the largest changes in target prices
- While we cannot rule out the possibility that some increase in coding intensity occurred, we can be confident that it is not widespread

Recap of MPA and Potential Changes for 2026

Recap of current traditional MPA

1. Attribute Medicare FFS beneficiaries to hospitals on a geographic basis
    1. AMCs have extra layer focused on high-acuity individuals
2. MPA penalizes or rewards hospitals based on a subtracting:
    1. The cumulative growth since 2019 in their attributed per capita TCOC from
    2. Cumulative national growth in per capita TCOC less a hospital specific growth rate adjustment
3. Each hospital's growth rate adjustment is set based on their position versus target in 2019.

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1st Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2nd Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3rd Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4th Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5th Quintile (+21% to +28% Relative to Benchmark)	-1.00%

4. The result is then multiplied by 0.33 and capped at 2% of Medicare revenue then adjusted for quality to derive the final value.

MPA Areas of Concern

- Misalignment of MPA and TCOC Results
  - MPA is cumulative since 2019, TCOC scoring is typically reviewed on a year-over-year basis
  - MPA performance compares to 2019 basis 2023 TCOC performance compared to much weaker 2022 basis
  - TCOC results include Non-claims-based payments. MPA only includes MDPCP related items in Maryland.
- MPA continues to be hard for hospitals to manage due to:
  - Large number of attributed beneficiaries who hospital does not touch
  - Dilution of “effort to outcome” connection experienced by hospitals, particularly smaller ones, in urban areas due, to significant overlaps in service areas
  - Challenge in connecting specific hospital initiatives to geographic-based populations on a year-to-year basis
- Hospitals can only receive detail data for beneficiaries with whom they have a treatment relationship, not all attributed beneficiaries.

Potential Changes

- Revise MPA attribution threshold and data sharing rules
  - Subject of AHEAD negotiation
- Add Non-Claims Based Payments to MPA scoring
  - CMS has also expressed an interest in doing this
  - Amounts would have to be an estimate during the year due to lack of data, with an update in final scoring
  - Maryland non-MDPCP amounts may not be available at a beneficiary level – value would have to be distributed evenly across all beneficiaries
- Revise attribution methodology to better align attribution with effort
  - Hybrid-CTI approach
  - See next section

Traditional MPA will continue under AHEAD, but it may make sense to defer changes to MPA to next year after AHEAD work is complete.

Revised MPA Attribution Proposal

MPA Opportunities – Revise MPA Attribution to Acknowledge Hospital Relationship

- Currently: MPA attribution is one size fits all and must address 95% of beneficiaries
- Challenge:
  - Attempts to adopt comprehensive primary care-driven approach to MPA attribution resulted in unstable attribution and significant administrative burden
  - Geographic approach prevents tight alignment between hospital initiatives and measured populations
  - CMS has rejected approaches to “buy out” of MPA downside based on CTI involvement

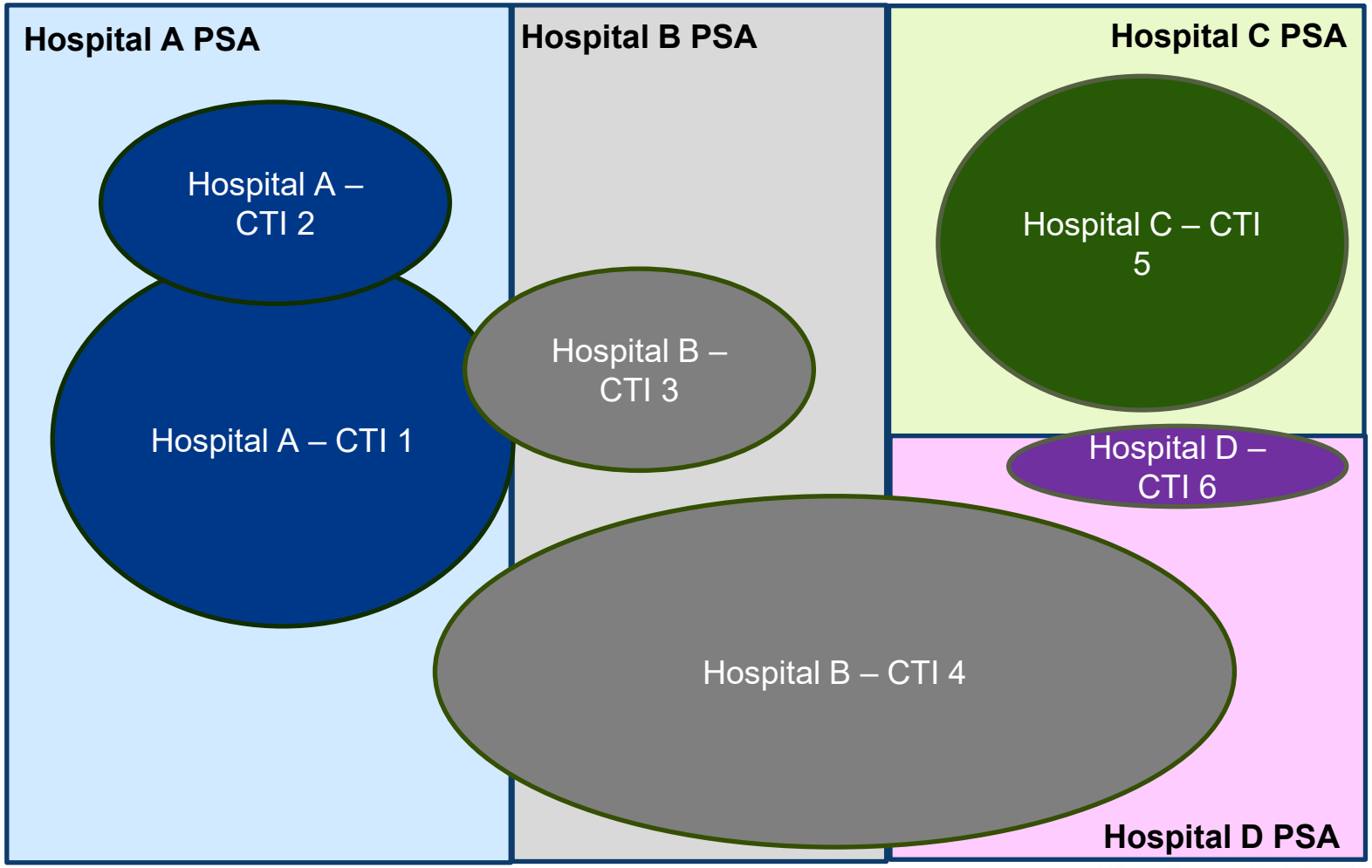
MPA Opportunities – Revise MPA Attribution to Acknowledge Hospital Relationship (Cont.)

Green = Additions since, May presentation

- Opportunity: Incorporate more flexible attribution approaches into contractual provisions, for example:
  - Step 1: Hospitals establish panel and/or geography based CTIs
    - Has to be CTIs with TCOC accountability (e.g. not Care Transitions)
    - Could be scored both as a CTI and for MPA or just for MPA (hospital decision)
      - If scoring as a CTI is elected all normal CTI rules and scoring apply (e.g. hospital selected baseline, comparison to hospital history as target)
        - Or could be used only for attribution and standard MPA scoring would apply.
      - For MPA scoring standard Statewide rules apply (e.g. 2019 baseline, comparison to national growth target)
  - Step 2: HSCRC aggregates all MPA-responsive CTIs
    - CTIs must be relevant to the hospital's service area
  - Step 3: Any beneficiaries not accounted for in a hospital CTI are attributed using geographic approach until minimum attribution level is reached
    - Results are weighted between CTI and Geographic attribution based on # of beneficiaries covered
    - CTI attribution would be full beneficiary and allow duplication (1 bene to multiple hospitals), geographic would continue to follow current splitting
    - Final attribution would be subject to "reasonableness" review
      - Each hospital has a reasonable panel size
      - Specific beneficiary demographic group are not under or overrepresented in the CTI versus geographic layers.

Illustration and Considerations for CTI-Based MPA Attribution

PSA = Primary Service Area (note actual PSAs sometimes overlap and hospitals share beneficiaries)



Standard Approach

- Hospital A gets all beneficiaries in their CTIs (dark blue) plus all beneficiaries in the blue box not in another hospital's CTI.
- Key issues:
  - Do beneficiaries in overlapping CTIs for the same hospital (CTI 1 vs 2) count twice? No
  - What about between hospitals (CTI 1 vs 3) Yes
  - Is it acceptable for Hospital B CTI 4 to "claim" many beneficiaries outside their PSA, thereby diluting the influence of their PSA? No, benes outside PSA would be dropped
  - Is it acceptable for Hospital D to "claim" a limited number of beneficiaries due to their small CTI and Hospital B's large CTI? Yes, subject to "reasonableness" rules

NOTE: A hospital's risk is 2% of their delivered care not their attributed care, therefore the size of attribution impacts the value of the care scored but not the size of the risk.

Advancing Innovation in Maryland (AIM)

AIM – Call for Ideas

- Advancing Innovation in Maryland (AIM) is a contest that seeks to surface ideas for potential implementation to advance Maryland's unique healthcare model, which has the goals of improved patient care and health outcomes, greater equity, and affordability. The AIM contest is supported by a public-private partnership involving the Maryland Department of Health (MDH), the Health Services Cost Review Commission (HSCRC), and local foundations.
- AIM is seeking ideas in three categories:
  - Innovative Interventions: Ideas for interventions that a hospital can implement, by themselves or in coordination with community partners;
  - Innovative Collaborations: Ideas for programs or platforms that the hospital system as a whole or in a region can implement, by itself or in coordination with community partners; and
  - Innovative Payment Approaches: Ideas for payment innovations that the Health Services Cost Review Commission can implement.
- Up to 10 applicants with winning ideas will be selected to receive cash prizes of $1000 from the Horizon Foundation and be presented to the Secretary of Health and HSCRC for further discussion.
- Submissions are due October 25 at 5PM EST.
- For more details and submission requirements please visit the AIM Webpage.

Next Steps

TCOC Workplan for Upcoming Months

- Next combined HSCRC TCOC Workgroup/H-TAC Meeting is September 25th
- Focus will be on:
  - AHEAD Update and Discussion
  - Benchmarking Update
  - CTI and EQIP Results
- Items discussed today will be reviewed further in the October TCOC workgroup
  - HSCRC will work to solidify the proposed changes
  - Feel free to comment in writing with specific suggestions
  - Comments will be needed by October 7th to be considered in October 23rd TCOC Workgroup

Thank You
Next Meeting September 25, 8-10 am