maryland
health services
cost review commission

Maryland Health Services Cost Review Commission

Steering Committee Meeting

October 9, 2020

Agenda

- Data Updates
- Revised MDPCP Accountability Policy
- Final Minimum Savings Rate
- Next steps for CTIs with requested modifications
- REMINDER: Final Intake Templates due October 23, 2020

Data Updates

Attribution at Point of Care

Goal: Display attribution and relevant program information (i.e. contact information) at the point of care where helpful.

Phase 1:

- CRISP to display prospective attribution (MDPCP, MPA, Panel based CTIs) at point of care.

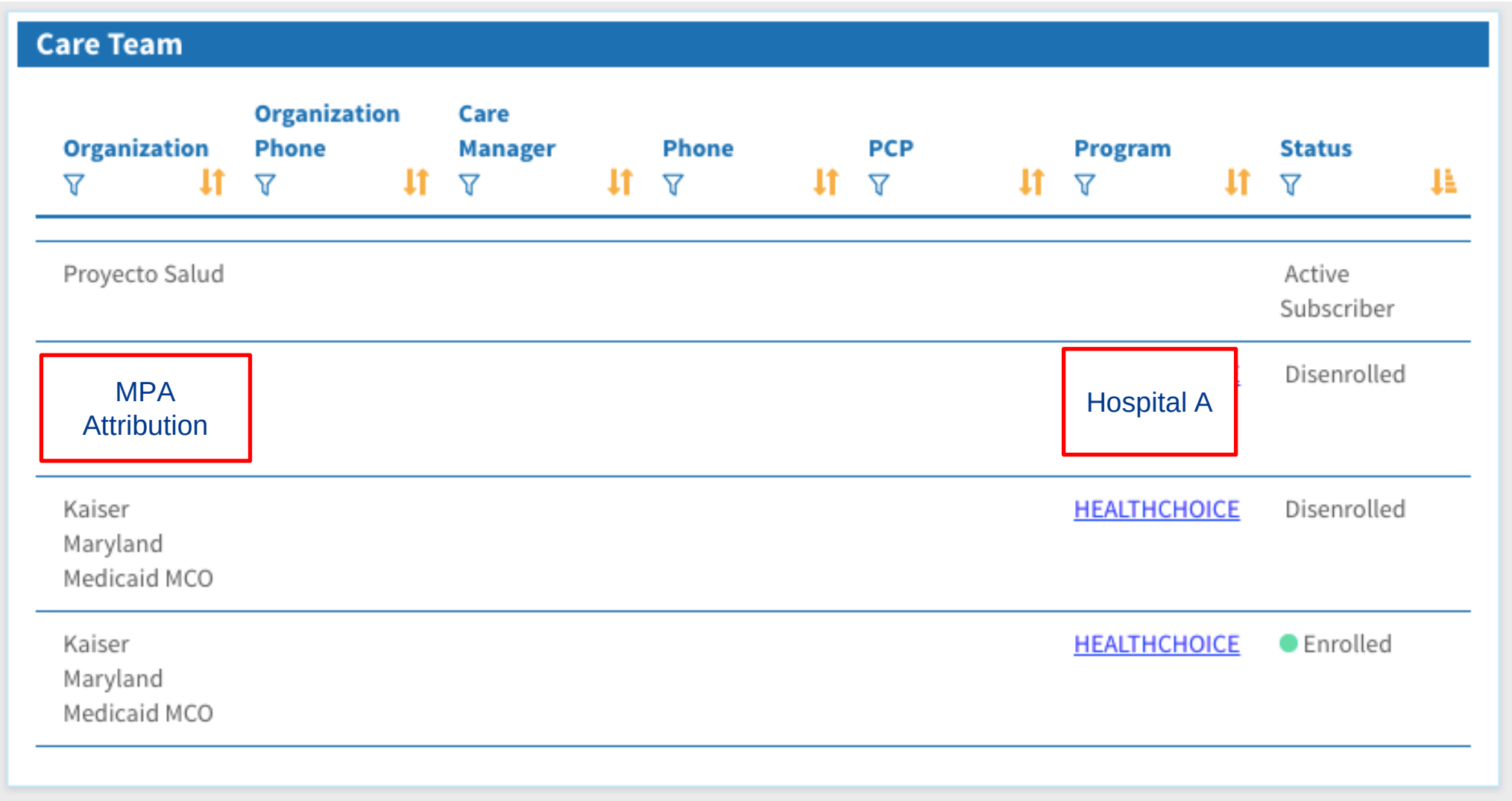
Phase 2:

- CRISP can explore use of ADT data to demonstrate touch relationship for potential earlier sharing of claims through CRS portal.
- CRISP can explore use of ADT data to support other attribution methodologies if helpful.

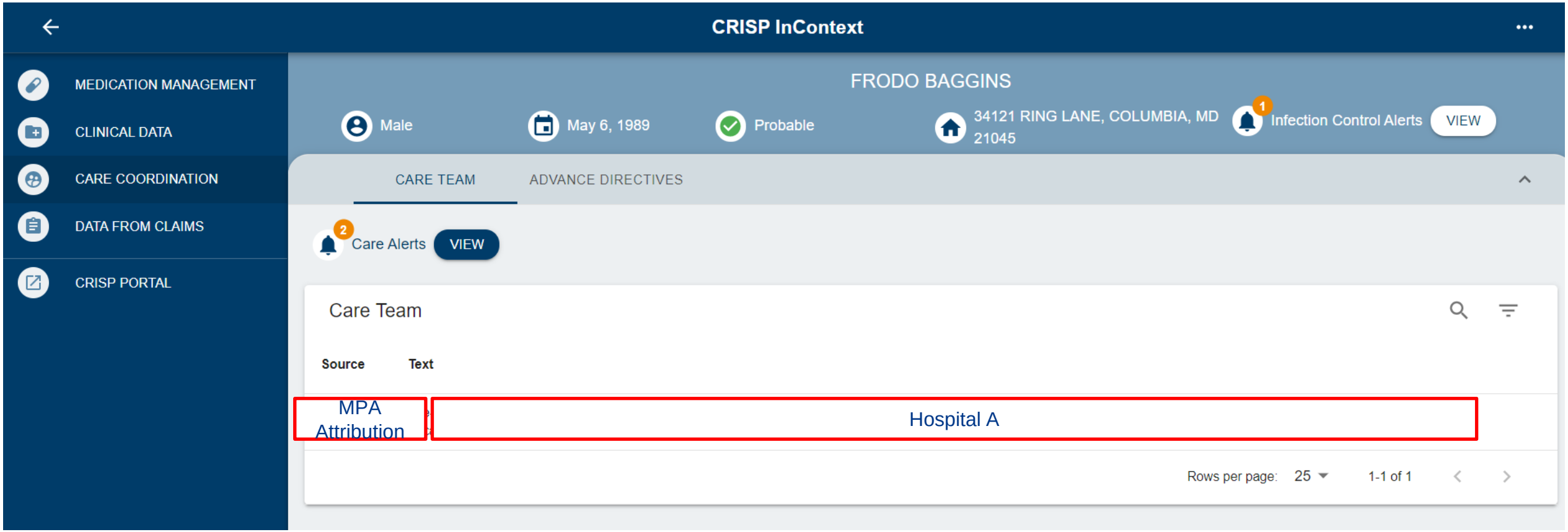
MPA Flags at Point of Care

- Requests from hospitals to know if a patient is MPA attributed to them when patient presents in hospital
- Requests from hospitals for employed physicians to see MPA attribution when patients presents for ambulatory visits
- Through the Care Team widget, CRISP will display if a patient is MPA attributed and which hospital(s).
  - This will be visible to anyone searching a patient in CRISP
- This flag will include geographically attributed beneficiaries, since the organization will have a treatment relationship when the patient presents for the first time.

Unified Landing Page: Patient Snapshot/Care Team



CRISP InContext EHR Embedded App



ENS Roster with Care Management Fields

- Hospitals can display patient care management information on CRISP's Point of Care tools via the Encounter Notification Service (ENS).
- ENS allows users to submit a roster (panel) of their patients via a manual spreadsheet or automated interface.
- Additional patient level fields can be submitted on this roster.
  - Care Program
  - 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)

CTI Data Updates

- All Baseline Period CTI will be available in the CTP by October 12. This includes all thematic area, including the ED CTI.
- Hospitals can view the specifications for any CTI (including other hospital's submissions) in the State through the CTP Tool.

MDPCP and CTI

MDPCP Accountability

- The Commission has expressed concern about the level of TCOC accountability for hospital affiliated CTOs and practices.
- Staff intend to recommend that that a supplemental MPA adjustment be made based on MDPCP performance.
  1. Hospitals will be required to submit all employed physicians that are participating in MDPCP.
  2. HSCRC will make a net neutral payment adjustment to hospitals based on their MDPCP performance.
  3. Payments will be capped at the amount of the care management fees that the hospital receives from its CTO and employed physicians.
  4. This ensures that hospitals cannot be made worse off by participating in MDPCP.
- This replaces the previous policy regarding MDPCP accountability. **Hospitals will not be required to submit an MDPCP CTI.**

Calculation of the MPDPC Savings

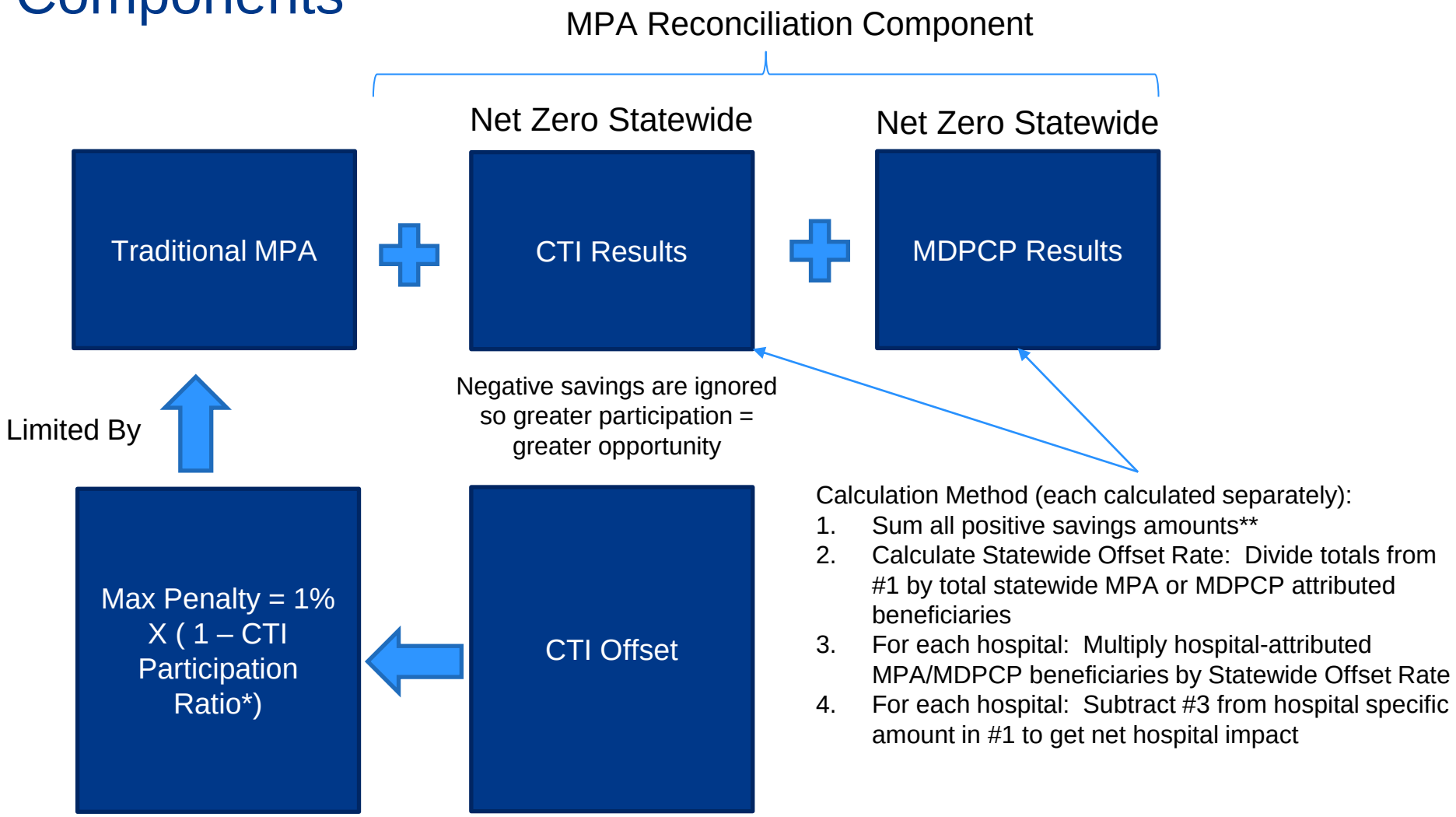
- Savings will be calculated by comparing the hospital's 2019 per capita costs to the performance period costs.
  - Hospitals will be compared to their own MDPCP panels. They will not be compared to 'non-participating practices'.
  - Costs will be updated using Medicare PPS payment updated for nonhospital costs and 'normalized' hospitals costs.
  - The hospitals will be compared to a consistent 2019 panel. E.g. 2021, 2022, etc. will be compared to the 2019 panel.
- CMMI's actual attribution will be used to create the panels.
- The care management fees will be included in the TCOC (both the 2019 baseline period and the performance period).

MDPCP Accountability

Example of Savings Accountability

	Statewide		Hospital A		Hospital B	
	Baseline	Performance Period	Baseline	Performance Period	Baseline	Performance Period
Benes	250,000	300,000	20,000	25,000	30,000	40,000
Claims-Based Payments	3,437,000,000	4,017,000,000	274,960,000	326,000,000	412,440,000	541,600,000
Care Management Fees	63,000,000	108,000,000	5,040,000	9,000,000	7,560,000	14,400,000
TCOC	$ 3,500,000,000	$ 4,125,000,000	$ 280,000,000	$ 335,000,000	$ 420,000,000	$ 556,000,000
TCOC per Capita	$ 14,000	$ 13,750	$ 14,000	$ 13,400	$ 14,000	$ 13,900
Per Capita Savings		$ 250		$ 600		$ 100
Savings in Excess of State		-		$ 350		$ -150
Net Payments		-		$ 8,750,000		$ -6,000,000

MPA Components



Calculation Method (each calculated separately):

1. Sum all positive savings amounts**
2. Calculate Statewide Offset Rate: Divide totals from #1 by total statewide MPA or MDPCP attributed beneficiaries
3. For each hospital: Multiply hospital-attributed MPA/MDPCP beneficiaries by Statewide Offset Rate
4. For each hospital: Subtract #3 from hospital specific amount in #1 to get net hospital impact

* Defined as Care Under CTIs divided by Care Attributed Under MPA

** Savings are measured as performance better than historic target for CTIs and better than state average results on MDPCP adjustment.

Overlaps between CTI and the Supplemental MDPCP Policy

- Hospitals may still participate in a panel-based primary care CTI. The CTI will be prioritized over the MDPCP MPA policy.
  - Savings will be paid through the CTI.
  - Other policies (CTI buyout, overlaps, etc.) will continue as per usual.
- MDPCP beneficiaries who are included a primary care CTI will reduce the reward / penalties in the MPA penalty.
  - The calculation of statewide savings and hospital specific per capita savings will remain unchanged.
  - Only the aggregate reward / penalty will be effected by the number of MDPCP beneficiaries in the CTI.
- All other CTI are unaffected.

	Hospital A	Hospital B
MDPCP Benes	25,000	40,000
Per Capita Savings	$600	$100
Savings in Excess of State	$350	-$150
MDPCP Benes in CTI	5,000	10,000
Net Beneficiaries	20,000	30,000
Net Payments	20,000 x $350 = $7,000,000	30,000 x -$150 = -$4,500,000

Minimum Savings Rate Policies

Overview of the Minimum Savings Rate Policies

- 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.
- Based on the actuarial evaluation, primary care CTI and other non-hospital anchored CTI have different levels of variation than care transitions and hospital anchored CTI.
  - The MSR for non-hospital anchored CTI are higher than the MSR for hospital anchored CTI.
  - The initiating event results in substantially lower variation for hospital-based CTI
  - ED care is being analyzed now and will be combined with one of the other two MSRs
- HSCRC proposes to set the MSR in order to be the most favorable to the hospital.
  - Care transitions and palliative care episodes will have a common MSR
  - Primary care and community care will have a common MSR
  - The two MSR will be combined if it results in a lower MSR for the hospital anchored CTI

CTI Minimum Savings Rates

Minimum Savings Rate for Care Transitions and Palliative Care CTI	
Number of 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%

Minimum Savings Rate for Primary Care and Community Care CTI	
Number of Episodes	**Minimum Savings Rate**
< 30	n/a
31 – 150	15.0%
151 – 300	9.0%
301 – 500	6.0%
501 – 750	5.0%
751 – 1500	4.0%
1501 – 3000	3.0%
3001 – 7500	2.0%
7501+	1.5%

Example of Combined MSRs

- HSCRC will combine the MSR for the Care Transitions and Primary Care CTIs if:
  - The MSR for the hospital's non-hospital anchored CTI is less than the MSR for the hospital anchored CTI.
  - If the hospital anchored MSR is smaller than the primary care CTI, then the hospital will have two separate MSRs.
- In the example to the right, Hospital A has would have a combined MSR while Hospital B would have two separate MSRs.

Hospital A	Number of Episodes	MSR
Care Transitions & Palliative Care	300	5%
Primary Care and Community Care	1000	4%
Combined MSR		4%

Hospital B	Number of Episodes	MSR
Care Transitions & Palliative Care	1000	2.5%
Primary Care and Community Care	1000	4%
Separate MSR		2.5% / 4%

CTIs with requested modifications

CTIs with requested modifications

- Requested modifications are special requests to CTIs that are outside of the scope of the intake templates. These CTIs are programmed separately, as each modified CTI requires its own unique specs and programming
  - HSCRC received 10 intake templates that will fall into this category and require separate programming for baseline preliminary data
  - Hospitals were informed via email after submitting their intake templates if they require modification
- The requested modifications will be completed on a rolling basis, one CTI at a time, beginning in October and continuing into 2021.
  - Hospitals will be allowed to enter the 2021 performance year with their requested modifications as they become available
  - Hospitals with requested modifications will receive custom intake templates from the HSCRC and must complete the intake template for their requested modification to be available
  - Performance will be retroactive

List of CTIs with requested modifications

These are the intake templates the HSCRC received that have requested modifications:

Care Transitions CTI:

- Limit to beneficiaries that have a touch with particular NPIs and include trigger hospitalizations from any acute care hospital (MedStar)
- Limit to beneficiaries between the ages of 65-84 (Anne Arundel)
- Exclude deceased patients (LifeBridge)
- Use procedure based codes (John's Hopkins)

Episodic Primary Care CTI:

- Limit to beneficiaries with a visit with PCP in past 18 months for list of NPIs provided (GBMC)
- Include 12 additional chronic conditions (GBMC)

Panel-Based 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 (MedStar)

Community Based Care, PAC Touch CTI

- Restrict the CTI population to beneficiaries that went to BOTH the hospital & the selected SNF (AAMC & Johns Hopkins)
- First limit to the facility NPI, then limit to beneficiaries treated by certain NPIs (Peninsula)

Next steps for hospitals with CTIs with requested modifications

Step	Description	Example
1	HSCRC is in the process of developing programming specifications and custom intake templates that reflect our understanding of the requested modifications.	GBMC requested to limit their CTI to beneficiaries with a visit with PCP in past 18 months for list of NPIs provided and include a list of 12 additional chronic conditions. HSCRC is developing a custom intake template that allows GBMC to choose a timeframe for an NPI touch and to specify the additional chronic conditions.
2	HSCRC will contact the relevant hospitals to share the custom intake templates on a rolling basis as intake templates are ready.	HSCRC will share the custom intake template with GBMC as soon as it is available
3	Hospitals will complete the custom intake templates and return them to the HSCRC.	GBMC will complete the intake template to their specifications and return it to the HSCRC.
4	The HSCRC and its contractors will program the preliminary baseline data for the requested modification. Preliminary baseline data should be available over the next three months.	The requested modifications will be programmed and preliminary baseline data will be available for GBMC.
5	Hospitals will review the preliminary baseline data and either inform the HSCRC that they will not change their initial submission or will submit a final intake template.	GBMC will review preliminary baseline data. If GBMC isn't making changes, they can inform the HSCRC via email. If they wish to change any criteria, GBMC will submit a final intake template.

CTIs with requested modifications

FAQ

- Why is the HSCRC requiring these hospitals to complete new intake templates?
  - *Some requested modifications were requested and discussed via email (rather than in intake templates) and some were not specified in great detail in intake templates. This step provides HSCRC with documented confirmation of the hospital's requested modifications and the specifics for the request.*
- If hospitals receive their data after 2021 starts, will the HSCRC modify the performance period for the modified CTIs?
  - Yes; hospitals may elect to retrospectively trigger episodes beginning in January 2021, or may elect a shorter performance period (e.g. if a hospital finalizes their CTI submission in May, the performance period would be May through the end of 2021)

REMINDER: Final CTI Submissions

Key Dates

- Final intake template CTI submissions due October 23
  - Hospitals should submit all the CTIs they wish to participate in, whether that CTI is one they created or whether it was created by another hospital
- Preliminary baseline data for all CTIs available by next week
- Preliminary baseline data for *CTIs with requested modifications* will be available on a rolling basis after October

Final intake template submission

For hospitals that do *not* wish to modify the criteria in their initial intake templates:

- If hospitals wish to use their initial submission as their final one (i.e. make no changes to the initial intake template), they do not need to submit new intake templates
  - Instead, hospitals without changes to intake template(s) must inform the HSCRC by email that they aren't making changes
  - HSCRC will then share their version of the initial intake template with the hospital via email and request confirmation that the hospital is not making changes
- This step ensures that the HSCRC and hospitals are on the same page regarding the correct, final criteria.
  - Some initial intake templates had errors in their submissions and were resolved via email communication between hospitals and the HSCRC.
  - The HSCRC then updated the initial submissions internally to reflect the correct criteria.

Next Steps

Next Steps Dates

- Upcoming CT Steering Committee Meetings:
  - November Care Transformation Steering Committee – Finalize the minimum savings rate
  - December Care Transformation Steering Committee – Finalize overlaps policies
  - January and Beyond – Discuss methodology for actuarial target prices & new CTI proposals
- Upcoming CTI Thematic Areas will include:
  - COVID Hospitalizations / Home Care
  - Others as submitted by hospitals
- Please reach out to hscrc.care-transformation@maryland.gov with any questions.