maryland
health services
cost review commission

Total Cost of Care Workgroup

September 30, 2020

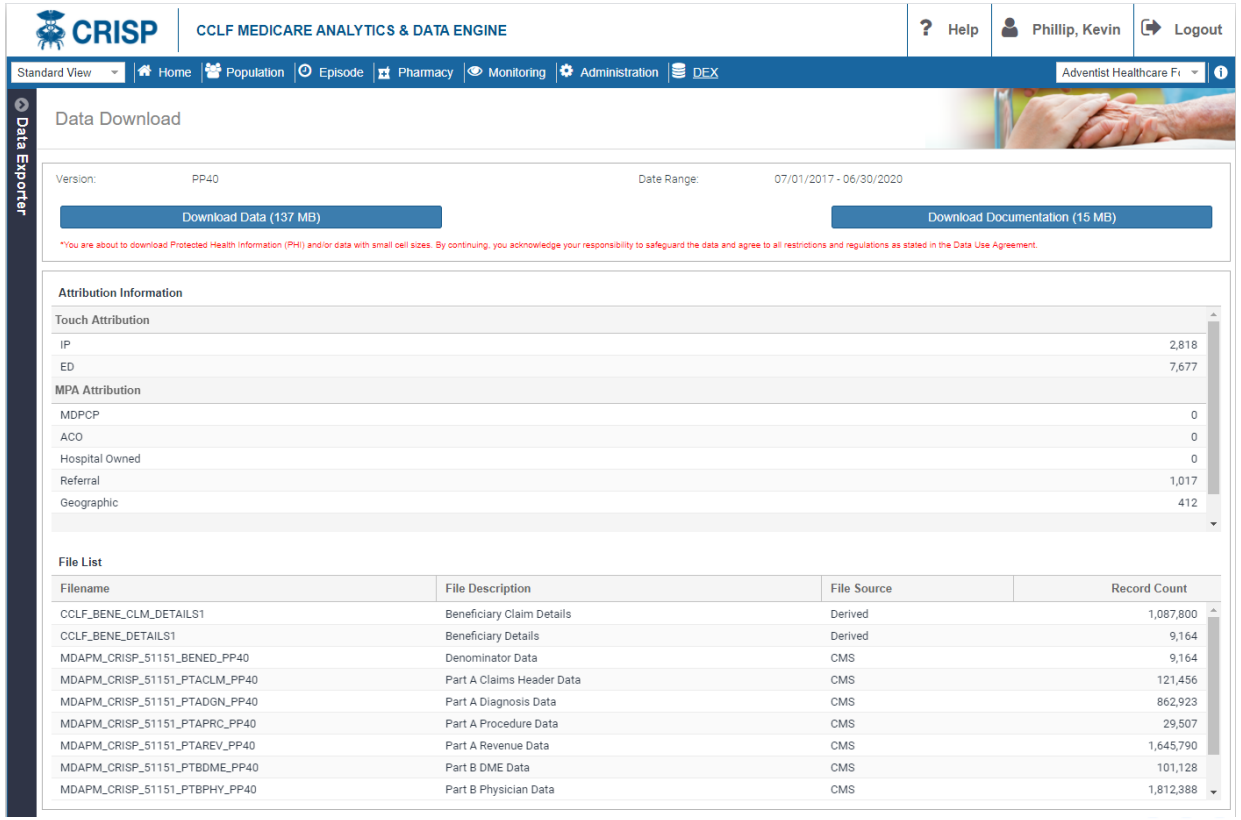
Agenda

1. Update on Reporting Tools
2. Overview of the MPA Recommendation
3. Implications of the MPA Targets on utilization
4. SIHIS Goals on Care Transformation

Update On Reporting Tools

DEX – Data Exporter

- The CRISP Reporting Services (CRS) team is excited to announce our newest application DEX – Data Exporter on Friday, September 25th.
- Embedded within the MADE (CCLF Medicare Analytics Data Engine) application, DEX allows approved hospital users to download the Medicare Claim and Claim Line Feed (CCLF) data files.
- With DEX, Users can download the full rolling 36 months set of CCLF claims data for all Medicare beneficiaries who have 'touched' the hospital during that time period as well as any MPA (Medicare Performance Adjustment) attributed patients approved for view in MADE.
- The available files will contain the exact files and data fields previously available for download via CMS but will also include additional derived fields that are currently available in MADE. Examples of these fields include Chronic Conditions, Dual Eligibility, hAM, and Beneficiary Address.
- Hospital Point of Contacts will designate 2 to 3 DEX users per hospital.



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.

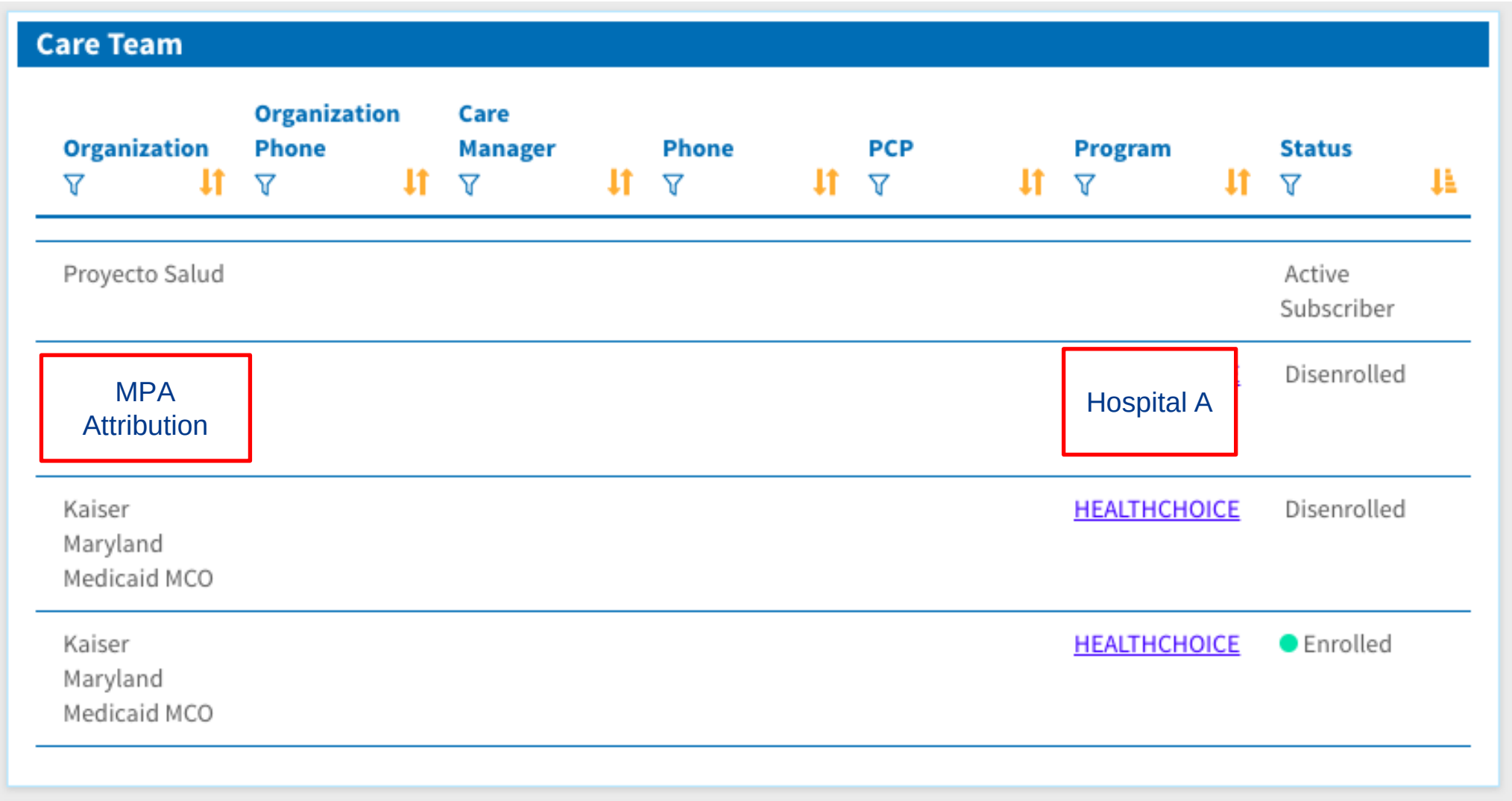
Phase 2:

- 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.

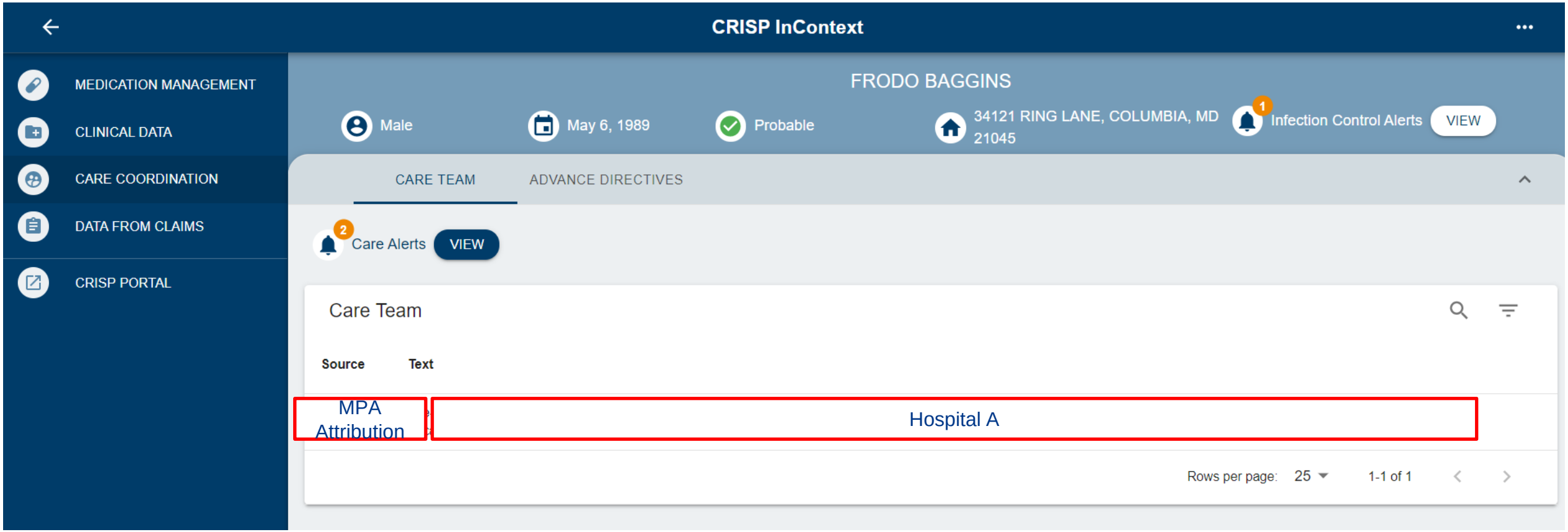
MPA Flags at Point of Care

- 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)

Updated Benchmarking Data

- Final benchmarking data is now available on the HSCRC website.
  - This includes all Medicare and unrestricted commercial benchmarking results
  - Please use the following link: https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx
- Minor corrections have been made to two of the files. The most current version is on the website.
  - Medicare Benchmark Data file (correction to normalized risk score on detail tabs)
  - New PSAP distribution file (correction to small number of zip codes, new version consistent with that release with DEX)

Draft Recommendation on the 2021 MPA

Overview of the MPA Recommendation

1. Attribution
   - The current attribution is based on a tiered hierarchy of attribution methods.
   - Staff intends to recommend a geographic attribution for all hospitals except the AMCs
2. Financial Methodology
   - The current MPA methodology requires hospitals to beat national growth rate less a discount
   - The current MPA requires year-over-year improvement regardless of prior progress or lack thereof
   - Staff intends to recommend setting a predictable attainment target that will be measured on a cumulative basis
   - Fees at risk wills till be capped at 1% (although additional amounts are at risk under CTIs)
3. Attainment Targets
   - Staff intends to recommend setting an attainment target based on the hospitals benchmark counties
   - Staff intend to use a schedule that would eliminate excess Medicare payments in 10 years
   - However, a broader conversation is necessary and staff will treat this schedule as preliminary
4. Interaction with CTI
   - Currently, CTI and the MPA cover many of the same beneficiaries but may attribute them to different hospitals
   - CTI attribution is better targeted at the interventions hospitals are employing to reduce the TCOC
   - Staff intend to recommend allowing hospitals to ‘buy-out’ of the traditional MPA penalties by increasing their CTI participation
5. MDPCP Accountability
   - Add a “supplemental MPA adjustment” based on the hospital’s affiliated MDPCP practices
   - Make MPA payments / cuts on a net neutral basis

Attribution Changes

- Geographic attribution is substantially simpler than the tiered attribution.
  - This will allow hospitals to follow their MPA attributed beneficiaries longitudinally
  - Hospitals have raised concerns assessing the extent to which performance is due to attribution issues versus actual changes in the total cost of care.
- Under the geographic attribution, beneficiaries will be attributed to hospitals based on their PSAPs.
  1. Beneficiaries within a hospital's PSAP are attributed to the hospital.
  2. In shared zip codes, the hospital is attributed a portion of the TCOC based on their share of ECMADs in that zip code.
- The existing physician-based attribution will be maintained in order to allow hospitals to receive PHI data.

Financial Methodology

- An attainment methodology will be more stable and more predictable for hospitals.
  - The current year-over-year improvement standard is volatile at the hospital level.
  - Long-term planning is difficult since the improvement target resets each year.
- Under the attainment approach, each hospital will have a per capita TCOC target.
  - Penalties are based on difference between the actual per capita TCOC and the savings target.
  - The target is based on prior year target x (National Growth – Trend Adjustment). The Trend Adjustment is larger for lower attainment hospitals.
  - This approach allows lower attainment hospitals to gradually catch up over time
  - This will allow hospitals to project their MPA targets in future years.
- This aligns the hospitals performance targets with statewide TCOC savings goals.

Example of Financial Methodology, Meritus

12.2% Above Benchmark, Growth Rate Adjustment = 1.4 % Below National

			2020	2021	2022	2023	2024
Calculate Target Growth	National Annual Actual Growth	A = Input		3.0%	2.0%	3.0%	MPA policy will be reassessed
	Current Growth Rate Adjustment	C = From Growth Rate Adjustment Table		-1.4%	-1.4%	-1.4%	
	Current Target	D = A + C		1.6%	0.6%	1.6%	
	Target TCOC	E = Prior Year E x (1 + D)	$11,716	$11,904	$11,975	$12,167	
Calculate Meritus Performance	Meritus Attributed TCOC	F = Input	$11,716	$11,868	$12,023	$12,083	
	Annual Actual Growth	Current Year F / Prior Year F – 1		1.3%	1.3%	0.5%	
Calculate Reward (Penalty)	Achievement % Reward (Penalty)	H = (E - F) / E		0.3%	-0.4%	0.7%	
	Bonus % Reward (Penalty)*	I = H / 3% X 1% (max of +/- 1%)		0.1%	-0.1%	0.2%	

While Meritus fell 0.7% short of target in 2022, their penalty is only 0.4% due to the advantage built in 2021.Then the inverse occurs in 2023 where they first fill the gap from the end of 2022.

* Bonus (Penalty) is still applied to a hospitals delivered cost of care, amounts do not reflect any potential CTI buyout.

Attainment Target

- There are multiple options for the attainment targets that could be used in the attainment methodology.
  - Staff intends to recommend using an attainment methodology regardless of which attainment target is used.
  - The attainment targets determine the magnitude of the trend factor adjustment for individual hospitals but does not penalize hospitals based on the absolute variance.
- On a preliminary basis, staff intend to recommend using the hospital's benchmark counties as the attainment standard.
  - Eventually, hospitals are expected to reduce their TCOC to their benchmark counties.
  - The MPA 'trend factor adjustment' will be set in order to phase in the benchmark costs by 2030.
- Staff will also recommend that 2021 is used to assess what the long-term attainment targets should be.

Attainment Adjusted MPA Growth Targets

Assuming $800 M over 10 years is the right target

- Hospitals' MPA performance target would be set so that hospital converge to their benchmark by 2030.
- The hospitals performance target for each year is equal to their 2020 TCOC times a compounded trend factor.
  - The compounded trend factor is equal to the national growth rate + the TCOC growth rate adjustment.
  - HSCRC will re-evaluate the hospitals' TCOC costs relative to the benchmark every 3 years.

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment (Replaces 0.33% in current calculation)
<0%	-0.0%
0-5%	-0.5%
5-10%	-1.0%
10-15%	-1.4%
15-20%	-1.8%
20-25%	-2.2%
25-30%	-2.6%

CTI Buyout Option

- The traditional MPA, with geographic attribution, creates a baseline level of accountability for hospitals.
  - The MPA ties individual hospital accountability to the State's collective accountability for TCOC.
  - The requirement that 95% of beneficiaries are attributed to hospitals begins to move towards panel-based population health management.
- However, the attribution is not linked to interventions that hospitals are using to reduce the TCOC.
  - For example, geographic attribution would not directly capture the efforts made by hospitals to better integrate physicians into their TCOC management strategies.
  - The CTI allows hospitals to define their own attribution and therefore can capture physician alignment strategies and other interventions without a one-size-fits-all attribution approach.
- Staff intend to recommend hospital's 'buying out' of the traditional MPA by increasing their participation in CTI.

CTI Buyout Option for the Traditional MPA

Example

The hospital's MPA penalty (rewards are unaffected) will be based on two components:

1. The traditional MPA adjustment, described previously.
2. The ratio of TCOC under the MPA to the TCOC under the CTI.
3. The hospitals final MPA penalty is equal to (1 - CTI TCOC / MPA TCOC) x Traditional MPA adjustment.

MPA Attributed Benes		50,000
MPA Attributed TCOC	$	700,000,000
CTI Attributed Benes		15,000
CTI Attributed TCOC	$	345,000,000
CTI TCOC / MPA TCOC		49%
Weight on Traditional MPA		51%
Traditional MPA Penalty	$	5,000,000
Weighted MPA Penalty	$	2,535,714

CTI Buyout Option for the Traditional MPA

PRELIMINARY Analysis of select hospitals

Hospitals	2019 MPA Adjustment	2019 MPA TCOC	CTI TCOC	Weight	Weighted Adjustment
Anne Arundel Medical Center	$(1,820,852.70)	$406,361,826.00	$184,128,274.22	45%	$(995,798.66)
Calvert Memorial	$(217,576.91)	$94,778,292.69	$21,828,897.90	23%	$(167,465.60)
Greater Baltimore Medical Center	$1,253,352.76	$211,943,753.91	$349,889,160.78	100%	$1,253,352.76
Johns Hopkins Hospital	$2,658,335.55	$599,928,762.78	$19,198,504.56	3%	$2,658,335.55
Mercy Medical Center	$1,309,688.30	$107,855,300.61	$7,695,759.99	7%	$1,309,688.30
Shady Grove Adventist	$(104,553.25)	$251,410,345.02	$23,242,443.95	9%	$(94,887.49)

- **Note** that these are preliminary numbers based on initial submissions.
- Does not include CTI that were submitted as a system.
- System submissions will be allocated based on the submitters preference.
- Preliminary CTI participation data and 2019 MPA data accompany this slide deck.

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.

Calculation of the MPDPC Savings

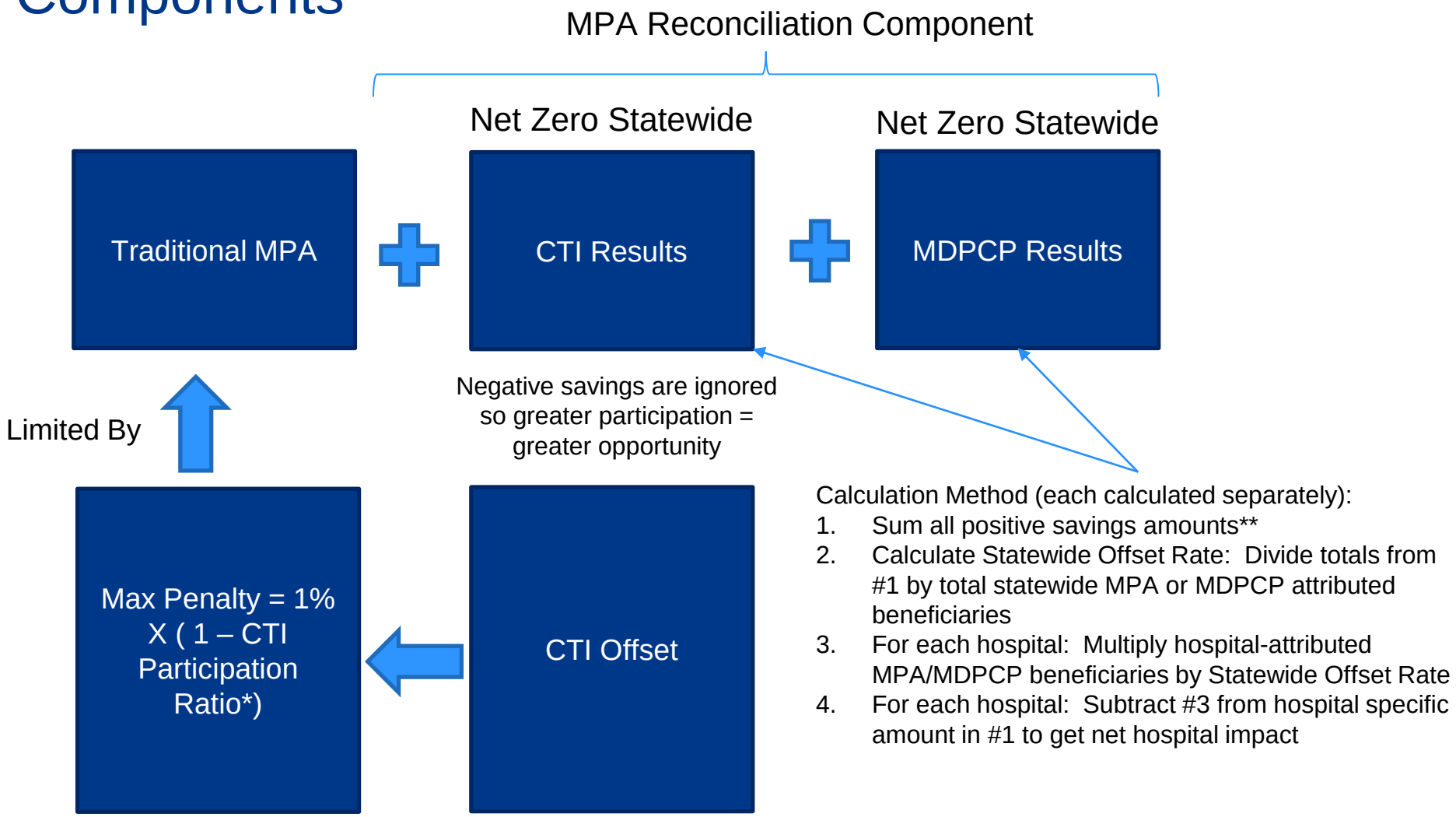
- Savings will be calculated by comparing the hospital's 2019 per capita costs to the performance period costs.
  - Hospitals will be compared to their own MDPCP panels. They will not be compared to 'non-participating practices'.
  - Costs will be updated using Medicare PPS payment updated for nonhospital 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.

Implications of the MDPCP MPA Adjustment

1. The MPA will redistribute payments between hospitals based on their success at reducing TCOC in MDPCP.
   A. Hospitals that produced greater than average savings will receive a reward; hospitals that produce less than average savings will receive a penalty.
   B. This will likely result in fewer penalties that if hospitals were directly responsible for offsetting their care management fees.
   C. This will also result in some hospitals receiving additional funds to invest in the most promising MDPCP interventions.
2. Any negative adjustments will be capped by the amount of the care management fees that a hospital receives.

Timing of the MPA recommendation

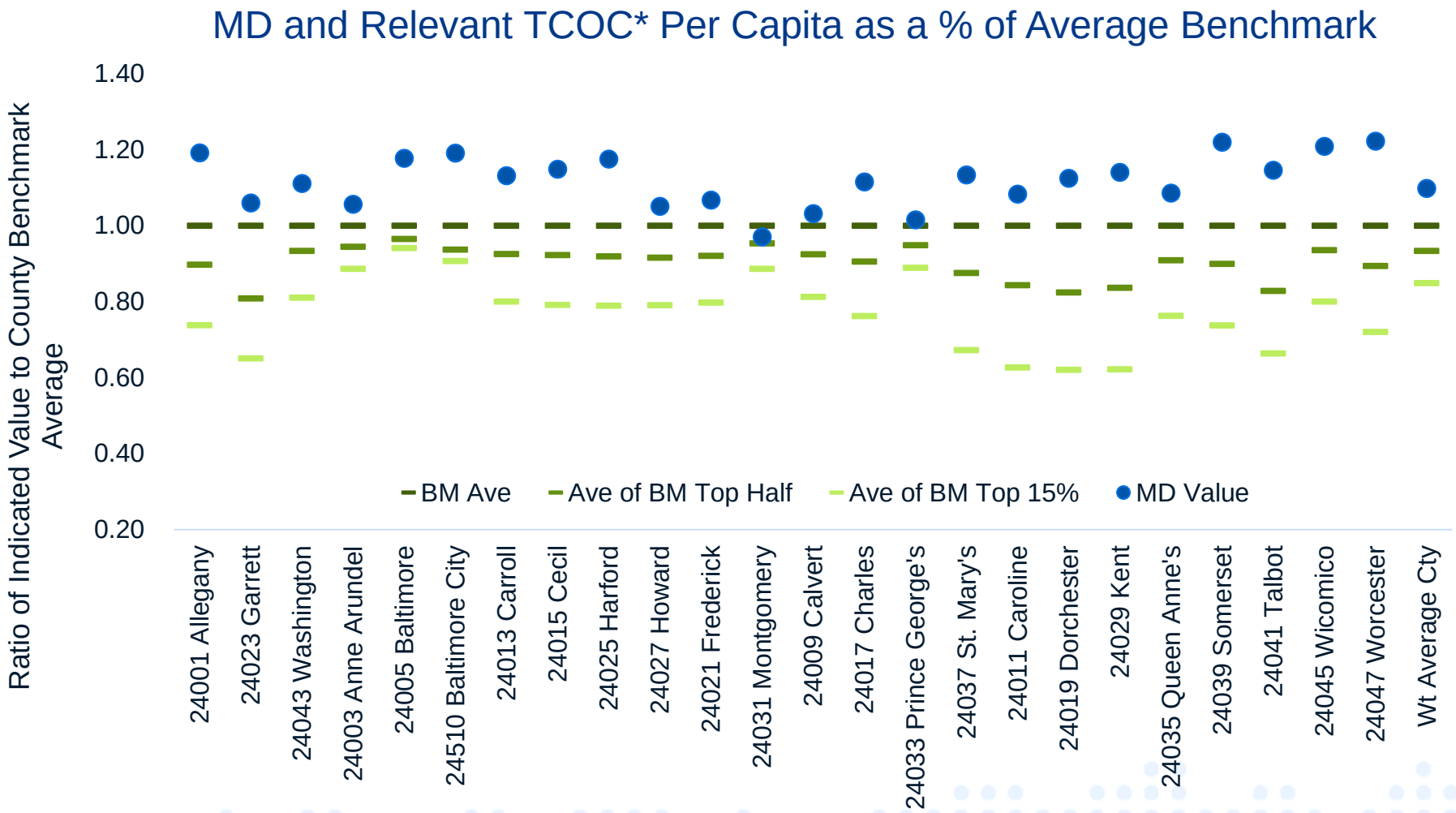
- Staff intend to present a draft MPA recommendation to the Commission during the October Commission Meeting.
  - There will be a two-month common period.
  - Stakeholder's comments & suggestions will be discussed during the October and November TCOC Workgroup meetings.
- The final MPA recommendation will be submitted to the Commission during the December Commission Meeting.
- HSCRC will submit the 'MPA Proposal' to CMMI in December, following a final commission vote.

Implication of MPA savings Targets on Long Term Utilization

Implications of the MPA Attainment Targets

- Stakeholders have asked for an analysis hospital utilization in the context of the long-term trajectory of the TCOC Model.
- Under the All-Payer Model, Maryland hospitals reduced utilization by 11.4% (relative to national growth) over six years.
  - This translates into an annual hospital utilization growth of 2.0 ppt below national.
  - Continuing to reduce utilization at the same rate would result in $800 million in savings by 2030.
  - This assumes that utilization savings can be achieved without nonhospital excess cost growth.
- However, utilization reductions may not be sustainable. Staff analyzed Maryland utilization compared to the benchmark counties in order assess where Maryland utilization would fall.

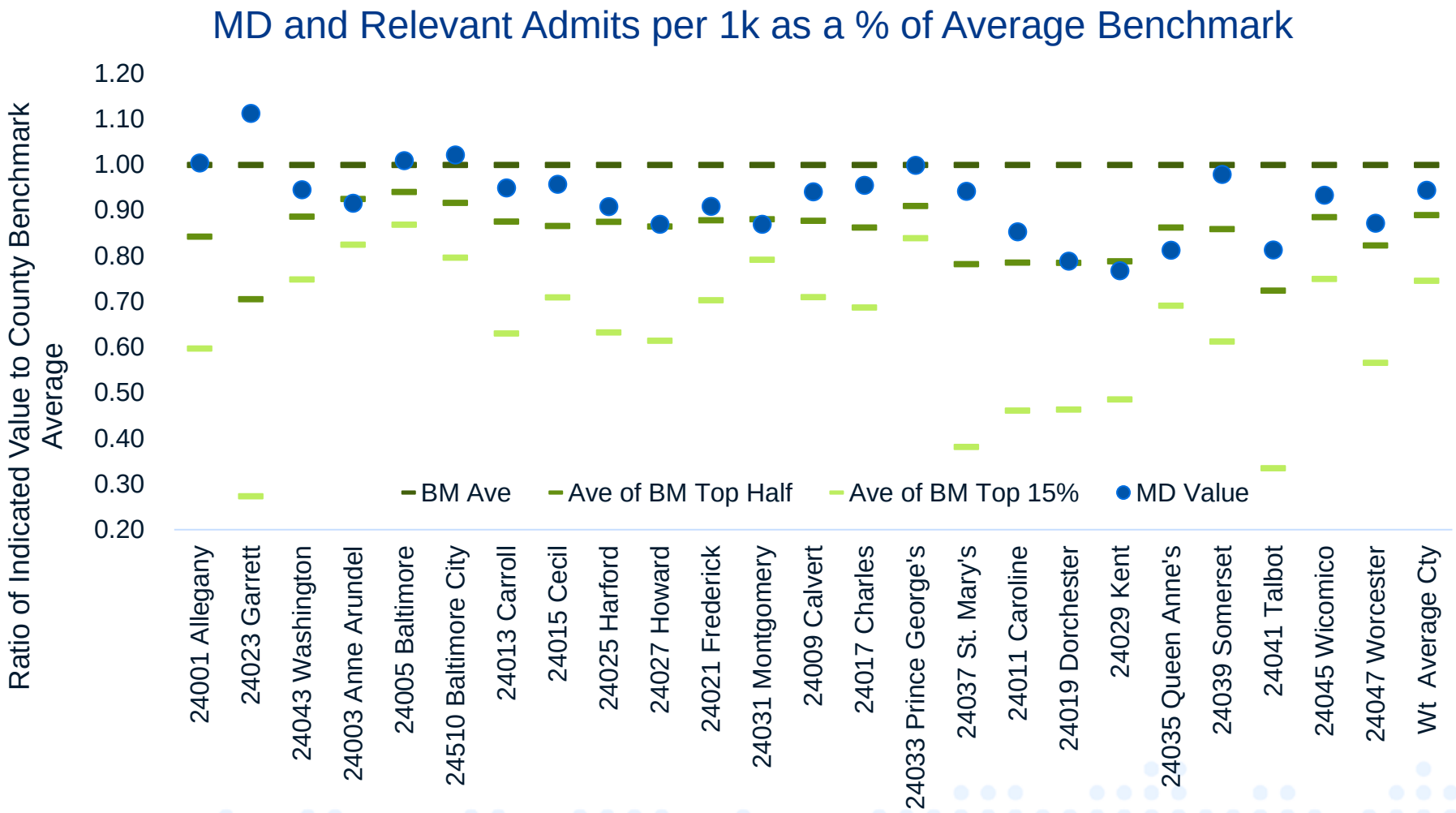
Recap of Benchmark Position, Total Cost of Care



- Same as data presented previously but
  - County Level
  - No Demographic adjustment (worth ~ 1%)
- Each value indexed to the benchmark for its county (so benchmark average = 1.00)
- Top half and top 15% based on **TCOC***

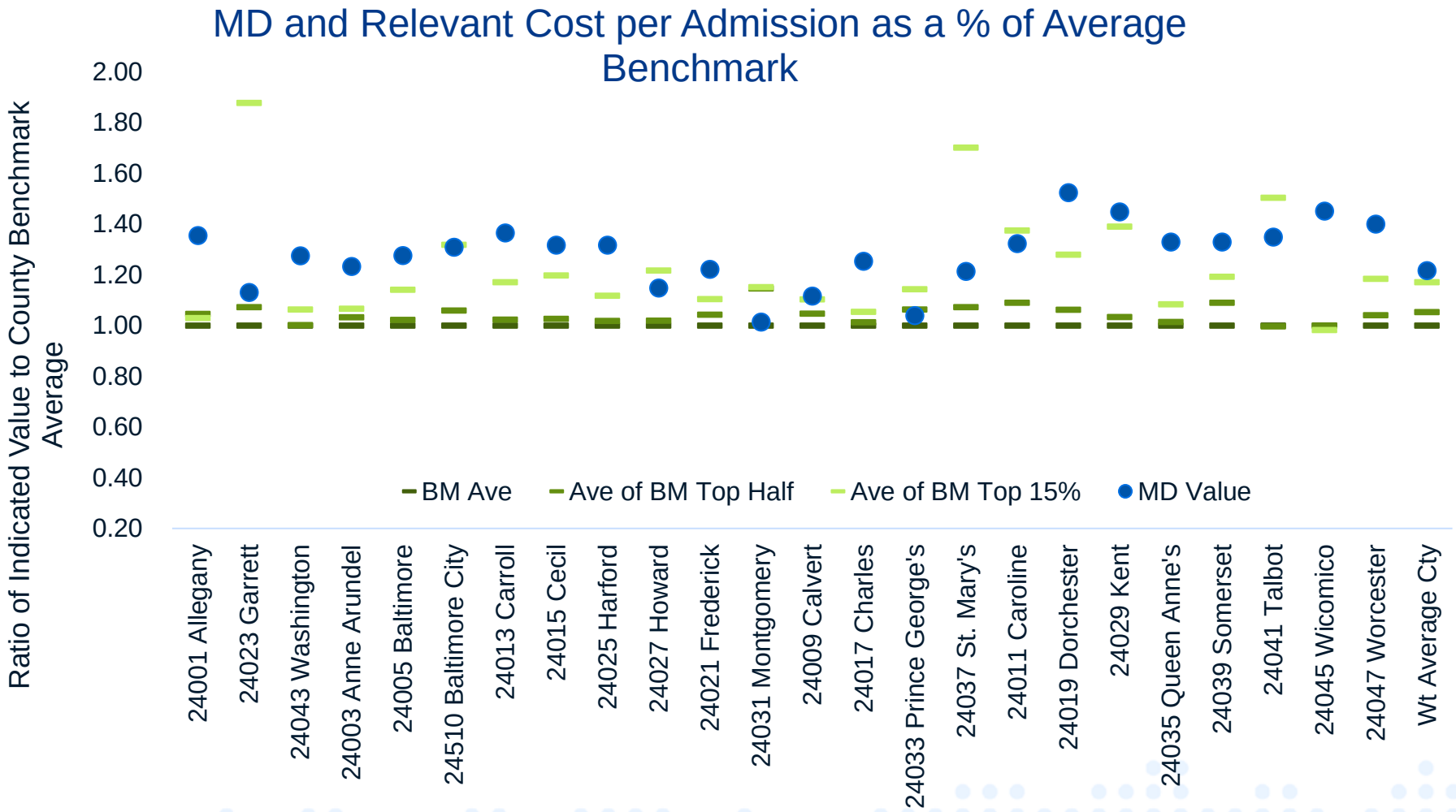
* TCOC used is after adjustment to remove Medical Education costs.

Benchmark Position, IP Admissions per 1000



- Same presentation as prior slide but showing IP admissions and top half and top 15% based on **IP Admits per 1000**
- Maryland performance extrapolates to the ~37th percentile of utilization (best performers are low).

Benchmark Position, Cost per Admission

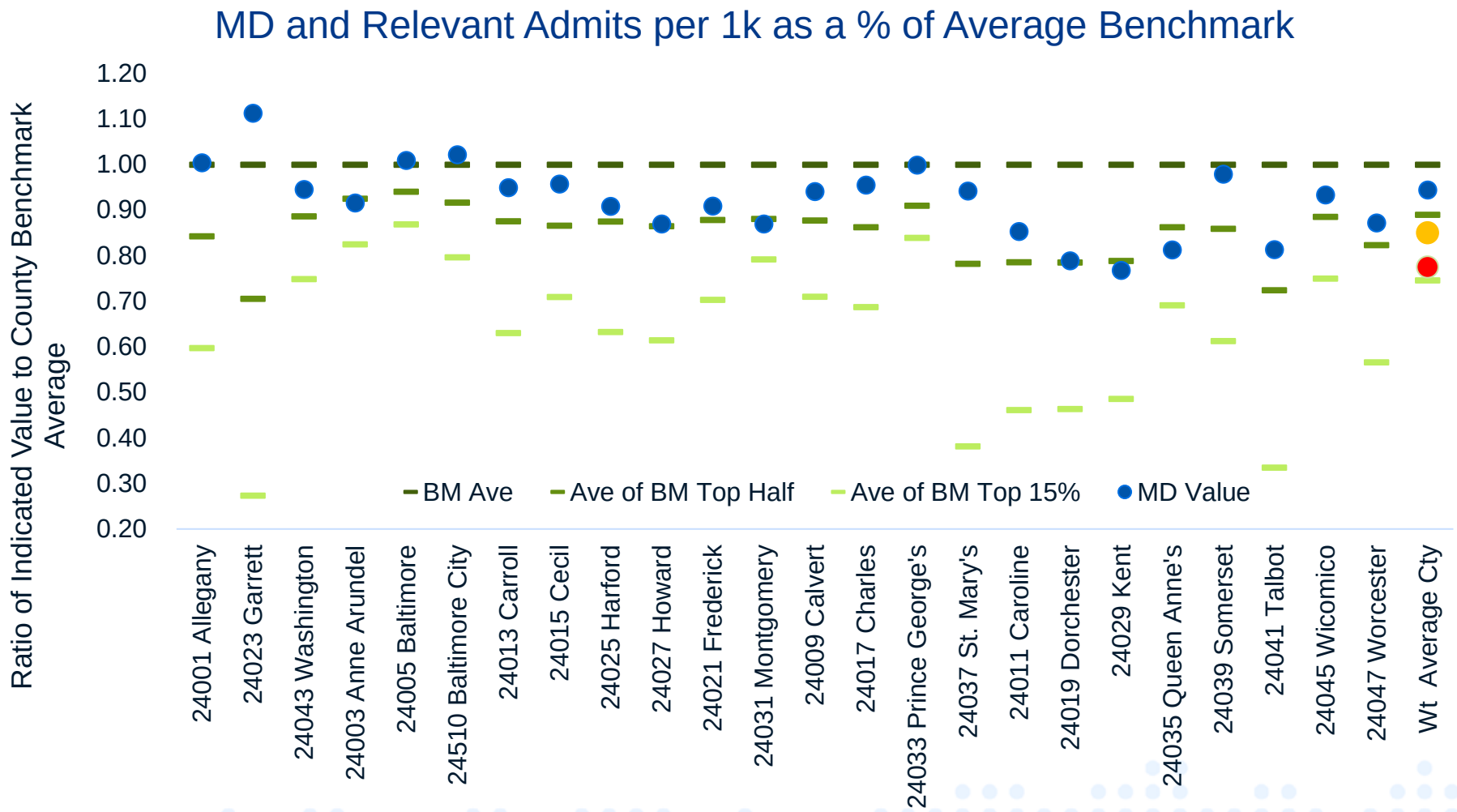


- Same presentation as prior slide Cost per admission with top half and top 15% still based on **IP Admits per 1000**
- Lower utilization counties generally have higher unit cost. MD is in the top 7.5% although utilization is only in the top 40%

Maryland Management Strategy

- National incentives result in an undesirable bargain where hospitals compensate for getting paid less by doing more
- Maryland model better aligns incentives but relies on excess total payments from Medicare. Staff believes eliminating these excess payments by effectively managing care but maintaining somewhat higher unit costs is preferable to reverting to the national model.
- Discussion with stakeholders and CMS is ongoing regarding an appropriate steady state but maintaining all of the current excess is not likely and is not supported under current contract terms
- Staff believe using $800 M as a reference point in analysis and methodologies is appropriate while these discussions are ongoing

Benchmark Position, IP Admissions per 1000, w Goal



- Eliminating 18% (red) of IP utilization puts MD at the 10th percentile. Since 2013 MD has beaten the nation by ~2% per year on IP admits, which is equivalent to this reduction
- Setting a 10% (orange) hospital target would put Maryland in the 20th percentile.
- Percentiles are set against a system that incents utilization.

Strategies to Reach $800 M

- Reducing facility utilization by 10% generates ~$400 M improvement (= end point of 80th percentile of volume driven benchmark on IP)
- If correct target is $800 M system would need to pursue complementary strategies:
  - Start to more directly incent reductions in avoidable outpatient care, e.g. implementing avoidable ED visits into PAU Shared Savings program
  - More effectively reduce fixed costs as volume drops allowing reductions in unit price. Many “fixed” costs are step variable
  - Pursue non-hospital costs through programs like CTI, ECIP and EQIP
  - Improve population health through programs like MDPCP, Community Benefit spending, and SIHIS programs
  - Consider further payment realignment if hospital savings do not translate to premium savings
- Timeline is important in considering feasibility of these strategies

SIHIS Milestones, Measures, and Targets

Care Transformation Targets

Measuring Care Transformation Activities Across the State

The SIHIS requires the State to identify system-wide care transformation goals that reflect activities under:

- The Care Redesign Program.
- The Maryland Primary Care Program.
- Other care transformation activities measured by the State.

The State's Statewide Integrated Health Improvement Strategy Proposal must include:

- A “goal.”
- A measure and the State’s baseline performance on that measure.
- A Model Year 3 milestone, a Model Year 5 interim target, and a Model Year 8 final target.

CMMI has stated that the measure must include some element of TCOC risk (thus MDPCP Tracks 1 and 2 will not count).

SIHISS Care Transformation Goals

Preliminary Targets

Staff are proposing the follow targets for the Care Transformation goals under the SIHISS. Comments from stakeholders are welcome.

- Interim Milestone (Calendar Year 2021): 25% of Medicare TCOC or 15% of Medicare Beneficiaries covered under a CTI or CRP or successor payment model.
- Interim Target (Calendar Year 2023): 37% of Medicare TCOC or 22% of Medicare Beneficiaries covered under a CTI or CRP or successor payment model.
- Final Target (Calendar Year 2026): 50% of Medicare TCOC or 30% of Medicare Beneficiaries covered under a CTI or CRP or successor payment model.

Preliminary Baseline for SIHIS Care Transformation

Based on preliminary CTI submission, the State would be well on its way to meeting the SIHIS targets for care transformation.

- Numbers for 2021 are expected to rise as final intake templates are submitted.
- Meeting the 2026 targets may require the development of additional CTI thematic areas.

	TCOC under CTI	Benes under CTI
CTI Baseline	$2,445 million (26%)	134,377 (18%)
2021 Interim Milestone	25%	15%
2023 Interim Target	37%	22%
2026 Final Target	50%	30%

Next Steps

October TCOC Workgroup

- The draft MPA recommendation will go to the commission during the October commission meeting.
- The next TCOC workgroup meeting will address stakeholders' comments on two topics:
  - Comments on the MPA draft and follow-up to the utilization targets.
  - Comments on the preliminary SIHIS targets