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Committee Steering Committee Meeting

December 18, 2020

Agenda

1. Administrative Updates
2. Final Minimum Savings Rate Policy
3. Overlaps Analysis and Policy
4. CTI Policy Direction
5. Next Steps

Administrative Updates

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Administrative Updates

Given the ongoing demands on hospitals' time and efforts due to the COVID crisis, the HSCRC will delay the payment implications of the CTI policy.

- The CTI will launch on January 1, 2021 as a measurement period only. No payments will be made for episodes initiated prior to July 1. There will be no offset for episodes during that time period;
- Data will be available for the measurement period through the Care Transformation Profiler (CTP) provided by CRISP. This will include both baseline period data and measurement period data relative to the target price;
- The first performance period will be from July 1, 2021, to June 30, 2022.

Initial CTI Submissions

HSCRC has process about 80% of the initial CTI submission. The remainder, including requested modifications and some necessary CTI revisions, will be addressed on an ad hoc basis with submitting hospitals.

- Data on the initial submissions will appear in the Care Transformation Profiler beginning in January;
- Hospitals will have an opportunity to submit/revise CTI submissions prior to the July 1 performance period start date.

Final Minimum Savings Rate Policy

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Final MSR Policy

During our previous meetings, we discussed the minimum savings rate policy. Staff are finalizing the minimum savings rates numbers and the sequential MSR analysis.

- The MSR and sequential analysis will be used for the performance period beginning on July 1, 2021.
- We will evaluate the appropriateness of these policies using the measurement period from January – June 2021.

Final Minimum Savings Rate

- The minimum savings rates in the table to the right will be used for the first performance year (July 21-June 22).
  - Setting specific CTI are triggered at a hospital (Care Transitions, Palliative Care, ED Care).
  - Community trigger CTI are triggered somewhere other than the hospital (all other CTI).
- Staff will review the MSR with the CT Steering Committee using the measurement period (January – June 2020).

Minimum Savings Rate	Setting Specific CTI	Community Triggered CTI
1.0	> 8977	> 19655
1.5	3991 - 8977	8736 - 19655
2.0	2246 - 3990	4916 - 8735
2.5	1441 - 2245	3146 - 4915
3.0	1001 - 1440	1286 - 3145
3.5	731 - 1000	1606 - 2185
4.0	561 - 730	1231 - 1605
4.5	441 - 560	971 - 1230
5.0	361 - 440	791 - 970
5.5	301 - 360	651 - 790
6.0	251 - 300	551 - 650
6.5	210 - 250	466 - 550
7.0	181 - 210	401 - 465
7.5	161 - 180	351 - 400
8.0	141 - 160	311 - 350
8.5	126 - 140	270 - 310
9.0	111 - 125	246 - 270
9.5	101 - 110	221 - 245
10.0	91 - 100	201 - 220
15.0	< 90	< 200

“Sequential” MSR Analysis

For the first performance period, the CTI will use the “Sequential MSR” policy. That is, HSCRC will evaluate the MSRs independently and allow excess savings to carry over other CTI.

Under this option, the MSR would be evaluated using the following algorithm:

1. CTI would be ranked according to how much they exceeded the required savings
2. Starting from the highest saving CTI:
    1. The total savings will be added together and compared to the sum of the required savings
    2. If the total savings exceeds the total required savings, then another CTI will be added
    3. If not, the hospital earns the total savings from all of the combined CTI

Example of the "Sequential" MSR Analysis

CTI	# Episodes	TCOC	MSR	Required Savings	Results	Difference	Cumulative TCOC	Required Savings	Cumulative Savings
CTI #3	275	$6,300,000	6.0%	$378,000	$485,000	$107,000	$6,300,000	$378,000	$485,000
CTI #6	315	$600,000	5.5%	$33,000	$35,000	$2,000	$6,900,000	$411,000	$520,000
CTI #1	260	$5,000,000	6.0%	$300,000	$292,000	-$8,000	$11,900,000	$711,000	$812,000
CTI #4	500	$10,500,000	4.5%	$472,500	$375,000	-$97,500	$22,400,000	$1,183,500	$1,187,000
CTI #5	260	$3,000,000	6.0%	$180,000	$50,000	-$130,000	$25,400,000	$1,363,500	$1,237,000
CTI #2	400	$9,800,000	5.0%	$490,000	-$200,000	-$690,000			

“Sequential MSR” Rationale

The sequential MSR policy means that CTI with positive savings that is close to the MSR may still receive payments. Furthermore, negative savings in the CTI cannot hurt the hospital.

- This policy does not reduce the MSR by combining MSR across CTI.
- There may be edge cases where the hospital is worse off than pooling the number of episodes.
- Staff believe that the sequential MSR will be more favorable to hospitals.

Staff will use the measurement period (January – June) to assess the MSR policy and will share with members of the CT Steering Committee.

Overlaps Analysis and Policy

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Overlaps Problem

The CTI are designed to provide hospitals with flexibility in determining who they are targeting for their care management programs. Given the level of flexibility it is inevitable there will be overlaps.

- Overlaps are undesirable because it creates the possibility of double payment and indicted potential clinical duplication;
- However, eliminating overlaps entirely requires complex and arcane rules that creates operational issues for hospitals.

Previously, staff indicated that a small number of overlaps will be allowed in order to simplify the attribution rules and allow hospitals to know who is attributed to them as soon as possible.

Overlaps Analysis

HSCRC has run the baseline period data for the hospitals' CTI submission.

- About 80 percent of the CTI were included in this initial run;
- The remainder are "requested modifications" or CTI submissions that will need revisions.

In the baseline period, there were 105,552 CTI episodes. Staff broke these episodes into three buckets:

1. Bucket 1 are unique CTI – These CTI episodes do not overlap with any other CTI episode. There were 90,242 CTI episodes that did not overlap (85% of the total).
2. Bucket 2 are definitional overlap CTI – These CTI episodes meet the criteria to be included in two different CTI based on the same trigger event. There were 11,392 episodes that overlapped based on the same trigger event (11% of the total).
3. Bucket 3 are CTI that overlap between Hospital/CTI – These CTI episodes meet the triggering condition at a second hospital during the episode window of a CTI at another hospital. There were 3,918 episode that overlapped (4% of the total).

Overlaps Policy

Based on the analysis, staff consider the extent of the overlaps is relatively modest. Therefore, staff will adopt the following overlaps policy:

1. The overlaps that occur based on the same event will be removed by using a hierarchical assignment;
2. **All other overlaps will be allowed.**

Allowing overlaps will ensure that hospitals know which beneficiaries are assigned to them at the time that beneficiary is seen by the provider.

- The benefit of this policy will avoid the possibility that CTI episodes do not trigger based on an event out of sight of the hospital/provider;
- The cost of this policy is that there will be some double counting of savings. However, the magnitude is relatively small.

HSCRC may revise this policy if the number of episodes that overlaps at the same hospital increases.

Tiering of CTI to Eliminate Overlaps

A single beneficiary can potentially meet the criteria for multiple CTI based on the same event. Overlaps based on the same event raises fewer operational issues for the hospital.

- For example, a Care Transitions episode based on any SOI 2+ could overlap with Palliative Care episode based on 1 chronic conditions and a diagnosis of endometrial cancer.
- The hospital knows that the beneficiary will be attributed to them. The question is which CTI the beneficiary will be credited to.

Overlaps that trigger based on the same event will be eliminated by ‘tiering’ the CTI.

- A CTI that meets the criteria for more than one CTI will be assigned to the CTI that is tiered higher;
- Hospitals may choose a hierarchy based on their own CTI submission;
- HSCRC will create a default hierarchy that will be used absent the hospital’s preference.

The default hierarchy will prioritize CTI with the least number of episodes in the baseline period.

- The purpose of this is to maintain a viable number of episodes in smaller CTI;
- In general, thematic areas will be prioritize by: Palliative Care, ED care, Care Transitions, PAC Touch, Geographic, Primary Care. Within a thematic area, CTI that use more selection criteria will be prioritized over those with fewer criteria.

Example of Tiered CTI

- A beneficiary admitted to the hospital with AMI and 2+ hospitalizations and an SOI of 3 will be assigned to Tier 1.
- A beneficiary admitted to the hospital with SOI 2 and without 2+ prior hospitalizations will be assigned to Tier 2.
- A beneficiary with ROM 4 none of the Tier 1 or Tier 2 criteria will be assigned to Tier 3.

Tier 1: Care Transitions	**Ischemic Heart Disease, Hypertension, and Acute Myocardial Infarction admissions with 2+ prior hospitals within 365 days**
Tier #2: Care Transitions	**All Medical DRGs with SOI 2-3, excluding those discharge to a SNF**
Tier #3: Palliative Care	**All Medical DRGs with Risk of Mortality 4**

CTI Policy Direction

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Statewide Strategy for Care Transformation

An initial objective for the CTI program was to create a catalog of care transformation efforts happening statewide.

- This allows the HSCRC to reward hospitals for their efforts to manage the total cost of care;
- It is necessary to educate CMMI on the care transformation efforts that are ongoing as part of the Total Cost of Care Model.

The State has committed to include a substantial number of Medicare Beneficiaries / TCOC under Care Transformation Initiatives or other value-based payment models.

- Staff expected that the first year of the program have approx. 15% of Medicare beneficiaries under CTI;
- In the future, either more CTI will be necessary, or successor models will need to be developed.

CTI Goals over Time

Goal: Increase the amount of Medicare TCOC or number of Medicare beneficiaries under Care Transformation Initiatives (CTIs), Care Redesign Program, or successor payment model		
Measure	Percent of TCOC under Care Transformation	Number of beneficiaries under CTI
2018 Baseline	$0	0
2021 Year 3 Milestone	12.5% of Medicare TCOC under a CTI or CRP or successor payment model	7.5% of Medicare Beneficiaries covered under a CTI or CRP or successor payment model
2023 Year 5 Target	37% of Medicare under a CTI or CRP or successor payment model	22% of Medicare Beneficiaries covered under a CTI or CRP or successor payment model
2026 Year 8 Final Target	50% of Medicare TCOC under a CTI or CRP or successor payment model	30% of Medicare Beneficiaries covered under a CTI or CRP or successor payment model

Next Steps

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Next Steps

- HSCRC will be reaching out to develop the requested modifications and resolve unnecessary issues.
- The CRISP reporting tools will go live in January.
  - Hospitals will see the baseline data for their CTI submissions;
  - Performance data will be populated throughout the first half of 2021.
- The Care Transformation Steering Committee will continue to meet throughout 2021 but the meeting schedule will be based on hospital capacity during the COVID crisis.
  - HSCRC will establish a timeline for modifying CTI submissions for the first performance year once workgroup meetings pickup in the new;
  - We will also discuss the development of new CTI.