Total Cost of Care (TCOC) Workgroup

November 29, 2017

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions
- Updates on initiatives with CMS
- Technical walk-through of Y1 policy for Medicare Performance Adjustment (MPA)
- MPA monitoring tools: Using CCW and CCLF data
- Discussion of Y2 MPA issues

Updates on Initiatives with CMS

- TCOC Model
- Care Redesign Programs (HCIP, CCIP)

Technical walk-through of RY 2020 MPA policy (Y1)

Medicare Performance Adjustment (MPA)

- **What is it?**
  - A scaled adjustment to each hospital's federal Medicare payments based on its performance relative to a Medicare Total Cost of Care (TCOC) benchmark

- **Objective**
  - Further Maryland's progression toward developing the systems and mechanisms to control TCOC, by increasing hospital-specific responsibility for Medicare TCOC (Part A & B) over time — not only in terms of increased financial accountability, but also increased accountability for care, outcomes and population health

MPA and Potential MACRA Opportunity

- Under federal MACRA law, clinicians who are linked to an Advanced Alternative Payment Model (APM) Entity and meet other requirements may be Qualifying APM Participants (QPs), qualifying them for:
  - 5% bonus on QPs' Medicare payments for Performance Years through 2022, with payments made two years later (Payment Years through 2024)
  - Annual updates of Medicare Physician Fee Schedule of 0.75% rather than 0.25% for Payment Years 2026+
- Maryland is seeking CMS determination that:
  1. Maryland hospitals are Advanced APM Entities; and
  2. Clinicians participating in Care Redesign Programs (HCIP, CCIP) are eligible to be QPs based on % of Medicare beneficiaries or revenue from residents of Maryland or of out-of-state PSAs*
- Other pathways to QP status include participation in a risk-bearing Accountable Care Organization (ACO)

* PSA stands for primary service area. It is the group of zip codes that each hospital has claimed responsibility for and submitted to HSCRC.

MPA and MACRA: Advanced APM Entities

- Advanced APM Entities must satisfy all 3 of the following:
  - Require participants to use certified EHR technology (CEHRT)
  - Have payments related to Medicare Part B professional services that are adjusted for certain quality measures
  - Bear more than a nominal amount of financial risk
- Notwithstanding Medicare financial responsibility already borne by Maryland hospitals, CMS says this last test is not yet met
  - MPA could satisfy the more-than-nominal test
  - If CMS accepts 0.5% maximum MPA Medicare risk for PY1, CMS would be recognizing risk already borne by hospitals, since federal MACRA regulations define "more than nominal" as potential maximum loss of:
    - 8% of entity's Medicare revenues, or
    - 3% of expenditures for which entity is responsible (e.g., TCOC)

Federal Medicare Payments (CY 2016) by Hospital, and 0.5% of Those Payments

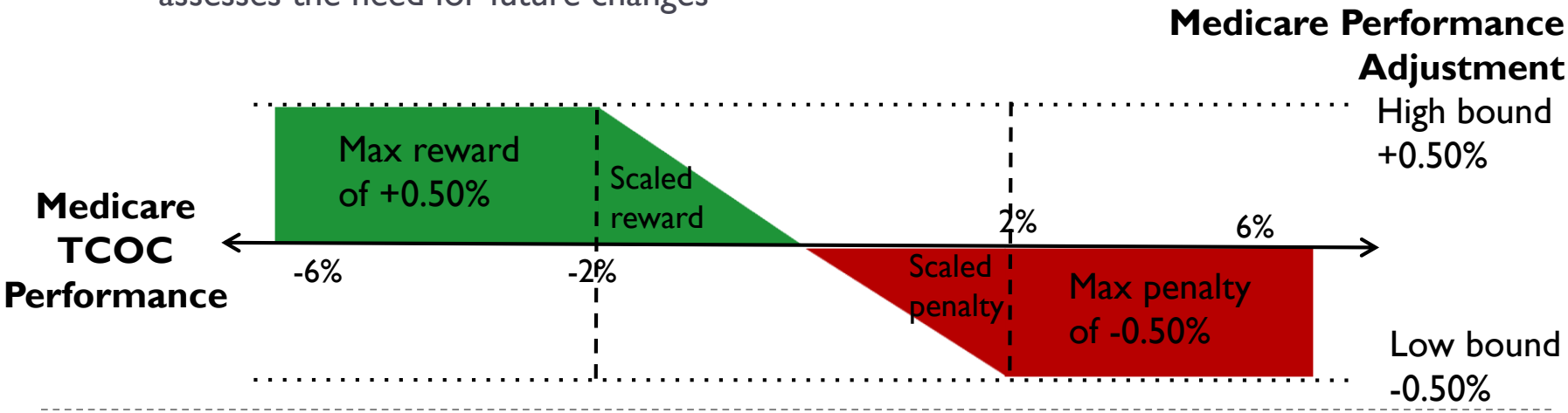
Hospital	CY 16 Medicare claims	
A	B	C = B * 0.5%
STATE TOTAL	**$4,399,243,240**	**$21,996,216**
Anne Arundel	163,651,329	818,257
Atlantic General	30,132,666	150,663
BWMC	137,164,897	685,824
Bon Secours	22,793,980	113,970
Calvert	45,304,339	226,522
Carroll County	85,655,790	428,279
Charles Regional	46,839,127	234,196
Chestertown	23,104,009	115,520
Doctors Community	71,932,763	359,664
Easton	105,796,229	528,981
Franklin Square	152,733,233	763,666
Frederick Memorial	107,572,532	537,863
Ft. Washington	12,404,606	62,023
GBMC	109,329,016	546,645
Garrett County	12,485,063	62,425
Good Samaritan	111,439,737	557,199
Harbor	49,811,070	249,055
Harford	32,986,577	164,933
Holy Cross	84,757,140	423,786
Holy Cross Germantown	17,709,263	88,546
Hopkins Bayview	166,936,445	834,682
Howard County	74,364,089	371,820
Johns Hopkins	385,219,507	1,926,098

Hospital	CY 16 Medicare claims	
A	B	D = B * 0.5%
Laurel Regional	$28,395,414	$141,977
Levindale	37,853,194	189,266
McCready	5,281,208	26,406
Mercy	123,251,053	616,255
Meritus	93,863,687	469,318
Montgomery General	58,955,109	294,776
Northwest	87,214,773	436,074
Peninsula Regional	129,202,314	646,012
Prince George	60,059,396	300,297
Rehab & Ortho	26,772,477	133,862
Shady Grove	92,559,096	462,795
Sinai	231,161,132	1,155,806
Southern Maryland	77,940,994	389,705
St. Agnes	122,910,533	614,553
St. Mary	53,984,389	269,922
Suburban	89,000,075	445,000
UM St. Joseph	135,505,261	677,526
UMMC Midtown	61,852,594	309,263
Union Of Cecil	47,233,811	236,169
Union Memorial	141,726,131	708,631
University Of Maryland	365,949,340	1,829,747
Upper Chesapeake Health	107,984,715	539,924
Washington Adventist	69,512,752	347,564
Western Maryland	100,950,387	504,752

Source: HSCRC analysis of data from CMMI

Year 1 MPA Design

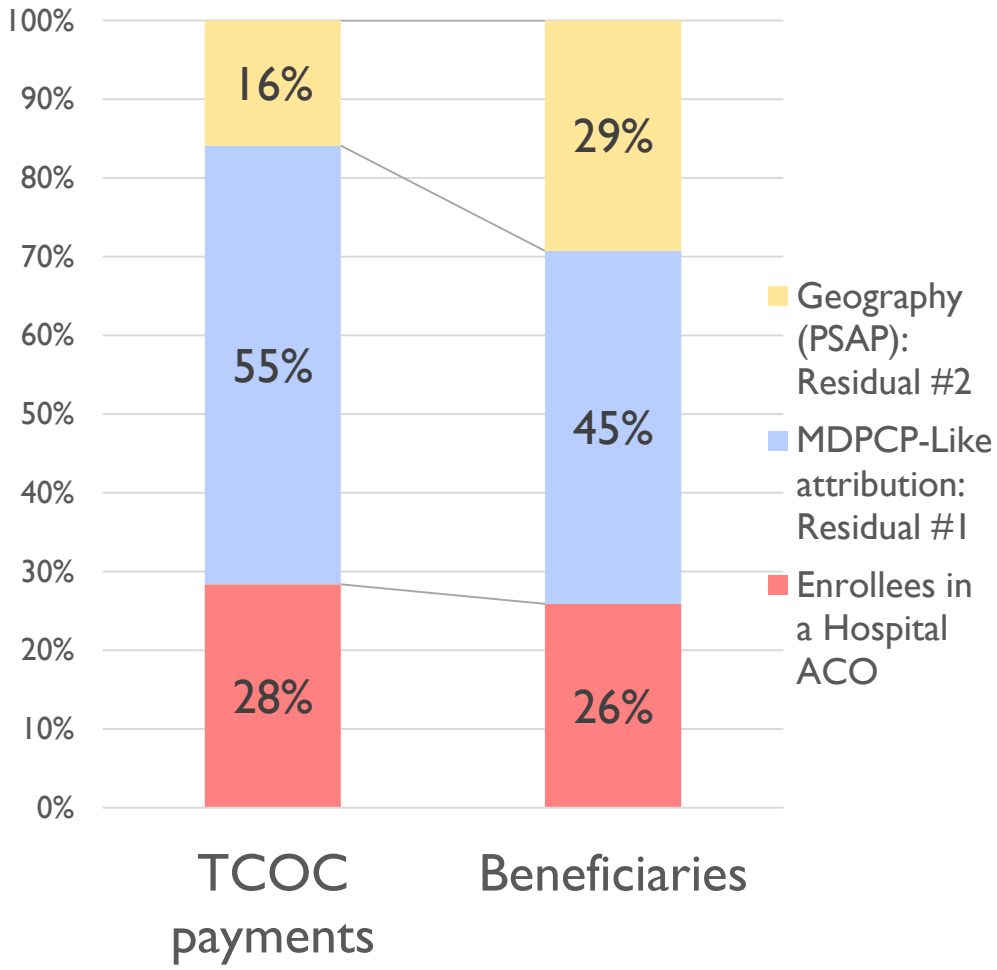
- Based on a hospital's performance on the Medicare TCOC measure, the hospital will receive a scaled bonus or penalty
  - Function similarly to adjustments under the HSCRC's quality programs
  - Be a part of the revenue at-risk for quality programs (redistribution among programs)
  - NOTE: Not an insurance model
- Scaling approach includes a narrow band to share statewide performance and minimize volatility risk
- MPA will be applied to Medicare hospital spending, starting at 0.5% Medicare revenue at-risk (which translates to approx. 0.2% of hospital all-payer spending)
  - First payment adjustment in July 2019
  - Increase to 1.0% Medicare revenue at-risk, perhaps more moving forward, as HSCRC assesses the need for future changes



Year 1 MPA Policy

- Algorithm for attributing Medicare beneficiaries (those with Part A and Part B) to hospitals, to create a TCOC per capita
- Assess performance
  - Base year TCOC per capita (CY 2017)
    - Apply TCOC Trend Factor (national Medicare FFS growth minus 0.33%) to create a TCOC Benchmark
  - Performance year TCOC per capita (CY 2018)
  - Compare performance to TCOC Benchmark (improvement only)
- Calculate MPA (i.e., percentage adjustment on hospital's federal Medicare payments – applying in RY 2020)
  - Maximum Revenue at Risk (±0.5%): Upper limit on MPA
  - Maximum Performance Threshold (±2%): Percentage above/below TCOC Benchmark where Maximum Revenue at Risk is reached, with scaling in between
- Include a Quality Adjustment

Hierarchy with prospective attribution: Hospital-based ACO-Like / MDPCP-Like / Geography



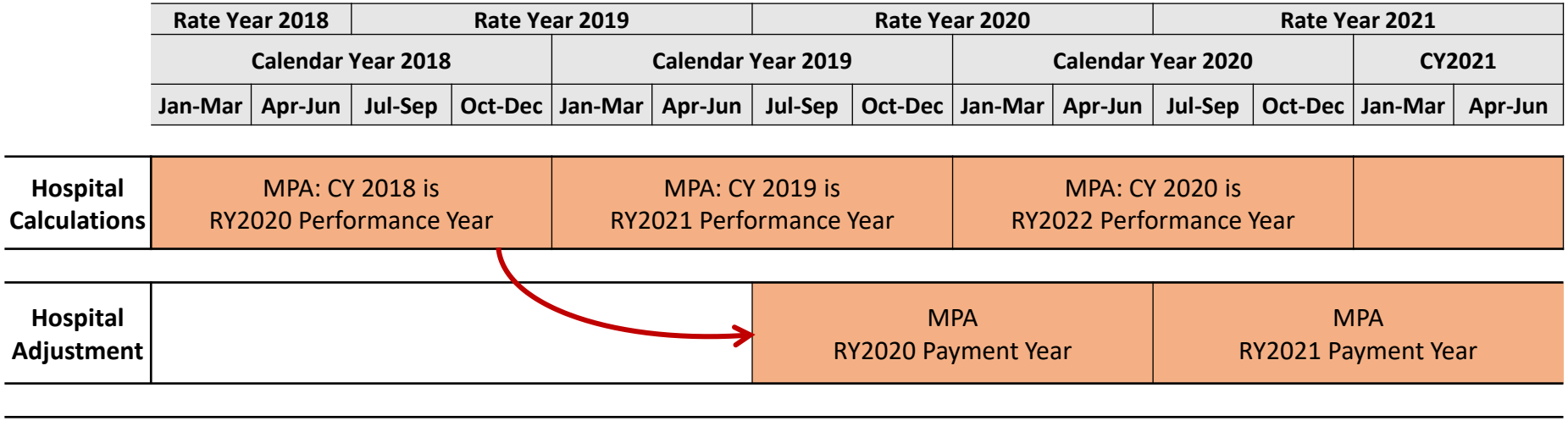
- Attribution occurs prospectively, based on utilization in prior 2 federal fiscal years, but then using their current CY TCOC
  1. Beneficiaries attributed first based on service use of clinicians in hospital-based ACO
  2. Beneficiaries not attributed through ACO-like are attributed based on MDPCP-like
  3. Finally, beneficiaries still not attributed would be attributed with a Geographic approach
- Performance would be assessed on TCOC spending per capita
- For hospitals not in an ACO, attribution would be MDPCP-like + Geography, among beneficiaries not in a hospital-based ACO

Source: Draft HSCRC analysis based on CY 2016 Medicare (CCW) data

Quality adjustment for Y1

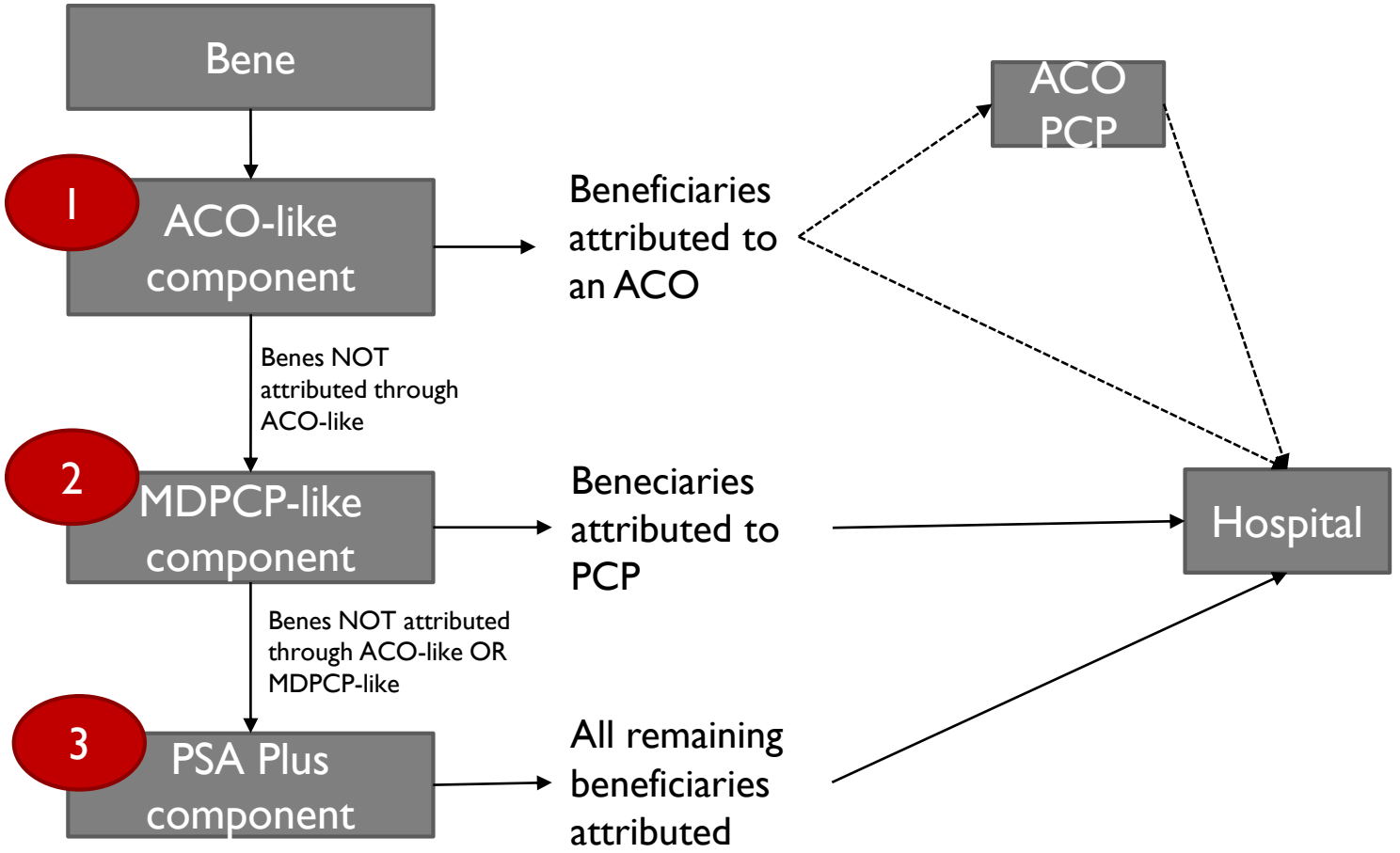
- Rationale
  - Payments under an Advanced APM model must have at least some portion at risk for quality
  - Because the MPA connects the hospital model to the physicians for AAPM purposes, the MPA must include a quality adjustment
- Use RY19 quality adjustments from Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Infections (MHAC).
  - Both programs have maximum penalties of 2% and maximum rewards of 1%.
- Mechanism
  - MPA will be multiplied by the sum of the hospital's quality adjustments
  - For example, a hospital with TCOC scaled reward = 0.3%, then with MHAC quality adjustment =1% and RRIP quality adjustment = 0% would receive an MPA adjustment of 0.303%.

MPA Timeline



- Once CMS provides 2018 list of clinicians in ACOs, HSCRC will produce:
  - Lists of clinicians associated with hospitals under ACO-like and MDPCP-like – to be shared with hospitals
  - Lists of beneficiaries attributed to hospitals under ACO-like, MDPCP-like and Geography – to be shared with CMS (for MACRA purposes)
- Lists will be finalized around January 2018

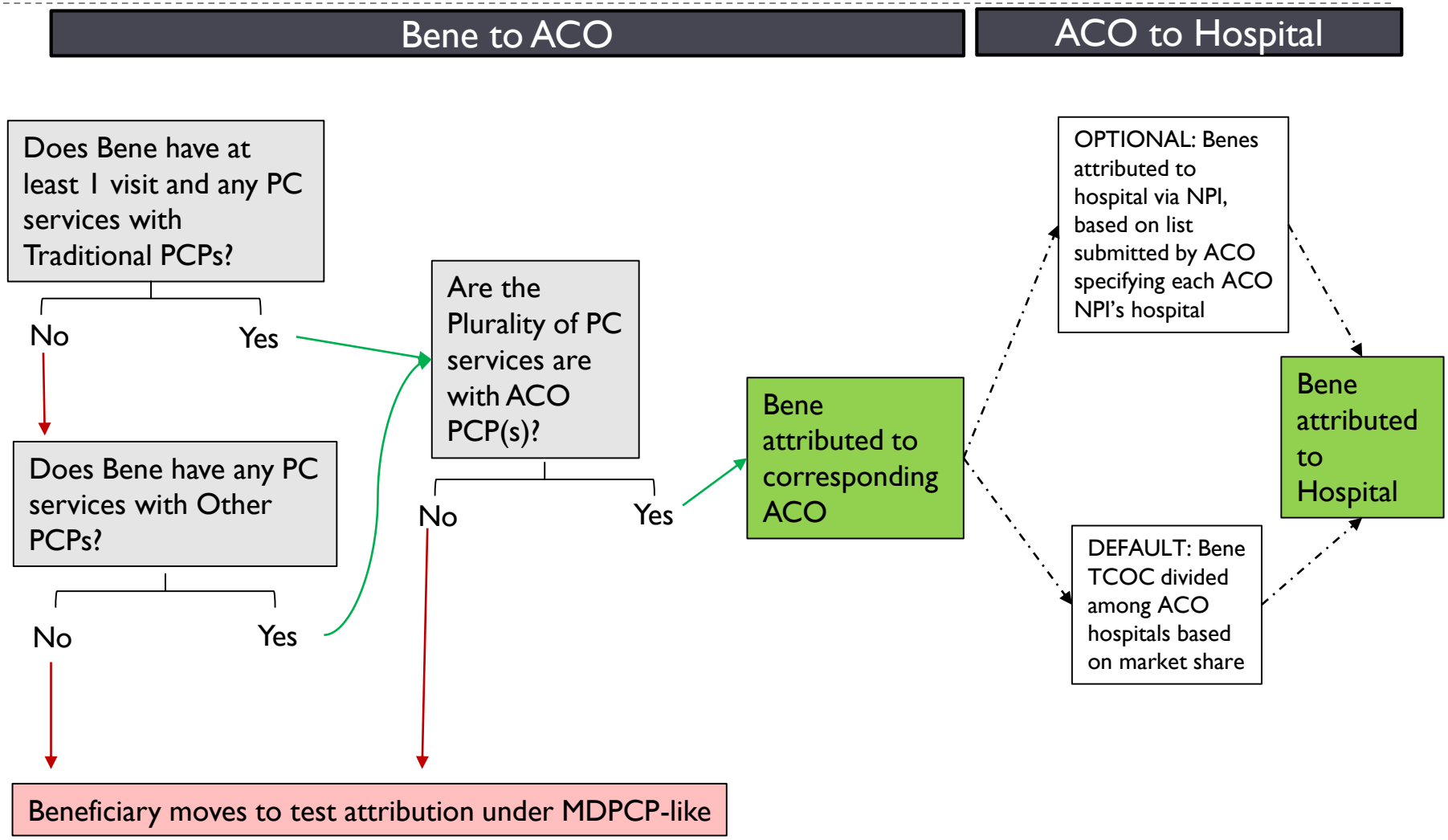
Attribution of Medicare beneficiaries to hospitals via Y1 MPA Attribution Algorithm



PCP stands for primary care provider. A PCP for this purpose includes traditional PCPs but also physicians from other selected specialties if used by beneficiary rather than a traditional PCP.

ACO-Like

Assessed for all MD Medicare FFS (A&B) beneficiaries



PC stands for primary care.
NPI is the National Provider Identifier and refers to an individual clinician.

Bene to ACO Attribution Example

Numbers represent # of Beneficiary's PC Services

ACO affiliation	Doctor	Bene A	Bene B	Bene C
ACO1	Dr. Jones	5 PC Services	3 PC Services	0 PC Services
ACO1	Dr. Phil	5 PC Services	2 PC Services	0 PC Services
ACO2	Dr. Smith	0 PC Services	4 PC Services	4 PC Services
Non-ACO	Dr. Chen	0 PC Services	1 PC Services	3 PC Services
Non-ACO	Dr. Fred	0 PC Services	0 PC Services	2 PC Services
		Would be attributed to ACO1; plurality of 10 PC Services were from ACO1 providers	Would be attributed to ACO1; plurality of 5 PC Services (3+2) were from ACO1 providers	Would not be attributed to either ACO; plurality of 5 PC Services were from non-ACO providers

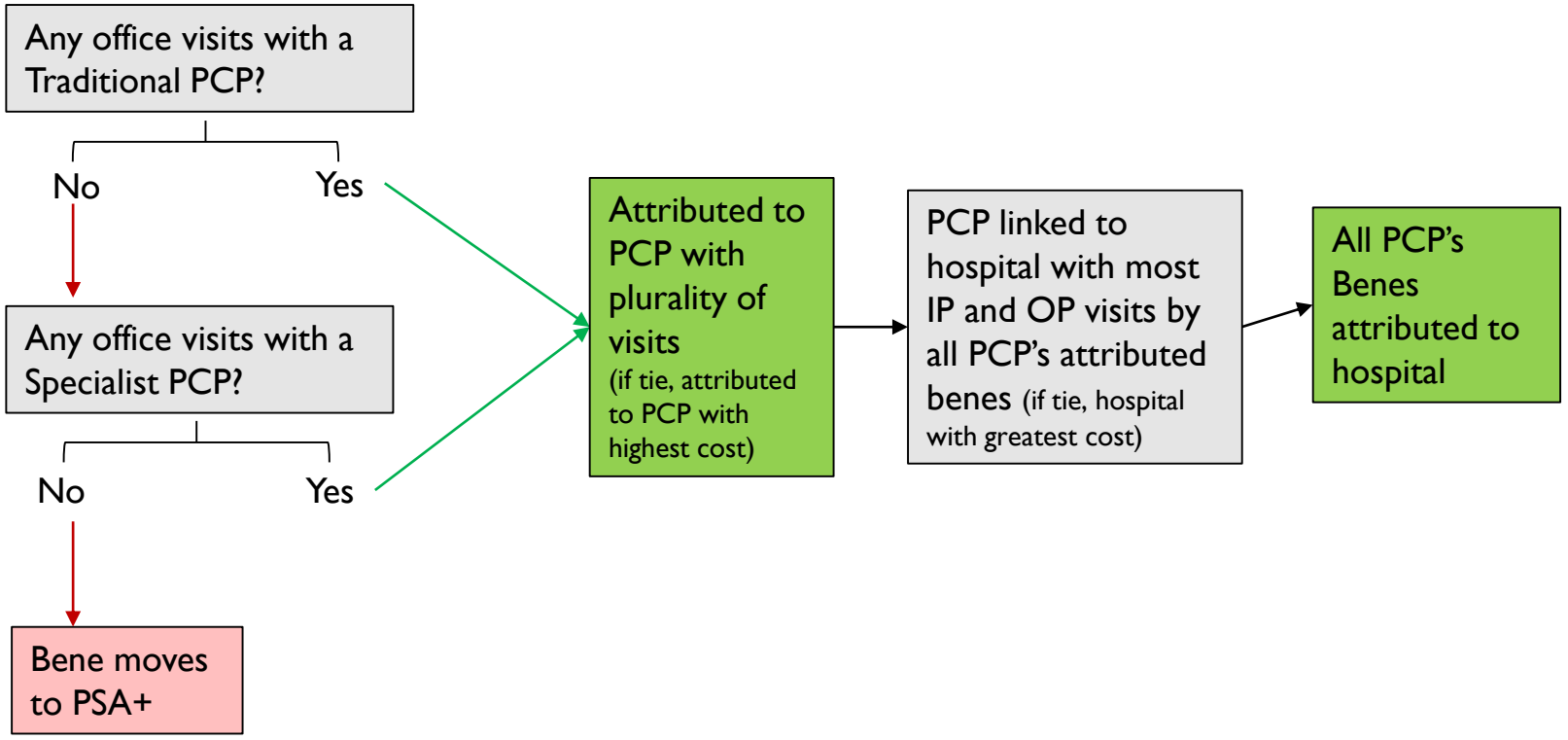
PC stands for primary care.

MDPCP-Like

Among beneficiaries not attributed under ACO-like

Bene to PCP

PCP to hospital



PCP to Hospital Attribution Example

Assuming beneficiaries have already been attributed to PCPs under MDPCP-Like.

ACO affiliation	Doctor	# of benes	Hospital A	Hospital B	Attribution to:
Non-ACO	Dr. Chen	100 benes	10 visits	0 visits	All 100 benes attributed to Hospital A
Non-ACO	Dr. Fred	100 benes	10 visits	20 visits	All 100 benes attributed to Hospital B

ACO PCPs Attributed in MDPCP-Like Attribution Example

ACO-like component (bene to ACO)

ACO affiliation	Doctor	Bene C
ACO2	Dr. Smith	4 PC Services
Non-ACO	Dr. Chen	3 PC Services
Non-ACO	Dr. Fred	2 PC Services

Would not be attributed to either ACO; plurality of 5 PC Services were from a non-ACO provider

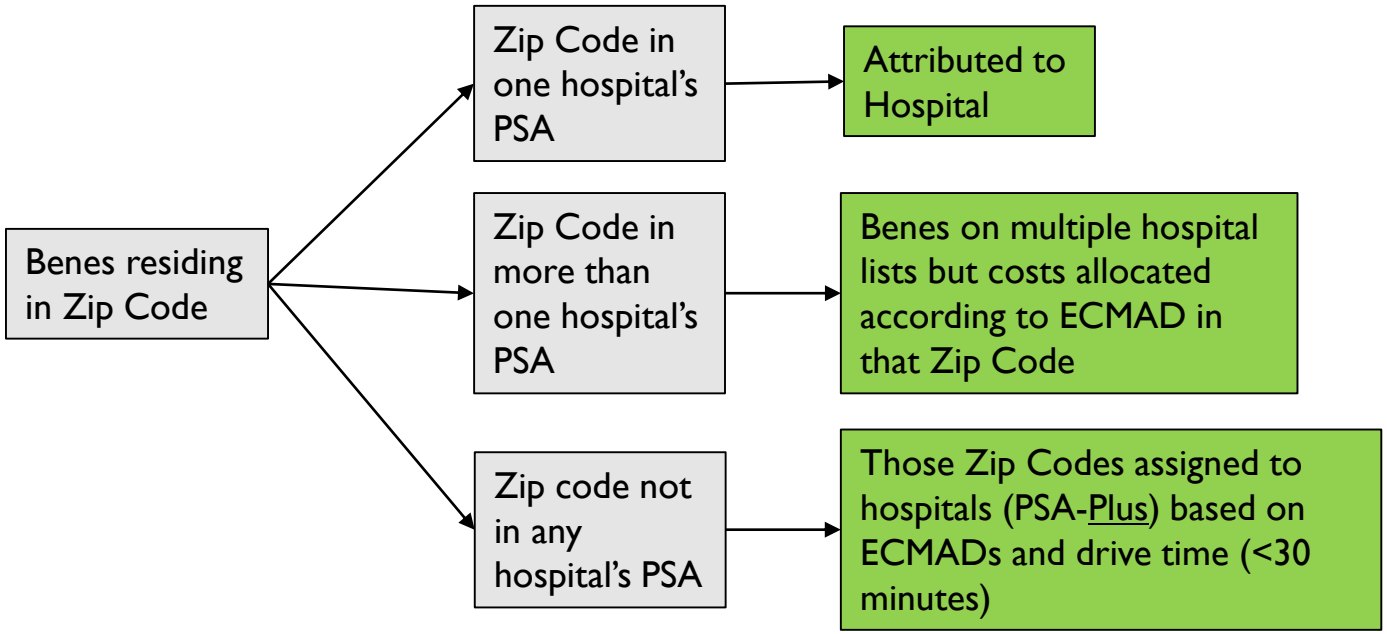
MDPCP-like component (bene to PCP)

ACO affiliation	Doctor	Bene C
ACO2	Dr. Smith	4 PC Visits
Non-ACO	Dr. Chen	3 PC Visits
Non-ACO	Dr. Fred	2 PC Visits

Would be attributed to Dr. Smith, who happens to be in ACO2

Geographic (PSA+)

Among beneficiaries not attributed under ACO-like or MDPCP-like



ECMAD stands for equivalent case-mix adjusted discharge. It is the number of (a) inpatient discharges and (b) outpatient visits scaled to reflect utilization similar to inpatient discharges.

MPA monitoring tools: Using CCW and CCLF data

Medicare Performance Adjustment Monitoring Tools

Using CCW and CCLF Data

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Current CRISP Tools for Care Redesign Efforts

- CRISP provides a range of tools for hospitals and providers

- CMS provided HSCRC and Care Redesign Program (CRP) participating hospitals with access to patient-identifiable Medicare claims data.
  - Medicare provides hospitals with patient data for any patient that was discharged from that hospital or had an 24+ hour observation visit. (“touch” approach).

- CRISP developed reporting tools using this Medicare data.

Building MPA Performance Monitoring Tools

CRISP is developing MPA performance monitoring tools

Goals of these tools:

1. Provide HSCRC and hospitals tools to monitor MPA performance
2. Provide hospitals tools to understand MPA populations for implementing quality improvement activities

CRISP Approach

← *Build into a new set of "statewide" reports*

← *Build MPA approach into current reporting capacity*

Two Data Sources Available for MPA Monitoring

Chronic Conditions Warehouse (CCW)

- Final “scorekeeping” with CMS
- Validation of data from other sources

CMS Claims Line Feed (CCLF)

- Source for detailed analytics and reporting to hospital on managing Total Cost of Care, Care Redesign

Understanding CCW and CCLF differences is key to leveraging each dataset

CCW to CCLF Comparison – Strengths and Weaknesses

	CCW	CCLF
Strengths	• Complete data set (particularly post 2017 when detail Substance Abuse data is available) • Historically reconciles with "scorekeeping" on program impact maintained by CMS (prior to recent beneficiary definition issue) • Includes beneficiary count	• Easy to access • Part D data available • Includes beneficiary count
Weaknesses	• Limited access to the data	• No Substance Abuse data • Beneficiaries not those used in CMS scorekeeping

CCW to CCLF Comparison

	CCW	CCLF
Geographic Coverage	100% for MD and border states, 5% sample of rest of country. Some uncertainty around how CMS defines what is included as MD.	Medicare FFS Maryland Residents and out-of-state beneficiary's hitting Maryland Provider
Periods	2012 to current, updated monthly. Run-out 3 Months after CY	September 2014 to current, updated monthly.
Beneficiary Types	All FFS for Part A and Part B (whether member has one or both). Some data for MA members where care is provided on a FFS basis (e.g. Hospice). These claims can be isolated.	Part A and B FFS members only
Beneficiary File	Available. Methodology changed in 2017, CMS moved from one membership definition approach (EDB) to another (CME). Resulted in shifting the cost of care picture and ongoing audit questions with CMS.	Available. Checking to determine source.
Beneficiary Identifiable	No	Yes
Pharmacy	None	Part D
Substance Abuse Data	SAMHSA included	SAMHSA excluded
Cost Fields	Billed Charges, Paid Amounts, Member Cost Share	Billed Charges, Paid Amounts, Member Cost Share
Dx/Procs	All	All
Availability	Limited access in terms of both number of seats and available tools, limited ability to export and share data	All hospitals: Summary data CRP Participating Hospitals: Fully available through CRISP

Reconciliation Update, CCW to CCLF

- Approximate high level tie out for 2015Q4, 2016 & 2017YTD (ICD-10)
  - Using MD beneficiary state to eliminate care for out-of-state members going to MD facilities in CCLF
  - Limiting to Part A + Part B members only (since this is all CCLF has)
  - Run-out 3 months after CY for prior years and 9/30/17 for 2017YTD

CCW to CCLF (cost)			
DOS Period	CCW	CCLF MD Benes	CCLF Above (Below) CCW
2015 Q4	$2,133,052,785	$2,114,293,176	-0.88%
2016 CY	$8,510,115,997	$8,440,555,979	-0.82%
2017 YTD	$6,055,111,442	$6,001,028,375	-0.89%

CCW to CCLF (cost)			
DOS Period	CCW	CCLF MD Benes	CCLF Above (Below) CCW
201601	$622,157,544	$619,795,936	-0.38%
201602	$681,467,139	$672,940,843	-1.25%
201603	$753,358,336	$746,757,252	-0.88%
201604	$714,986,658	$707,074,332	-1.11%
201605	$718,229,435	$709,418,169	-1.23%
201606	$751,344,217	$720,552,031	-4.10%
201607	$661,431,384	$674,751,974	2.01%
201608	$732,162,838	$726,866,056	-0.72%
201609	$716,664,017	$714,284,963	-0.33%
201610	$729,292,187	$724,357,652	-0.68%
201611	$709,712,861	$705,166,613	-0.64%
201612	$719,309,382	$718,590,157	-0.10%

Reconciliation Update, CCW to CCLF (cont'd)

- Approximate service level tie out for 2015Q4, 2016 & 2017YTD (ICD-10)
  - Using MD beneficiary state to eliminate care for out-of-state members going to MD facilities in CCLF
  - Limiting to Part A + Part B members only (since this is all CCLF has)
  - Run-out 3 months after CY for prior years and 9/30/17 for 2017YTD

CCW to CCLF (Cost)				
Claim Type	DOS Period	CCW-EDB	CCLF MD Benes	CCLF Above (Below) CCW
Inpatient	2015 Q4	$775,240,114	$763,235,191	-1.55%
Outpatient	2015 Q4	$436,235,201	$436,915,476	0.16%
SNF	2015 Q4	$152,598,509	$152,185,678	-0.27%
HHA	2015 Q4	$69,807,356	$69,567,111	-0.34%
Hospice	2015 Q4	$44,339,685	$43,472,233	-1.96%
Physician	2015 Q4	$654,831,921	$648,917,486	-0.90%
Inpatient	2016 CY	$3,109,529,846	$3,091,134,986	-0.59%
Outpatient	2016 CY	$1,789,250,915	$1,780,078,498	-0.51%
SNF	2016 CY	$601,249,526	$600,334,488	-0.15%
HHA	2016 CY	$277,371,355	$274,176,777	-1.15%
Hospice	2016 CY	$190,627,957	$191,076,203	0.24%
Physician	2016 CY	$2,542,086,397	$2,503,755,026	-1.51%
Inpatient	2017 YTD	$2,257,708,050	$2,255,226,927	-0.11%
Outpatient	2017 YTD	$1,280,662,084	$1,267,507,583	-1.03%
SNF	2017 YTD	$384,599,819	$382,971,032	-0.42%
HHA	2017 YTD	$205,694,122	$203,278,496	-1.17%
Hospice	2017 YTD	$135,047,312	$137,594,391	1.89%
Physician	2017 YTD	$1,791,400,055	$1,754,449,946	-2.06%

Reconciliation Update, CCW to CCLF – Next Steps

- Working on refined tie out across specific cost break outs
- Making progress on CCW audit with CMMI will be important for resolving CCW to CCLF comparison
  - Meetings Scheduled with CMMI and GDIT
- Working with hMetrix on MPA reporting/modeling
  - Beneficiary attribution algorithm
  - Facility specific practitioner lists
  - Total cost of care performance monitoring

Tools for Implementing Quality Improvement Initiatives

- Add MPA approach in addition to the current "touch" approach
  - HSCRC considering which populations to include (ACO-like, MDPCP-like)
- Reporting: Building off current CCLF reporting capabilities
- HSCRC will continue conversations on populations to include in the MPA detail reporting

Key Next Steps in Developing Monitoring Tools

- Complete reconciliation with CCLF
- Determine if there are beneficiary definition issues and the impact of these
- Establish process/need to have summary level substance abuse data from CCW in CCLF to support CCLF reporting
- Develop specifications for CRISP reports
  - Develop specifications for new monitoring reports, including inclusion of CCW totals and drill down options
  - Determine populations to include in detail reports
  - Develop best solution for adding MPA approach to current CCLF report package

Discussion of Y2 MPA Issues

Medicare TCOC Measure Methodology: Year 2 Considerations

- Beneficiary and cost consistency over time in attribution algorithm (evaluate 2-year prospective nature of methodology)
- Ways to link doctors to hospitals
  - Reassess ACO-like and MDPCP-like (e.g., CTO?)
  - New possibilities such as employment/ownership, HCIP, CCIP, Clinically Integrated Networks
- Appropriate Maximum Performance Threshold still 2% as Maximum Revenue at Risk increases to 1%?
  - This would be a 50% ratio – versus Y1 25% ratio
  - CMS generally prefers 30%+
- Potential options for hospital to voluntarily take on more risk and/or use All Geographic attribution approach
  - Effects on other hospitals?
  - How much more risk?

Medicare TCOC Measure Methodology: Year 2 Considerations, cont.

- Even under "improvement," risk adjust?
  - For example, based on health, demographics, dually-eligible status
- Incorporate "attainment"?
  - What blend of attainment versus improvement, especially considering the State TCOC requirements are improvement-only?
  - What other cross-hospital differences should be controlled for?
    - For example, GME payments, labor market differences
  - What attainment benchmark to use?
    - For example, lowest adjusted quartile of TCOC among Maryland hospitals, comparisons to best quartile of national benchmarks with peer groupings
- Quality adjustment
- Pre-set trend factor
- Exclusions from TCOC
- Multi-year smoothing

Total Cost of Care Workgroup

November 29, 2017

HSCRC
Health Services Cost Review Commission