Total Cost of Care Workgroup

September 27, 2017

HSCRC
Health Services Cost Review Commission

Agenda

- Updates on initiatives with CMS
- Overview of MPA
- Review of options for Medicare TCOC attribution
- Elements to be included in RY 2020 MPA Policy (Y1)

Updates on Initiatives with CMS

- Enhanced Model
- Care Redesign Programs (HCIP, CCIP, …)

Overview of MPA

Medicare Performance Adjustment (MPA)

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

- **Objectives**
  - Allow Maryland to step progressively toward developing the systems and mechanisms to control TCOC, by increasing hospital-specific responsibility for Medicare TCOC (Part A & B) over time (Progression Plan Key Element 1b)
  - Provide a vehicle that links non-hospital costs to the All-Payer Model, allowing participating clinicians to be eligible for bonuses under MACRA

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:
  - Maryland hospitals are Advanced APM Entities; and
  - 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 ACO

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

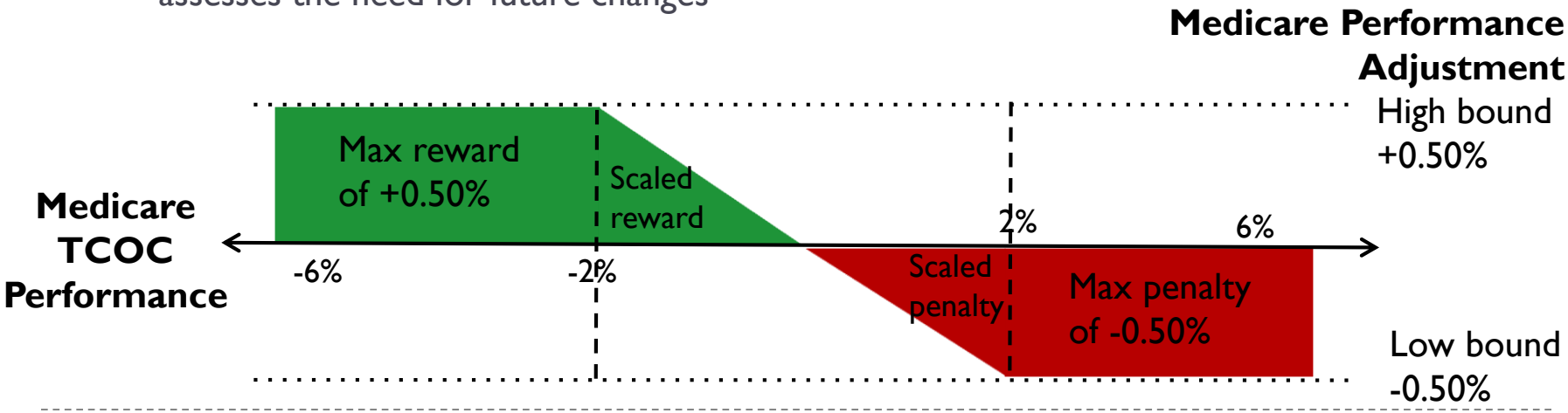
Hospital	CY 16 Medicare claims	
A	B	C = B * 0.5%
STATE TOTAL	**$4,399,243,240**	**$21,996,216**
Anne Arundel	163,651,329	818,257
Atlantic General	30,132,666	150,663
BWMC	137,164,897	685,824
Bon Secours	22,793,980	113,970
Calvert	45,304,339	226,522
Carroll County	85,655,790	428,279
Charles Regional	46,839,127	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

MPA: Current Design Concept

- 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



High-level Issues to be Addressed in Year 1 MPA Policy

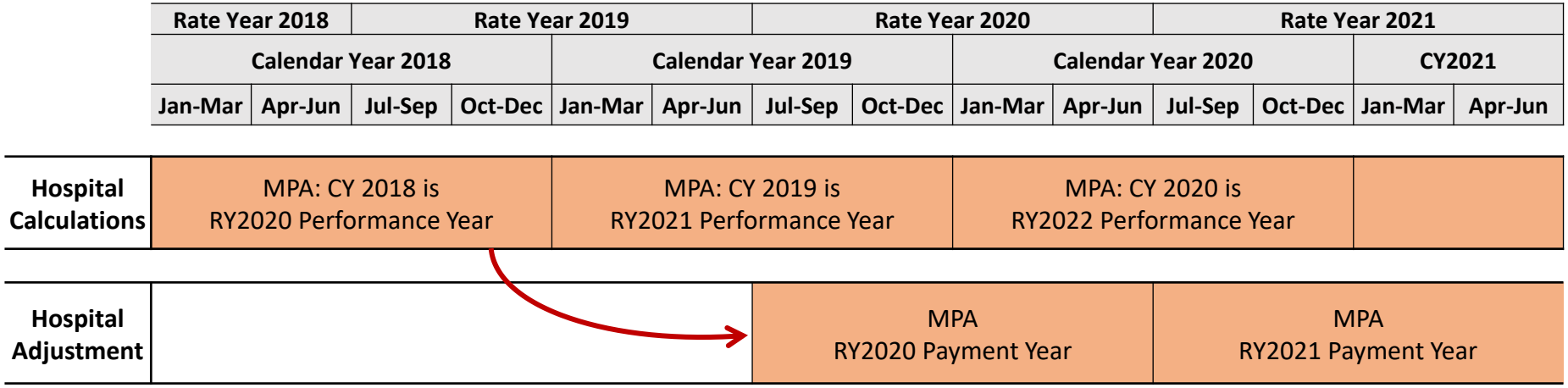
- Algorithm for attributing Medicare beneficiaries (those with Part A and Part B) to hospitals, to create a TCOC per capita
- Assess performance
  - Base year TCOC per capita (e.g., CY 2017 for Y1)
    - Apply TCOC Trend Factor (e.g., national Medicare FFS growth minus X%) to create a TCOC Benchmark
  - Performance year TCOC per capita (CY 2018 for Y1)
  - Compare performance to TCOC Benchmark (improvement only for Y1)
- Calculate MPA (i.e., percentage adjustment on hospital's federal Medicare payments – applying in RY 2020 for Y1)
  - Maximum Revenue at Risk (0.5% for Y1): Upper limit on MPA
  - Maximum Performance Threshold (2% for Y1, shown on prior slide): Percentage above/below TCOC Benchmark where Maximum Revenue at Risk is reached, with scaling in between

Medicare TCOC Measure Methodology: Year 2 Considerations

- Assessing for possible refinements
  - Beneficiary and cost consistency over time (evaluate 2-year prospective nature of methodology)
  - Additional ways to sensibly link doctors to hospitals (e.g., Care Redesign, Clinically Integrated Networks, hospital ownership, etc.)
  - Refinements on geography and impact of geography changes over time
- Increased Maximum Revenue at Risk under MPA (+/- 1%)
  - Appropriate Maximum Performance Threshold still 2%?
- Steps toward Attainment?
  - Adjusting for demographics/risk?
- Effects on other programs/unintended consequences

Tentative MPA Timeline

Date	Topic/Action
Ongoing	TCOC Work Group meetings, transitioning to technical revisions of potential MPA policy with stakeholders
Ongoing	Staff drafts RY 2020 MPA Policy
October 2017	Draft RY 2020 MPA Policy presented to Commission
November 2017	Commission votes on Final RY 2020 MPA Policy
Jan 1, 2018	Performance Period for RY 2020 MPA begins



Review of Options for Medicare TCOC Attribution

Medicare TCOC Attribution Algorithm: Year 1 Considerations

- Appropriate capture of hospital spending and total spending across the state
- Conceptually sensible for hospitals (clear goals, incentives for transformation)
- Build on existing transformation efforts
- Performance should reflect hospital and provider efforts to improve TCOC
  - Ability to track performance
  - Measure stability over time
- Payment adjustments should provide controlled levels of responsibility, even as responsibility increases over time

MPA: Potential Components of Attribution Algorithm

Medicare beneficiary attribution could be based on one or more:

- ACO-like
  - Attribution of beneficiaries to ACO doctors based on primary care use
  - Linking of ACO doctors to Maryland hospitals in that ACO
- Primary Care Model (PCM)-like
  - Attribution of beneficiaries to PCPs based on primary care use
  - Linking of doctors to Maryland hospitals based on plurality of hospital utilization by those beneficiaries
- MHA-like
  - Attribution of beneficiaries to hospitals based on hierarchy of hospital use based on (1) same hospital/system, (2) majority of payments, and then (3) plurality of both payments and visits
- PSA-Plus (PSAP): Geography (zip code where beneficiary resides)
  - Hospitals' Primary Service Areas (PSAs) under GBR Agreement
  - Additional areas based on plurality of utilization and driving time

MPA: Potential Methods for Assigning Hospital-Specific Medicare TCOC

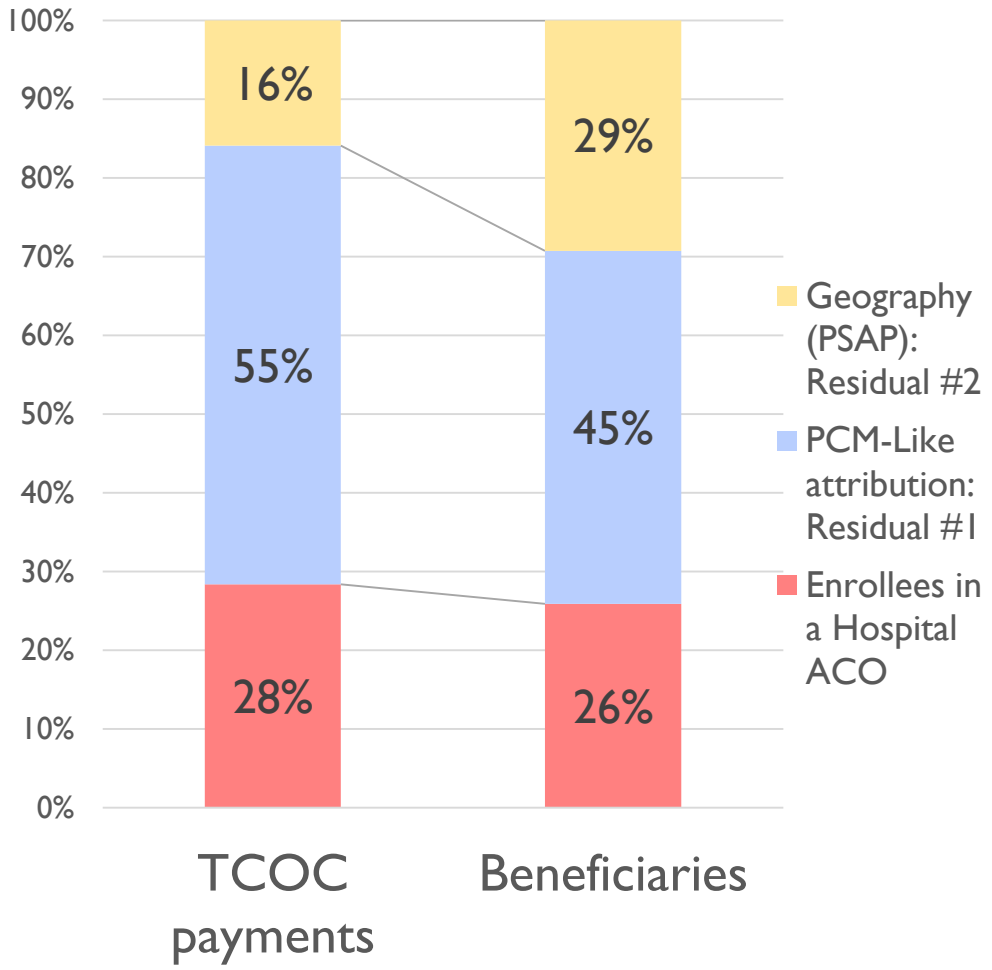
Beneficiary attribution based on combination of methods in a hierarchy:

- ACO-Like / PCM-Like / PSAP
- PCM-Like / PSAP
- ACO-like / MHA-Like / PSAP
- PCM-Like / MHA-Like / PSAP

Attribution Algorithm: Key Differences from Last Meeting

- Doctors Community Hospital included in ACO-like attribution

Option of hierarchy with prospective attribution: Hospital-based ACO / PCM-Like / Geography



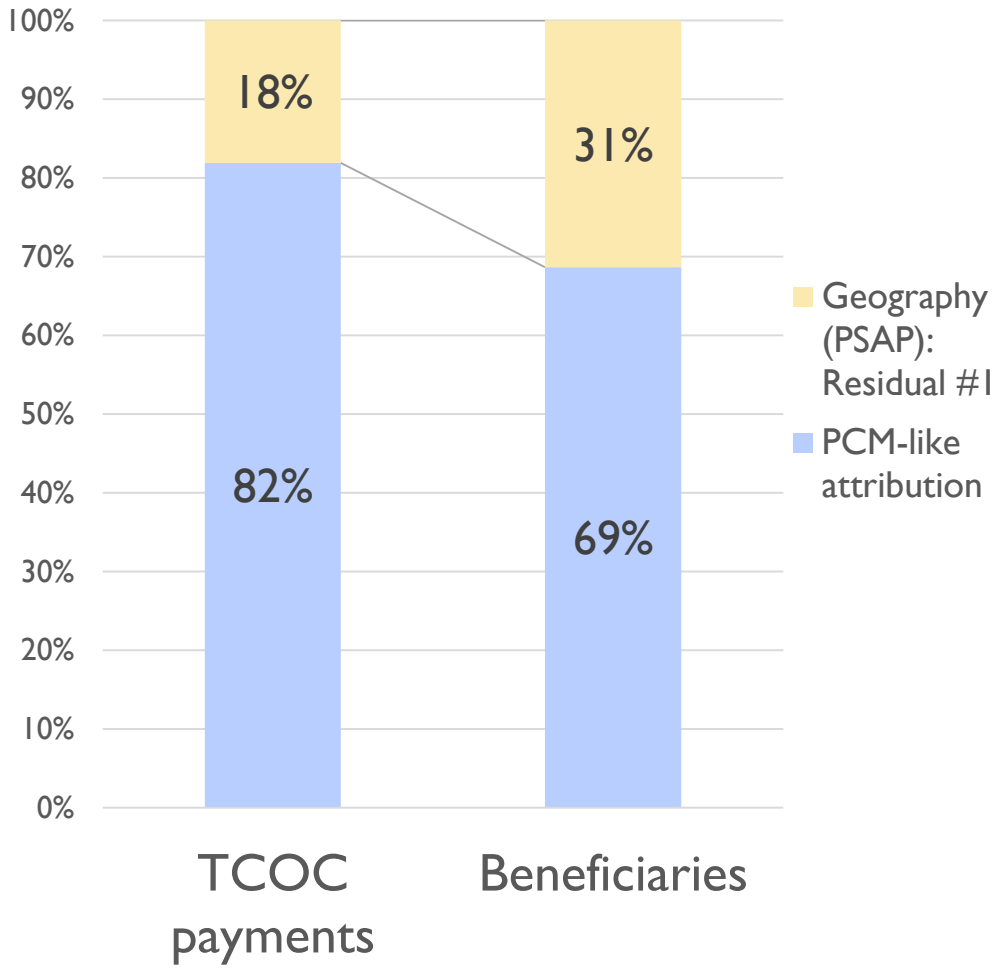
- Attribution occurs prospectively, based on utilization in prior 2 years, but using their current-year TCOC
  1. Beneficiaries attributed first based on link to clinicians in hospital-based ACO
  2. Beneficiaries not attributed through ACO are attributed based on PCM utilization
  3. Finally, beneficiaries 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 PCM Use + Geography, among beneficiaries not in a hospital-based ACO

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

If MPA Had Been In Effect on CY2016 Data with Hospital-based ACO / PCM-Like / Geography …

- Statewide net payout by Medicare to hospitals of $3.4 million
  - 15 hospitals at maximum positive 0.5% MPA
  - 9 hospitals with positive MPA less than maximum of 0.5%
  - 18 hospitals with negative MPA less than maximum of 0.5%
  - 4 hospitals at maximum negative 0.5% MPA
- Out of $22.0 potential at-risk, $14.1 million realized (positive and negative)
- Other attribution methods yielded net payouts of $0.8-$3.1 million, vs. $3.4 million

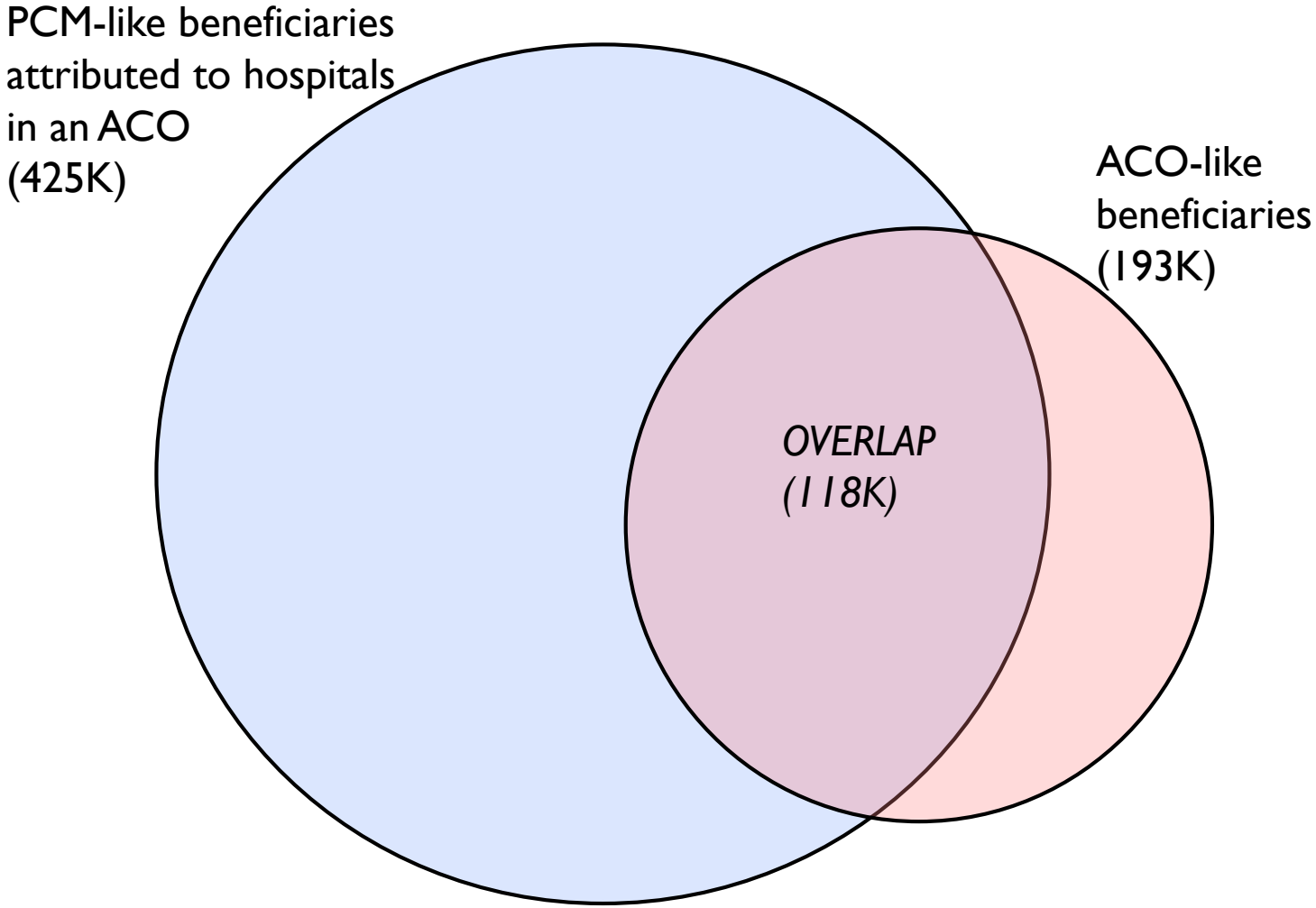
Dropping ACO-like: Primary Care Model-like / Geography



- Since ACO-like may attribute the same doctors/patients to hospital as PCM-like, is the ACO-like attribution necessary?

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

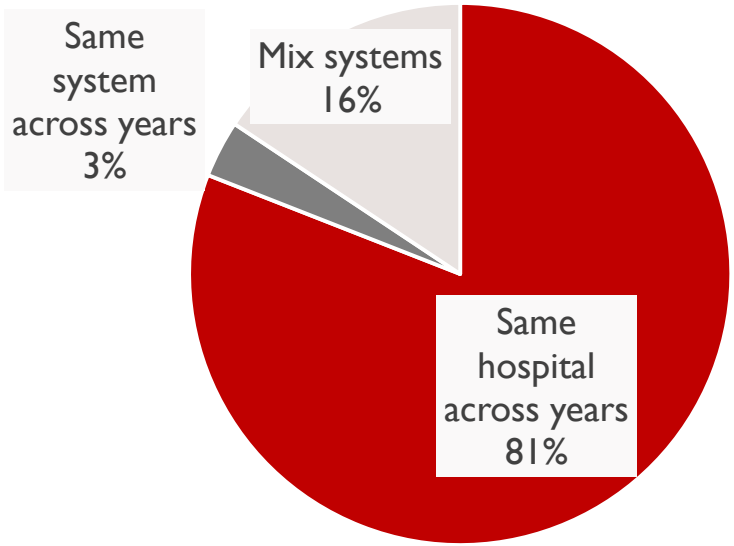
For ACO hospitals, 61% of beneficiaries in ACO-like would also be in PCM-like



PCM-like PCP-to-hospital attribution consistency

- PCM-like PCP-hospital match is consistent for most PCPs across years
  - PCM-like approach based on the plurality of hospital utilization by attributed beneficiaries
  - Compares 2016 attribution to all other years

PCP-Hospital link in 2016 (n = 2803)

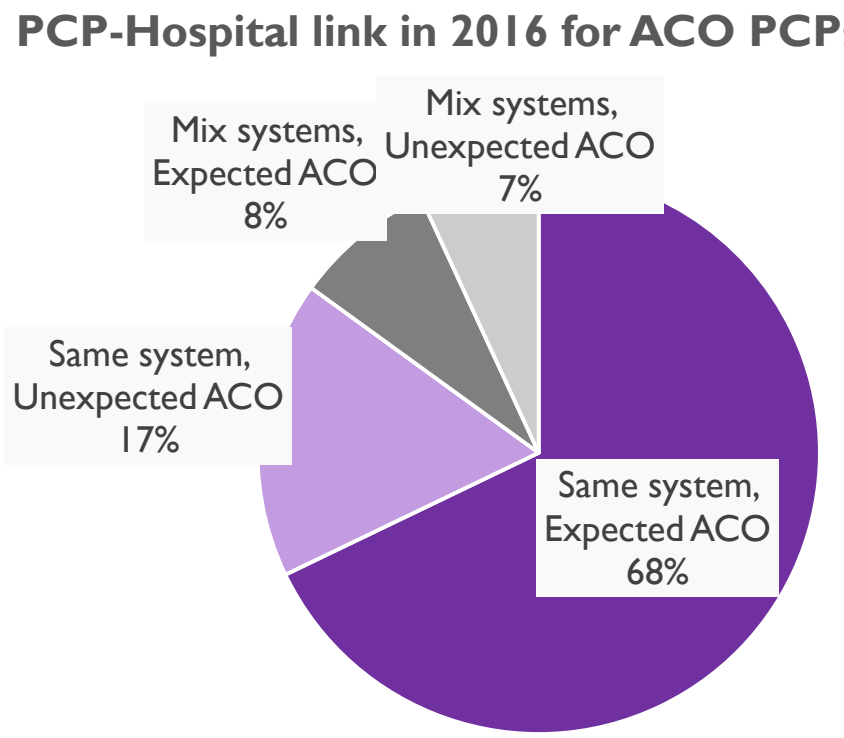


Definitions

- Same hospital = PCPs matched to the same hospital for all years the PCP was in the dataset
- Same system = PCPs matched to the same system for all years the PCP was in the dataset
- Mix system = PCPs matched to more than one system over the years the PCP was in the dataset

Consistency of PCM-like PCP-System match among ACO PCPs

- Analysis builds off of PCP-hospital link but also examines the expected system attribution based on CMS ACO lists (2017)



Definitions

- Expected ACO = in 2016, provider matched to the expected system based on CMS ACO data
- Unexpected ACO = in 2016, provider matched to a different system than expected based on CMS ACO 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
- Year 1: Propose to 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%.

Elements to be Included in RY 2020 MPA Policy (Y1)

Elements of RY 2020 (Y1) Draft MPA Policy

- Attribution algorithm
  - ACO-like / PCM-like / PSAP?
  - Or PCM-like / PSAP?
- Assess performance
  - Base year TCOC per capita: CY 2017
  - Apply TCOC Trend Factor to create a TCOC Benchmark
    - Benchmark is national Medicare FFS growth (CY 2018 vs. 2017) minus some percentage
    - HSCRC Commissioners would vote on percentage less than national growth
    - Based on Term Sheet for Enhanced Model, achieving required Medicare TCOC savings by CY 2023 translates to ~0.33% annually under national growth
    - Current draft language with CMS has no deadline for submitting TCOC Trend Factor; current expectation is to provide CMS with draft TCOC Trend Factor next summer, with revisions possible as more data come in
  - Performance year TCOC per capita: CY 2018
  - Compare performance to TCOC Benchmark: Improvement only

Elements of RY 2020 (Y1) Draft MPA Policy, cont.

- Calculate initial MPA (i.e., prior to quality adjustment)
  - Maximum Revenue at Risk: ±0.5%
  - Maximum Performance Threshold: ±2%, with linear scaling in between
- Quality adjustment to create final MPA
  - Sum of each hospital's RY 19 quality adjustments for:
    - readmissions and
    - hospital acquired conditions,
  - Which is then multiplied by initial MPA (accounting for negatives as appropriate)
  - Final MPA cannot exceed ±0.5% Maximum Revenue at Risk
- CMS implements MPA % provided by HSCRC – applied to each hospital's federal Medicare payments in RY 2020 (July 2019 – June 2020)

Discussion

Total Cost of Care Workgroup

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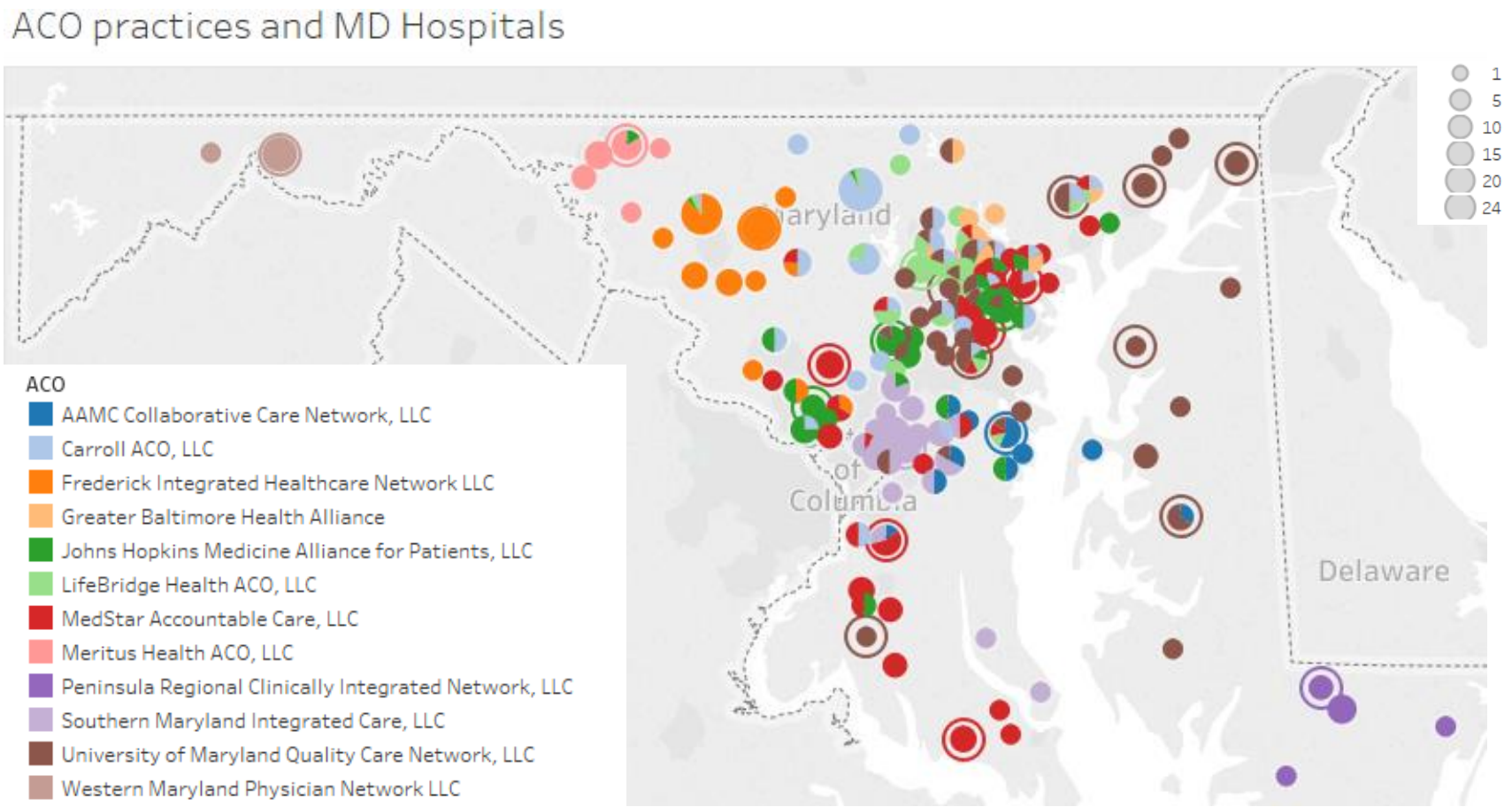
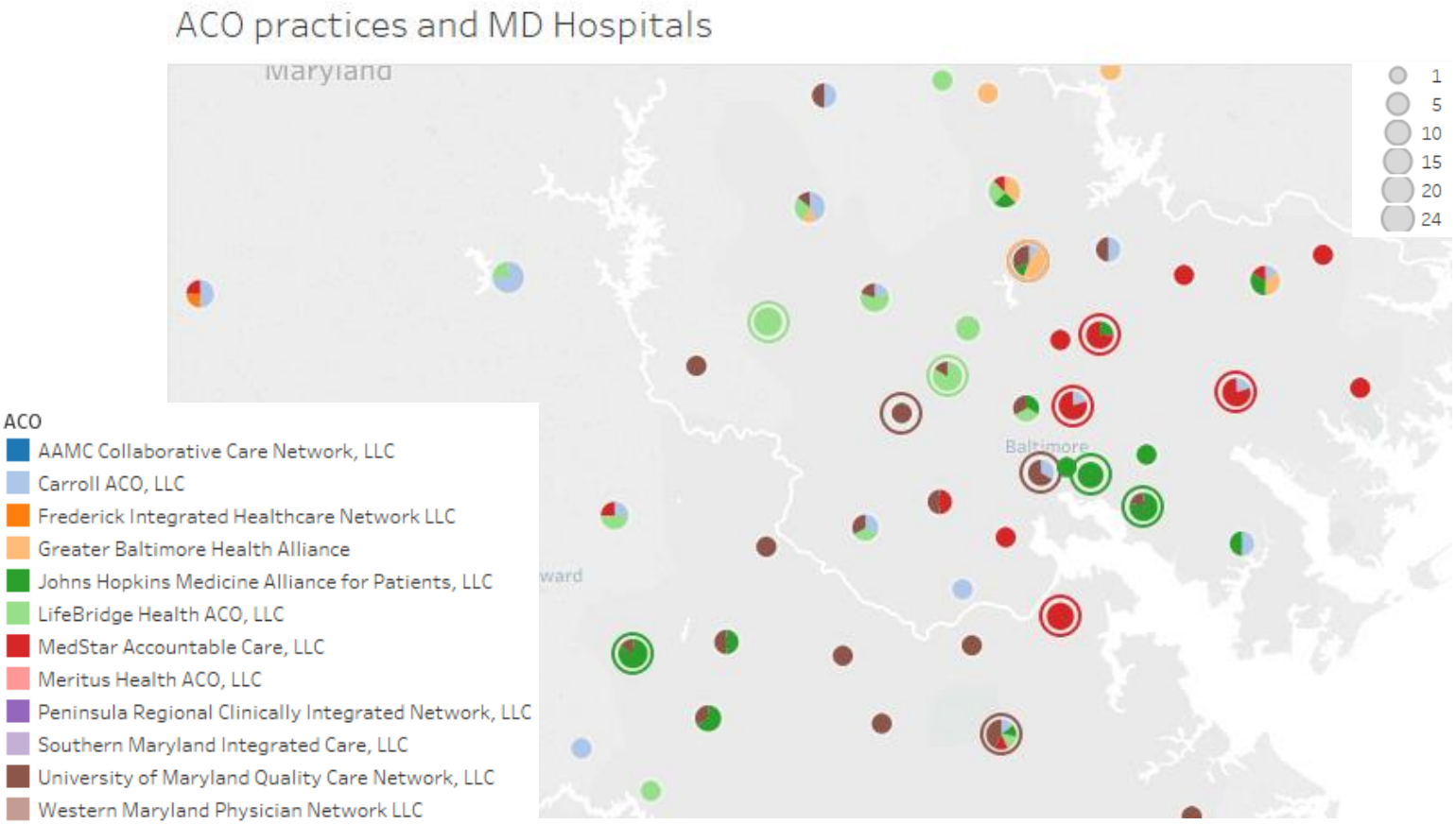
Appendix

ACO Practice Location Distribution



Larger size circles represent a greater number of practice locations in that zip code. (see top right for size indicators). Circle outlines represent hospitals in the ACO systems.

ACO Practice Location Distribution- Baltimore



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