Total Cost of Care (TCOC) Workgroup

January 24, 2018

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions
- Updates on initiatives with CMS
- Overview of Y1 policy for Medicare Performance Adjustment (MPA)
- Update on Y1 MPA implementation
- Approach for modeling Y2 MPA issues
- Discussion of Y2 MPA issues
  - Additional options for linking doctors to hospitals
  - Risk adjustment
  - Potential geographic option

Updates on Initiatives with CMS

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

Overview of Y1 MPA Policy

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:
  1. Require participants to use certified EHR technology (CEHRT)
  2. Have payments related to Medicare Part B professional services that are adjusted for certain quality measures
  3. 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

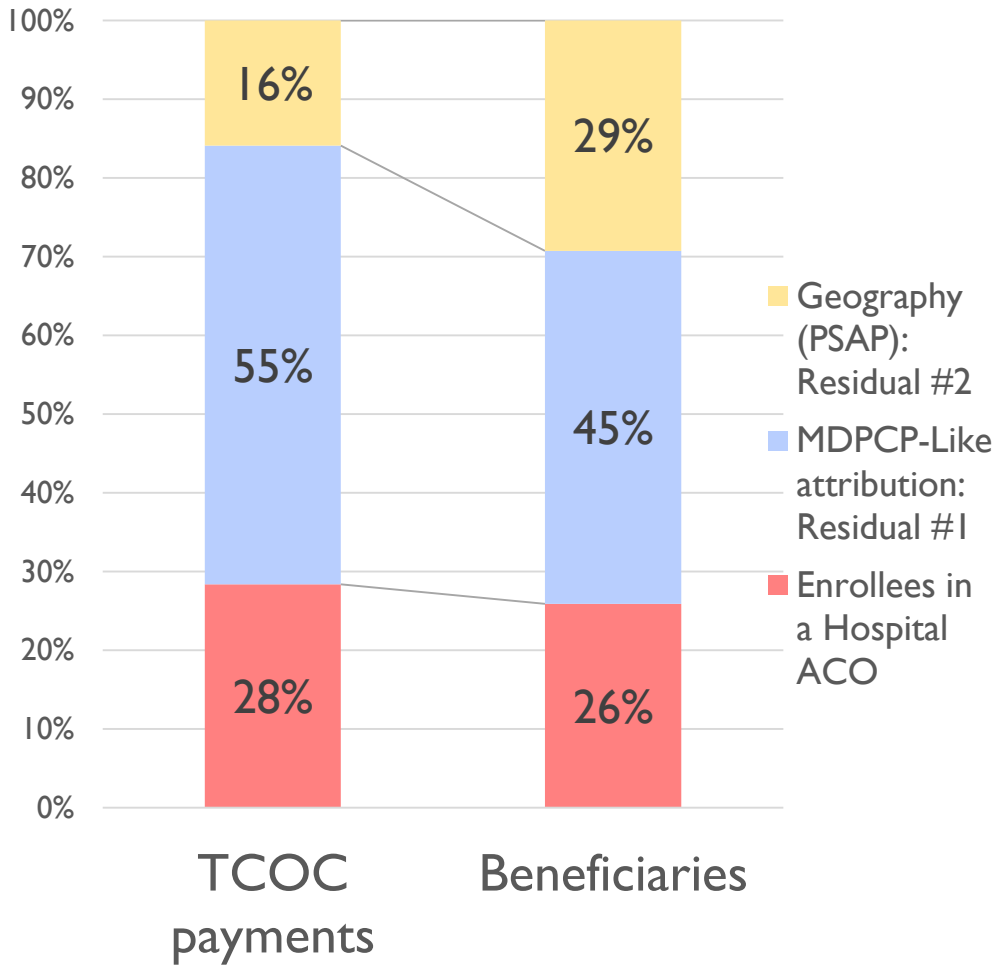
Year 1 MPA Design

- 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 minimize volatility risk
- MPA will be applied to Medicare hospital spending, 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) increased by 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
- Quality Adjustment: RY19 quality adjustments from Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Infections (MHAC)

Attribution Algorithm: Hierarchy of ACO-Like / MDPCP-Like / Geography

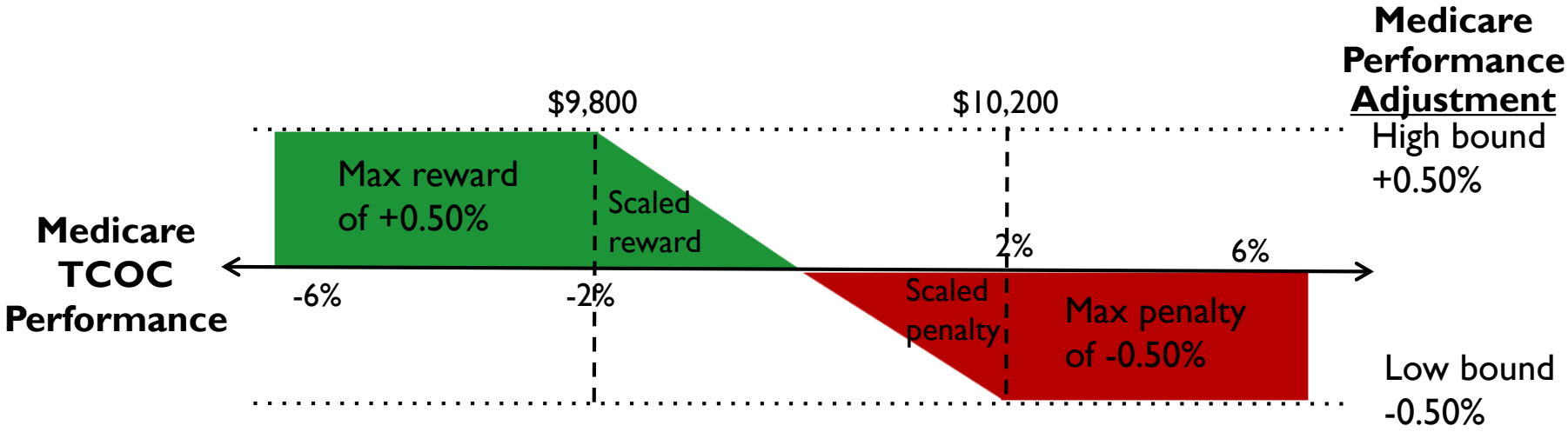


- Attribution occurs prospectively, based on utilization in prior 2 federal fiscal years, but then using their current CY TCOC
  1. Beneficiaries attributed first based on service use of clinicians in hospital-based ACO
  2. Beneficiaries not attributed through ACO-like are attributed based on MDPCP-like
  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

Year 1 MPA Assessment Example

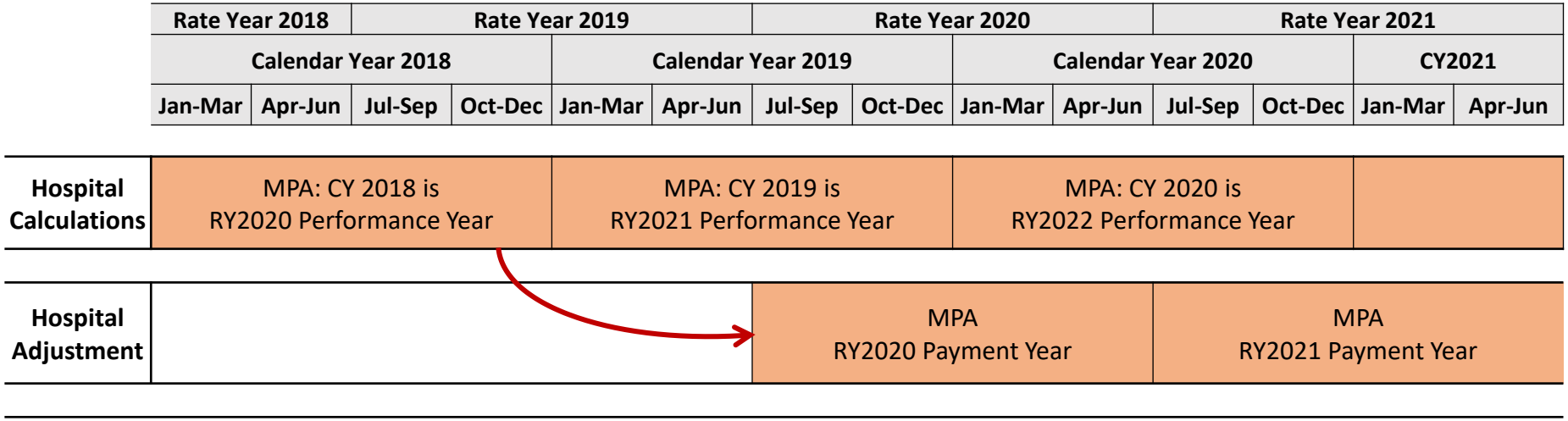
- CY 2017 per capita Medicare TCOC: $9,852
- National Medicare FFS growth in CY 2018 (totally made-up example) = 1.83%
- TCOC Benchmark = $9,852 * (1 + 1.83% - 0.33%) = $10,000
- If CY 2018 per capita TCOC is:
  - $10,200+ (2%+ above Benchmark), then full -0.5% MPA
  - $9,800 or less (2%+ below Benchmark), then full +0.5% MPA
  - Scaled MPA ranging from -0.5% to +0.5% between $9,800 and $10,200



Note: For simplicity's sake, example assumes Quality Adjustment of 0%.

Update on Y1 Implementation

MPA Timeline



- This week, CMS is to provide 2018 list of clinicians in ACOs
- HSCRC will produce:
  - For hospitals, lists of clinicians associated with hospitals under ACO-like and MDPCP-like
  - For CMS (for MACRA purposes) and CRISP (for statewide and hospital-specific MPA reports), lists of beneficiaries attributed to hospitals under ACO-like, MDPCP-like and Geography

Year 1 Attribution Implementation

- Performance Year of CY 2018
  - Beneficiaries attributed based on utilization data from Federal Fiscal Years 2016 and 2017
  - MPA performance reporting available through CRISP when adequate CY 2018 data become available (mid-2018)
- Base Year of CY 2017
  - Beneficiaries attributed based on utilization data from Federal Fiscal Years 2015 and 2016
  - Before finalizing Base Year CY 2017 TCOC, need to wait for claims runout until at least end of March 2018; preliminary results could be provided

Year 1 Attribution Implementation, cont.

- What will be knowable to hospitals?
  - NPIs "attributed" to hospitals under MDPCP-like and their beneficiaries' TCOC
  - NPIs "attributed" to hospitals under ACO-like and their beneficiaries' TCOC
    - While beneficiaries are not attributed directly to clinicians in the ACO-like approach, hospitals requested the number of beneficiaries attributed to each clinician in the ACO-like approach. Therefore, staff has attributed ACO beneficiaries to ACO PCPs based on the plurality of qualified primary care services in the ACO

- In forthcoming draft spreadsheet:
  - NPIs "attributed" to hospitals under ACO-like and MDPCP-like
    - Same NPIs for Base Year CY2017 and Performance Year CY 2018
    - Note: Similarly, for Y2, expectation is that the CY 2019 Performance Year list of NPIs will be used for the CY 2018 Base Year, as well
  - Included in those two tabs ("ACO-like by NPI" and "MDPCP-like by NPI") will be the number of beneficiaries and their TCOC "attributed" to those NPIs based on data from 2015, 2016 and 2017
  - Remaining tabs will show (as usual) what would have occurred if the MPA had been in place for Performance Year of CY 2016 (performance in 2016 over 2015)

Year 1 Attribution Implementation: Multiple hospitals in an ACO

- Default approach
  - Beneficiaries and their TCOC will be shared proportionally according to each participating hospital's federal Medicare payments
- System option to assign ACO PCPs to specific hospitals
  - ACOs with multiple hospitals can elect to provide to HSCRC a list of ACO PCPs and the specific ACO hospital to which each PCP will be attributed
  - All hospitals in the ACO must agree to the list
  - These lists should be submitted to HSCRC **two weeks** after receiving spreadsheet from HSCRC with NPIs in ACO at hscrc.tcoc@maryland.gov

State-Level MPA Based Reporting

- Overview
  - CRISP has developed a preliminary reporting strategy and a mock-up of the initial report modules
  - Will review strategy overview on following slides
  - Strategy and mock-up was based on:
    - Input from HSCRC staff
    - Ongoing review with hospital representation through CRISP's reporting subcommittee (which includes hospital and MHA representation and was formed to provide detailed input on CRISP's reporting initiatives)
  - Will share report mock-ups with this group as follow-up to this meeting
- Key next steps:
  - Reports mock-ups will be shared with TCOC group as a follow-up to this meeting. CRISP staff happy to schedule time to review in detail or respond to written questions/suggestions.
  - Working with hMetrix on developing initial reports beginning later this month.

Overview of Report Modules and Sequencing

Initial Phase Target: April '18	Second Phase Target: Summer '18	Potential Future Development Timeline TBD
(1) Per Capita Scorecard	(1B) Benchmarks	
	(2) Market Shift Analytics	
(3A) Quality Monitoring, Phase 1	(3B) Quality Monitoring, Phase 2	(3C) Potentially Unnecessary Utilization or other future concepts
	(4A) State level adaptation of existing post-acute episodes	(4B) Comprehensive Episodic Analysis

Module Definitions

Module	Phase	Description
1	A	Implement per capita reporting (cost, utilization) both at the state level and MPA-attributed hospital level. Report will also include: ▪ High level reconciliation of CCLF and CCW ▪ Break out of members within the MPA attribution layers
	B	Develop per capita benchmarks by acquiring and analyzing national Medicare data
2		Support HSCRC's Market Shift analysis.
3	A	Provide additional PAU analytics using CCLF data and compile initial quality measures ▪ Provide complete pre and post admission profile on members with a case mix PQI, PAU readmission, and IP readmission ▪ Reporting on 14-day follow up metric, reviewing potential OP measures
	B	Add additional quality metrics
	C	Consider reporting using new approaches to avoidable and unnecessary utilization
4	A	Adapt existing hMetrix implemented post-acute bundles to State-level reporting purposes
	B	Consider the implementation and use of additional episodic analytics

Approach for Modeling Y2 MPA Issues

Approach for Modeling Y2 Issues

- Staff models options based on TCOC WG input
- Until now, modeling has been based on 2017 list of ACO NPIs:
  - Performance in CY16 over CY15, based on beneficiaries attributed based on utilization in federal fiscal years 2014-2015 and 2013-2014, respectively
- For modeling Y2 options, plan is to use 2018 list of ACO NPIs:
  - CY17 over CY16, based on beneficiary utilization in federal fiscal years 2015-2016 and 2014-2015, respectively
  - CY16 over CY15, based on beneficiary utilization in federal fiscal years 2014-2015 and 2013-2014, respectively

How Will "Soundness" Be Assessed?

Principles and assessment for Y1 were:

- Scope: Measured by share of Medicare TCOC and beneficiaries attributed statewide.
  - 100% of Maryland Medicare beneficiaries attributed
- Incentives: Measured by share of Medicare TCOC and beneficiaries uniquely attributed to hospitals, in total and by hospital
  - 75% of beneficiaries, with 92% of TCOC, are uniquely attributed to a system/hospital
  - Beneficiaries are assigned to multiple systems/hospitals only if multiple systems/hospitals have claimed the same PSA
- Relation to existing efforts: Promoted by adopting existing ACO and primary-care arrangements
  - Combined, ACO-like and MDPCP-like yield attribute 71% of beneficiaries and 83% of TCOC
- Hospital efforts reflected: The stability of attribution resulting from proposed methods to ensure that hospital efforts are reflected, measured as the share attributed to the same provider, hospital, and system (as applicable) in consecutive years.
  - 87% of beneficiaries attributed to same system/hospital between 2015 and 2016 under the recommended approach (excluding beneficiaries who during those two years were newly enrolled, died, or otherwise were not in both years of data, with whose inclusion this number would be 82%).
- Calibrated responsibility: Measured as the association of hospitals' Medicare revenue with the Medicare TCOC to which they were assigned responsibility, and the impact of current and proposed future payment adjustments on hospitals' revenues.
  - 0.5% maximum revenue at risk for Y1
  - 1.0% for Y2

Y2 MPA Issue: Additional Options for Linking Doctors to Hospitals

Y1 MPA Methods for Linking Doctors to Hospitals

- ACO-like
- MDPCP-like

Y2 Considerations for Linking Doctors to Hospitals

- What to do with ACO-like and MDPCP-like?
  - Are TINs possible?
  - Are TINs preferable?
- Additional options to link doctors to hospitals
  - Employment/ownership
  - HCIP and CCIP
  - Others?
- Can HSCRC obtain the necessary information to implement those linkages in the MPA algorithm (e.g., employment)?
- Once particular options are chosen, what is the correct order in the hierarchy?

Y2 MPA Issue:
Risk Adjustment

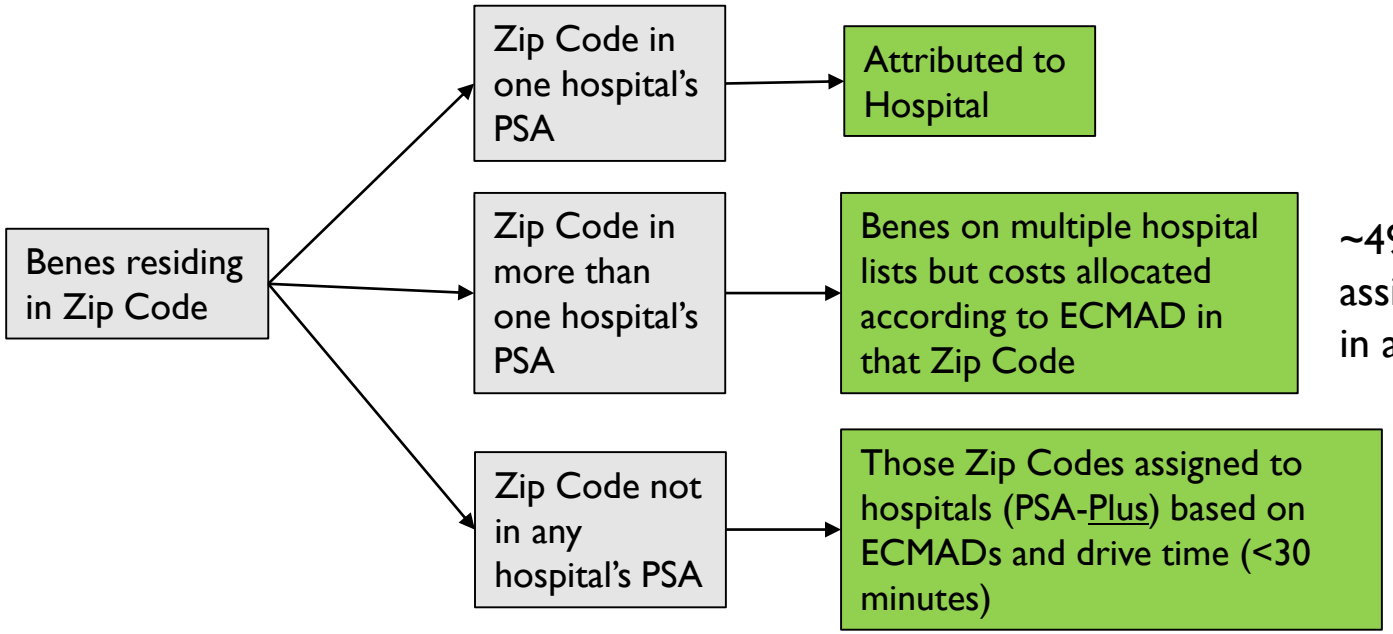
What risk adjustment is worth exploring?

- Possible methods
  - Demographic characteristics
    - HCCs: Age bands x Dual-eligible status x Aged/disabled x Sex x Institutionalized
  - Health status
    - HCCs group codes and make hierarchies of diseases based on claims
  - Others?
- Considerations
  - Purpose: What is the risk that should be controlled for in MPA?
    - Perhaps demographics but not health care utilization?
    - Are specific risk adjustment criteria consistent with Model goals (e.g., sensible to ask for improved population health but then risk adjust for diabetes with complications)?
  - Simplicity vs. accuracy
- Possible next steps: Model changes if various risk adjustment had been applied for performance in CY 2016 and CY 2017

Y2 MPA Issue:
Potential Geographic Option

Y1 Use of Geography in Attribution Algorithm

- PSAP is the residual of the residual (29% of benes, 16% of TCOC), capturing all remaining beneficiaries not attributed through ACO-like and MDPCP-like



~49% of beneficiaries assigned through PSAP are in a shared Zip Code

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.

Overview of Potential Y2 Geographic Option

- A hospital could elect to have beneficiaries attributed to it based solely on geography (that is, those beneficiaries who live in the hospital's PSAP)
- As a result, the Geographic Hospital (potentially) would not be part of the default attribution algorithm
  - The Geographic Hospital would not be attributed certain beneficiaries it otherwise would have received under default algorithm
  - The Geographic Hospital would be attributed certain beneficiaries it otherwise would not have received under default algorithm
  - Effects on other hospitals depend on design

Y2 Design Considerations If a Hospital Could Elect to Use Geographic Option

- How are beneficiaries attributed in certain scenarios:
  - 1. When the Geographic Hospital and other hospital(s) share a Zip Code(s) in their PSAPs?
  - 2. Inside the Geographic Hospital's PSAP, when other hospitals would otherwise be attributed beneficiaries via ACO-like/MDPCP-like?
  - 3. Outside of Geographic Hospital's PSAP, when Geographic Hospital otherwise would be attributed beneficiaries via ACO-like/MDPCP-like?
- What effects on Geographic Hospital as well as on all other hospitals?
- How to assess soundness of approach?
  - **Incentives:** Share of Medicare TCOC and beneficiaries uniquely attributed
  - **Relation to existing efforts/arrangements** (e.g., ACOs)
  - **Year-over-year stability of beneficiary attribution**
  - **Also,** TCOC attributed as share of hospital's Medicare payments?

Illustration of Geographic Approach: Overview

- Hospital A wants to take full responsibility for its PSAP, rather than participate in the default attribution algorithm (ACO/MDPCP/PSAP)
- Hospitals B and C also share some of the Zips in that PSAP and are attributed beneficiaries under the default algorithm in that PSAP (Scenarios 1 and 2 from prior slide)
- Hospitals D and E do not share a PSAP with Hospital A. However, under the default algorithm, Hospital A would have been attributed beneficiaries under ACO-like or MDPCP-like (Scenario 3 from prior slide)

Illustration of Default vs. Geographic Approach: Effect in a Specific Shared Zip Code

Approach	Hosp A	Hosp B	Hosp C	Total
Default (ACO/MDPCP/PSAP)	340	280	380	1000
-- Amount from ACO/MDPCP	*300*	*200*	*300*	*800*
-- Amount left for PSAP	*40*	*80*	*80*	*200*
If all 3 hospitals chose Geographic	200	400	400	1000
Only Hospital A chooses Geographic. <u>Option 1: Geographic First</u>				
-- 1st: Amount for Geographic Hospital (A)	1000	-	-	1000
-- 2nd: Amount for hospitals under default attribution (B&C)	-	0	0	0

- Hospital A takes all beneficiaries in PSAP from other hospitals
- Base Year and Performance Year would need to be consistent
- What say, if any, should Hospitals B and C have in A's election?

Illustration of Default vs. Geographic Approach: Effect in a Specific Shared Zip, p. 2

Approach	Hosp A	Hosp B	Hosp C	Total
Default (ACO/MDPCP/PSAP)	340	280	380	1000
-- Amount from ACO/MDPCP	*300*	*200*	*300*	*800*
-- Amount left for PSAP	*40*	*80*	*80*	*200*
If all 3 hospitals chose Geographic	200	400	400	1000
Only Hospital A chooses Geographic: Option 2: ACO/MDPCP First				
-- 1st: Amount for hospitals under ACO/MDPCP (B&C)	-	200	300	500
-- 2nd: Amount for Geographic Hospital (A)	500	-	-	500

- Hospital A takes the beneficiaries it would have gotten under ACO/MDPCP plus all beneficiaries left for PSAP
- Hospitals B and C get same beneficiaries as under default algorithm except for those under PSAP

Illustration of Default vs. Geographic Approach: Effect in a Specific Shared Zip, p. 3

Approach	Hosp A	Hosp B	Hosp C	Total
Default (ACO/MDPCP/PSAP)	340	280	380	1000
-- Amount from ACO/MDPCP	*300*	*200*	*300*	*800*
-- Amount left for PSAP	*40*	*80*	*80*	*200*
If all 3 hospitals chose Geographic	200	400	400	1000
Only Hospital A chooses Geographic: Option 3: Blend				
-- 1st: All hospitals attributed based on their choice first	1000	200	300	1500
-- 2nd: Shared beneficiaries are reweighted to sum to total	**750**	**100**	**150**	**1000**

- Hospital A attributed all beneficiaries in PSAP, but reduced weight on those shared
- Hospitals B and C attributed same beneficiaries as under ACO/MDPCP, but reduced weight
- Reweighting by simple 50/50 (as in example above)? Or by share under 1st step?

Illustration of Geographic Approach: Effect in a Zip Code NOT in Hospital A's PSAP

Approach	Hosp A	Hosp D	Hosp E	Total
Default (ACO/MDPCP/PSAP)	500	250	250	1000
-- Amount from ACO/MDPCP	*500*	*175*	*200*	*875*
-- Amount left for PSAP	*0*	*75*	*50*	*125*
If all 3 hospitals chose Geographic	0	600	400	1000
Only Hospital A chooses Geographic. <u>Options 1-3 could yield same result</u>				
-- Amount for Geographic Hospital (A)	0	-	-	0
-- Amount for hospitals under default attribution (D&E)	-	550	450	1000
- Amount from ACO/MDPCP	-	*175*	*200*	*375*
- Amount left for PSAP	-	*375*	*250*	*625*

- In this PSAP, Hospital A ends up with no responsibility and other hospitals have more based on PSAP

Illustration of Geographic Approach: Effect in a Zip Code NOT in Hospital A's PSAP, cont.

Approach	Hosp A	Hosp D	Hosp E	Total
Default (ACO/MDPCP/PSAP)	500	250	250	1000
-- Amount from ACO/MDPCP	*500*	*175*	*200*	*875*
-- Amount left for PSAP	*0*	*75*	*50*	*125*
If all 3 hospitals chose Geographic	0	600	400	1000
Only Hospital A chooses Geographic. Option 3b: Reduce rather than eliminate A's attribution in this Zip				
-- Partial amount for Hospital A from ACO/MDPCP	250	-	-	250
-- Amount for hospitals under default attribution (D&E)	-	367	383	750
- Amount from ACO/MDPCP	-	*175*	*200*	*375*
- Amount left for PSAP	-	*192*	*183*	*375*

Summary of Conceptual Trade-offs If Geographic Option is Available

- Greater responsibility to Geographic Hospital results in biggest change in attribution to other hospitals that:
  - Share any part of PSAP with Geographic Hospital
  - Have beneficiaries attributed under default algorithm in Geographic Hospital's PSAP
  - Have PSAP outside of Geographic Hospital's PSAP but where Geographic Hospital would be attributed beneficiaries under the default algorithm
- Blended options reduce effects on other hospitals, but also:
  - Diminish Geographic Hospital's responsibility under Geographic option
- Impact on other hospitals relative to overlap with Geographic Hospital
- Next steps: Model possible effects if an individual hospital(s) elected Geographic approach

Total Cost of Care Workgroup: Next meeting is 8 AM, Wed., Feb. 28

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