Total Cost of Care (TCOC) Workgroup

April 25, 2018

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions
- Updates on initiatives with CMS (including QPP update)
- Update on Y1 MPA implementation
  - CRISP: Demo of draft hospital-level (statewide) MPA reporting
  - Y1 attribution
- Discussion of Y2 MPA issues
  - Y2 Maximum Revenue at Risk & Maximum Performance Threshold
  - Incorporating Attainment
  - Linking doctors to hospitals

Updates on Initiatives with CMS

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

Revisiting timing IF CMS approves (1) MD hospitals as Advanced APM Entities and (2) QP calculation

- 3 times a year, CMS looks at whether or not a provider is on a CMS "list" of Advanced APM participants:

- For Maryland clinicians in CCIP and HCIP, the "list" is the Certified Care Partner List sent to CRISP/HSCRC to CMS
- If CMS determines Maryland hospitals are Advanced APM entities, a clinician on the Certified Care Partner List of a CRP hospital* after the CMS Determination would have QP Threshold Score assessed
- For CY 2018, assuming QP assessment will be on clinicians on Certified Care Partner List submitted by hospitals in June 2018, for CMS's 8/31 QP alignment window

*That is, a hospital that has an executed new Participation Agreement (i.e., signed by all parties)

Final disclaimer

- CMS is continuing to assess the QPP attribution rules
- No decision has been made by CMS
- Nothing is official until CMS announces it

Y1 Implementation:
CRISP MPA Monitoring Report

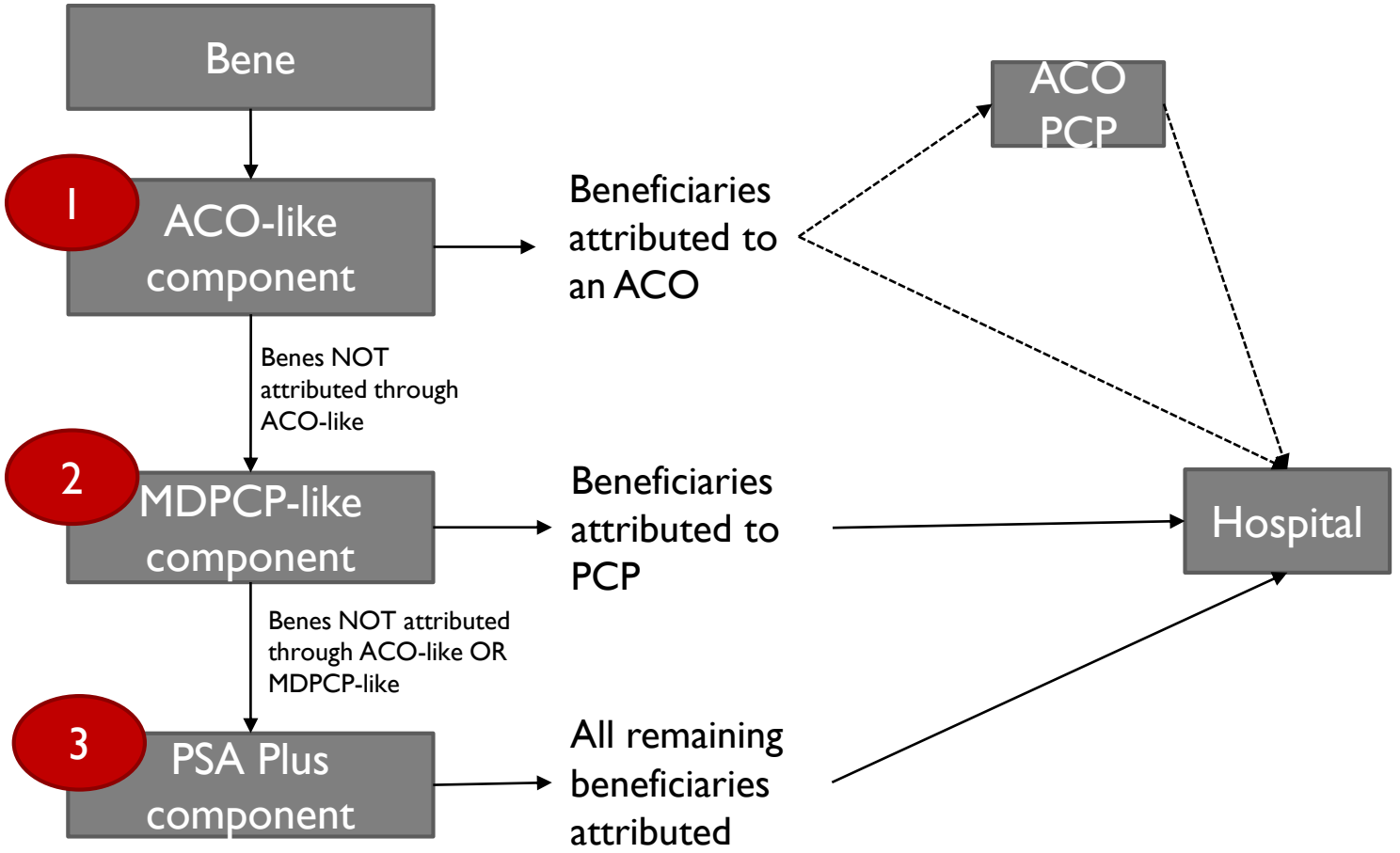
Y1 Implementation: Attribution

MPA: Components of Attribution Algorithm

Medicare beneficiary attribution based on hierarchy of:

- ACO-like
  - Attribution of beneficiaries to ACO doctors based on primary care use
  - Linking of ACO doctors to Maryland hospitals in that ACO
- Maryland Primary Care Program (MD-PCP)-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
- 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

Attribution of Medicare beneficiaries to hospitals via Y1 MPA Attribution Algorithm



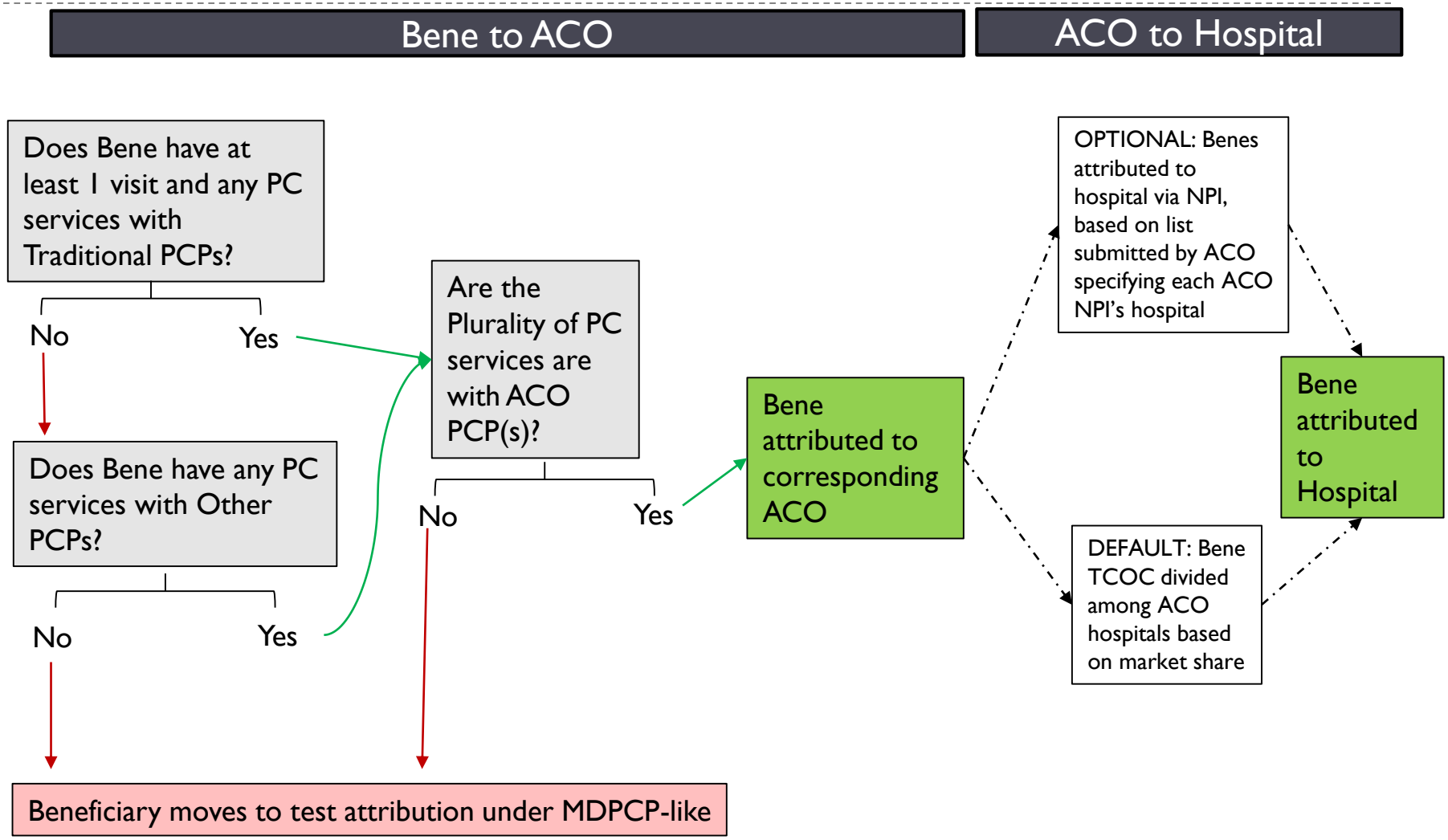
PCP stands for primary care provider. A PCP for this purpose includes traditional PCPs but also physicians from other selected specialties if used by beneficiary rather than a traditional PCP.

ACO-like

- Beneficiaries are attributed to a specific ACO if the plurality of primary care services are with ACO providers
  - Algorithm looks for Traditional PCPs first, then other types of providers
  - If a beneficiary sees a non-ACO PCP for their primary care needs, and all ACO doctors for their specialty needs, we would not expect that bene to be attributed to the ACO
- As originally designed, ACO-like beneficiaries are attributed to ACO hospitals based on market share
- Some ACOs asked to elect which ACO PCPs were aligned with specific ACO hospitals
  - In order to accomplish this, HSCRC attributed ACO benes to specific ACO PCPs
  - ACOs then elected to link specific ACO NPIs with specific ACO hospitals

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

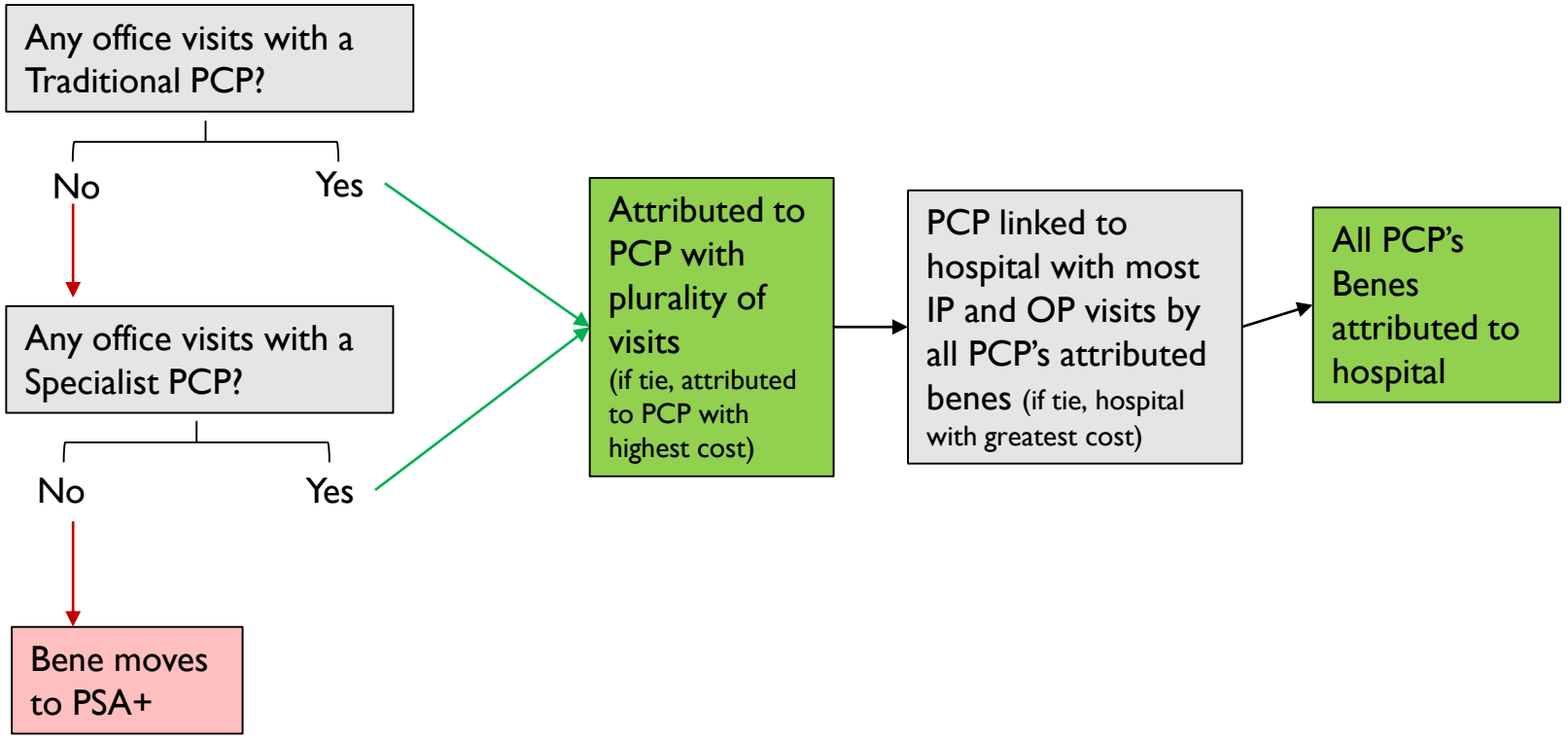
PC stands for primary care.

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

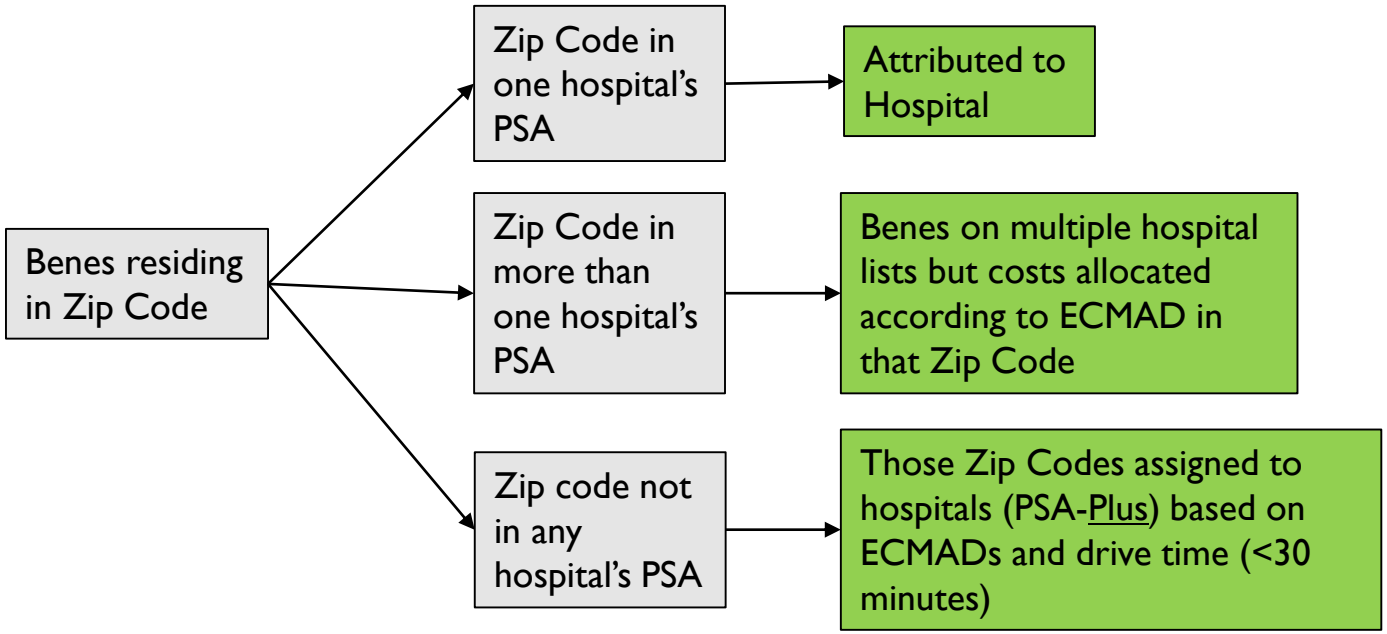
MDPCP-like component (bene to PCP)

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.

Year 1 attribution implementation: Attribution lists and info

- Beneficiary attribution has been run for base period CY17 and performance period CY18 within Chronic Condition Warehouse
- Lists provided to hospitals of Practitioner NPIs for both ACO-Like and MDPCP-Like
  - Beneficiary counts for CYs 2015-2018
  - Total Cost of Care amounts for CYs 2015-2017
- Attribution programs and ACO-Like NPI lists have been shared with CRISP/hMetrix for performance monitoring and beneficiary identifiable data

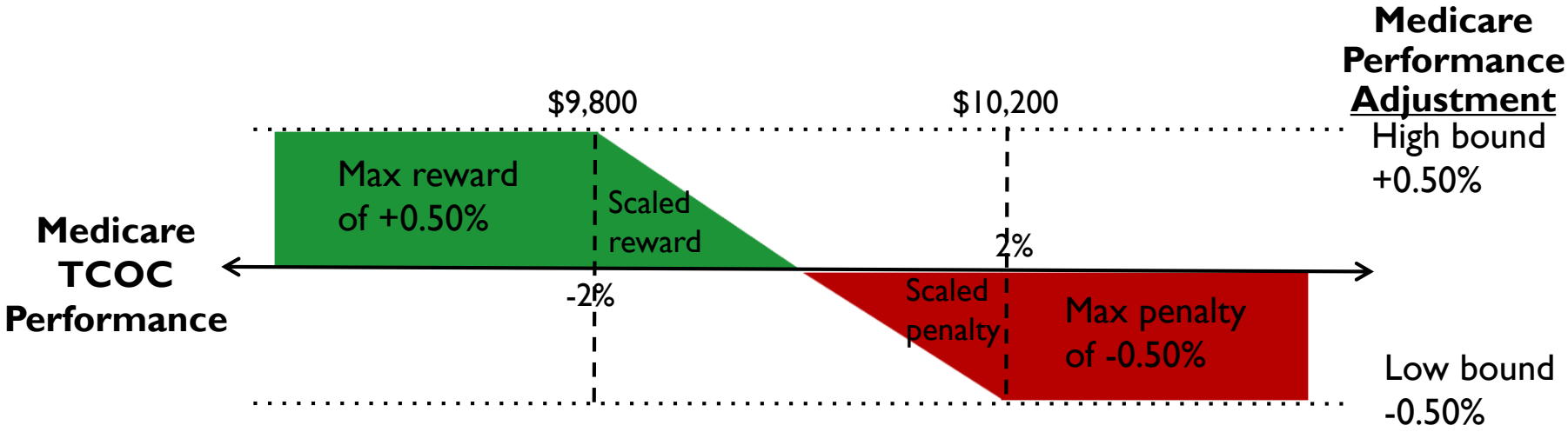
Additional attribution information

- ACO-like component
  - About 8000 NPIs were submitted by ACOs
  - About 3600 NPIs had attributed benes in any year of the algorithm
    - Many excluded NPIs have specialties not included in the algorithm, such as podiatry, anesthesiology or surgery.
  - About 1850 NPIs had at least 11 attributed benes in 2018 (average number of benes per provider: 124)
    - A little less than half of ACO-like NPIs with at least 11 benes also appeared in the MDPCP-like list.
      - About 75% of these NPIs were linked with the same hospital or system in both ACO-like and MDPCP-like
- MDPCP-like component
  - About 2900 NPIs were attributed at least 11 benes in 2018 (average number of benes per provider: 126)

Y2 MPA Issues: Maximum (Medicare) Revenue at Risk, Maximum Performance Threshold

Year 1 MPA is "improvement only" with 0.5% hospital Medicare Max Revenue at Risk

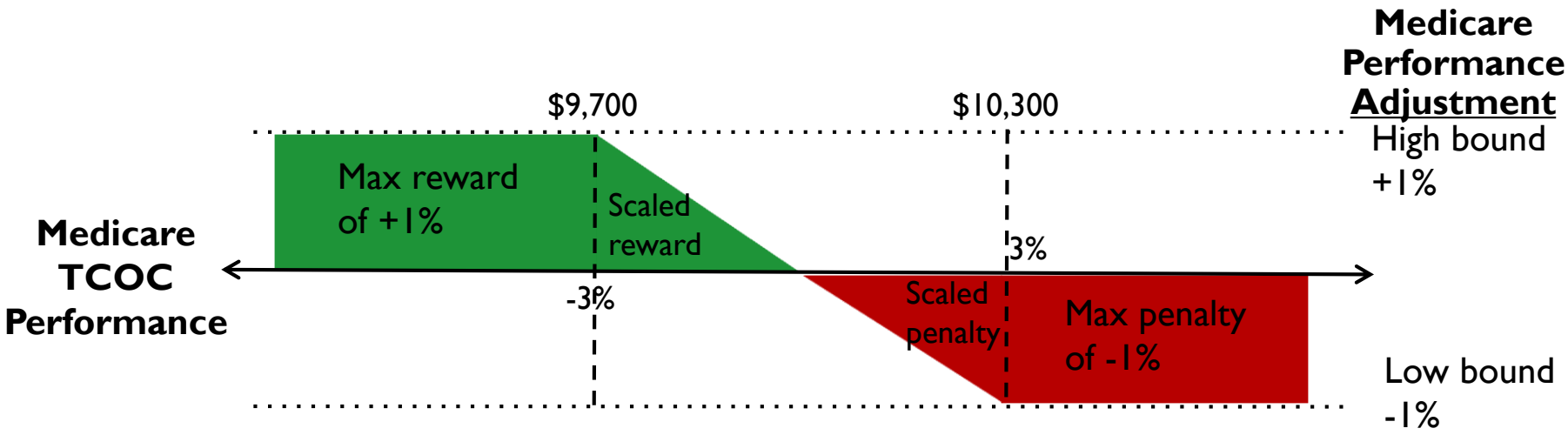
- Maximum Performance Threshold = 2%
- National Medicare FFS growth in CY 2018 (totally made-up example) = 1.83%
- TCOC Benchmark = $9,852 * (1 + 1.83% - 0.33%) = $10,000
- If CY 2018 per capita TCOC is:
  - $10,200+ (2%+ above Benchmark), then full -0.5% MPA
  - $9,800 or less (2%+ below Benchmark),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

Year 2 MPA: Must increase Medicare revenue at risk to 1%

- Maximum Performance Threshold to 3%
  - CMS wants ratio of Maximum Revenue at Risk / Maximum Performance Threshold to be at least 30%
  - Y1 ratio is 25% (0.5%/2%)
  - Y2 ratio is 33% (1%/3%)



Note: For simplicity's sake, example assumes Quality Adjustment of 0%, and dollar amounts in prior slide applied here as well (i.e., updated one year).

Y2 MPA Issues: Options for incorporating Attainment

How to potentially reflect Attainment in this formula for Year 2?

- Simplest approach is to adjust hospitals' TCOC Benchmark based on Attainment
  - Current TCOC Benchmark is previous year TCOC per capita plus national growth minus 0.33%
- Which hospitals should qualify for the Attainment Adjustment?
- What is the appropriate size of the Attainment Adjustment?
- What is the appropriate risk adjustment (and how much does it matter)?

Attainment adjustment: Potential policy rationales and trade-offs

- Lower the bar for improvement MPA for hospitals already at low TCOC per capita
  - Arguably harder for these hospitals to improve TCOC
  - However, State's financial tests are improvement only, with no accounting for attainment
  - Hospitals with lowest TCOC could have benchmark equal to national growth
- Raise the bar for improvement MPA for hospitals with high TCOC per capita
  - Arguably easier for these hospitals to improve TCOC
  - However, State's financial tests are improvement only, with no accounting for attainment

Attainment adjustment: Option for implementation – upside

- For hospitals in the lowest risk-adjusted decile of TCOC per capita: Benchmark = national growth
- For hospitals between lowest risk-adjusted quartile and decile: Benchmark is scaled:
  - 25th percentile = national growth minus 0.33% (standard)
  - 10th percentile = national growth
  - ~17.5th percentile = national growth minus 0.165%

Attainment adjustment: Option for implementation – downside

- For hospitals in the highest risk-adjusted decile of TCOC per capita: Benchmark = national growth – 0.66%
- For hospitals between lowest risk-adjusted quartile and decile: Benchmark is scaled:
  - 75th percentile = national growth minus 0.33% (standard)
  - 90th percentile = national growth minus 0.66%
  - ~82.5th percentile = national growth minus 0.495%

Y2 MPA Issue:
Linking Doctors to Hospitals

Practice sites and TINs

- Currently the MDPCP-like portion of the algorithm is based on individual NPIs
  - Multiple providers practicing in the same office may be linked to different hospitals, leading to potential duplication of resources
- Work Group members have expressed interest in linking providers to hospitals using practice site or TIN information
- Update on receiving TIN information from CMS

Y1 Specialty Breakdown 2017

ACO-LIKE ATTRIBUTION			
Specialty	2017 Benes	2017 TCOC	2017 TCOC per Capita
Internal medicine	127,676	$1,561,592,232	$12,231
Family practice	55,687	$614,952,430	$11,043
Nurse practitioner	15,937	$223,200,406	$14,005
Physician assistant	5,163	$67,032,331	$12,984
Geriatric medicine	3,810	$52,856,302	$13,872
Cardiology	2,876	$28,947,064	$10,067
Pulmonary disease	1,001	$13,734,397	$13,723
Neurology	631	$7,007,192	$11,103
Pediatric medicine	553	$6,666,452	$12,064
Hem/onc	493	$9,163,634	$18,572
Medical oncology	447	$12,498,520	$27,945
Psychiatry	409	$3,168,557	$7,750
OB/GYN	339	$1,909,859	$5,628
General practice	334	$3,944,021	$11,803
Nephrology	318	$8,819,339	$27,770
Physical med /rehab	175	$1,555,284	$8,909
Hematology	82	$1,123,093	$13,780
CNS	56	$1,014,847	$17,988
GYN ONC	30	$273,049	$9,230
Preventive medicine	9	$161,447	$18,106
	216,025	$2,619,620,454	$12,126

MDPCP-LIKE ATTRIBUTION			
Specialty	2017 Benes	2017 TCOC	2017 TCOC per Capita
Internal medicine	210,869	$2,884,038,859	$13,677
Family practice	73,913	$859,175,649	$11,624
Cardiology	20,191	$341,020,445	$16,890
Nurse practitioner	12,563	$154,605,363	$12,306
Pulmonary disease	11,038	$217,447,296	$19,699
Psychiatry	7,605	$107,828,212	$14,178
Gastroenterology	5,139	$68,645,400	$13,358
OB/GYN	3,900	$33,148,448	$8,499
Geriatric medicine	3,120	$46,839,225	$15,015
Nephrology	2,922	$119,550,865	$40,912
General practice	2,109	$27,186,491	$12,891
Medical oncology	501	$12,595,131	$25,148
Hem/onc	361	$10,008,792	$27,764
	354,231	$4,882,090,176	$13,782

Ways to link doctors to hospitals

- New possibilities such as:
  - Employment/ownership
    - Concerns about data source and definition issues
  - Care Redesign Alignment: HCIP, CCIP
  - Clinically Integrated Networks
  - Others?
- Reassess ACO-like and MDPCP-like
  - Adjust specialties to include when PCP not found?

Next meeting:

8:00 a.m. Wednesday, May 23

Total Cost of Care (TCOC) Workgroup

HSCRC
Health Services Cost Review Commission