Total Cost of Care (TCOC) Workgroup

July 25, 2018

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions
- Updates on initiatives with CMS
- Y1 MPA implementation
- Y2 MPA attribution
- Y2 MPA performance measurement
- Benchmarking work plan for future attainment options

Updates on Initiatives with CMS

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 7/5/18

By: _____

Adam Boehler, Director, Center for Medicare and Medicaid Innovation

GOVERNOR OF MARYLAND

Date: 7/9/18

By: _____

Lawrence Joseph Hogan, Jr., Governor

MARYLAND DEPARTMENT OF HEALTH

Date: 7/9/2018

By: _____

Robert R. Neall, Secretary of Health

HEALTH SERVICES COST REVIEW COMMISSION

Date: 7/9/2018

By: _____

Nelson Sabatini, Chairman

TCOC Contract Status

Signed July 9, 2018!

Care Redesign Program (CRP) Update

Current CRP Tracks: HCIP and CCIP

- 42 hospitals submitted Participation Agreements (PAs) by July 1, 2018, to participate in HCIP and/or CCIP for July 1 – Dec. 31, 2018

Hospital Care Improvement Program (HCIP)
• Designed for hospitals and Care Partners practicing at hospitals • Hospitals improve care and save money through more efficient episodes of care • Physicians may share in those gains • **Goal**: Facilitate improvements in hospital care that result in care improvements and efficiency

Complex and Chronic Care Improvement Program (CCIP)
• Designed for hospitals and community-based Care Partners • Hospitals and Care Partners collaborate on care of complex and chronic patients • Hospitals provide resources to practices that should improve quality and reduce costs • **Goal**: Enhance care management and care coordination

Hospital submitting Care Redesign PAs Performance Period 3: July 1 – December 31, 2018

- Adventist - Shady Grove
- Adventist - Washington Adventist
- Anne Arundel
- Atlantic General
- Calvert
- Doctors
- Frederick Memorial
- Garrett Regional
- GBMC
- Holy Cross
- Holy Cross - Germantown
- JHHS - Bayview
- JHHS - Howard County
- JHHS - JHH
- JHHS - Suburban
- Lifebridge - Carroll
- Lifebridge - Northwest
- Lifebridge - Sinai
- Medstar - Frankin Sq
- Medstar - Good Sam
- Medstar - Harbor
- Medstar - Montgomery
- Medstar - Southern MD
- Medstar - St. Mary's
- Medstar - Union Mem
- Mercy
- Meritus
- Peninsula Regional
- St. Agnes
- UMMS - Baltimore Washington
- UMMS - Charles Regional
- UMMS - Chestertown
- UMMS - Easton/Dorchester
- UMMS - Harford Memorial
- UMMS - Laurel Regional
- UMMS - Midtown
- UMMS - Prince George's
- UMMS - Rehab
- UMMS - St. Joseph's
- UMMS - UMMC
- UMMS - Upper Chesapeake
- Western Maryland

Status of Bundled Payments for Care Improvement in Maryland (BPCIM)

- April 2018: Stakeholder Innovation Group (SIG) recommended that State should seek federal approval of voluntary bundled payment programs through hospital-led effort to create new Care Redesign track (#3) for January 2019
- June 2018: Secretary's Vision Group agreed to pursue new Care Redesign track for January 2019
- June 2018: State submitted to CMS a draft Implementation Protocol for BPCIM
- **July 6, 2018: CMS approved BPCIM Implementation Protocol**

* For details of BPCIM, see HSCRC meeting slides from July 11, 2018

Calculating Clinicians' QP Scores in Maryland Care Redesign Programs*

* Subject to change based on official guidance from CMS

Hospitals' Medicare Performance Adjustment (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+
- CMS has determined, **effective 7/1/18**, that due to MPA:
  1. Maryland hospitals are Advanced APM Entities; and
  2. A clinician participating with hospital(s) in Care Redesign Program is eligible to be QP based on % of clinician's Medicare beneficiaries or revenue linked to that specific hospital*
- Other pathways to QP status include participation in a risk-bearing Accountable Care Organization (ACO), MDPCP

* Described on upcoming slides but, in short, via MPA or hospital encounter

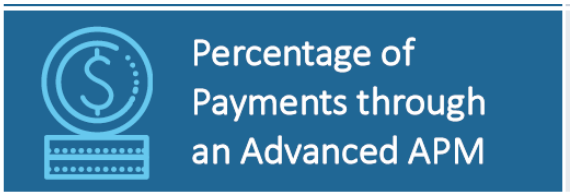
Clinicians' QP Thresholds to Obtain MACRA Incentive

- Clinicians who participate with hospitals in a Care Redesign Program would still need to meet the following thresholds to be a Qualifying APM Participant (QP)

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017 NA for CRP	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

* Clinicians must also meet these thresholds to qualify for MACRA incentives in risk-bearing ACOs (e.g., 1+) and other Advanced APMs

Additional details



- What is included in "Percentage of Payments"?
  - Denominator is "aggregate of payments for Medicare Part B covered professional services furnished by" the clinician (42 CFR 414.1435(a))
  - Numerator is the subset of those payments for the beneficiaries linked to the APM Entity
- For most Advanced APMs, CMS calculates QP Threshold Scores based on groups of clinicians.
  - However, for CRP, QP Threshold Scores are calculated for each individual clinician

QP Threshold Score for Maryland CRP

Numerator (among those beneficiaries in Denominator)

Accountability exists to hospital(s) where clinician is CRP Care Partner:

(1) Beneficiary had encounter at that hospital* **or**

(2) Beneficiary attributed to that hospital under MPA

Denominator

Beneficiaries with Medicare Part A and B
for whom the clinician had an E&M claim

* **Note:** The beneficiary does NOT need to be enrolled in the specific CRP program (HCIP, CCIP, BPCIM) to be in the numerator. The Hospital is the Advanced APM entity, so if the beneficiary visited that hospital or was in that hospital's MPA, either of those represent hospital responsibility in Maryland as the Advanced APM Entity.

Saying it again: How QP Threshold Scores calculated for clinicians in CRP

- Care Partner's **denominator**:
  - Based on Medicare beneficiaries with Part A and Part B for whom the clinician had one evaluation and management (E&M) service*
- Care Partner's **numerator**: Among beneficiaries in the Care Partner's denominator, the numerator would be based on those who meet either of the following criteria:
  - (1) Beneficiary had an encounter (inpatient stay, outpatient encounter) at the specific Maryland Hospital(s) with which the Care Partner participates, or
  - (2) Beneficiary is attributed under the MPA algorithm to the specific Maryland Hospital(s) with which the Care Partner participates

* For full requirements, see 42 CFR §414.1305 (e.g., age 18+, US resident)

Timing for QP calculation for 2018

- In general, CMS looks 3 times a year at whether or not a provider is on a CMS "list" of Advanced APM participants
- Since Maryland just received its MACRAtization on July 1, 2018:
  - 2 of those 3 QP windows have already passed for 2018
  - Only clinicians on a hospital's HCIP or CCIP Certified Care Partner List as submitted to HSCRC by mid-July 2018 may be assessed for QP eligibility for 2018
- CMS's calculation for Maryland CRP clinicians' QP Threshold Score will use claims from July 1 through August 31
- If a clinician qualifies, the MACRA incentive will be applied to the entire CY 2018 year of the clinician's Part B professional claims
- The QP's MACRA incentive for 2018 will be paid in 2020

Timing for QP calculation for 2019+

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

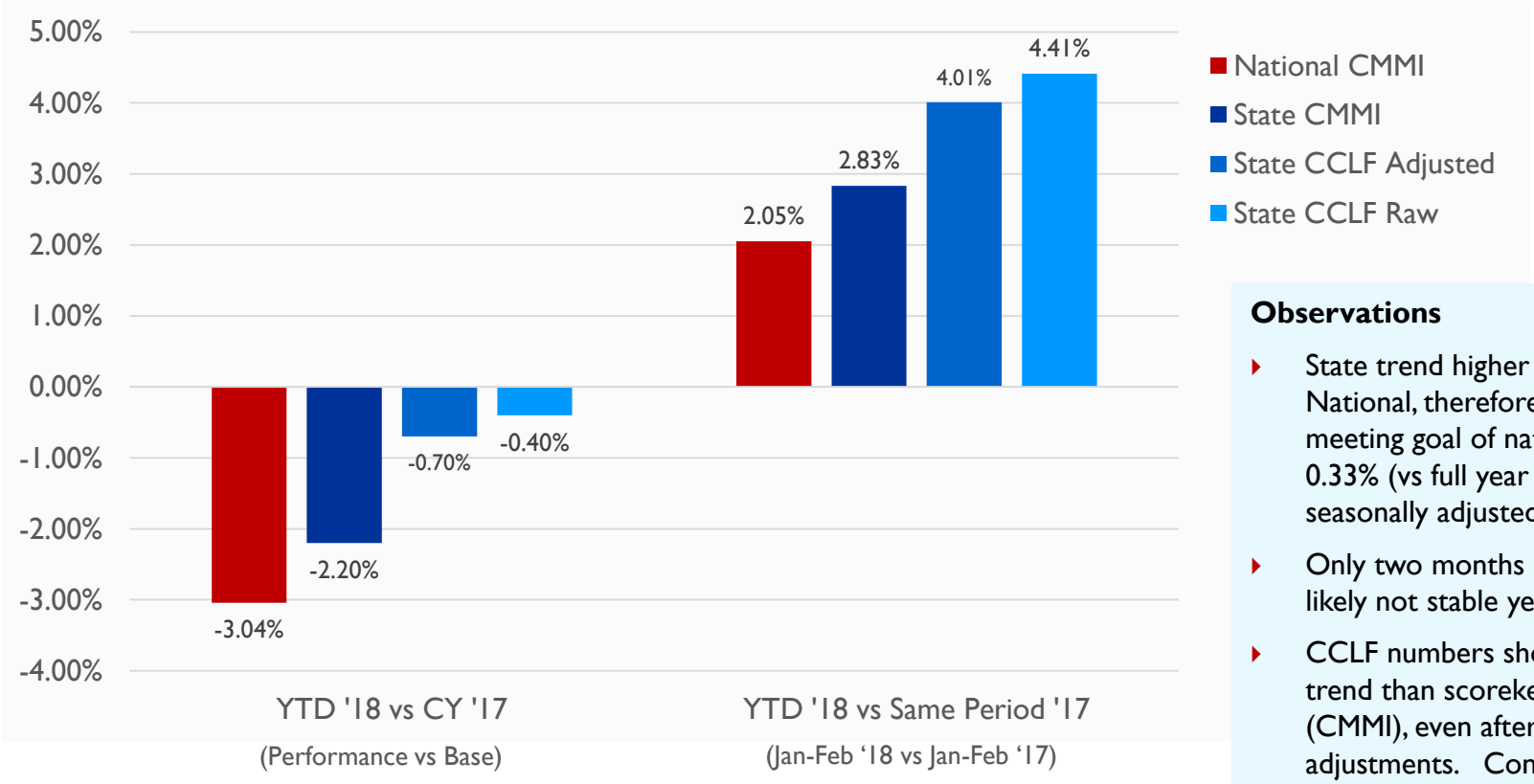
- Again, for CRP, this "list" is the hospital's Certified Care Partner List for HCIP, CCIP or BPCIM (which hospitals submit quarterly)
- A clinician on that list during any of the 3 QP windows in 2019 will be assessed for QP threshold score
- In 2019, CMS's QP calculation will use claims from January 1 through the QP window date
- If qualifying in any of the 3 QP windows, the MACRA incentive will be applied to the entire CY 2019 year of clinician's Part B professional claims
- The QP's MACRA incentive for 2019 will be paid in 2021

Y1 Implementation: CRISP MPA Reporting Tools for Hospitals

MPA Monitoring Reports - Release

- Report release
  - A month after the "soft release", CRISP released MPA monitoring reports to CRISP Reporting Services credentialed users on June 22.
- Report training
  - 70 users attended web-based training
  - Recorded training and written documentation is available on the CRISP Reporting Services portal
- Report use
  - 15 organizations/hospitals (21 users) have accessed the reports

MPA Monitoring Reports

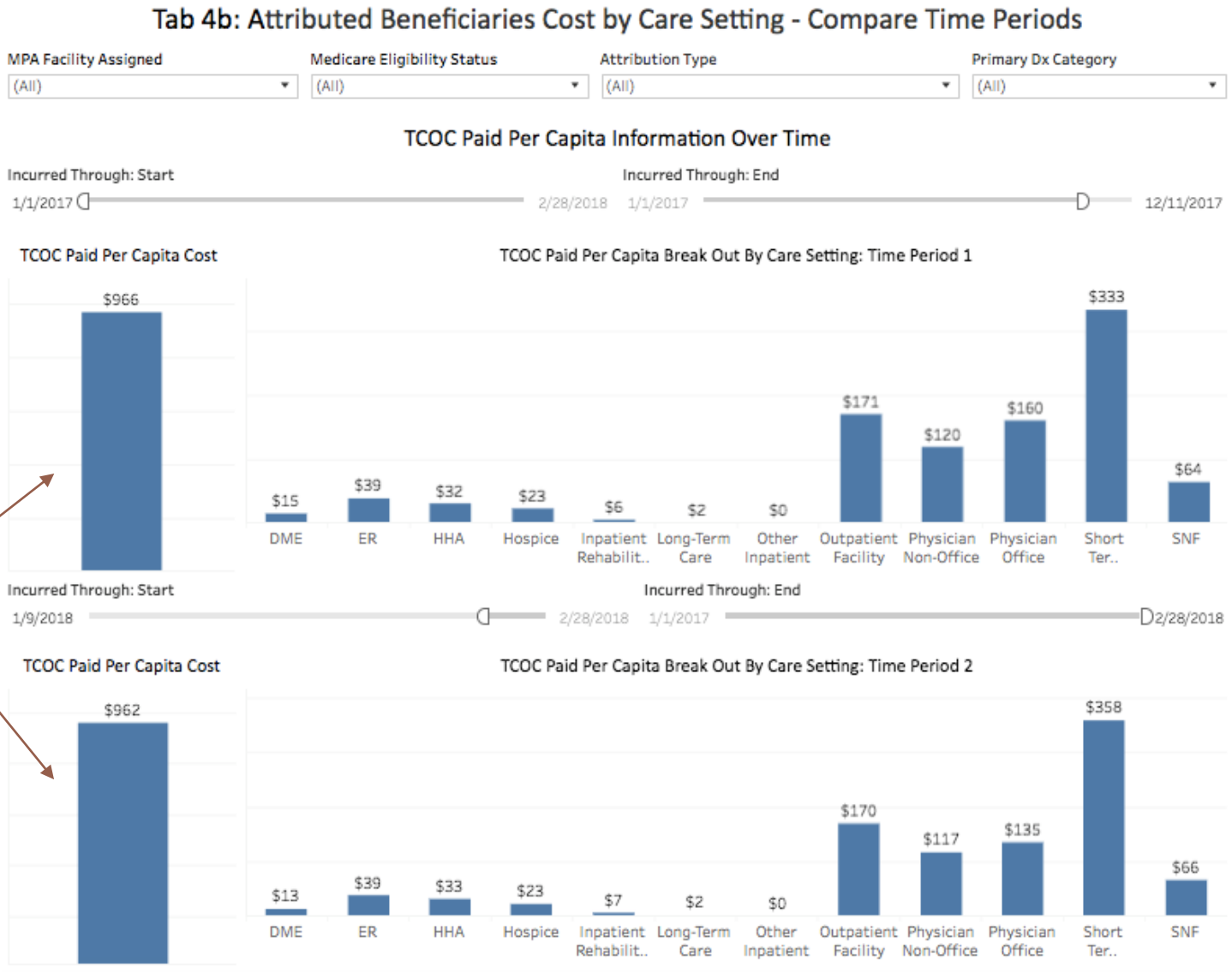


- Actual results, YTD February, run out to May.
- Information reflects Tab 1 in MPA reports but revising Tab 1 to capture it more completely

Observations

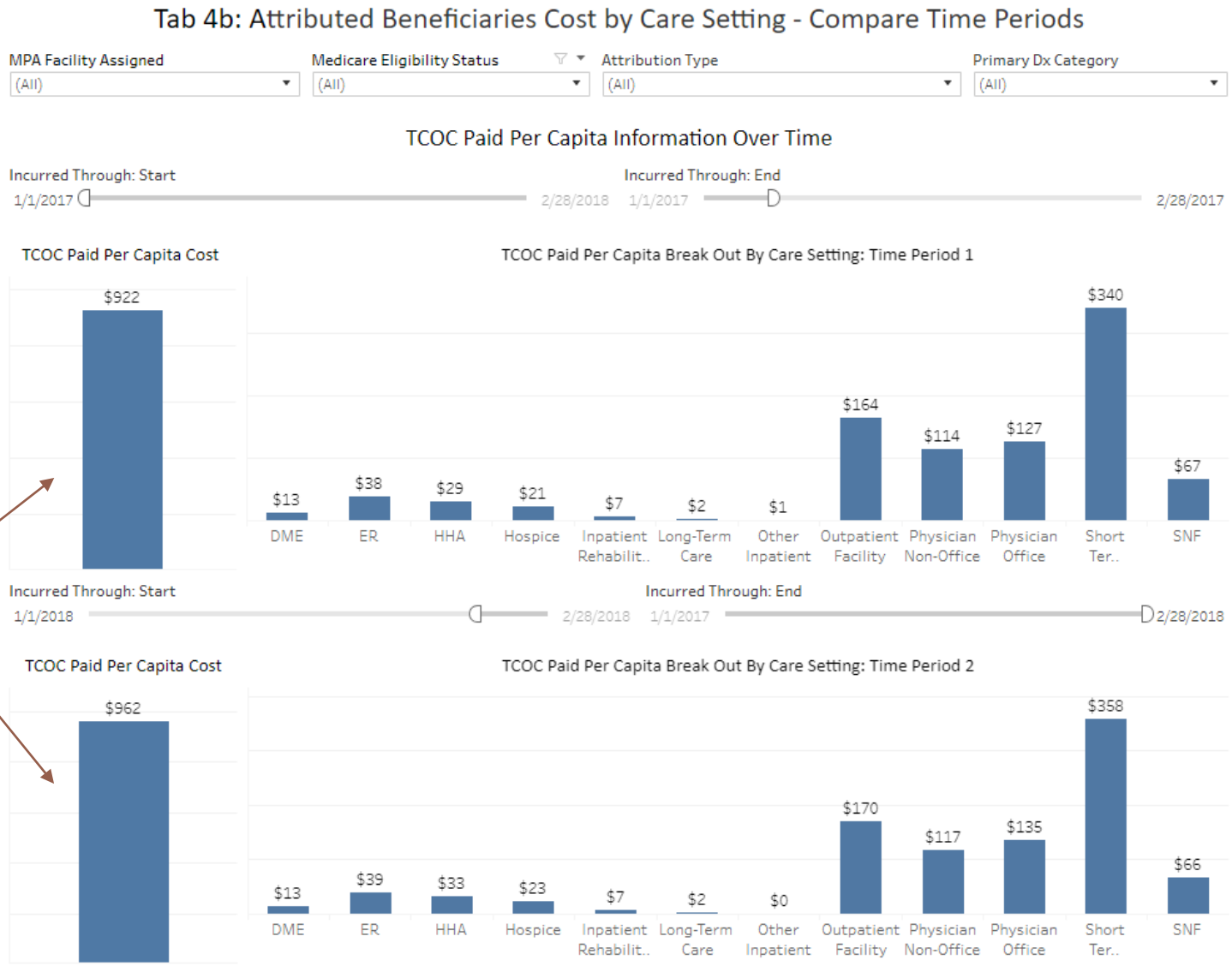
- State trend higher than National, therefore not meeting goal of national less 0.33% (vs full year or seasonally adjusted)
- Only two months of data so likely not stable yet
- CCLF numbers show higher trend than scorekeeping (CMMI), even after adjustments. Consistent with findings that CCLF and CCW data has seasonal variations. Expect gap to close as year progresses.

YTD 2018 vs CY '17 TCOC by Care Setting



-0.40% Decline Overall

YTD 2018 vs Same Period '17 TCOC by Care Setting



4.41% Increase Overall

MPA Monitoring Reports – Upcoming Efforts

- Continue to add data as monthly CCLF data released from CMS
- Refine a few tabs, primarily Tab 1, including adding new comparison, update headings
- Review reports with CRISP Reporting and Analytics Committee and Subcommittee for usability feedback
- Add small cell size redacted version allowing access to a broader group of users

Y2 MPA Attribution Algorithm

MDPCP-actual

Provider to hospital consistency

Review Period

Elements of RY2021(Y2) Attribution

- Existing elements from RY2020 (Y1)
  - ACO-like
  - MDPCP-like
  - Geography

- Should we incorporate MDPCP-ACTUAL?
  - With MDPCP launching in January 2019, opportunity to align the beneficiaries and providers participating in MDPCP with the MPA attribution

Brief Overview of MDPCP

- Strengthening primary care is critical to promoting health and reducing overall health care costs in Maryland.
- Program approved as an integral component of TCOC Model
- 8 year program: January 1, 2019 – Dec 31, 2026
- Focused on Maryland FFS Medicare beneficiaries to start
- 2 levels of practices – Track 1 (Standard)/ Track 2 (Advanced)
- Practices must move to track 2 by beginning of 4th Year
- Voluntary for all primary care practices
- Payments from CMS to Practices and Care Transformation Organizations to support practices' care transformation requirements
  - Care Management Fees – PBPM
  - Performance Based Incentive Payments – PBPM
  - Track 2 Hybrid payments

Brief Overview of MDPCP attribution

- Eligible beneficiaries are prospectively attributed to eligible participating MDPCP Practice Sites, rather than individual practitioners
  - A Practice Site is composed of a unique grouping of primary care practitioners and TINs
- CMS provides care management fees and performance based incentive payments based on this prospective attribution

MDPCP-actual in the MPA: Beneficiary attribution

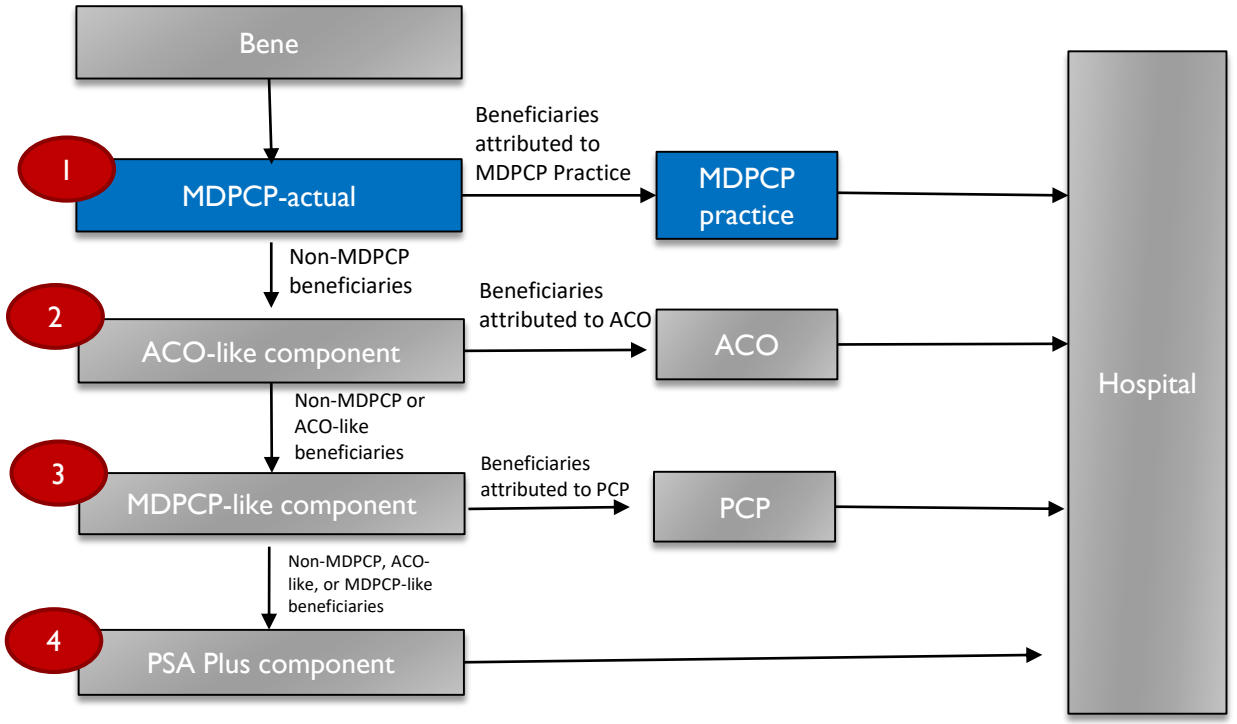
- HSCRC is requesting an additional flag in the Medicare data to indicate MDPCP enrollment
  - Will allow MPA algorithm to line up exactly with actual MDPCP beneficiaries
  - Reduces the chance of discrepancies between MDPCP beneficiaries in the MPA and in practice.

MDPCP-actual Practice to Hospital link

- Once beneficiaries are attributed to MDPCP practices/NPIs, these providers need to be linked to a hospital
- Practice NPIs linked with hospitals could be based on:
  1. Participation with hospital-affiliated CTO
     - Link MDPCP practice/NPIs to hospital/system based on participation with hospital-affiliated CTO
  2. Not in hospital-affiliated CTO but in hospital-affiliated ACO
     - Link MDPCP practice/NPIs to hospital/system based on participation with hospital-affiliated ACO
  3. Practice referral patterns for MDPCP clinicians not in hospital-affiliated CTO or ACO
- MDPCP-actual with hospital-affiliated CTO represents the most tightly defined patient relationship between beneficiaries, PCPs and hospitals

Where should MDPCP-actual go in the attribution hierarchy?

Figure 1. Overview of 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.

Summary: Potential MDPCP-actual in attribution

- Should the attribution hierarchy be:
  - MDPCP-actual
    - Practice NPIs are linked with hospitals based on:
      1. Participation with hospital-affiliated CTO
      2. Not in hospital-affiliated CTO but in hospital-affiliated ACO
      3. Practice referral patterns for MDPCP clinicians not in hospital-affiliated CTO or ACO
  - ACO-like
  - MDPCP-like
  - Geography

Provider-Hospital consistency

- What to do when ACO-like and MDPCP-like conflict?
  - In Y1, doctor could be attributed beneficiaries to one hospital under ACO-like and another hospital under MDPCP-like
  - Led to concerns about potential confusion and resource duplication
- Potential Y2 Solution
  - Adjust attribution so that NPIs are only attributed to one hospital by defaulting to earlier steps in the hierarchy
    - For example, when MDPCP-like and ACO-like conflict, all of the doctor's beneficiaries are attributed to the ACO-like hospital
    - Referred to last meeting in the TIN discussion as the "wraparound"

Review Period and Unique Situations

- Review Period to address attribution tweaks
  - For Y2, review period to resolve issues/tweaks needed for the attribution to work as intended
    - For example, a provider is inadvertently attributed to two hospitals
  - Not for fundamental changes to the attribution methodology
- Unique situations requiring alternative approaches
  - Allow proposals for unique situations that may require alternative approaches
  - These approaches should aim to minimize any effect on other hospitals

Other Y2 Attribution Considerations

- Fundamental principle of "if it's not broke, don't fix it"
  - Will not plan on changing underlying logic in MDPCP-like or ACO-like unless concerns are raised
  - Want to provide adequate time to test approach
- TIN information
  - As noted last meeting, the TIN information from CMS cannot be used consistently for attribution purposes
  - However, HSCRC will work to use the TIN information to provide additional information for hospitals for Y2 and evaluate how the algorithm is operating

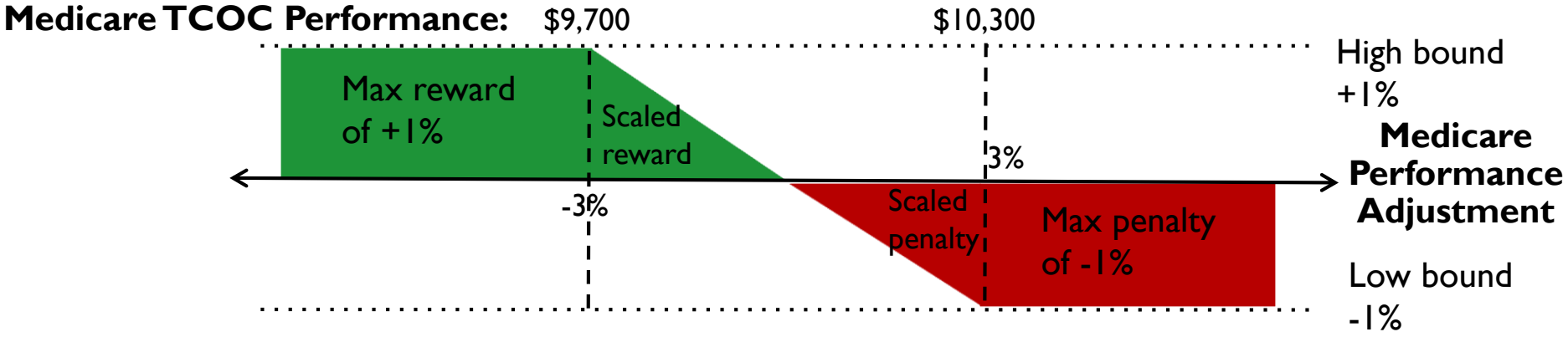
Primary Service Area – Plus (PSAP)

- Hospitals selected Primary Service Areas (PSAs) but not all the state's zip codes were captured
- To create PSA-Plus, remaining zip codes were assigned to the hospital with the most Medicare Equivalent Case-Mix Adjusted Discharges (ECMADs)
- Medicare ECMADs are also used when multiple hospitals selected a zip code in their PSA – to apportion the TCOC to those hospitals
- To the extent PSAPs may differ based on all-payer ECMADs, should we move to all-payer PSAPs?
- Both sets of PSAPs will be shared for assessment

Y2 MPA Performance Assessment

Year 2 MPA: Increase Max 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%)
- Besides Maximum Revenue at Risk, HSCRC may also apply "Efficiency Adjustment" in MPA – for example, to provide Medicare-only payments to hospitals under BPCIM



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).

Staff is recommending that Y2 MPA still use "improvement only"

- Attainment adjustment makes sense conceptually
- Only readily available Medicare TCOC measure is comparing Maryland hospitals to Maryland hospitals
  - Not necessarily indicative of TCOC success but other factors (e.g., rural vs. urban)
  - Need analyses comparing Maryland hospitals to comparable hospitals nationally
  - Work is underway to obtain these data/analyses
- No attainment adjustment in MPA until we have appropriate benchmarks/comparisons

Y2 MPA Improvement with Risk Adjustment options

- CMS-HCC New Enrollee (NE) Risk Scores based on national data
  - Relies on Gender/Age-Band/Dual Status/ESRD Status
  - Risk Scores published for Medicare Advantage, generally for those without 12 months of claims experience (same buckets as above)
  - Does not adjust for diagnoses

MPA Quality Adjustment

- 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 MACRA purposes, the MPA must include a quality adjustment
- Other requirements
  - Must be aligned with measures in the Merit-Based Incentive Payment System (MIPS) to the extent possible
- For the Y2 MPA policy, staff is recommending:
  - Using the RY20 quality adjustments from Readmission Reduction Incentive Program (RRIP) and hospital-acquired infections
- Additional measures may be considered for Y3 MPA policy, consistent with TCOC goals

Benchmarking Work Plan for Future Attainment Options

Defining hospital peer groups for comparison

- The HSCRC is working with a contractor to test different methodologies to identify benchmark peer groups/geographies.
  - These approaches will create national comparison groups that are similar to each Maryland hospital
  - The methodologies and outputs will be evaluated for accuracy, stability, and understandability
- Peer groups can then be used to develop additional benchmarks
  - Benchmarks will be used to assess attainment across HSCRC policies and programs
  - Will start with MPA but may expand to quality programs, etc.

Future meetings

- TCOC Work Group meetings
  - Sept. 26
  - Oct. 24
  - Nov. 28
- HSCRC Commission meetings
  - Oct. 10
  - Nov. 14
  - Dec. 12

Next meeting:

8:00 a.m. Wednesday, September 26

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