Total Cost of Care (TCOC) Workgroup

November 28, 2018

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions
- Updates on initiatives with CMS
- Y2 MPA Final Recommendation Review
- MPA Implementation: CRISP MPA Reporting Tool
- MPA Implementation: Submission Requirements
- Appendix A: Attribution Algorithm Details

Updates on Initiatives with CMS

Y2 MPA Final Recommendation

- Overview and Summary of Changes
- Attribution Algorithm
- Performance Assessment
- Future Plans

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**
  - Brings direct accountability to individual hospitals on Medicare TCOC performance
  - Links non-hospital costs and quality measures to the TCOC Model, allowing participating clinicians to be eligible for bonuses under MACRA
  - Additional flexibility to use as Efficiency Adjustment and as a Care Redesign tool

Summary of Y2 Policy Changes

- Algorithm Reorganization
  - Attribution algorithm reorganized into two sections:
    - 1) Beneficiary Attribution
    - 2) Provider-to-Hospital Linkage
  - Ensures that all of a provider's attributed beneficiaries are linked with the same hospital, but otherwise does not affect attribution
- Other Algorithm Changes
  - Added MDPCP-actual to both the beneficiary attribution and provider-to-hospital linkage steps
  - Added employment as option for hospitals for provider-to-hospital linkage step after MDPCP and ACO linkages
  - Added review period for hospitals

Summary of Y2 Policy Changes, cont.

- Y2 Performance Assessment
  - Set each hospital's maximum reward and penalty at 1% of federal Medicare hospital revenue
  - Use maximum performance thresholds of ±3%
  - Set the TCOC Benchmark as each hospital's CY 2018 TCOC, updated with a Trend Factor of 0.33% below the national Medicare growth rate for CY 2019
  - Add New Enrollee Risk Adjustment
  - Continue to work on TCOC benchmarking methodology for attainment
  - Winsorize extreme cases at 99th percentile
  - Address incorporating MDPCP expenditures over time

Y2 MPA Attribution Algorithm

Summary Diagram of MPA Y2 Attribution

Goal: Develop an attribution algorithm that accurately captures the beneficiary-to-provider and provider-to-hospital relationships.

Step:

01 **Beneficiary Attribution**

1A. MDPCP-Actual | *1B. ACO-Like* | *1C. PCP-Like*

02 **Provider-to-Hospital Linkage**

2A. MDPCP Provider to CTO Hospital | *2B. ACO Provider to ACO Hospital* | *2C. Employment Linkage** | *2D. Referral Pattern Linkage*

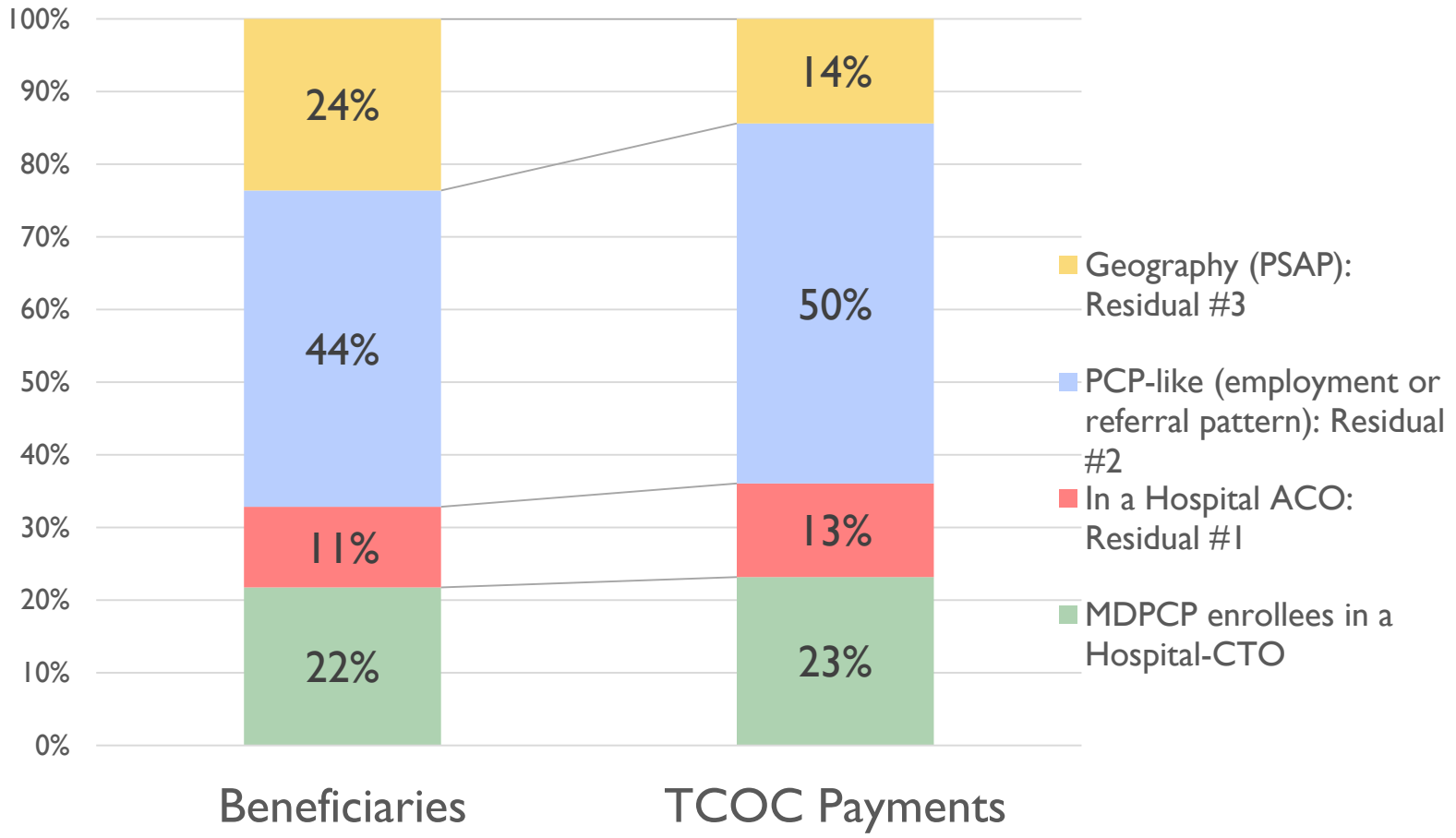
03 **Remaining Beneficiary Geographic Attribution**

* For hospitals voluntarily submitting information on employed PCPs

Attribution

- Once beneficiaries are attributed to PCPs, those PCPs are then linked to hospitals.
  - All beneficiaries attributed to a PCP are attributed to the same hospital
- PCPs will be linked to hospitals using the following hierarchy
  1. *New:* Participating with a hospital-affiliated Care Transformation Organization (CTO)
  2. Participating with a hospital-affiliated ACO
  3. *New:* Employed by a hospital entity (voluntary submission)
  4. Provider referral patterns
- PCPs participating together in MDPCP practice will be considered as a single provider throughout the PCP-to-hospital linkage process

Y2 MPA Provider-to-Hospital Attribution Algorithm



Source: HSCRC analysis based on CY 2017 Medicare (CCW) data

Review Period and Unique Situations

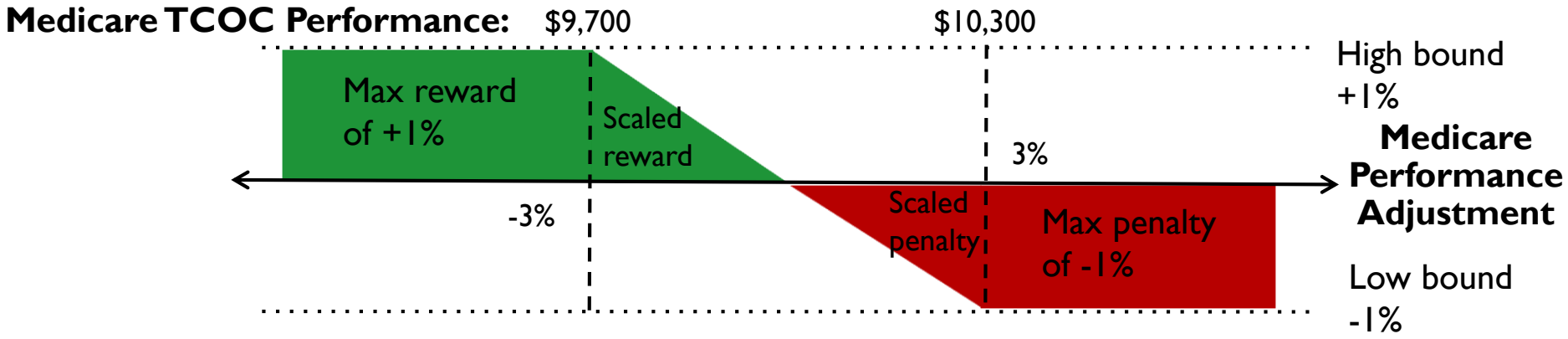
1. Review Period to resolve issues for attribution to work as intended
   - For example, if a provider is inadvertently attributed to two hospitals
   - Not for fundamental changes to the attribution methodology
2. Review Period for unique situations that may merit alternative approach
   - For example, if two hospitals agree to share responsibility for certain physicians and their beneficiaries
   - Not for fundamental changes to the attribution methodology

- Any changes based on submissions during Review Period would require HSCRC approval

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%)
- Provide some financial protection to hospitals by winsorizing extreme values at the 99th percentile (approximately $200,000)
- Besides Maximum Revenue at Risk, HSCRC may also apply "Efficiency Adjustment" in MPA – for example, to provide Medicare-only payments to hospitals under ECIP



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).

RY 2021 MPA Staff Recommendations, cont.

Accounting for MDPCP Expenditures:

- Staff propose gradually incorporating MDPCP expenditures into the MPA performance assessment.
- Excluding Care Management Fees (CMF) and Performance-based Incentive Payments (PBIP) in CY19 allows hospitals to be held harmless while this additional revenue is incorporated into the base year comparison for future rate years.

		CPCP	CMF	PBIP
RY2021	Base: CY18	✗	✗	✗
	Performance: CY19	✓	✗	✗
	Tentative CMS State Financial Test	✓	✓	✗
RY2022	Base: CY19	✓	✓	✗
	Performance: CY20	✓	✓	✗
	Tentative CMS State Financial Test	✓	✓	Net CY19 PBIP
RY2023	Base: CY20	✓	✓	Net CY19 PBIP
	Performance: CY21	✓	✓	Net CY20 PBIP
	Tentative CMS State Financial Test	✓	✓	Net CY20 PBIP

Types of MDPCP expenses:

1. Comprehensive Primary Care Payments (CPCP)
2. Reduced FFS expenses for Track 2 participants
3. Care Management Fees (CMF)
4. Performance-based Incentive Payments (PBIP)

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

Consistency in Provider Linkage in MPA Performance Assessment Over Time

- Background: Providers attributed to a hospital in a performance year in Y1 may not always be included in that hospital's base year
  - Example: Dr. Jane is attributed to Hospital A in CY19 (performance year) through referral-linkage but does not show up in Hospital A's base period because she was attributed to Hospital B in CY18.
  - In MPA Y1, only ACO-like providers were held constant between the performance period and base years.
  - In MPA Y2, providers linked to hospital through MDPCP-actual, ACO-like and Employment will be held constant, but PCP-like is TBD.
- Question: To what extent, in Y2, should providers in a hospital's performance year attribution be included in their base year for performance assessment?

Consistency in Provider Linkage in MPA Performance Assessment Over Time, cont.

- Staff are considering three potential options for the Referral Pattern linkage in Y2:
  1. *No Change*: As occurred in the Y1 policy, clinicians (except for MDPCP and ACO participants) and beneficiaries are re-linked/attributed separately for the base year vs. performance year
  2. *Provider Consistency:* Clinicians attributed to a hospital in the performance year are automatically attributed to that hospital for the base year but beneficiaries recalculated/reattributed for each year
  3. *Beneficiary Consistency:* Beneficiaries are attributed to a hospital in the performance year are automatically attributed to that hospital for the base year

MPA Looking Forward

Looking Forward on MPA Policy

- Once Commission decides on an appropriate all-payer rate update, what if additional Medicare savings are still necessary?
- Impact to RY 2021 revenue at risk for quality programs
- Attainment adjustment makes sense conceptually
  - But need appropriate benchmarks/comparisons
  - Benchmarking work has begun
  - Additional risk adjustment merited when including attainment?
- Continue to monitor MPA performance, tools, and possible changes with TCOC Work Group

MPA Implementation: CRISP MPA Reporting Tool

2018 Report Set Update

Current data issue: HSCRC believes new beneficiaries are not being added to the CCW appropriately, resulting in an overstatement of trends in all available data. The magnitude of the issue is greater for the Nation than Maryland, so Maryland's trend advantage versus the nation is likely overstated.

Updates Completed:

- Revisions to Tab 1 and Tab 2 to make the comparisons clearer and better aligned
- Clean up on definition of ESRD
- Clean up on terminology, labeling and layout throughout
- Updates to user guide for layout and definition changes

Other Updates In Process:

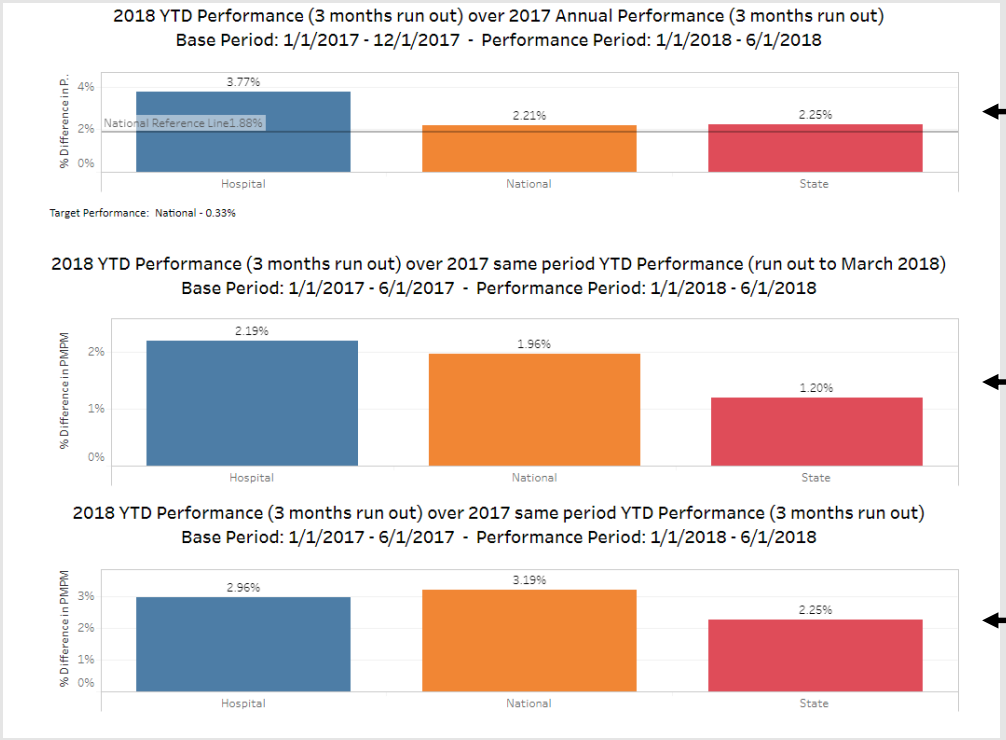
- National targets to exclude beneficiaries with A Only or B Only
- Updates to CCLF cohort
- Further comparison of CCLF and CCW
- Supplemental tabs on MPA-attributed PCP and summary of key statistics by facility.
- Process to allow sharing of member level detail for MPA assigned beneficiaries, where permissible, is underway

Revisions to Tab 1

Key Changes:

- New Graph with limited 2017 run out added at bottom
- Comparison to CCLF removed from right hand side of graph. CCLF comparison can now be found on Tab 1A, along with new 3rd graph.

Extract from New Tab 1



Unchanged

- 2018 – YTD, 3 months run out
- 2017 – Full Year, Run out to March 2018

Unchanged

- 2018 – YTD, 3 months run out
- 2017 – YTD, Run out to March 2018

New

- 2018 – YTD, 3 months run out
- 2017 – YTD, 3 months run out

2019 MPA Reporting

- 2019 MPA will require a new report set because 2018 as a base year for 2019 ≠ 2018 as a performance year
  - Attribution algorithm and provider panels (e.g., ACO lists) are different.
  - Will be two report sets, Current: 2018 over 2017 and New: 2019 over 2018. Current report set will be updated through final run-out in March 2019 but will continue to be available.
- 2019 MPA Reporting will start from most updated 2018 model but include:
    - Revised assignment algorithm including MDPCP-actual and employment
    - New ACO lists
    - Risk scoring following MPA methodology
    - Winsorizing of values at 99th percentile following MPA methodology
    - Payments under MDPCP where included in the model (CPCP)
  - Additional upgrades, see preliminary list on the next slide
- Release of 2019 will be targeted for May/June of 2019 after January claims with 3 months run-out is available.

2019 MPA Reporting Upgrades Under Consideration

- Additional historic year
  - Ideally 2019 tool will include data back to 2017 but the deterioration in the applicability of 2019 specifications in 2017 may make 2017 too inconsistent to be reliable.
  - Adding additional year also increases performance challenges.
- Care Tracking Metrics (aka "Quality Module")
  - Four components under consideration for reporting*:
    (1) Chronic Diabetes module including care and quality data focused on those with Diabetes chronic flag,
    (2) Population-based PQI and readmissions
    (3) Additional utilization metrics – e.g. knee surgeries per 1000
    (4) Senior falls
  - CMS will be expecting the State move forward on expanded quality tracking under MPA
- Static tab that makes it easier to view MPA performance simultaneously across multiple facilities.
- Looking for additional recommendations from this team in the next 30 days

*Currently there are two scored quality components in the MPA quality adjustment: readmission and MHAC. The components listed above are intended initially for monitoring and not for changes to that scoring.

MPA Implementation: Hospital Submission Requirements

Hospital Submission Requirements

- Staff are developing a process/templates to collect provider-to-hospital linkage information and developing protocols for the review period
- Required Actions:
  - Hospitals participating in accountable care organizations (ACOs) will be required to submit their certified ACO provider list to the HSCRC for use in the MPA Attribution
  - All hospitals will be required to attest that providers submitted to the HSCRC for the MPA Attribution are accurate and represent a care coordination relationship with attributed Medicare beneficiaries
- Optional Actions:
  - All hospitals will have the opportunity to share additional, voluntary provider information for use in the MPA Attribution Algorithm
    - Assign providers to specific hospitals (MDPCP, ACO). Employed providers.
  - Hospitals can elect to address Medicare Total Cost of Care (TCOC) together and combine MPAs

Data Release: Care Coordination Attestation

- The HSCRC is requiring hospitals to attest that their list of submitted providers is accurate and represents a voluntary care coordination relationship.
- This care coordination relationship allows hospitals to receive the individually identifiable beneficiary data for voluntary coordination or management of health care services.
- Draft Language:
  - *"The Hospital certifies that it has a Business Associate Agreement (BAA), as such term is defined by 45 CFR §164.504, with each Medicare-enrolled practitioner on the attached list to receive Protected Health Information (PHI) for healthcare operations and for voluntarily coordinating or managing health care and related services in a manner allowable under 45 CFR §§164.501, 164.502, and 164.504. The Hospital agrees to hold harmless the State, the HSCRC, and CRISP and to defend and indemnify these parties, individually or collectively, from any actions arising from a false certification made herein."*

Options to Combine for MPA

- Multiple hospitals are permitted to work together to address TCOC
- Process:
  - The MPA attribution will still be performed for all hospitals individually. Then, for hospitals being combined for purposes of the MPA, the total cost of care and beneficiaries will be pooled
  - The combined total cost of care per capita will be used to assess performance. The adjustment calculated on the combined total cost of care per capita will be applied to each hospital in the combination
  - Hospitals outside of the combination will not be affected
- The HSCRC will review and work with hospitals to refine options for a combined MPA assessment

MPA Information Submission and Review Timeline

Estimated Timing	Action
December 2018	• *Required for ACOs:* Hospitals provide HSCRC with ACO Participant List for Performance Year 2019 (also used for Base Year 2018) • *Voluntary*: Hospitals participating in multi-hospital ACOs designate which ACO providers should be linked with which ACO hospital. • *Voluntary:* Hospitals provide HSCRC with a list of full-time, fully employed providers
January 2019	• Performance year begins • HSCRC combines hospital lists and identifies potential overlaps • HSCRC runs attribution algorithm for Base Year 2018 and Performance Year 2019, and provides hospitals with preliminary provider-attribution lists
February 2019	• Official review period for hospitals of 2 weeks following preliminary provider-attribution lists. • HSCRC reruns attribution algorithm for implementation
March 2019	• *Voluntary:* Hospitals wanting to be treated as a combination under the MPA submit a joint request to HSCRC

Future meetings

- TCOC Work Group meetings
  - No meeting in December (Happy Holidays!)
  - Propose to continue monthly meetings in 2019, starting with January 30, 2019
- HSCRC Commission meetings
  - Dec. 12
  - Jan. 9
  - Feb. 13

Next meeting:
January 30, 2019

Appendix A:
Attribution Algorithm Details

Beneficiary-to-provider attribution

Step 01

Beneficiary-to-Provider Attribution

1A. MDPCP-Actual *1B. ACO-Like* *1C. PCP-Like*

Goal: Link beneficiaries to providers based on provision of primary care services.

Hierarchy: Beneficiary attribution based on hierarchy of:

- 1A. Maryland Primary Care Program (MD-PCP)-actual
- 1B. ACO-like
- 1C. PCP-like (formerly MDPCP-like)

Rationale:

- Keeps care management relationships at the forefront
- MDPCP-actual represents the most tightly defined patient relationship between beneficiaries and PCPs
- Each step broadens the definition of primary care provider (including certain specialists) to minimize the number of beneficiaries attributed based on geography

Provider-to-Hospital Linkage

Step 02

Provider-to-Hospital Linkage

2A. MDPCP Provider to CTO Hospital | *2B. ACO Provider to ACO Hospital* | *2C. Employment Linkage* | *2D. Referral Pattern Linkage*

Goal: Link providers and their attributed beneficiaries to a hospital using existing relationships.

Hierarchy: Provider Linkage based on hierarchy of:

- 2A. Participation with hospital-affiliated CTO
- 2B. Participation with a hospital-affiliated ACO
- 2C. Employment (voluntary)
- 2D. Referral patterns

Note: MDPCP practices that are not associated with a Hospital CTO will be grouped together for linkage in Step 2B – 2D.

Rationale

- Keeps care management relationships at the forefront
- MDPCP-actual with hospital-affiliated CTO represents the most tightly defined patient relationship between beneficiaries, PCPs and hospitals
- Allows for different organizational relationships between providers and hospitals

Provider-to-Hospital Linkage: Inclusion Rationale for Employment

- Rationale for inclusion
  - Employment may be strong link between hospitals and providers that allows for easier coordination, resource sharing, and collaboration
  - Many hospitals expressed strong interest in adding in an employment component to the MPA algorithm for Year 2
- HSCRC staff agree that employment linkages have merit, but also have significant challenges
  - Concerns about placing a higher value on employment over continuing participation in official payment structures with CMS oversight, such as MDPCP or ACOs
  - No consistent definition of employment used by all hospitals
  - Requires voluntary submission of employment lists
- To balance these considerations, staff recommends using employment as a voluntary link between providers and hospitals following MDPCP-actual and ACO-like provider attribution

Remaining Beneficiary Geographic Attribution

Step 03

Remaining Beneficiary Geographic Attribution

Goal: Link remaining beneficiaries to hospitals based on geography.

Hierarchy: Beneficiary linkage to hospital based on:

- 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

Rationale:

Ensures that all beneficiaries are attributed to a hospital for purposes of accountability.