Total Cost of Care (TCOC) Workgroup

May 23, 2018

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions
- Updates on initiatives with CMS
- Update on Y1 MPA implementation
  - Update on hospital-level (statewide) MPA reporting
- Discussion of Y2 MPA issues
  - Y2 Maximum Revenue at Risk & Maximum Performance Threshold
  - Risk adjustment
  - Incorporating Attainment
  - Linking doctors to hospitals

Updates on Initiatives with CMS

- TCOC Model
- Care Redesign Programs
- QPP details

Timing with (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
- 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, 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**

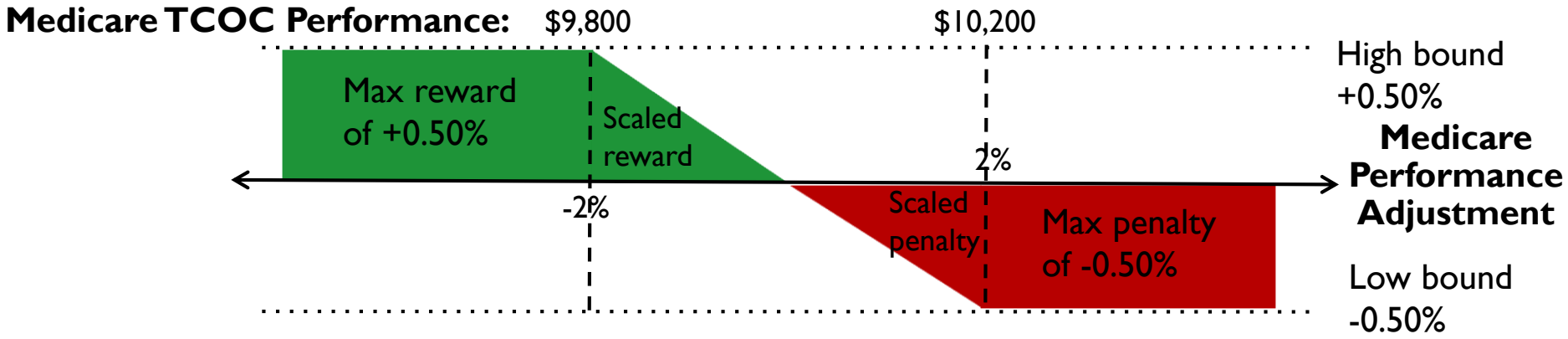
*That is, a hospital that has an executed new Participation Agreement (i.e., signed by all parties)

Y1 Implementation:
CRISP MPA Reporting

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

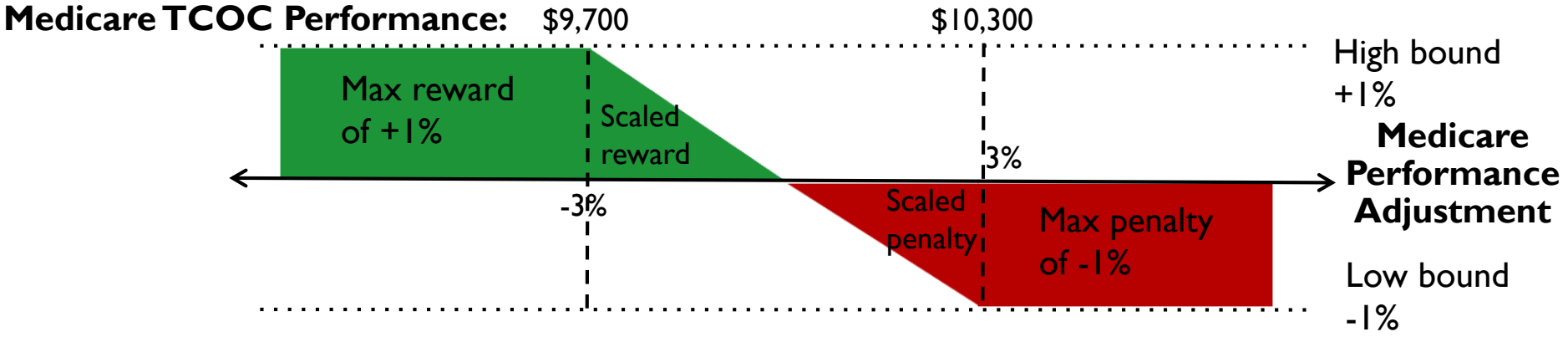
- Maximum Performance Threshold = 2%
- National Medicare FFS growth in CY 2018 (totally made-up example) = 1.83%
- TCOC Benchmark = $9,852 * (1 + 1.83% - 0.33%) = $10,000
- If CY 2018 per capita TCOC is:
  - $10,200+ (2%+ above Benchmark), then full -0.5% MPA
  - $9,800 or less (2%+ below Benchmark), 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%)
- Maximum Revenue at Risk may also be increased for "Efficiency Adjustment" – for example, to provide Medicare-only payments to hospitals under potential new CRP track



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: Risk Adjustment

- Hospital's own MPA population's changing risk profile YOY as affecting Improvement Only
- Hospital MPA population relative to other Maryland hospital as affecting Attainment Adjustment

Risk Adjustment options

- Data on Maryland beneficiaries to adjust TCOC
  - Adjust for demographics only based on Gender, Age Band, Dual Status and ESRD Status
    - Normalize TCOC per capita for population change from Base Year to Performance Year based on 66 demographic buckets
    - Removes coding intensity differences between providers, which can occur when using HCC Scores based on diagnoses
- CMS-HCC New Enrollee (NE) Risk Scores based on national data
  - Relies on same 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)
    - Thus, also removes coding intensity differences
    - Normalize TCOC per capita for risk score change from Base Year to Performance Year

Risk Adjustment modeling: Effect on hospitals' improvement

- Modeling approach:
  - Adjust 2015 actual per capita to show what the 2015 per capita would have been with 2016 risk profile
- Focuses on reducing the impact of beneficiary characteristics change within each hospital's population from year to year
  - Does not compare risk profiles between hospitals
- The change in the risk profile from 2015 to 2016, and its modeled effect on the MPA if in place in 2016, does not predict effects in future years
- Policy questions:
  - Is it appropriate to risk adjust for a hospital's changing population year over year?
  - If appropriate, what is the best risk-adjustment methodology?

Risk Adjustment Application

- Improvement
  - Adjust base period (2015) TCOC for attributed beneficiaries' demographic characteristics
  - Measure performance year (2016) unadjusted TCOC/bene
  - Follow MPA calculations

Example Hospital

	Unadjusted	Maryland Adjustment	National Adjustment
2015 TCOC/bene	10,846	10,895	10,873
2016 TCOC/bene	10,964	10,964	10,964
Growth rate	1.08%	0.64%	0.83%
MPA result (calculation not shown)	-0.252%	-0.103%	-0.168%

Risk Adjustment Application

- Attainment example

$$2016 \text{ adj. TCOC/beneficiary} =$$

$$2016\ unadj.TCOC/bene\ x\ (\frac{2015\ statewide\ adj.TCOC/bene}{2015\ statewide\ unadj.TCOC/bene})\ /\ (\frac{2015\ hospital\ adj.TCOC/bene}{2015\ hospital\ unadj.TCOC/bene})$$

Example Hospital

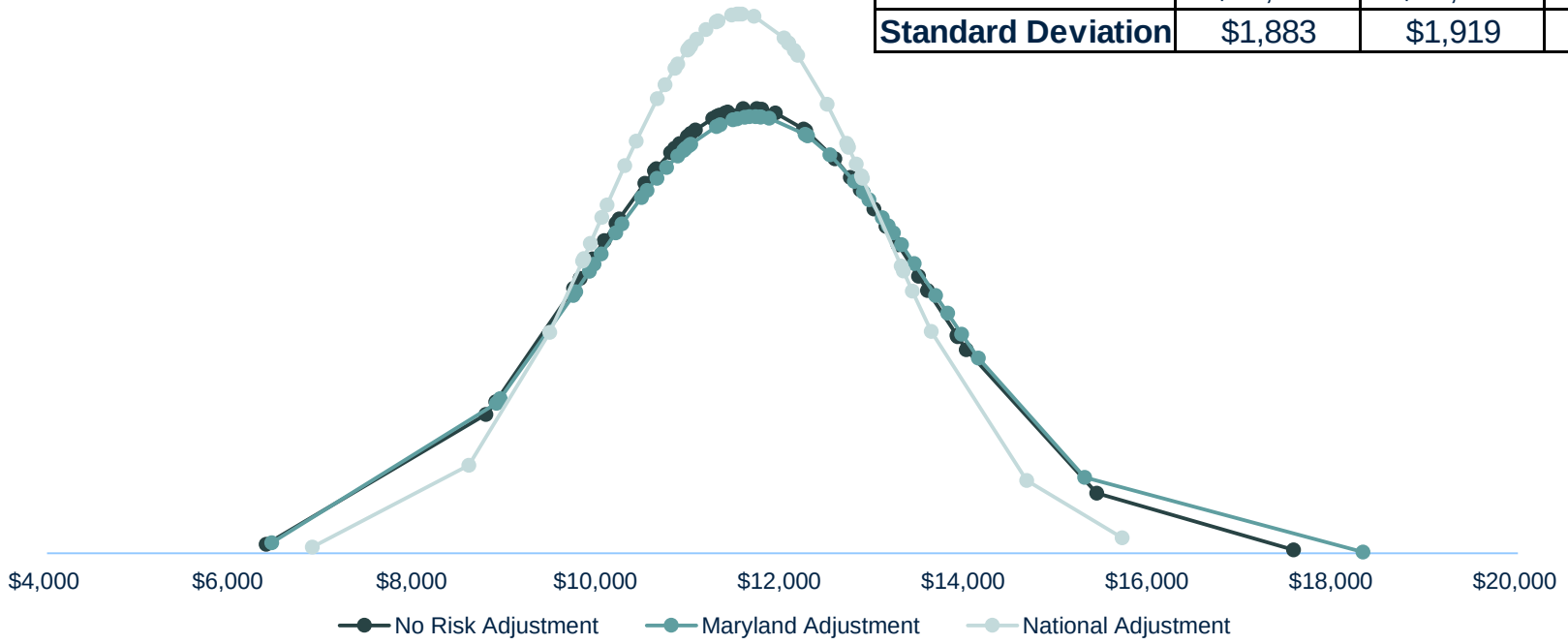
	Unadjusted	Maryland Adjusted	National Adjusted
Example Hospital 2015 TCOC/bene	10,846	10,895	10,873
Statewide 2015 TCOC/bene	11,667	11,674	11,688
Example Hospital 2016 Attainment	10,964	*10,922	10,720

$$*2016 \text{ MD adj. TCOC/beneficiary} = 10{,}964\ x\ (\frac{11{,}674}{11{,}667})\ /\ (\frac{10{,}895}{10{,}846})$$

MPA Risk-Adjustment: Attainment

Medicare TCOC per Beneficiary

	No Risk Adjustment	Maryland Adjustment	National Adjustment
Mean	$11,646	$11,694	$11,546
Standard Deviation	$1,883	$1,919	$1,554



Risk adjustment with national data yields a tighter distribution and a lower TCOC per beneficiary than the MD demographic risk adjustment and no adjustment.

MPA Risk-Adjustment: Improvement

	No Risk Adjustment	Maryland Adjustment	National Adjustment
Mean	0.14%	0.06%	0.21%
Standard Deviation	0.58%	0.55%	0.56%

Variation in MPA result amongst hospitals is relatively the same for all three scenarios. The national risk adjustment methodology yields a slightly higher MPA result for hospitals on average than the MD demographic risk adjustment methodology, and no adjustment.

Y2 MPA Issues: Options for Incorporating Attainment

Policy questions on reflecting Attainment in MPA formula for Year 2

- How? Simplest approach is to adjust hospitals' TCOC Benchmark based on Attainment
  - Current TCOC Benchmark is previous year TCOC per capita increased by 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 MPA improvement 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

Ways to link doctors to hospitals

- New possibilities such as:
  - Employment/ownership
    - Concerns about data source and definition issues
  - Others?
- Reassess ACO-like and MDPCP-like
  - Adjust specialties to include when PCP not found?

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

Next meeting:

8:00 a.m. Wednesday, June 27

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