Total Cost of Care (TCOC) Workgroup

October 30, 2019

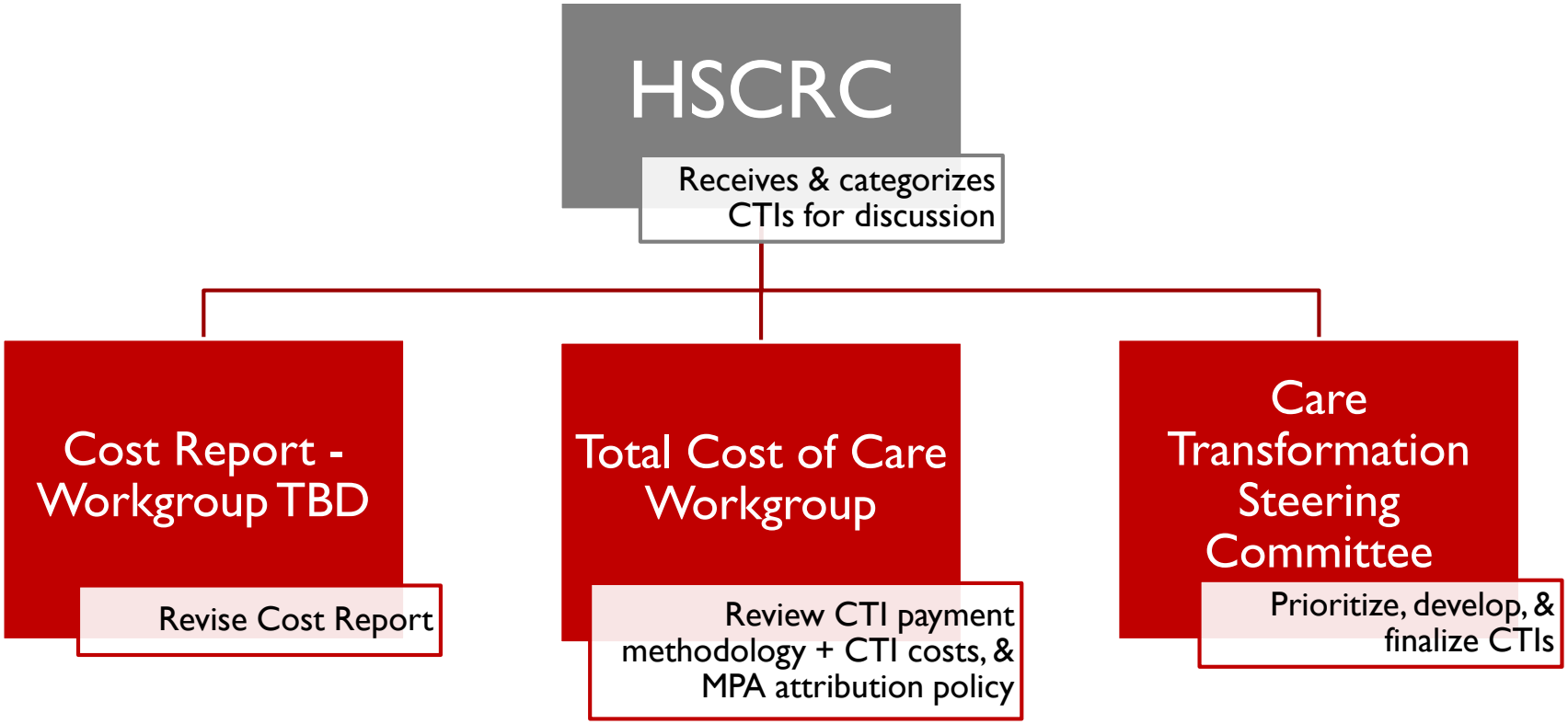
HSCRC
Health Services Cost Review Commission

Agenda

1. Administrative Updates
   i. User Guide and FAQs for CTIs
   ii. Strategic Priorities for the TCOC Workgroup
   iii. MPA Y2 Reporting (moved to CCLF scorekeeping with MPA Reporting updated in November 2019)
   iv. Update on churn analysis
2. Medicare Performance Adjustment Policy
   i. MPA Y3 Comments
   ii. MPA Y4 Options
3. Policy around cost reporting for CTIs

Charter for Care Transformation Initiatives

- Work group roles in developing Care Transformation Initiatives (CTIs)



TCOC Workgroup Timeline

- December 2019
  - Drivers of Medicare cost growth
  - Further information on benchmarking
  - Recap/finalization of CTI payment methodology
  - Feedback for approach to cost reporting modification on CTIs
- Q1 2020
  - Finalize requirements for cost report modification
  - Revisit MPA attribution methodology
  - Report to the Commission on CTI methodology and overlap with MPA and Regional Partnership program
  - Consider revisions MPA amount at risk

Y3 MPA (PY20)

- Response to Comments

Comments on the Purpose of the MPA

- Six stakeholders commented on the MPA Y3 policy.
- Stakeholders were generally supportive of the policy recommendation:

Commenter	Feedback
AAMC & DCHS	• Helps meet TCOC Model goals • Creates TCOC accountability
CareFirst	• Holds hospitals at risk for Medicare performance • Allows hospitals to meet their Medicare at-risk levels (required for quality program exemptions) • Encourages hospitals to become more efficient and reduce potentially avoidable utilization and TCOC
MHA	• Allows Maryland's TCOC Model to qualify as an Advanced Alternative Payment Model – providing eligibility for MACRA payments
MedStar	• Supports MHA's letter
UMMS	• Demonstrates progress in developing policies that have a positive impact on Maryland TCOC

Comments on Moving from Improvement to Attainment

- All but one stakeholder offered feedback on moving the MPA from improvement-only to attainment.
- The feedback was not consistent across stakeholders:

Comment	AAMC	CareFirst	JHHS	MHA	MedStar
Urge move to attainment	✓	✓			
Discussed but did not endorse moving to attainment			✓	✓	✓
Include socio-economic risk factors adjustments in attainment approach			✓	✓	✓

- The HSCRC is currently working with a contractor on benchmarking and will discuss a move to attainment in MPA Y4.

Comments on Adjustments to Revenue-at-Risk

- Four stakeholders expressed support for holding revenue-at-risk at 1% and one stakeholder encouraged an increase.
- CMS has expressed their support for increasing revenue-at-risk to HSCRC staff.

Commenter	Feedback
AAMC & DCHS	• Do not increase the amount of revenue at-risk above 1% of Medicare revenue until attainment is added in
CareFirst	• Encourage increasing maximum reward and penalty under the MPA to levels that are higher than the current +/- 1.0%
JHHS	• Appreciate holding revenue at risk to 1% to maintain stability until comprehensive MPA review
MHA	• Revenue at risk should remain unchanged
MedStar	• Supports MHA's letter

- The HSCRC will consider an increase to the revenue-at-risk for MPA Y4.

Comments on the MPA Attribution Methodology

- Stakeholders expressed a variety of concerns with the MPA attribution methodology:

Commenter	Feedback
JHHS	• Attribution methodology needs to be refined to align with the principles outlined in the development of the MPA • Appreciate TCOC WG doing a comprehensive review
MedStar	• Need to align attribution methodology with revenue-at-risk (current incentives are misaligned)
MHA (and MedStar)	• Use attributed spend per beneficiary analysis to inform most appropriate attribution method • Attribution should allow hospitals to affect total beneficiary spending
UMMS	• Evaluate stability of the attribution methodology and its plausibility in future years – suggesting potential new focus on quantifiable CTI populations

- HSCRC plans to conduct a comprehensive review of the MPA policy in Y4.

Comments on MPA Overlap with Other HSCRC Policies

- Stakeholders expressed general concern with the MPA overlapping with other HSCRC policies:

Comment	AAMC	MedStar	UMMS
Monitor interaction between MPA, CTIs, and other HSCRC policies	✓		✓
Address issues of payment overlap (e.g. double rewards/double penalties)	✓		✓
Align incentives to prioritize competing programs	✓	✓	

- At the request of the Commission the HSCRC staff will be producing a report on the overlap of the CTIs with other HSCRC policies. This overlap will also be considered in the Y4 MPA policy review.

Comments Requesting Further Analyses

- All but one stakeholder requested further analysis on one of the following areas:

Comment	AAMC	JHHS	MedStar	MHA	UMMS
Analysis and clarification on impact of MDPCP funding for hospitals	✓	✓			
Analysis on the attributed spending per beneficiary by hospital		✓	✓	✓	
Analysis on what is driving changes in TCOC			✓		✓

- HSCRC staff will recommend removing Track 1 MDPCP payments from hospital's MPA in both the performance and base period, but do not plan to delay this change beyond MPA Y4
- Hospitals are accountable for understanding their population health experience, the HSCRC will survey hospitals on what is driving their Medicare TCOC and will discuss reporting enhancements with the RAC
- HSCRC staff plan to present an update on Maryland cost drivers at the November TCOC WG

Y4 MPA (PY21)

- Upcoming reassessment of the MPA attribution approach
- Benchmarking / Attainment

MPA Y4 Intent

- Intent to focus TCOC group, starting in October, on more comprehensive review of the MPA approach. Staff have suggested options but welcome suggestions / analytic questions to inform decision making.
- HSCRC staff are recommending no changes to the MPA Y3 in order create stability for hospitals and the time for a review of the MPA policy:
  - CTIs begin in July 2020 and include the first half of 2021
  - There will be 6 months of overlap with the traditional MPA before changes can be made in January of 2021

Overall MPA Considerations

- The MPA's purpose is to hold hospitals accountable for managing the Medicare TCOC.
  - The TCOC Agreement requires that 95% of all beneficiaries be attributed to some hospital.
  - This requires the residual beneficiaries are attributed based on geography regardless of the primary approach.
- The MPA population may be mismatched with the population that the hospital is trying to manage and is picked up through CTI.
- The review of the MPA policies will focus on two different policy levers:
  - Attainment vs. improvement
  - Attribution methodology

Goals for Discussion

1. HSCRC staff will outline how we are thinking about the options for revising the MPA.
2. Gather initial input from Workgroup members
3. Outline analysis that will inform ultimate decisions
4. Future TCOC WG will include a decision on these options informed by the analysis and further input by Workgroup members

Options for Attainment and Improvement

	Current State	Potential Future State
Medicare Performance Adjustment	• Rewards based on improvement	Options for the MPA: • MPA remains improvement-only • MPA is a blend of attainment and improvement • MPA is attainment-only
Care Transformation Initiatives	• Rewards based on improvement	• Rewards based on improvement

Analysis of MPA Options

- **Option 1:** MPA remains improvement-only
  - The TCOC of attributed beneficiaries would continue to be measured relative to the statewide growth limit.
  - CTI measures the improvement in a target population. If the MPA remains improvement only, then the overlap/mismatch with CTI attribution should be addressed.
- **Option 2:** MPA is a blend of attainment and improvement
  - The TCOC of attributed beneficiaries would be measured by a blend of the statewide growth limit and relative to a TCOC benchmark.
  - Blending does not mitigate the downside noted in Option 1.
- **Option 3:** MPA is attainment-only
  - The TCOC of attributed beneficiaries would be measured relative to a TCOC benchmark.
  - The MPA would reward hospitals that attain efficient Medicare TCOC and would acknowledge improvements through CTIs.

Ongoing: Benchmarking and Attainment

- Benchmarking work is continuing.
  - Approach to selecting benchmark geographies has not changed significantly from that described earlier this year.
  - Ongoing work is on normalizing results between geographies and creating equivalent commercial outcomes.
  - HSCRC is currently planning to release commercial and Medicare results together:
    - Expect to share in the calendar Q4 of this year
    - Balance likely results from Medicare and Commercial
    - Ensure considerations of all elements to normalize results are considered for both payers, and results are equivalent
- Results will then be evaluated for use in an attainment element for the MPA Year 4 (CY2021) policy and other HSCRC policies.

Options for Attribution

	Incorporate CTI into the MPA	Do not Incorporate CTI into the MPA
Don't Change MPA Attribution	**A** • Makes CTI the first layer in the MPA attribution • Aligns CTI beneficiaries with MPA attribution	**B** • Current MPA remains the best approach • Mismatch with CTI and MPA attributed beneficiaries
Change MPA Attribution	**D** • Replace primary care with CTI-based attribution • Remainder would be allocated based on geography • Assumes primary care strategy could be a CTI	**C** • Switch MPA attribution to be based on geography • Exclude CTI attributed beneficiaries

Option A

	Incorporate CTI into MPA Attribution
Don't Change MPA Attribution (other than adding in CTIs)	**A** • Makes CTI the first layer in the MPA attribution • Aligns CTI beneficiaries with MPA attribution

- Pros:
  - The MPA and CTI attribution would be aligned
  - Gives hospitals a measure of control over the MPA attribution
- Cons:
  - Another attribution layer in the MPA attribution algorithm would add to the complexity of the algorithm
  - Policies for multiple CTIs would also add to the complexity
  - Double counts savings if we keep improvement in the MPA

Option B

	Do not Incorporate CTI into MPA Attribution
Don't Change MPA Attribution	**B** • Current MPA remains the best approach • Mismatch with CTI and MPA attributed beneficiaries

- Pros:
  - Would result in the fewest number of changes in the MPA
- Cons:
  - Double counts savings if we keep improvement in the MPA
  - Mismatch between MPA hospitals and CTI hospitals cause potential clinical coordination problems and assigns savings to the wrong hospital

Option C

	Do not Incorporate CTI into MPA Attribution
Change MPA Attribution	**C** • Switch MPA attribution to be based on geography • Exclude CTI attributed beneficiaries

- Pros:
  - Simple
  - Least overlap between MPA and CTI
  - Alignment with other TCOC measures (e.g. integrated efficiency policy)
- Cons:
  - Attribution based on geography lacks important attributes of primary-care based attribution
  - CTI beneficiaries lost in the MPA calculation (which is particularly problematic under an attainment calculation)
  - Excluding CTI beneficiaries will lessen the stability of the MPA and consistency from hospital to hospital

Option D

	Incorporate CTI into MPA Attribution
Change MPA Attribution	**D** • Replace primary care with CTI-based attribution • Remainder would be allocated based on geography • Assumes primary care strategy could be a CTI

- Pros:
  - Would allow hospitals to define the first tier of the MPA attribution by proposing a CTI
  - Alignment with other TCOC measures (e.g. integrated efficiency policy)
- Cons:
  - Replacing primary care attribution with CTI will lessen the stability of the MPA and consistency from hospitals to hospital
  - Double counts savings if we keep improvement in the MPA

Where Next?

- HSCRC staff will prepare analyses on:
  - Correlation in Geographic vs. PCP-based beneficiaries and TCOC costs
  - Estimate of CTI penetration rates (i.e. understand overlap with MPA)
  - Attainment vs. improvement outcomes using current benchmarking data
  - Impact of varying attribution methods on alignment between share of Medicare spend and share of attributed beneficiaries

Costs of CTI Investments

- Goals of CTI Cost Reporting
- Initial Proposal
- Incorporation into Other Policies

Goals of Cost Reporting

- Provide greater understanding of the level and nature of dollars invested in Population Health and Care Transformation by Maryland hospitals
  - Including:
    - Executive and oversight resources
    - Resources committed to enhancing care beyond what is billed under traditional reimbursement (e.g. follow-up after discharge)
  - Excluding:
    - Spending on physicians and physician management
- Allow credit in the ICC and other methodologies, where appropriate, for resources clearly aligned with an effective Care Transformation Initiative (CTI)

Initial Proposals

- Proposals outlined in this presentation will need:
  - Continued review of the policy implications by the TCOC Workgroup and other forums
  - Review with industry experts to identify the best approaches to revising the annual cost report and to provide reliable definitions for data capture

- Goal to revise cost reports for FY2020:
  - Pilot data collection in FY20 cost report (released in June 2020)
  - Finalized requirements in FY21 cost report

Reporting Goals:
- Definitions that result in consistent reporting
- No incentive/ability to maximize or minimize population health and CTI costs

Two-Layer Approach

Summary Layer

- Goal: Informational
- Cost Report Impact: Shift relevant $ from other regulated overhead cost centers (schedule C and UA) into a "Population Health" cost center

CTI Specific Layer

- Goal: Allow credit for costs clearly related to a Care Transformation Initiative in the ICC (& elsewhere as appropriate)
- Cost Report Impact: In a regulated cost center, capture dollars related to Care Transformation Initiatives that meet specific requirements

Summary Layer - Draft Definition

- Split out a regulated cost center to capture broad population health costs currently reported in other regulated cost centers.
- Eligible costs to include:
  - Population health executive resources
  - Population health analytical resources not tied to a specific CTI
  - Population health clinical resources not tied to a specific CTI
    - Resources not billable under traditional reimbursement
    - Resources doing value added services focused on reducing TCOC
- Excludes resources specifically involved in managing employed physicians and costs of practicing physicians
- Cost could be specifically identified or shared from other areas (e.g. 50% of Analytical Dept. X)

CTI Specific Layer - Draft Definition

- Capture direct costs specifically associated with a CTI plus fixed overhead costs in a regulated cost center

- Eligible cost to include:
  - The direct cost of full time equivalents (FTEs) that are directly implementing specific CTI interventions. May currently be regulated or unregulated, see box at right.
  - Non-labor costs directly tied to a CTI
  - Fixed overhead rates
    - Transferred from Population Health and/or other administrative cost centers
    - Amount of allowed overhead will be set by the HSCRC as a % of direct costs

Potential FTE Eligibility criteria:

- ✓ Must be actively involved with beneficiaries
- ✓ Must represent 20% of FTE time
- ✓ Must be specifically identifiable (person/position)
- ✓ Must not be otherwise billed

Physician time could meet these criteria (e.g. Dr. Smith spends Wednesdays doing patient follow-up for a Care Transitions CTI)

Crediting CTI Specific Costs in ICC

- Costs reported under the CTI specific layer would be included in allowed costs under ICC thereby reducing the amount of profits stripped from hospitals (to the extent they were previously unregulated)
  - Staff is also considering capping regulated overhead – CTI attributed costs would be a safe harbor in this calculation.
- To qualify for this CTI specific layer, costs reported would have to:
  - Match a budget submitted to the HSCRC
  - Pass auditing under special audit
  - Not exceed savings generated under the relevant CTIs; costs in excess of savings would be treated as margin

Glossary

- **Care Transformation Initiative (CTI)**: An intervention, care protocol, population health investment or program undertaken by a hospital or group of hospitals to reduce unnecessary hospital utilization and/or Medicare TCOC
- **Care Transformation Steering Committee (CT-SC):** Committee convened by the Health Services Cost Review Commission (HSCRC) to review, prioritize and advise CTI development; members consist of key hospital, payer and health policy representatives and meetings are held monthly for the public
- **Claim and Claim Line Feed (CCLF):** Medicare data file which contains claims, beneficiary services, and data from hospital and non-hospital utilization
- **Inter-Hospital Cost Comparison (ICC):** Methodology to evaluate how cost efficient a hospital is relative to select peers and how related costs are to charges
- **Maryland Primary Care Program (MDPCP):** A voluntary program open to all qualifying Maryland primary care providers that provides funding and support for the delivery of advanced primary care throughout the state
- **Medicare Access and CHIP Reauthorization Act (MACRA):** Legislation that changes the way Medicare rewards clinicians for value over volume by giving bonus payments for participation in eligible alternative payment models (APMs)
- **Medicare Performance Adjustment (MPA):** An annual adjustment to individual hospital Medicare revenues to reward or penalize a hospital's performance on controlling total costs of care for an attributed population
- **Regional Partnership (RP) Program:** An HSCRC grant program designed to foster collaboration between hospitals and community partners and enable partners to create infrastructure, test, and measure the impact of interventions
- **Reporting and Analytics Committee (RAC):** A CRISP committee responsible for reviewing CRISP Reporting Service initiatives
- **Regulated overhead cost centers (schedule C and UA):** Schedules in the hospital annual cost report filings that capture overhead costs such as management, malpractice, etc.
- **Total Costs of Care (TCOC):** Medicare costs in Parts A and B services for fee-for-service beneficiaries