Total Cost of Care (TCOC) Workgroup

March 27, 2019

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions & Updates
- Y1 MPA (PY18)
  - MPA Implementation Timing
- Y2 MPA (PY19)
  - MPA Operations, Review Period, Combination MPA
- Y3 MPA (PY20)
  - County Comparisons
  - Attainment Approach
  - MPA Efficiency Component Allocation

Updates

- BPCI Advanced Update
- SIG Idea Intake Form

Y1 MPA (PY18)

- CMS Data Update
- MPA Implementation Timing

Y1 MPA Implementation Timing

- The HSCRC is waiting for 2018 claims to run-out before implementing the Y1 MPA
- The HSCRC and CMS anticipate moving forward assuming the data is correct. Current estimates of the Medicare run-rate savings are $240M

Steps Moving Forward:

- To implement the MPA, HSCRC calculates the MPA and tells CMS what percentage adjustment to make to hospitals' Medicare payments
- Expected July 1, CMS implements adjustment with the Medicare Administrative Contractor (MAC)
- The MPA does not go into rates, does not affect hospitals' GBR, and is not reflected in rate orders

Y2 MPA (PY19)

- MPA Operations
  - Y2 Timing Overview
  - Review Period
  - Combination MPA

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
Update: March 2019	• Official review period for hospitals of ***4 weeks*** following preliminary provider-attribution lists.
April 2019	• HSCRC reruns attribution algorithm for implementation • *Voluntary:* Hospitals wanting to be treated as a combination under the MPA submit a joint request to HSCRC

Review Period and Unique Situations

Review Period extension to April 12th, 2019

1. Review Period to resolve issues for attribution to work as intended
   - For example, if a provider is inadvertently attributed to two hospitals
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

- The Review Period is not for fundamental changes to the attribution methodology:
- Any changes based on submissions during Review Period would require HSCRC approval.

April 2019: Options to Combine for MPA

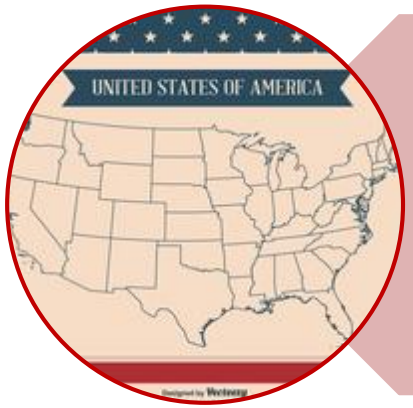
- Multiple hospitals are permitted to work together to address TCOC
- Process:
  - The MPA attribution will still be performed for all hospitals individually. Then, for hospitals being combined for purposes of the MPA, the total cost of care and beneficiaries will be pooled
  - The combined total cost 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

Y3 MPA (PY20)

- National Medicare Benchmarking and County Comparisons
- Y3 MPA Attainment Approach
- MPA Efficiency Component Update and Allocation Options

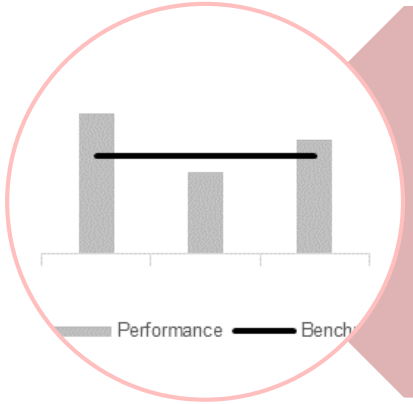
National Medicare Benchmarking and County Comparisons

Overall Policy Needs



Build an understanding of national per capita trends and achievements

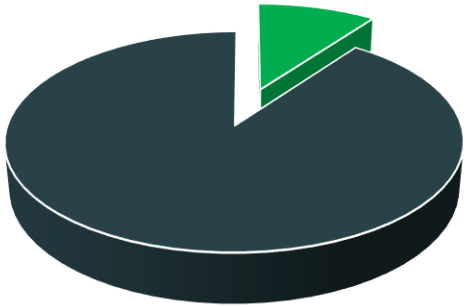
- Obligations under the TCOC Model
- Setting statewide goals and targets



Establish comparison points for setting targets and evaluating hospitals' performance under an attainment approach

The Broad Goal of Benchmarking

Allow comparison of Maryland performance to national performance while recognizing differences that drive legitimate variation.



Maryland regional differences account for ~10% of variation versus national MC FFS average

Because Maryland has a significant concentration in high cost urban areas, Maryland's costs relative to national averages look significantly higher when geographies are not matched.

Likely Policy Applications

- Medicare Performance Adjustment (MPA) –support an attainment approach and trend factor targets
- Inter-hospital Cost Comparison (ICC) – include total cost of care per capita performance in evaluation
- Quality Benchmarking – support a per capita attainment approach with national/comparison benchmarks
- Others to be determined

Multi-Payer Benchmarking

- Initial focus where data is most available:
  - Medicare Fee-for-service (MC FFS) -
    - Includes patients covered by the traditional Medicare program, not including those covered under a Medicare Advantage program
    - Version 1 introduced in these materials
  - Private Payer -
    - For this project private payer includes commercial group and individual markets but not Medicare Advantage or Medicaid MCOs.
    - Share analysis outcomes in Summer 2019
- Look to expand in the future

Medicare FFS Peer County Selection Approach

Medicare FFS Evaluation Unit: County

- **Focus for this effort is member/beneficiary geography:**
  - Per capita measures align best with geographies
  - Selection of comparison group relies on measures that are available on a geographic basis
  - Different site of service mixes makes it important to consider total cost of care, not just hospital per capita costs
  - Since most HSCRC methodologies are hospital based will need to determine a weighting approach to blend per capita results into each methodology
- **For this phase we are generating peer groups at the county level.** See discussion in next steps of efforts to provide additional specificity

Characteristics Used to Select Peer Counties

- Focused initially on evaluating a wide variety of factors such as demographic, health status, economic and healthcare system (e.g. academic presences)

- Approach to Final Version 1 Counties:
  - *Step 1*: Narrow potential peer counties to counties with a similar level of urbanization
  - *Step 2*: Calculate potential peer county "similarity" to Maryland counties across 4 demographic characteristics selected from the original list
  - *Step 3*: Identify Peer Counties for each Maryland county

- Further detail on each step follows

Step 1: Narrow Counties based on Urbanization

- Only counties with same Rural-Urban Continuum Code as the Maryland county were considered as peer counties.
- Rural-Urban Continuum codes* range from 1 (most urbanized) to 9 (least urbanized)
  - Based on the population, degree of urbanization and adjacency to a metro area
- Due wide range of population and density within Urban/Rural Indicator Level 1, this level was further divided based on population size and density (See attached excel file)

* Rural-Urban Continuum codes are assigned to each US county by the US Department of Agriculture.

Step 2: Measure Differences and Identify Peer Counties

- After narrowing possible comparison counties in Step 1 the "similarity" between each Maryland county and each comparable county was calculated across 4 metrics

Demographic	*Economic*
Median Income Source: American Community Survey (ACS)	**Regional Price Parities (RPP)*** Measure of price levels across US Source: Bureau of Economic Analysis
Socio-economic Status (SES)	*Disease Burden*
Deep Poverty Percent of individuals below 50% of poverty line Source: ACS	**Hierarchical Condition Category (HCC)** Measure of healthcare cost risk in a population Source: CMS

- Peer counties are those with the most "similarity" across all 4 measures. The measures are weighted equally in calculating the similarity.

*As RPP is calculated at a metro-area level values for counties in the same metro area are the same.

Step 3: Identify Peer Counties

- Different numbers of peers were used to balance across county size

- For the 5 large urban counties (Anne Arundel, Baltimore, Baltimore City, Montgomery , Prince Georges) the peer group was defined to include the 20 most "similar" peer counties.
  - The limited number of potential comparable counties for larger counties (only 78 counties are in the largest urban cohort to which all these counties belong).

- For all other counties the closest 50 peer counties were selected.
  - The instability in the demographic and healthcare cost data of the smaller counties.

Next Steps

Next Steps

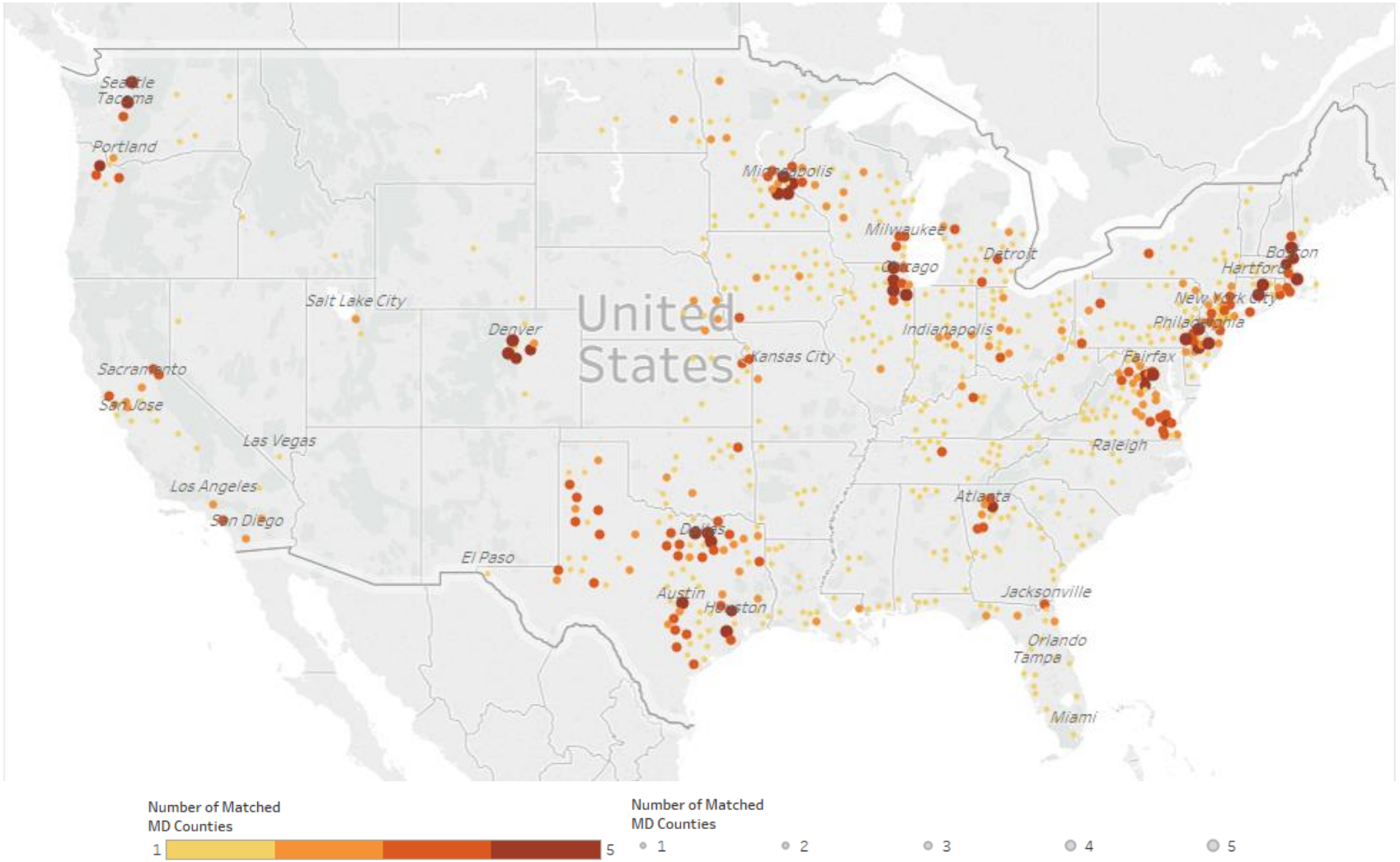
- By April: Gather feedback on methodology and selected counties
- By beginning of May: Release HCC-Adjusted Medicare FFS Cost Comparison between Maryland Counties and identified Peers
- By end of May: Release approach to match specific hospitals with county level data (See next slide).
- Summer 2019: Complete similar process for Private payer spending

Options for Mapping Hospitals to County level benchmarks (Adjusted-County Benchmark)

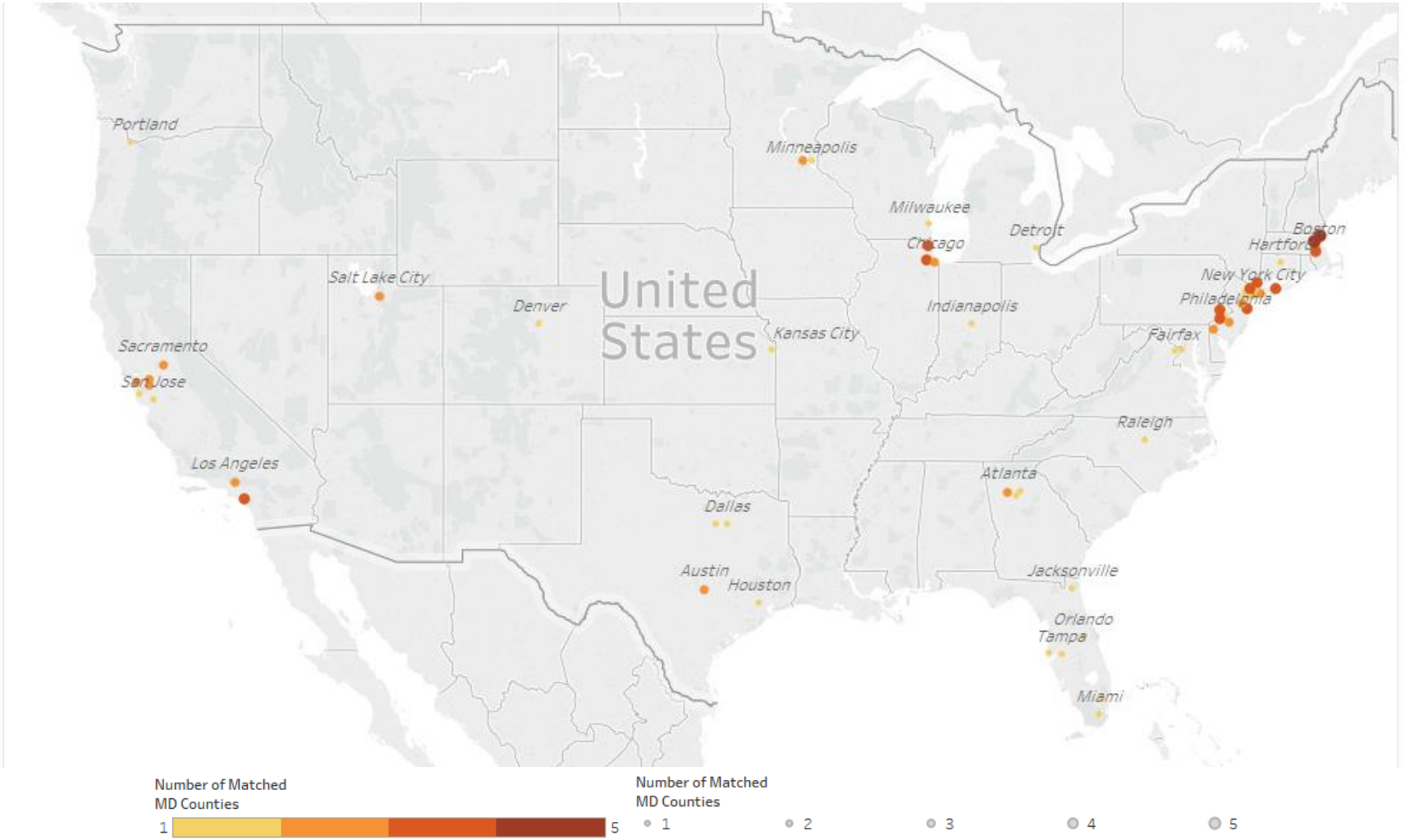
- HSCRC is considering approaches to best match hospitals with county level benchmarks, including:
  - Assigning MPA based county mixes to each hospital to allow for the creation of a more specific benchmark
  - Evaluating the use of MPA attributed beneficiaries to build a hospital specific demographic profile
  - Analyzing the relationship between the individual metrics used in selecting comparable counties and healthcare costs to allow for more refined adjustment of cost benchmarks

Reference Maps

Distribution of Peer Counties for All Maryland Counties



Distribution of Peer Counties for 5 Largest MD Counties*



* Anne Arundel County, Baltimore City, Baltimore County, Montgomery County and Prince George's County.

Y3 MPA Issues: Options for Incorporating Attainment

Policy questions on reflecting Attainment in MPA formula for Year 3

- 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?

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

Proposed Adjustment to MPA target based on benchmark performance

- A hospital's Traditional MPA target would be set based on how its adjusted performance versus its peer group compares to Maryland's overall performance (assumes Maryland will be more expensive on a blended basis).
- Example columns assume:
  - Maryland is 8% above the nation (1.08)

Hospital Performance vs Benchmark	MPA Traditional Target will be National Growth – X%,	Example Range of Values
2% points or more above Maryland Level	– 0.66%	Greater than 1.10
Between 2% points above Maryland Level and 2% points below Peer Benchmark	– 0.33%	Between 1.10 and 0.98
2% points or more below Peer Benchmark	– 0.00%	Less than 0.98

Potential considerations:

- Make targets more / less challenging
- Make middle tier linear to avoid "cliffs"
- Should we add additional "tiers" of attainment performance or more differentiated growth targets between tiers

See next slide for specific calculations

Proposed Adjustment to MPA target based on benchmark performance

1. Calculate each hospital's Adjusted-County Benchmark and Benchmark Level
   - Adjusted-County Benchmark is the straight average of its peer counties per capita TCOC performance adapted to a hospital's specific population as discussed in the benchmarking section.
   - Benchmark Level is the ratio of the hospital's per capita TCOC to the Adjusted County Benchmark stated as a ratio to 1.0

2. Establish the overall Maryland comparison to the nation based on the blend of the county performance (Maryland Benchmark Level):
   - County benchmarks are calculated (no hospital adjustment)
   - The resulting difference is aggregated to the state level using the relative number of MC FFS beneficiaries in each county
   - The result is stated as a ratio to 1.0

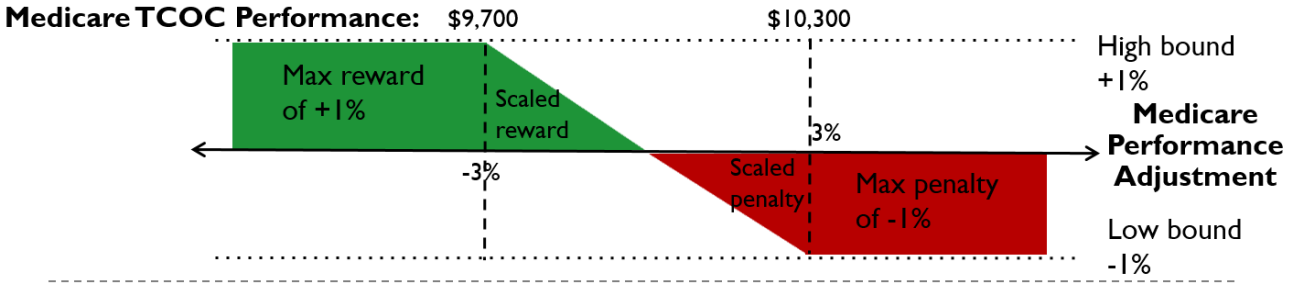
3. Hospital MPA Traditional Component targets are set by comparing its Benchmark Level to the Maryland Benchmark Level and 1.0 (average peer group performance)
   1. Above the Maryland Benchmark Level plus 2% points: National Growth – 0.66
   2. Between the Maryland Benchmark Level plus 2% points and 0.98: National Growth – 0.33
   3. Below the 0.98: National Growth

Review of Draft Recommendation: MPA Efficiency Component (MPA-EC)

Medicare Performance Adjustment (MPA)

- MPA has two components, both implemented as a percentage adjustment to hospitals' Medicare payments.
- Can be "titrated" semi-annually with the Update Factor

1. Traditional MPA: TCOC attribution algorithm, ±1% Medicare revenue



2. MPA Efficiency Component:

- Move money to/from hospitals on a Medicare-only basis, e.g.:
  - A. To hospitals for performance in episode-based CRP track, ECIP
  - B. From hospitals to get CMS their required Medicare savings

Efficiency Component has two primary functions

- Medicare Savings Statewide Cut ("haircut")
  - To achieve $300 million Medicare savings by CY 2023
  - To offset net statewide Medicare payments for Traditional MPA
  - To offset Medicare Individual Hospital Payments for care transformation

- Medicare Individual Hospital Payment ("hair transplant")
  - ECIP payments to hospitals
  - Payments for other quantifiable Medicare TCOC reductions through care transformation

Achieving Required Incremental Medicare Savings and Incentivizing Care Transformation

- HSCRC intends to use:
  - Update Factor to control all-payer hospital revenue growth
  - Medicare Performance Adjustment (MPA) Efficiency Component to achieve the required incremental savings to Medicare
- The MPA Efficiency Component is intended to:
  - Prospectively reduce hospitals' Medicare payments to achieve the Medicare savings target
  - Be paired with opportunities for hospitals to earn reconciliation payments through care transformation to offset these reductions
- The HSCRC will work with hospitals to quantify care transformation efforts and "credit" hospitals
- Hospitals that do not transform care will bear a larger proportion of the required incremental Medicare savings

Medicare Specific Savings Requirement: Incremental Savings to Add Up to $300M

- Increase the current run rate (from 2013 base) to $300M by the end of 2023

Year	2019	2020	2021	2022	2023
Required level of TCOC savings	$120M	$156M	$222M	$267M	$300M
Incremental savings from prior year	$0	$36M	$66M	$45M	$33M

- In other words, increase in annual Medicare TCOC Savings of $180M from 2019 to 2023
- If the run rate is ahead of target, provides opportunity to smooth MPA Efficiency Component to hit $300M

Example: Applying MPA Efficiency Component in CY 2020

- CY 2018 Medicare TCOC savings run rate is $240 million
  - Assuming this remains the amount, additional $60 million necessary in the four CYs 2020-2023 – that is, $15 million per year
- Prospectively determine how the MPA Efficiency Component will be allocated among hospitals
  - If $15M in additional Medicare savings are required, and Hospital A has a 10% share, Hospital A's MPA Efficiency Component = $1.5M
- Simplest and most likely is each hospital's share of statewide Medicare payments
  - This translates to flat ~0.3% adjustment to hospitals' Medicare payments in CY 2020
- Allow hospitals to recoup their savings through care transformation efforts, such as Episode Care Improvement Program (ECIP)

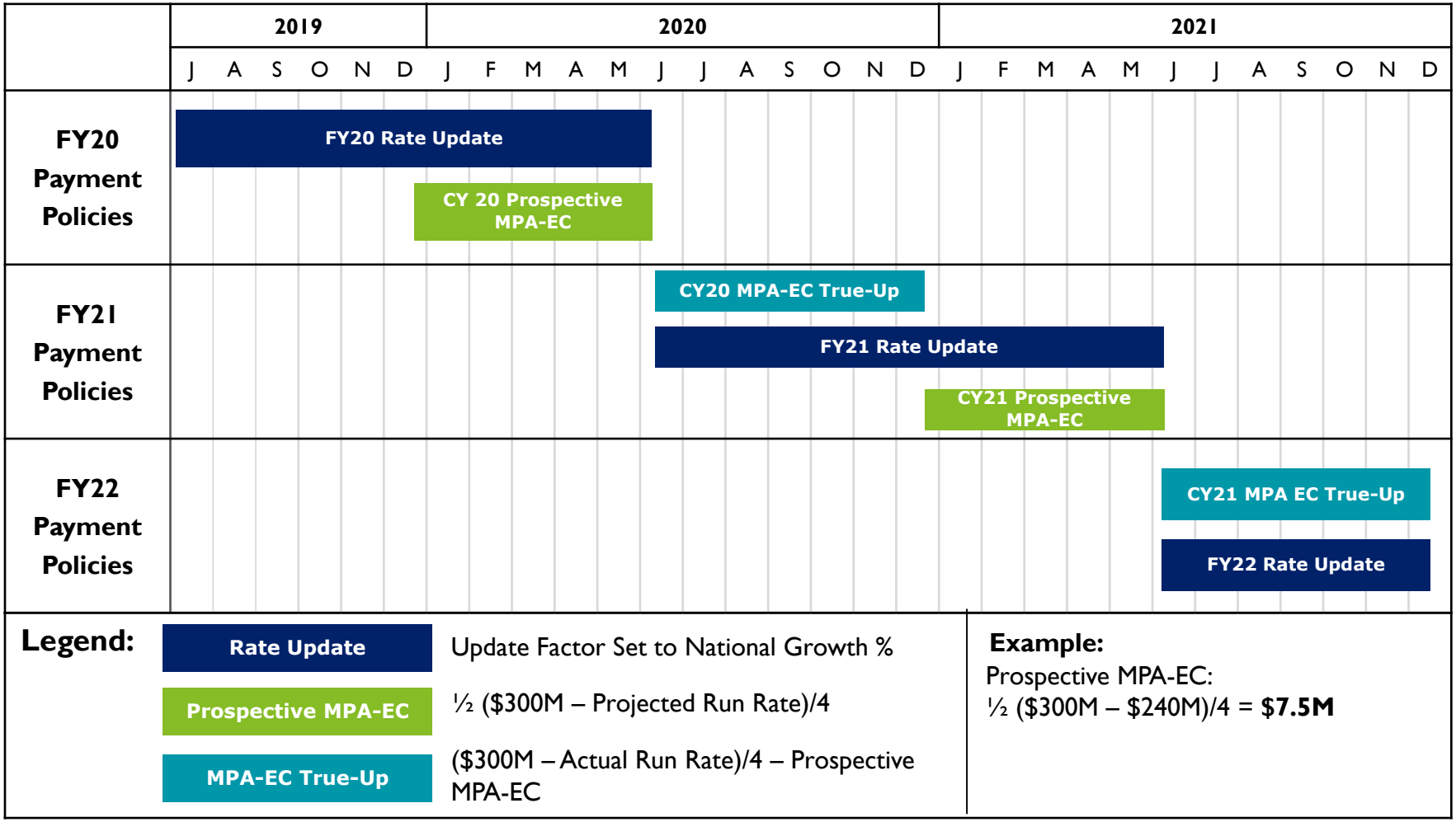
Total Percent of Revenue at Risk through the Medicare Performance Adjustment

HSCRC Policy	Medicare Revenue Adjustment
Traditional MPA Mechanism	
"Traditional" MPA	Lower Bound: -1%, Medicare Revenue Upper Bound: 1% Medicare Revenue
MPA-EC Mechanism	
Medicare Savings Target (~$15M annually)	Determined semi-annually based on the difference between the projected Medicare Run-Rate and Medicare Savings Target
Episodes of Care Improvement Program (Total $ dependent on performance)	Reconciled semi-annually based on hospital performance in ECIP
Other Care Transformation Programs (Total $ dependent on performance)	Reconciled semi-annually based on hospital performance

HSCRC Reopening ECIP to Hospitals for July 2019 Start

- Last February, MDH Secretary called for creation of Stakeholder Innovation Group (SIG) to "recommend approach for voluntary stakeholder-developed models and programs to be considered for adoption/approval"
- Hospitals and other providers recommended creation of ECIP
  - MDH Secretary and CMMI approved
  - ECIP started January 1, 2019 with 9 hospitals
- Generally, hospitals may only enroll in Care Redesign Programs (CRP) like ECIP on an annual basis
  - However, in response to discussions on MPA Efficiency Component, hospitals requested an opportunity to enroll in ECIP as of July 1, 2019
- Hospitals with a signed CRP Participation Agreement may submit an ECIP Implementation Protocol by May 1, 2019 for a start date in ECIP of July 1, 2019 (if approved by HSCRC and CMS)

Timing for (MPA-EC) built around other policies to provide hospitals' budget predictability



Draft Recommendation: MPA Efficiency Component

1. Update Factor ensures hospitals' Medicare payments do not exceed Medicare TCOC Guardrail. Efficiency Component set to attain additional incremental savings necessary to attain $300 million Medicare savings target by CY 2023
2. Efficiency Component on hospitals' Medicare payments for January to June 2020 equal to the sum of:
   - $7.5 million
   - ECIP payments to hospitals for performance January-June 2019
   - Net statewide hospital payments for CY 18 Traditional MPA
3. Staff will work with hospitals through TCOC Workgroup on the best method to allocate MPA-EC across hospitals
4. Staff will continue to work with hospitals to develop opportunities to offset the MPA Efficiency Component

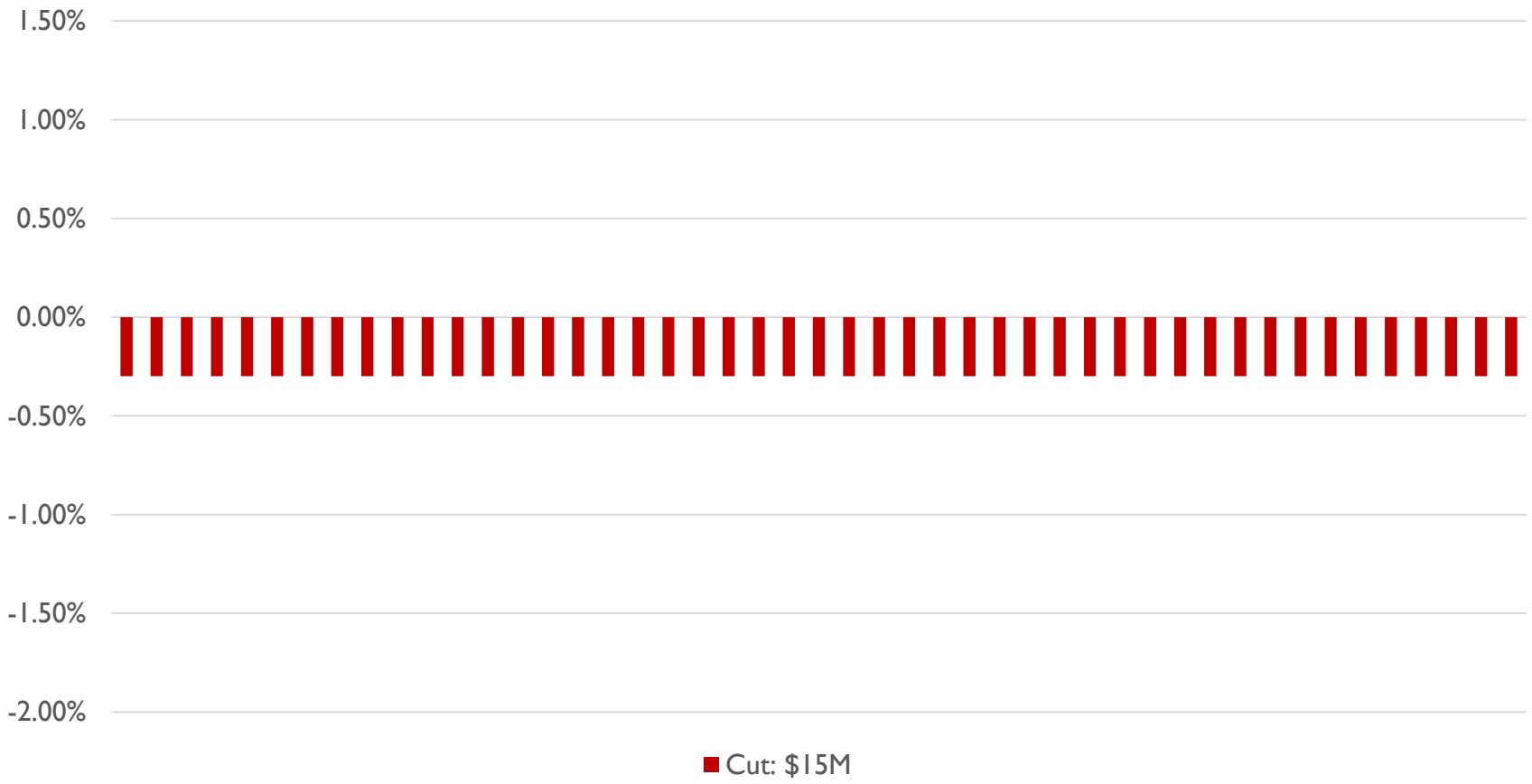
MPA-EC in Action

Example: Statewide

- Step 1: Medicare Savings Statewide Cut of $15M
  - -0.3% on each hospital
- Step 2a: Traditional MPA Individual Hospital Payments
  - Assume net totals +$10M
- Step 2b: Offset Traditional MPA payments with Medicare Statewide Savings Cut of $10M (-0.2%)
  - Ensures Traditional MPA does not cause state to backslide on Medicare TCOC
- Step 3a: ECIP Individual Hospital Payments
  - Assume totals +$5M
- Step 3b: Offset ECIP payments with Medicare Statewide Savings Cut of $5M (-0.1%)
  - Ensures ECIP does not cause state to backslide on Medicare TCOC

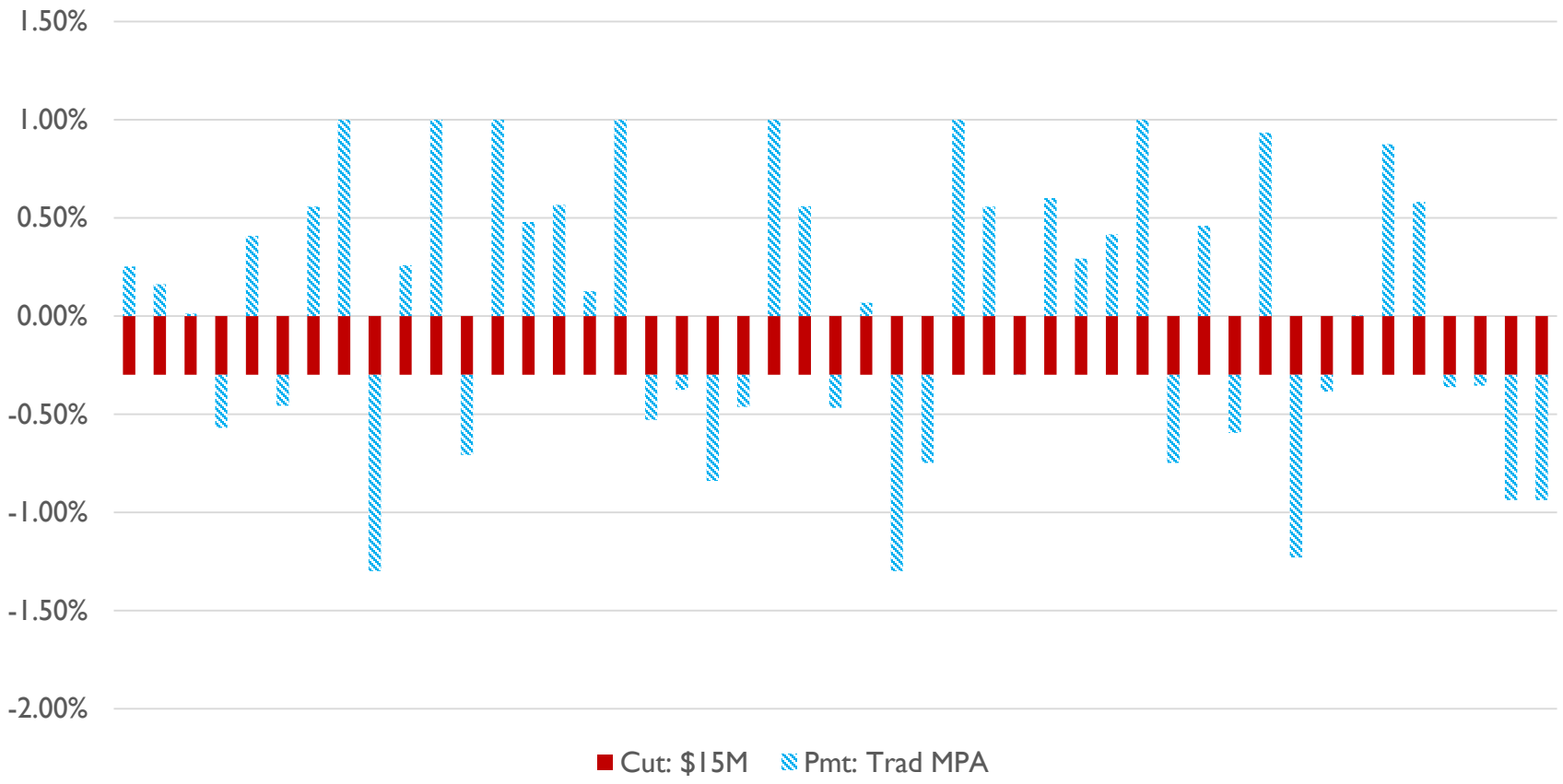
Step 1: Statewide hospital Medicare offset for achieving Medicare savings (-$15M= -0.3%)

Total Statewide Savings = $15M



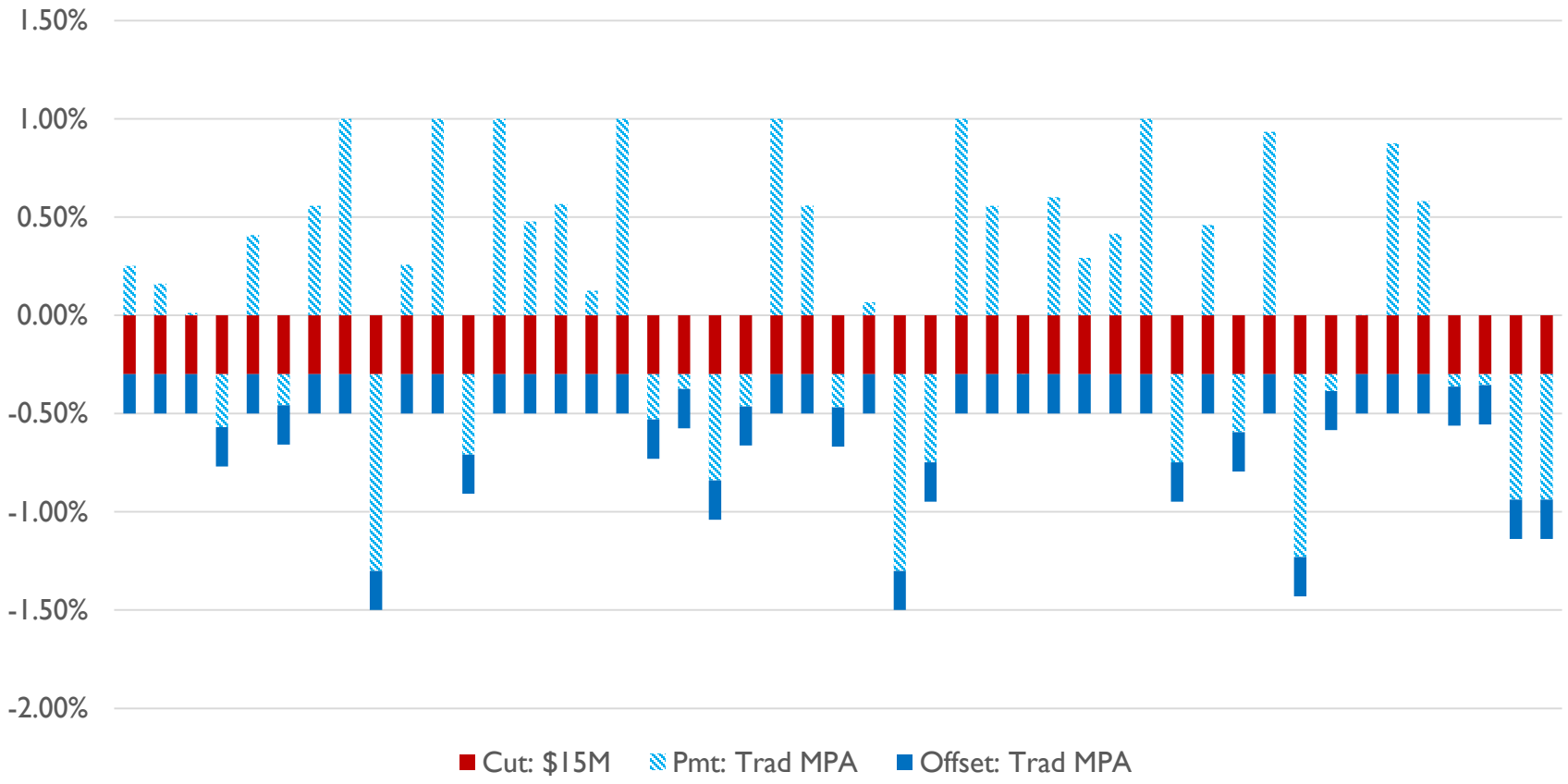
Step 2a: Individual hospital Medicare payments for Traditional MPA (e.g., net +$10M)

Total Statewide Savings = $5 ($15M-$10M)



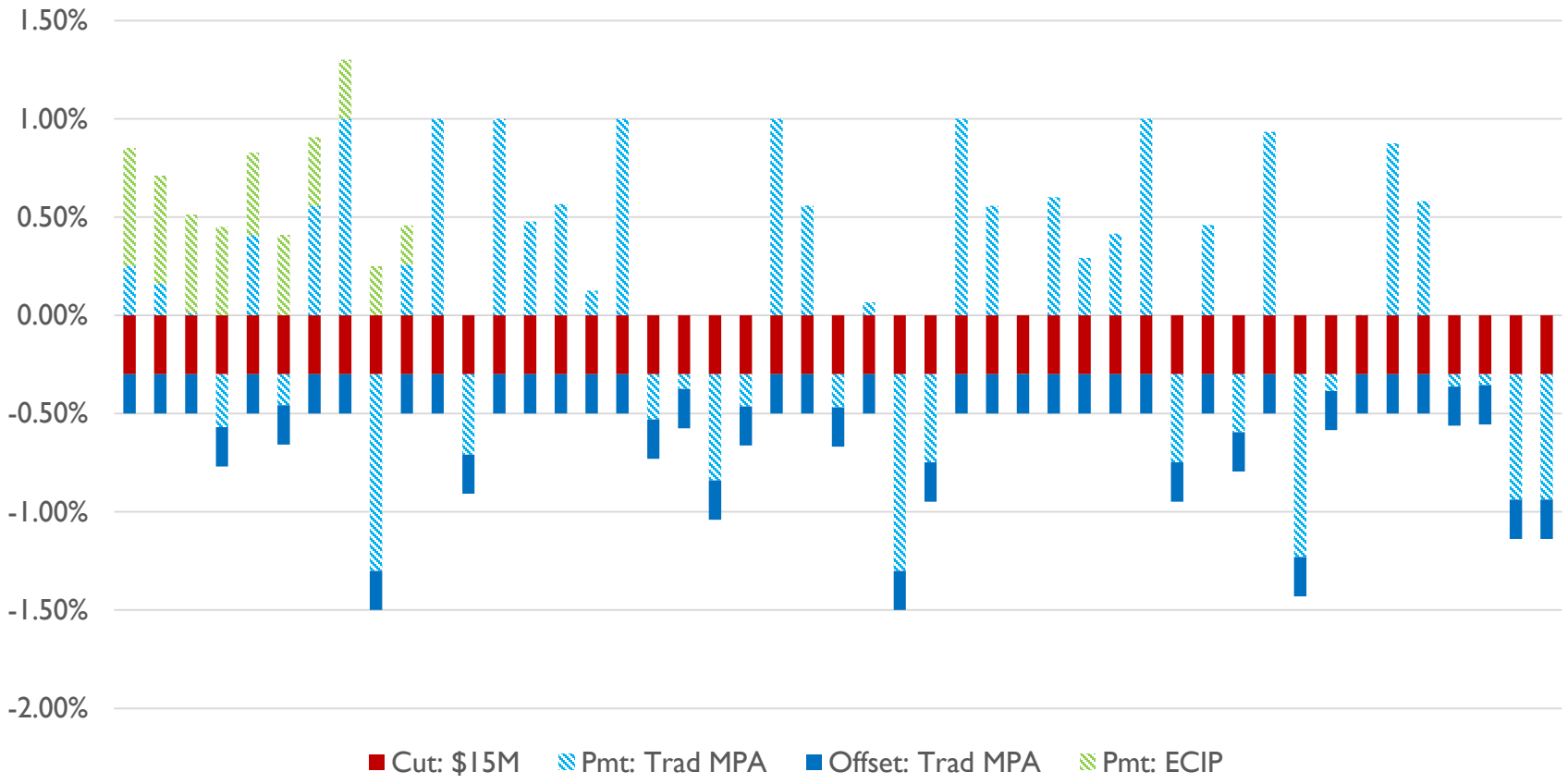
Step 2b: Statewide hospital Medicare offset for Traditional MPA (e.g., -$10M = -0.2%)

Total Statewide Savings = $15 ($15M-$10M+$10M)



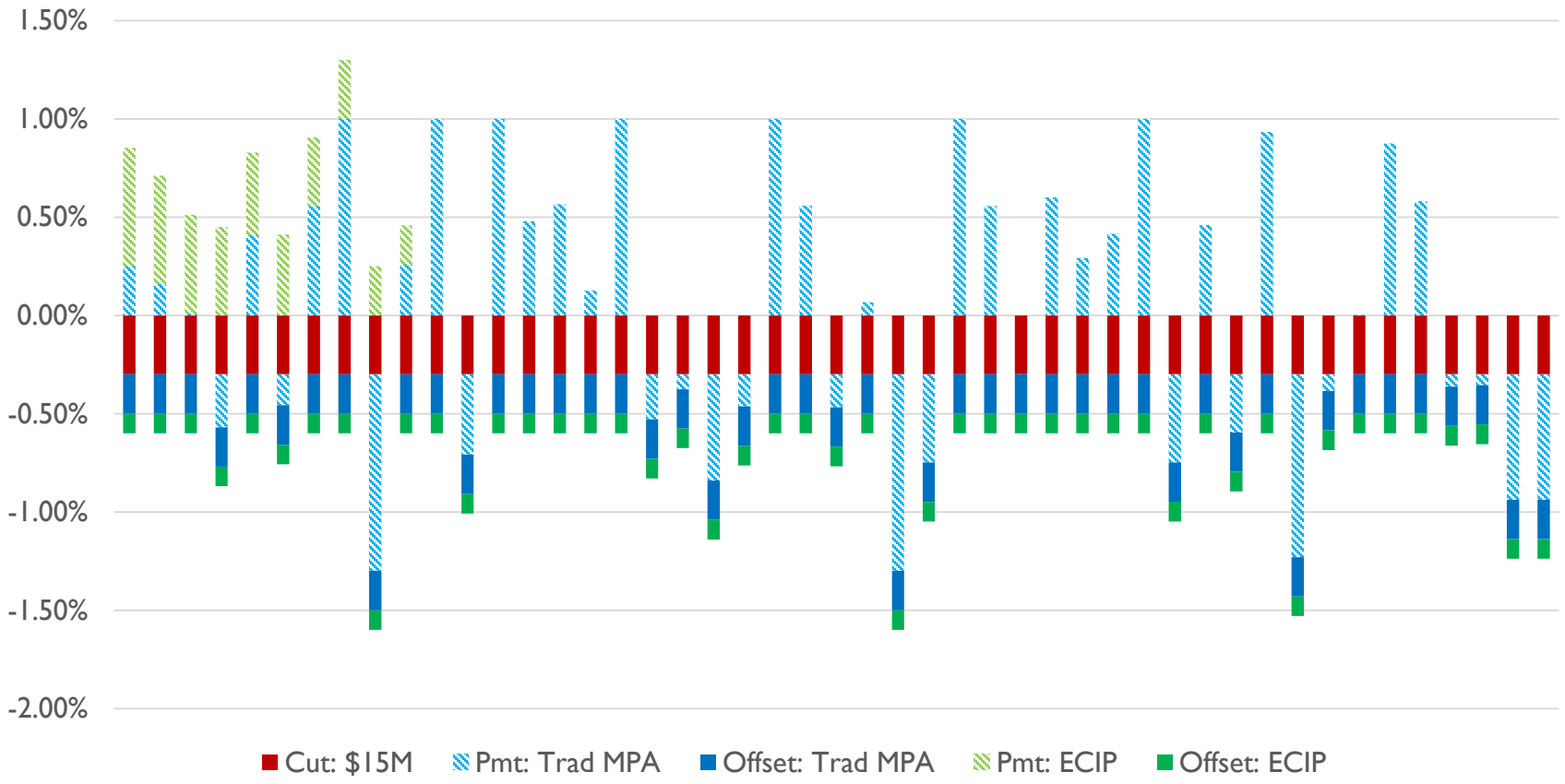
Step 3a: Individual hospital Medicare payments for ECIP (e.g., +$5M to 10 hospitals)

Total Statewide Savings = $10 ($15M-$10M+$10M-$5M)



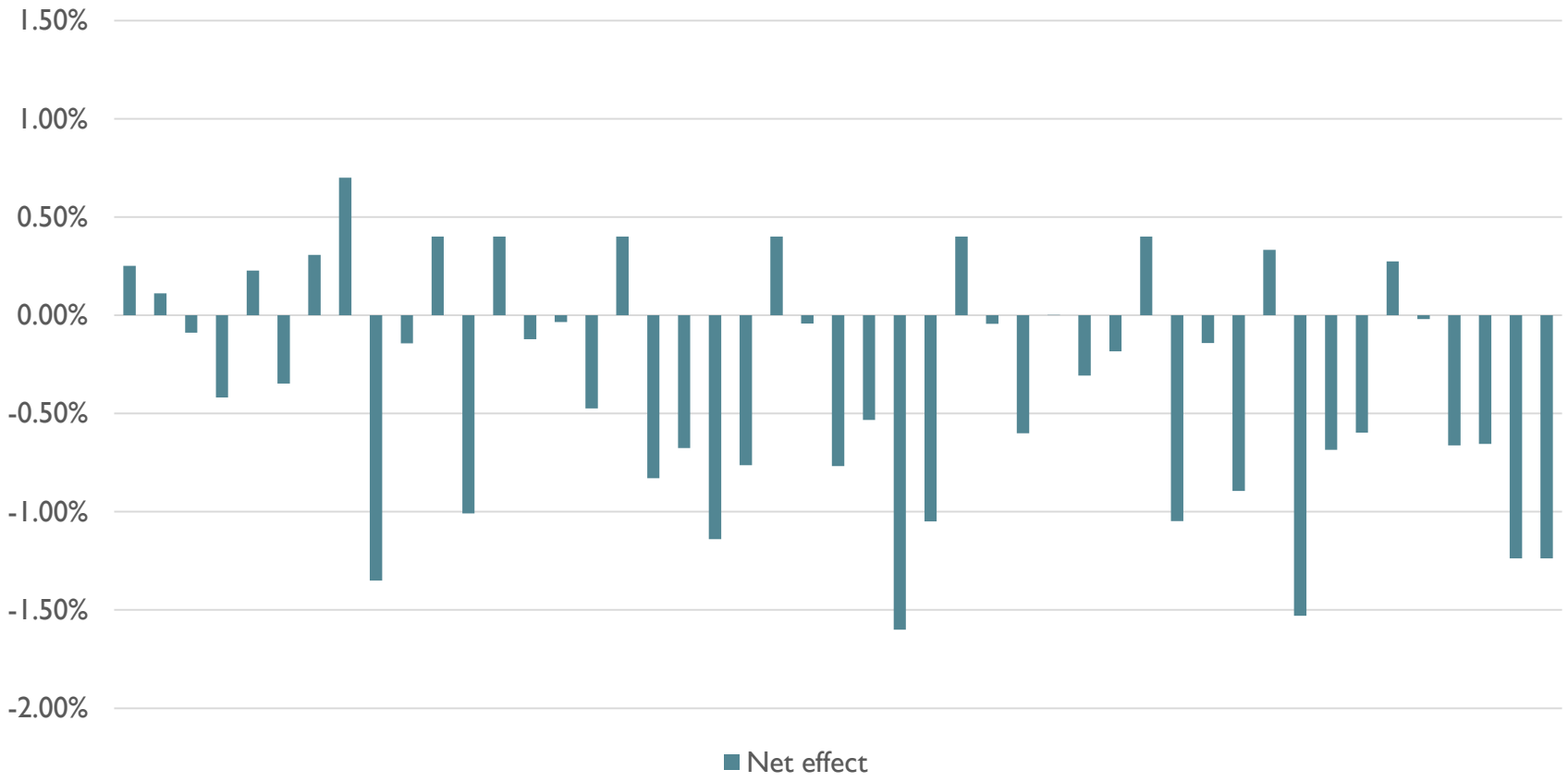
Step 3b: Statewide hospital Medicare offset for ECIP (e.g., -$5M = -0.1% statewide)

Total Statewide Savings = $15 ($15M-$10M+$10M-$5M+$5M)



Example: Net effect on each hospital

Total Statewide Savings = $15M; hospitals differentially impacted based on their success under the traditional MPA and care transformation activities.



Using MPA-EC to Achieve Savings and Reward Care Transformation

Example:
Under All-Payer Model (2014-2018)

10 hospitals implemented a strategy in CY18 to save $7 million in Medicare post-acute spending, improve quality, reduce hospital readmissions

"Thank you, 10 hospitals."

-- Feds, State, beneficiaries

Example: Under TCOC Model (2019-2023) with MPA Efficiency Component "haircut"

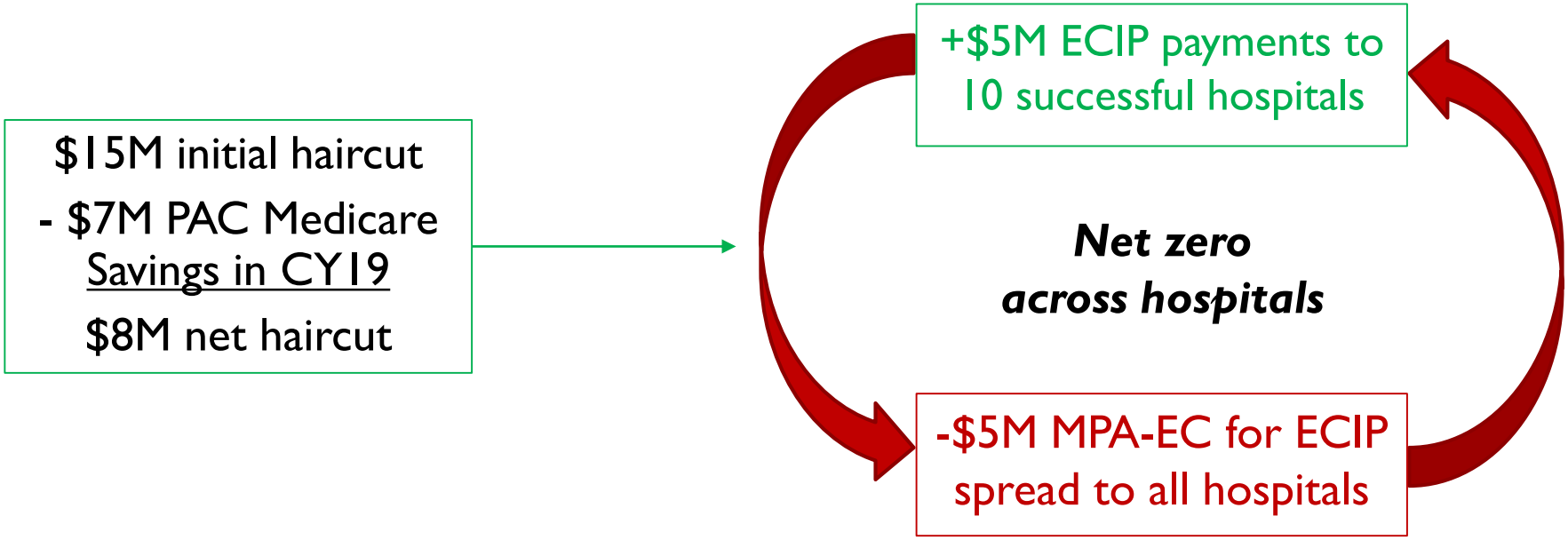
- CY20 Efficiency Component haircut of $15 million
- 10 hospitals implemented a strategy in CY19 to save $7 million in Medicare post-acute spending, improve quality, reduce hospital readmissions
  - All hospitals share in the $7 million savings because
  - CY20 Efficiency Component haircut reduced to $8 million

$15M initial haircut
- $7M PAC Medicare Savings in CY19
$8M net haircut

"Thank you, 10 hospitals."
-- Feds, State, beneficiaries, all hospitals

Add ECIP: $7M in TCOC savings in CY19 yields $5M in ECIP payments in CY 20

- Efficiency Component haircut reduced from $15M to $8M
- New: 10 hospitals receive $5M in ECIP payments

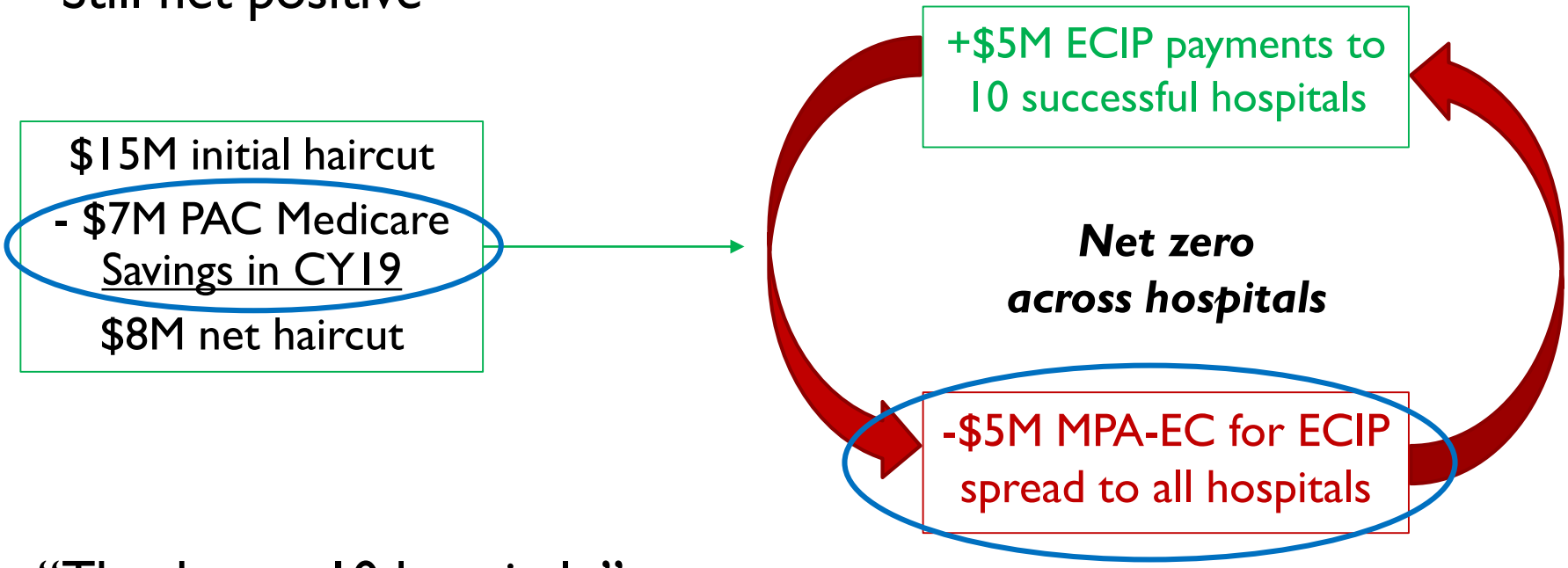


"Thank you, 10 hospitals."

-- Feds, State, beneficiaries, all hospitals, especially 10 successful hospitals in ECIP

Effect of ECIP on Hospitals NOT in ECIP

- Benefit from $7M reduction in haircut
- Pay $5M toward other hospitals' ECIP payment
- Still net positive



"Thank you, 10 hospitals."

-- Feds, State, beneficiaries, all hospitals, especially 10 successful hospitals in ECIP

Next meeting:
April 24, 2019

Future meetings

- TCOC Work Group meetings
  - April 24
  - May 29
  - June 26
- HSCRC Commission meetings
  - April 10