Total Cost of Care (TCOC) Workgroup

January 29, 2020

Agenda

1. MPA Collection Timeline for Y3
2. Finalizing the CTI Payment Methodology
   i. Summarize comments
   ii. Revised risk adjustment
   iii. Savings and volume thresholds
   iv. Inclusion of post-acute care providers
3. Attribution Stability
   i. Update on currently measured churn
   ii. Comparison and evaluation across hospitals
4. MPA Attribution Options
   i. Objectives and principles for MPA redesign
   ii. Three options for MPA attribution
   iii. MPA and CTI attainment vs. improvement

2020 MPA (Y3) Implementation: Submission Requirements & Timeline

MPA Attribution Tracking Tool (MATT)

- MATT is a new tool to streamline the submission of MPA provider information
  - Launched on the CRS: January 27, 2020
- Hospitals will use MATT to:
  - Input annual MPA NPI submission lists
  - Check their list during the review period
  - Manage PHI data access (annual and monthly)
- Two trainings were held in January 2020 to introduce MATT and explain its functionality, with recordings of the sessions available on CRS
- Hospitals must select up to three MATT Users by Friday, January 31, 2020

MPA Submission Timeline

Timing	Action
January 2020	• January 31st: Submit MATT Users • *Review 2019 lists and provide monthly PHI updates, as needed*

February 2020	• February 14th: Submit annual NPI lists through MATT
	  • Required for Hospital-Based ACOs: ACO Participant List
	  • Voluntary: full-time, fully employed provider list
	  • Systems provide mapping of CTO MDPCP providers to specific hospitals
	• February 17th – February 28th: HSCRC runs attribution algorithm
	  • Hospitals notified of potential overlaps
	• *Review 2019 lists and provide monthly PHI updates, as needed*

March 2020	• March 9th: Preliminary provider-attribution lists available to hospitals through MATT • March 9th – March 20th: Official review period begins • March 23rd – April 3rd: HSCRC re-runs attribution algorithm for implementation • *Review 2019 lists and provide monthly PHI updates, as needed*
April 2020	• April 13th: Final MPA lists available in MATT • Voluntary: Hospitals can elect to address Medicare Total Cost of Care (TCOC) together and combine MPAs • *Review 2020 lists in MATT and provide routine PHI updates, as needed*
May 2020 and Ongoing	• *Review 2020 lists in MATT and provide routine PHI updates, as needed*

Finalizing the CTI Payment Methodology

Responses to the CTI Methodology

- Staff received two comments on the CTI User Guide and Methodology:
  - The Rockburn Institute recommended that:
    - The actual HCC score be used instead of HCC strata and provide more detail about the HCC calculation;
    - Provide more information about the minimum volume requirements / thresholds for savings.
  - The Lifespan Network recommended that the CTI policy be delayed until after a comprehensive plan for including post-acute care providers in the model be completed and that:
    - Savings should only be distributed to hospitals that are participating in a care redesign program that could share savings with post-acute care providers; and
    - The State should invest additional resources to engage post-acute providers in care transformation.
- While not received in a comment, Staff want to remind participants starting July 1, 2020 the savings generated under ECIP will be disbursed through the same MPA Reconciliation Component policy as CTIs (eliminating the 3% discount in ECIP).

Risk Adjustment

- Staff agree with the concerns regarding the HCC risk adjustment.
  - Staff will revise the risk adjustment methodology and are considering using a continuous HCC risk adjustment
  - Staff believe it will significantly simplify the risk-adjustment process in the methodology and will eliminate the need for HCC cut-points to be identified.
- Staff will also provide additional information regarding which HCC model is employed. We are exploring using the concurrent v24 HCC model for primary care-based CTIs and may expand that to all CTIs.

Savings and Volume Thresholds

- Staff cannot provide details on the savings threshold prior to reviewing the hospitals' proposed CTI definitions.
- The minimum savings rate for actuarial significance depends on the variance of CTI episode costs.
  - If there is large variation in costs between episodes a high threshold is necessary.
  - If there is low variation in costs between episodes a low threshold is necessary.
- The HSCRC allows hospitals to propose their own CTI definitions and so we cannot assess the variance in CTI episode costs until we receive proposals.
  - We could set a 'worst case' savings threshold which would likely be very high and a disincentive to participation.
  - We therefore opted to set the minimum savings rate *after* the CTI definitions are submitted to the HSCRC.
- We are analyzing the initial wave of CTI definitions and will provide additional details on the savings threshold for the Care Transitions CTI shortly.

Inclusion of Post-Acute Care Providers

- Staff do not support delaying the CTI policy.
- Staff will be happy to work with any hospital that wants to partner with a post-acute care provider.
  - Hospitals have proposed CTIs that include SNF partners
  - Staff are working on a Care Redesign track (PACCAP) for that CTI
- Staff believe that hospitals should make the determination about whether to pay incentive payments to their care partners.
  - If the care partners are effective at reducing the TCOC, then they are in a strong position to negotiate a share of the savings with hospitals.
  - If the care partners are ineffective at reducing the TCOC, then staff do not believe that the state should require hospitals to pay them.

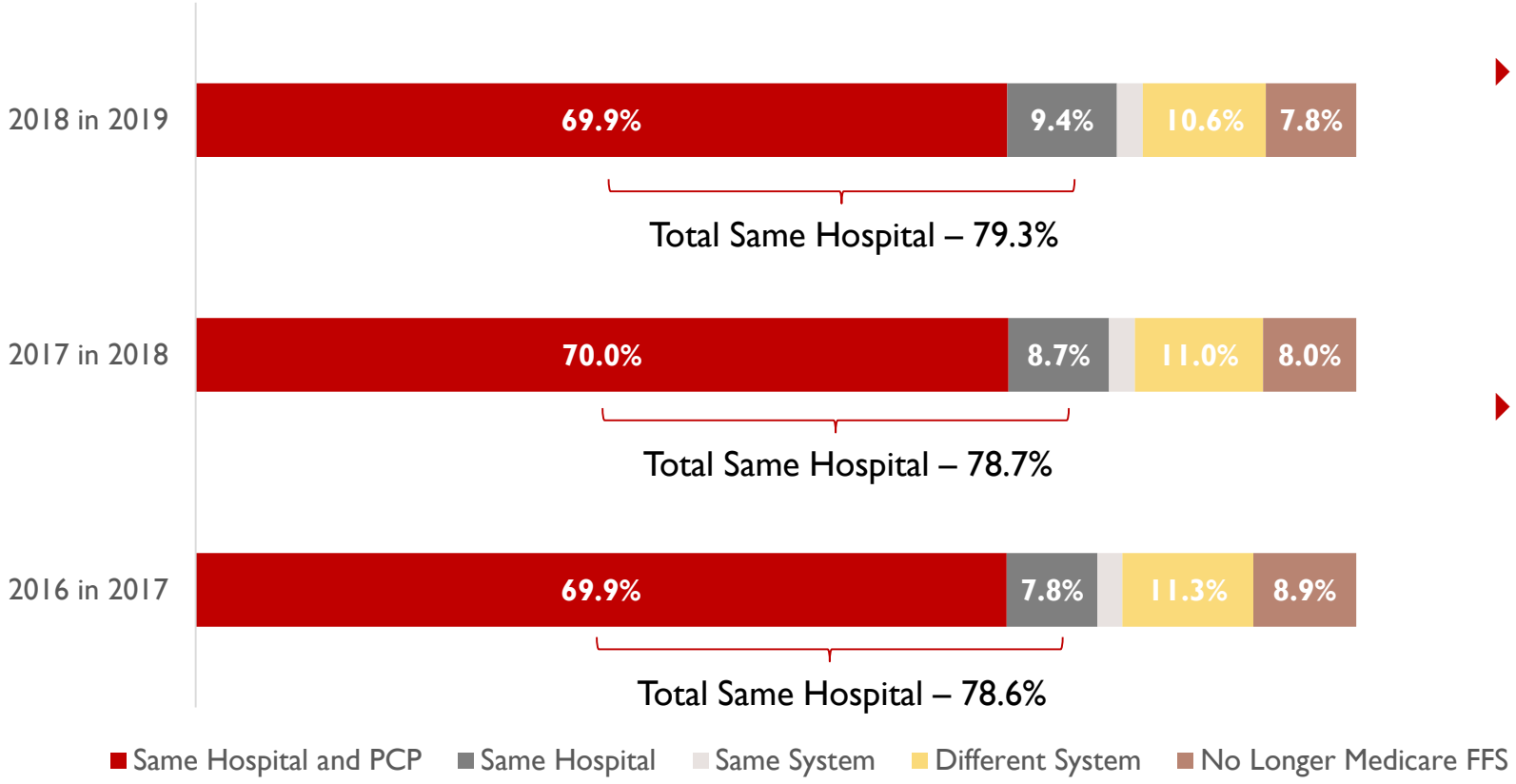
Next Steps

- Staff will update the CTI User Guide and methodology prior to the next TCOC Meeting.
- The first wave of CTIs have been finalized.
  - Staff will report on the participation in the first CTIs at the next TCOC Workgroup meeting.
  - Staff expect that 5-6 CTI Thematic Areas will be approved by the start of the program in July, encompassing 95+% of the hospital's initial CTI submissions.
- The Commission directed the Staff to present a report on CTI implementation.
  - Staff intend to present this report in March or April.
  - Staff will circulate a draft of the report with the TCOC Workgroup in February.

Attribution Stability

Churn Statistics – Non-Geographic

- Results reflect applying MPA Y2 approach to various years



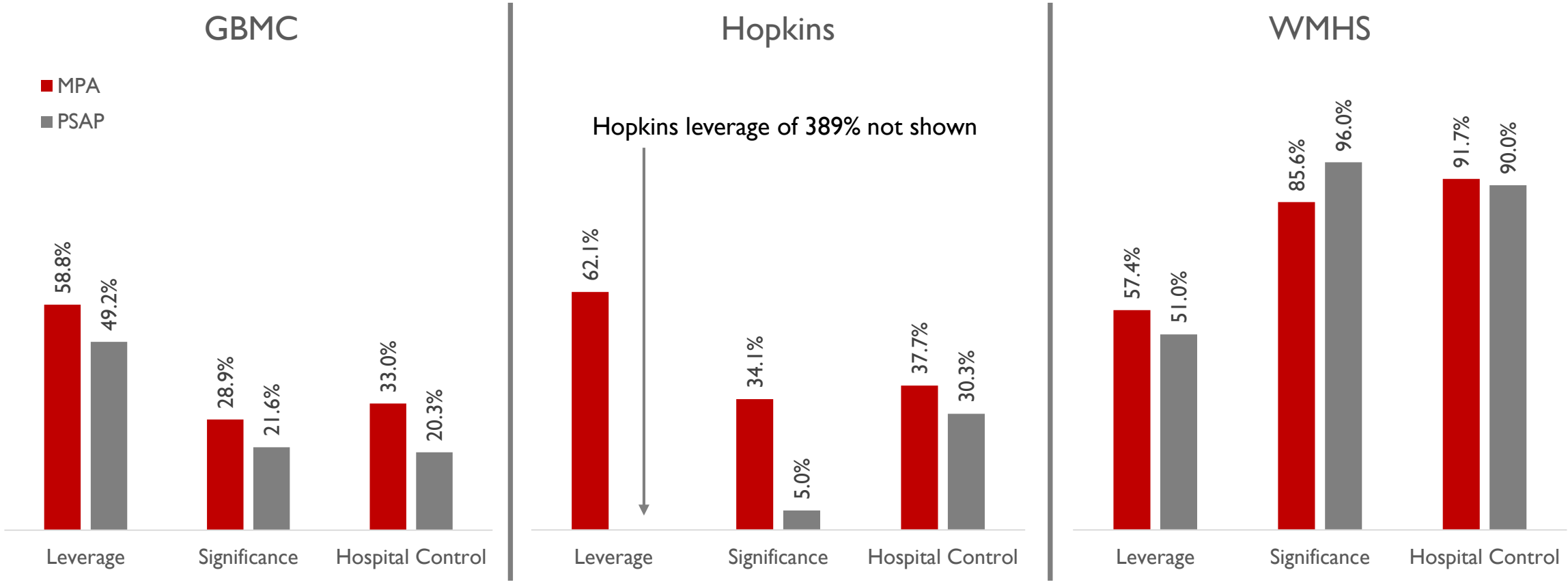
- Under the current methodology year over year same hospital beneficiary stability is ~79%.
- Excluding dropped beneficiaries from the denominator increases this to 85%. Adding same system increases it to 88%.

Comparison of Impact by Attribution Approach

Metric	Purpose	Calculation	Meaning	Median Value (1)	90th Percentile (1)	10th Percentile (1)
Leverage	How much leverage does a hospital get for good or bad MPA results	Delivered $ over Attributed $	High value indicates the hospital's reward or penalty multiplied across much larger base than it was calculated on	MPA 46.2% PSAP 37.8%	MPA 110.6% (2) PSAP 73.0% (3)	MPA 25.5% PSAP 24.7%
Significance	How significant is attributed care in terms of all care delivered by a hospital	Attributed and Delivered $ over Delivered $	High value means a hospital is working for their own attributed beneficiaries more	MPA 39.6% PSAP 45.3%	MPA 80.2% PSAP 89.6%	MPA 11.0% PSAP 8.4%
Control	How much direct control does a hospital have over its MPA results	Attributed and Delivered $ over Attributed $	A high value indicates a hospital delivers more of its attributed care	MPA 16.7% PSAP 17.4%	MPA 29.1% PSAP 31.0%	MPA 8.4% PSAP 6.8%
Hospital Control	How much direct control does a hospital have over the hospital-driven portion of its results	Attributed and Delivered $ over Attributed $ that were delivered at a hospital	A high value indicates a hospital delivers more of its attributed hospital care	MPA 36.1% PSAP 39.6%	MPA 68.6% PSAP 70.5%	MPA 19.0% PSAP 19.2%

1. All data based on 2018 CCLF. Certain very small facilities were excluded in calculating the median and percentile values.
2. For MPA leverage UMMC is an extreme outlier on this measure at 684%, reflecting the very small attribution to the main campus.
3. For PSAP leverage both UMMC and Hopkins are significant outliers at ~390%.

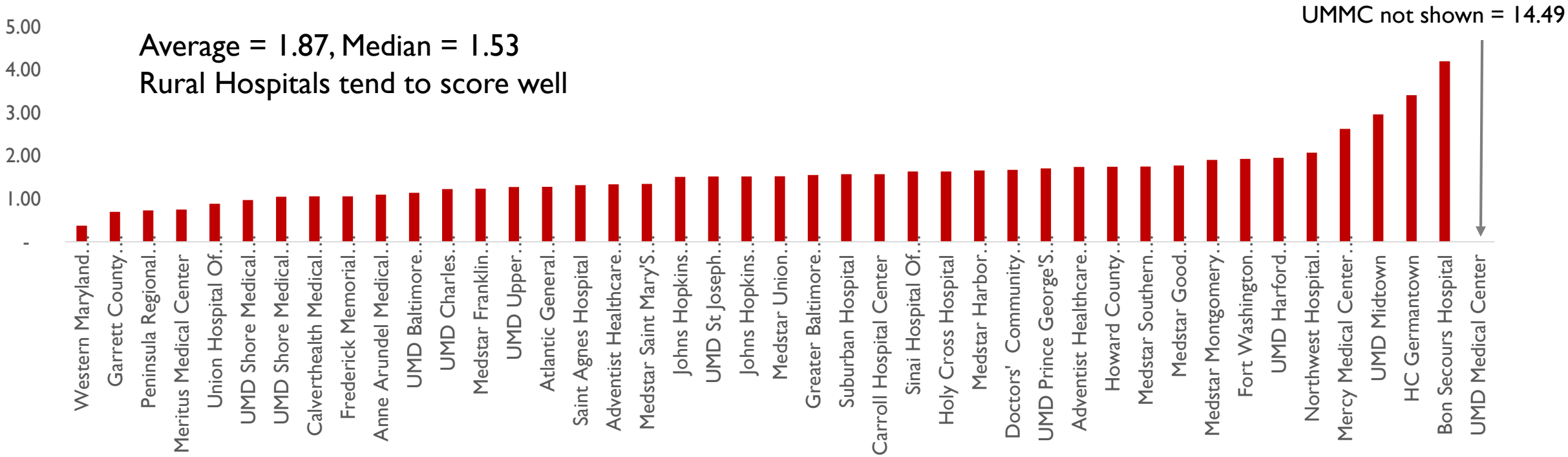
Values for Sample Hospitals



- GBMC's values are all somewhat higher for MPA, suggesting a smaller allocation that is more tightly aligned with care delivered by GBMC
- Under PSAP, Hopkins' leverage is very high and significance is very low due to the small primary service area
- As the dominant regional player WMHS has high values under either methodology

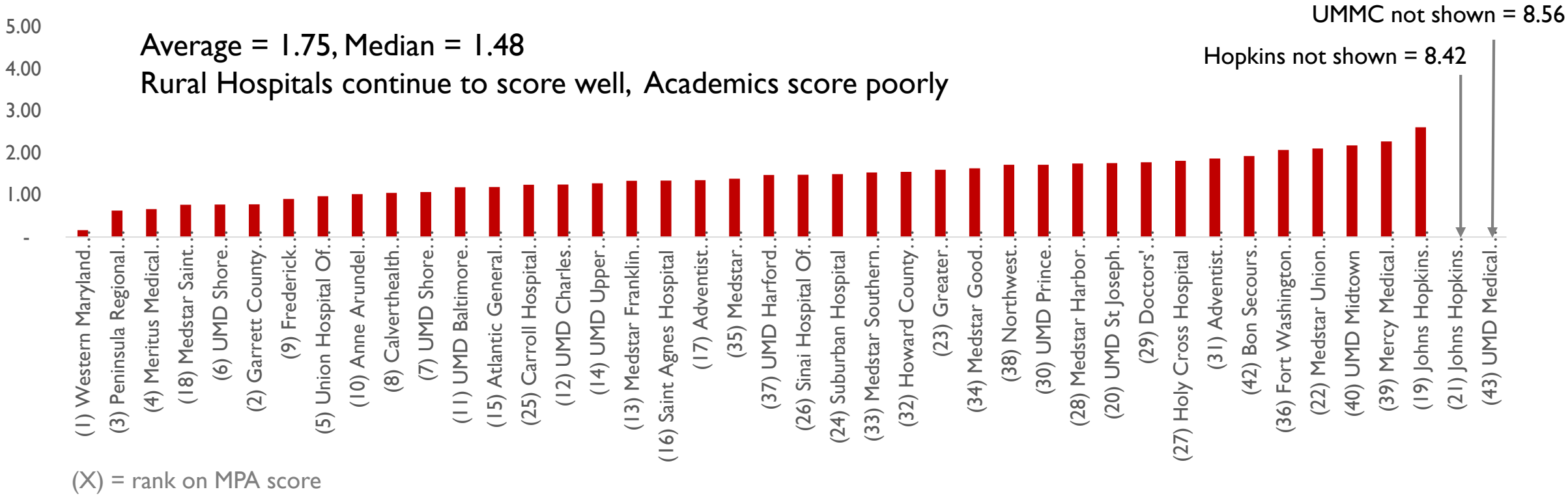
Overall Evaluation - MPA

- Evaluation score combines values into one score based on closeness to an "ideal" score (ideal = 0.5 for Leverage and 1.0 for Significance and Hospital Control). Lower score = closer to "ideal". Calculation as follows:
  - Score = Abs(0.5 – Leverage) * 2 + (1-Significance) + (1-Hospital Control)



Overall Evaluation - PSAP

- Evaluation score combines values into one score based on closeness to an "ideal" score (ideal = 0.5 for Leverage and 1.0 for Significance and Hospital Control). Lower score = closer to "ideal". Calculation as follows:
  - Score = Abs(0.5 – Leverage) * 2 + (1-Significance) + (1-Hospital Control)



MPA Attribution Options

Objectives & Principles for the MPA Redesign

- Primary Objectives for the MPA:
  - Satisfy the Maryland TCOC Agreement that the MPA "must result in the attribution to one or more Regulated Maryland Hospitals of at least 95 percent of Maryland Medicare Beneficiaries who are enrolled in both Part A and Part B."
  - Incentivize hospitals to manage the TCOC of "their" population.
- Principles for the MPA:
  - Leverage: The Hospital's attributed TCOC should be proportionate to the overall hospital share of TCOC.
  - Significant: A high proportion of the care provided by the hospital should be provided to attributed beneficiaries.
  - Controllable: The Hospital should provide a high proportion of the care to its attributed beneficiaries.
  - Predictable and Stable: Beneficiary is retained by the same hospital over time and the hospital can determine whether a beneficiary is attributed to them prospectively.

Option #1: Modify Existing Methodology

- Use the current MPA approach but add CTI as the first attribution layer.
  - Current attribution works well for rural hospitals but not academics.
  - Current attribution is 'relatively' stable.
  - Methodology is complex.
- Variants:
  - Measure a hospitals MPA performance only on the beneficiaries who are attributed to the hospital for two consecutive years.
  - Set separate target prices based on how a beneficiary is attributed to the hospital, e.g.:
    - Beneficiaries attributed to the same hospital for two consecutive years
    - Beneficiaries new to Medicare
    - Beneficiaries switching between hospitals

Option #2: Geographic Attribution

- Beneficiaries would be attributed to hospitals based on the primary service areas.
  - Attribution performs similarly well for rural hospitals and has a mixed impact on academics (worse for Hopkins, better for UMMC).
  - Attribution is more stable than current attribution (to be confirmed).
  - Simpler attribution than existing methodology
- Variants:
  - Use CTI attributed beneficiaries and then geographic service area
  - Allow hospitals to share geographic service areas

Option #3: Attribution Based on Hospital Services

- Attribute beneficiaries based on hospital touch and attribute beneficiaries who do not have any hospital utilization based on geography.
  - Potentially increases the leverage of the academic hospitals
  - Potentially results in less stable attribution
- Variants:
  - Attributed beneficiaries based on the nature of their services, for example
    - Only Primary and Secondary: Primary and Secondary Touch or Primary Care Based
    - Tertiary and Quaternary: Touch in those services
    - Limited services: Geographic
  - Different types of attribution for different hospitals (e.g. plurality of hospital touch for academics and then geographic attribution)
  - Attribution to hospitals based on a certain set of services
- Staff will assess the leverage, control, and significance of the attribution methodology for the next TCOC Workgroup meeting.

Reminder: Overlap between CTI and the MPA

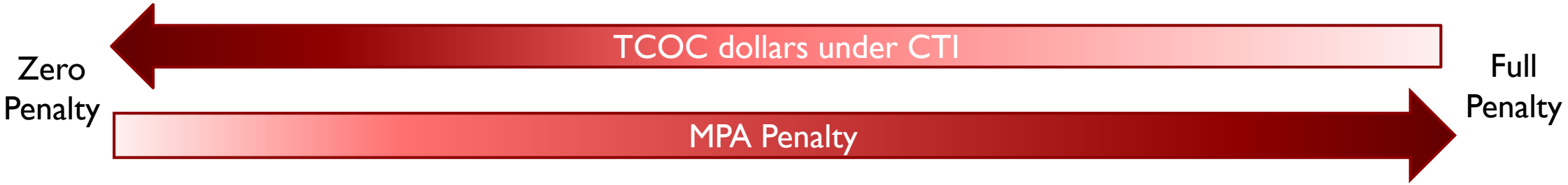
	Incorporate CTI into the MPA	Do not Incorporate CTI into the MPA
Don't Change MPA Attribution	**A** • Makes CTI the first layer in the MPA attribution • Aligns CTI beneficiaries with MPA attribution	**B** • Current MPA remains the best approach • Mismatch with CTI and MPA attributed beneficiaries
Change 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

MPA and CTI Attainment vs. Improvement

- CTI and the MPA currently measure hospitals based on their effectiveness at reducing TCOC.
  - Numerous stakeholders have suggested moving the MPA to an attainment measure.
  - An attainment score is likely to be more stable of than a year-over-year growth measure.
- Potential Option: Use the current (or slightly revised) MPA approach for an attainment measure and use the CTI as an improvement measure.
  - Weight the hospitals MPA attainment score in the MPA adjustment based on its CTI improvement
  - A hospital with a poor attainment score but large CTI improvement would receive a smaller or zero negative adjustment to allow for continued focus on improvement.
  - This would allow hospitals to chose between targeted CTI interventions and the broader MPA adjustment.

Impact of Proposed Weighting

- Assume the Traditional MPA score is initially calculated 100% based on attainment
  - If a hospital has a positive score, the Final Traditional MPA = Initial Value
  - If a hospital has a negative MPA Score:
    - Hospital can reduce negative initial value based on investments in CTIs
    - Final Traditional MPA = Blend of MPA initial attainment and no penalty, weighted based on level of TCOC dollars in CTIs



- CTIs would require validation as "real"
- Rewards for CTIs under the MPA-Reconciliation Component would be unchanged

Next Steps

- Staff will assess the impact on the leverage, significance, and control on the following two options:
  - Allowing hospitals to share geographies
  - Attributing beneficiaries based on plurality of hospital care + geographic residual
- Staff will present options for measuring the MPA on an attainment basis (regardless of what attribution method is chosen).
  - Include options for scaling Traditional MPA under attainment based on CTIs
  - Update on benchmarking
- Staff would appreciate comments and suggestions on whether the MPA should move to attainment and whether CTI should be used as the improvement score.

Next TCOC WG Meeting:
February 26, 2020

Future meetings

- TCOC Work Group meetings
  - February 26, 2020
  - March 25, 2020
- HSCRC Commission meetings
  - February 12, 2020

Glossary

- **Accountable Care Organizations (ACO):** groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve
- **CRISP Reporting Service (CRS):** interactive dashboards that help identify patients who could benefit from services and provide program reporting
- **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 Organization (CTO):** MDPCP entity that hires and manages an interdisciplinary care management team capable of furnishing an array of care coordination services to Maryland Medicare beneficiaries attributed to Participant Practices
- **Claim and Claim Line Feed (CCLF):** Medicare data file which contains claims, beneficiary services, and data from hospital and non-hospital utilization
- **Evaluation and Management (E&M):** a category of medical codes that include services for patient visits
- **Episode Care Improvement Program (ECIP):** links payments across hospital providers during an episode of care, modeled on CMS's BPCI-A
- **Hierarchical Conditioning Categories (HCC):** a risk adjustment model to predict health care spending
- **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

Glossary (cont.)

- **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
- **MPA Attribution Tracking Tool (MATT):** automates the process of gathering and maintaining provider data required for the creation of the MPA attribution and granting hospitals PHI access
- **National Provider Identifier (NPI):** a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS)
- **Post Acute Care for Complex Adults Program (PACCAP):** a potential Care Redesign Program that would allow hospitals to share resources with SNFs/HHAs to facilitate complex patient discharge
- **Primary Care Provider (PCP):** the clinician that manages overall patient care
- **Primary Service Area (PSA)**: hospital's service area zip codes as indicated in hospital's GBR agreement
- **Primary Service Area Plus (PSAP):** hospital-specific service area zip codes based on PSA, adjusted for unclaimed zip codes and zip codes served by more than 1 hospital
- **Protected Health Information (PHI):** health data created, received, stored, or transmitted by HIPAA-covered entities and their business associates in relation to the provision of healthcare, healthcare operations, and payment for healthcare services
- **Total Costs of Care (TCOC):** Medicare costs in Parts A and B services for fee-for-service beneficiaries