Total Cost of Care (TCOC) Workgroup

February 26, 2020

Agenda

1. MPA Y3 Updates and Initial Attribution Review
2. Benchmarking Update
3. Evaluation of Additional Attribution Approaches
    i. Review types of attribution approaches
    ii. Leverage, significance, and control results
4. Options on CTI Weighting
5. Feedback from the Industry on MPA Options
6. Discussion: State-Wide Integrated Health Improved Strategy (SIHIS)

CTI Update

1. HSCRC is working on a draft report to the Commission on the initial CTI policy and definitions.
   - Initially we hoped to have a draft of the report to distribute at this TCOC workgroup meeting.
   - We expect it will be available prior to the March meeting.
2. We expect the data on the first CTI to be available in the first week or two of March.

2020 MPA (Y3) Implementation: Submission Requirements & Timeline

MPA Y3 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*

Reviewing MPA Y3 Lists

- Once the Y3 MPA algorithm has been run, the HSCRC will be providing the following information for each hospital:
  - NPIs attributed to the hospital
  - MPA tier the NPI was attributed to (e.g. MDPCP, ACO, Employed, or Referral)
  - Number of beneficiaries attributed to that NPI in 2019 and 2020, by tier
  - Costs and TCOC per capita attributed to that NPI in 2019, by tier
- This information will come as an Excel document during the week of March 2
- Hospitals should email hscrc.tcoc@maryland.gov if they have any concerns or comments on their lists by **March 20**

Benchmarking Update

Preliminary County Level Outcomes[1]

	CY 2017 Commercial % Over (Under) Benchmark Demographic-Adjusted Total Cost of Care	CY2018 Medicare % Over (Under) Benchmark Risk-Adjusted Total Cost of Care	Commercial Relative Rank	Medicare Relative Rank
24027 Howard	-30.7%	8.6%	1	4
24003 Anne Arundel	-23.6%	8.4%	5	3
24009 Calvert	-25.1%	9.1%	4	5
24031 Montgomery	-20.9%	1.9%	9	2
24033 Prince Georges	-17.3%	-0.9%	13	1
24035 Queen Anne's	-21.4%	11.4%	7	7
24510 Baltimore City	-25.7%	15.0%	3	13
24011 Caroline	-17.3%	10.0%	14	6
24039 Somerset	-29.1%	19.7%	2	18
24019 Dorchester	-17.7%	11.8%	12	9
24017 Charles	-19.8%	13.8%	10	12
24037 Saint Marys	-15.5%	13.3%	15	11

	CY 2017 Commercial % Over (Under) Benchmark Demographic-Adjusted Total Cost of Care	CY2018 Medicare % Over (Under) Benchmark Risk-Adjusted Total Cost of Care	Commercial Relative Rank	Medicare Relative Rank
24045 Wicomico	-22.5%	22.6%	6	20
24013 Carroll	-18.0%	19.0%	11	17
24021 Frederick	-13.5%	12.7%	19	10
24025 Harford	-21.2%	23.4%	8	22
24043 Washington	-14.9%	15.4%	17	14
24023 Garrett	-0.2%	11.4%	24	8
24029 Kent	-12.4%	15.9%	20	16
24001 Allegany	-15.2%	23.3%	16	21
24041 Talbot	-6.3%	15.7%	23	15
24015 Cecil	-9.7%	19.9%	22	19
24047 Worcester	-14.4%	26.0%	18	24
24005 Baltimore County	-10.2%	24.8%	21	23

- Amounts are preliminary and do not reflect:
  - Commercial 2018 data, normalizing Medicare demographics, updated HCC scores from CMS and refined medical education strip, commercial medical education strip
- Anticipate these modifications will collapse the relative range of values but not change the rankings dramatically.

Expect undated numbers reflecting all updates noted above, except 2018 commercial data and updated HCC scores, at next Efficiency work group.

1. See prior presentations for additional detail on process and qualifications.

Proposed MPA adjustment based on hospitals 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.

Hospital Performance vs. Benchmark	MPA Traditional Target will be National Growth – X%	Example Range of Values (Assume MD = 1.0)
5 ppt or more above Maryland Average	-0.66%	Greater than1.05
Between 5 ppt above Maryland Average and 5 ppt below Peer Benchmark	-0.33%	Between 1.05 and 0.95
5 ppts or more below Peer Benchmark	-0.00%	Less than 0.95

Potential Considerations

- Make targets more or less challenging
- Make the middle tier linear to avoid "cliffs"
- Add additional tiers of attainment performance or more differentiated growth targets

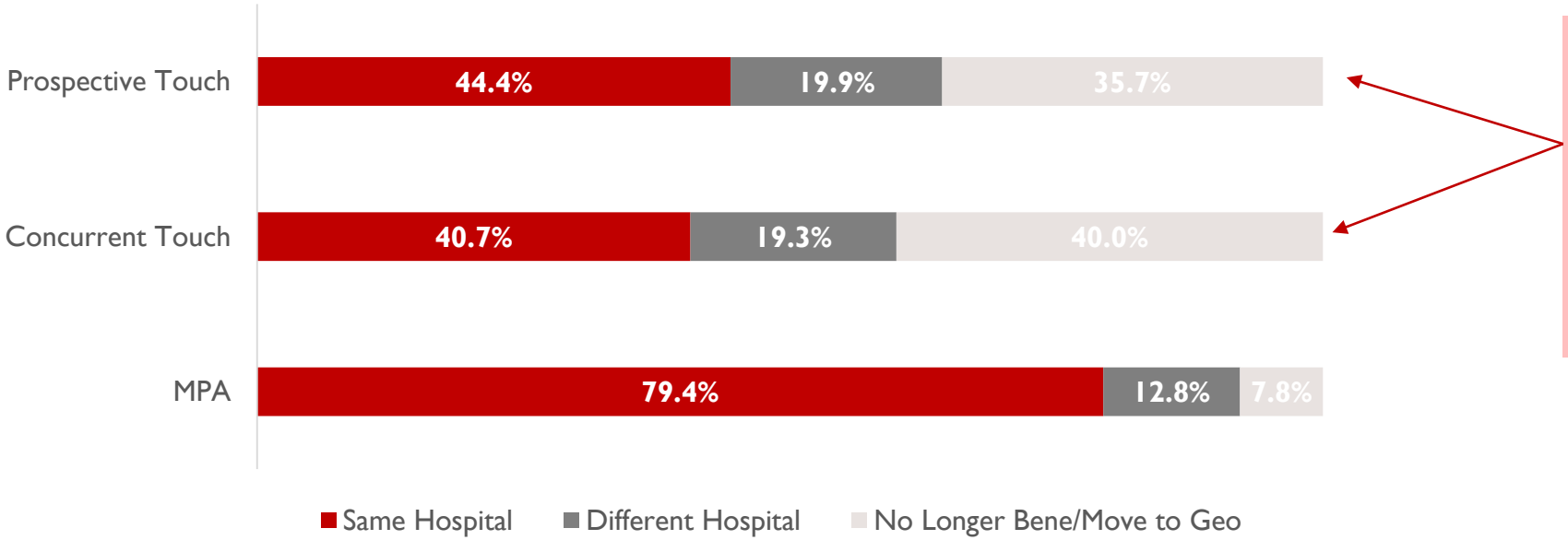
Additional Attribution Updates

Evaluated 3 Additional Attribution Methodologies

- PSAP Shared Attribution: PSAP without splitting beneficiary results in shared zip codes
  - Total attributed $ is ~2x the total spend with double counting
- Prospective Touch: Touch based on the plurality of hospital touches **in the federal fiscal year before the target year**
- Concurrent Touch: Touch based on the plurality of hospital touches **in the target year**
  - Final attribution will not be known until the year is complete

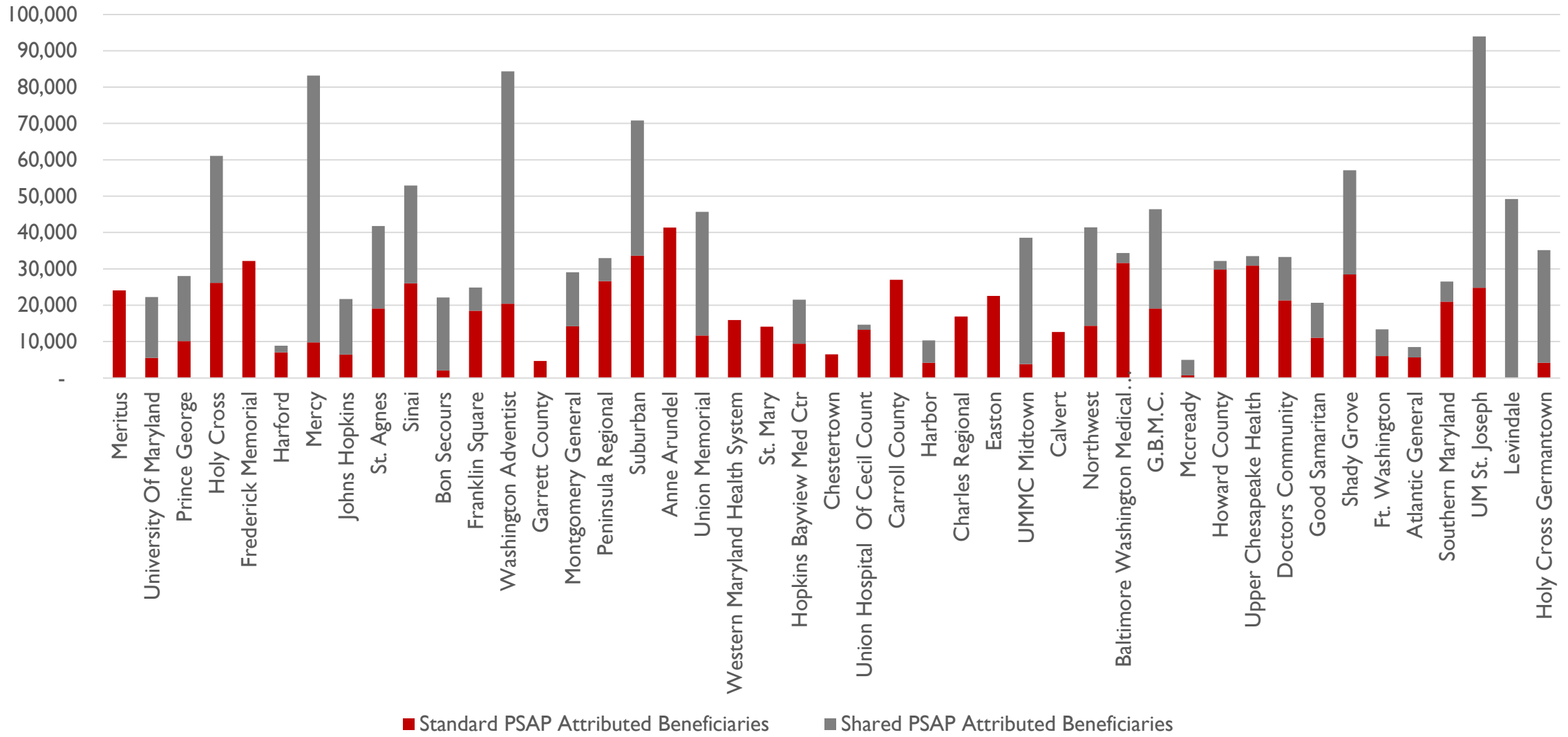
Churn Statistics – Non-Geographic

- Results reflect 2018 to 2019 Calendar Years
- Touch methods attribute ~300k beneficiaries, remainder will be geographic. MPA attributes ~550k
- Pure geographic attribution is ~95% stable but when used as a residual stability will decline due to beneficiaries shifting in and out of the primary attribution.



High numbers reflect beneficiaries with no hospital touch moving to geographic. May well be retained by the hospital in that attribution. Same store retention is about 70% versus 86% for current MPA.

Added Beneficiaries Under Shared PSAP



Comparison of Impact by Attribution Approach

Metric	Purpose	Calculation	Meaning
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
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
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
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
Combined Evaluation	Combines Leverage, Significance and Hospital Control into a single measure	Abs(0.5 – Leverage) * 2 + (1-Significance) + (1-Hospital Control)	Lower score indicates more appropriate leverage and higher hospital control and significance. A value of 0 indicates 50% leverage, 100% significance and 100% hospital control.

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%.

Comparison of Impact by Attribution Approach

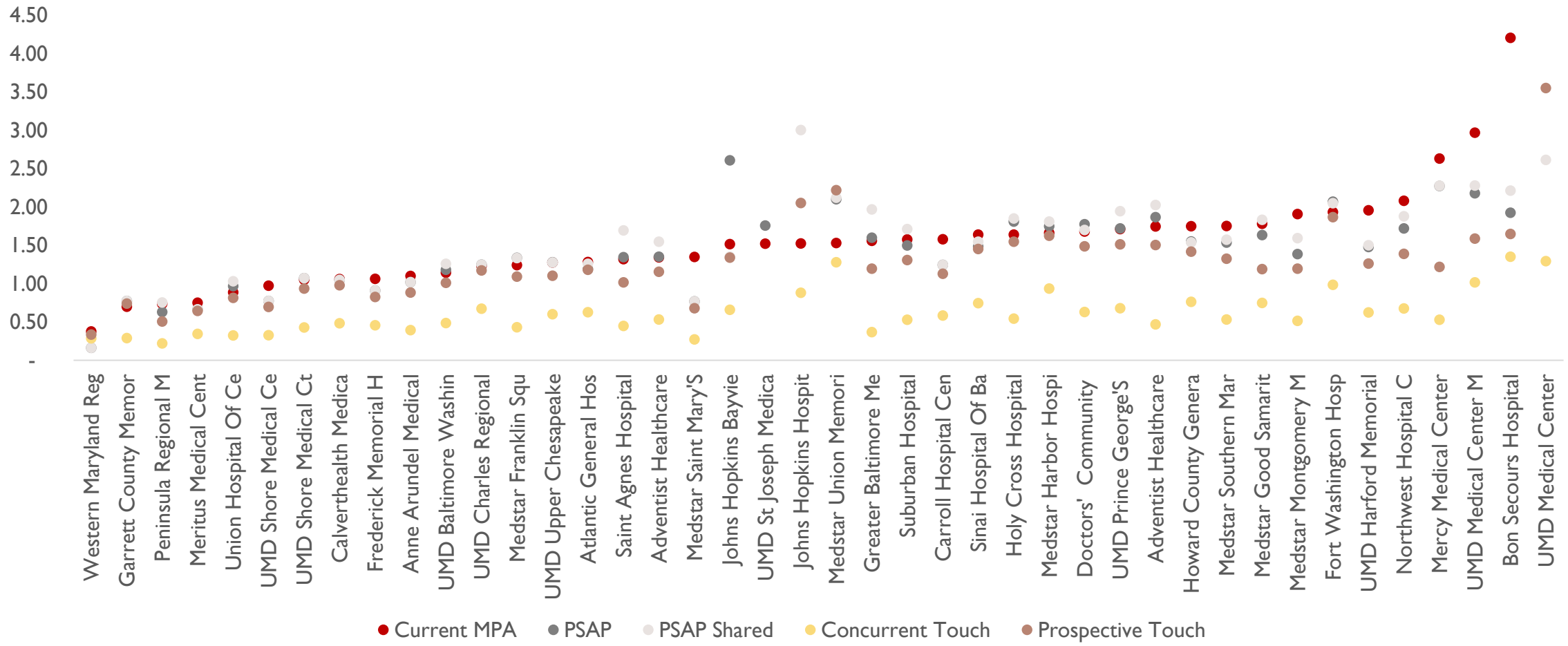
Metric	Calculation	Value (1)	MPA	PSAP	PSAP Shared Attribution	Concurrent Hosp. Touch	Prospective Hosp. Touch
Leverage	Delivered $ over Attributed $	Median (1) 10th Percentile 90th Percentile	46.2% 25.5% 110.6% (2)	37.8% 24.7% 72.9% (3)	25.0% 8.6% 45.0% (3)	46.0% 37.3% 72.9% (3)	40.0% 32.1% 67.3% (3)
Significance	Attributed and Delivered $ over Delivered $	Median (1) 10th Percentile 90th Percentile	39.6% 11.0% 80.2%	45.3% 8.4% 89.6%	68.9% 39.8% 92.2%	81.4% 65.1% 91.0%	51.6% 28.4% 81.0%
Hospital Control	Attributed and Delivered $ over Attributed $ that were delivered at a hospital	Median (1) 10th Percentile 90th Percentile	36.1% 19.0% 68.6%	39.6% 19.2% 70.5%	33.2% 11.4% 67.6%	81.0% 68.8% 90.4%	50.5% 32.9% 73.1%
Combined Evaluation	Abs(0.5 – Leverage) * 2 + (1-Significance) + (1-Hospital Control)	Median (1) 10th Percentile 90th Percentile	1.53 0.80 2.83	1.48 0.77 2.24	1.55 0.77 2.26	0.53 0.29 1.01	1.19 0.68 1.82

- Concurrent touch scores the best. Prospective touch only retains a minority of the benefit
- PSAP shared results in low leverage with moderate improvement in significance.

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%, but when the beneficiary split is removed UMMC and Hopkins are ~100%. The concurrent touch approaches also bring UMMC and Hopkins down below 100% but under prospective UMMC is still 164% and Hopkins 101%.

Combined Score Under Each Methodology*

Concurrent touch has the highest scores, prospective touch is better for hospitals at far right.



*Points not shown: UMD Medical Center, PSAP (8.56), MPA (14.29) and Hopkins, PSAP (8.42)

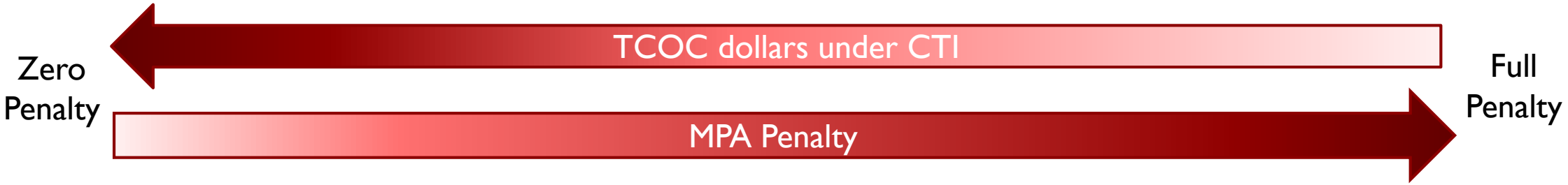
Conclusions

- The concurrent touch attribution works the best of all options. But…
  - The attribution is unstable from year to year
  - Touch attribution alone does not meet the MPA attribution threshold
  - Concurrent touch attribution will overlap substantially with the Care Transitions CTI
- Based on this analysis:
  - CTI may be an accurate way of measuring improvement
  - CTI are less desirable for attributing the entire population
  - Geographic attribution will be necessary
- Potential options for modifications:
  - Simplify the MPA to geographic and add an attainment measure
  - Blend attainment and improvement using the CTI

Options on CTI Weighting

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

Potential Option: MPA Attainment & CTI Improvement

- A hospital has a poor traditional MPA result but a good CTI Improvement Result. For example:
  - The hospital's traditional MPA adjustment is -0.6%.
  - The hospital's CTI savings as a percent of Medicare revenue is + 0.3%.
  - Under current policy, the hospital's MPA adjustment is the sum of the traditional component and the improvement component (e.g. -0.6% + 0.3% = 0.3%).
- Potential Option: Weight the traditional component of the MPA based on the leverage that the hospital has in the traditional MPA and the CTI
  - Leverage for the traditional MPA and CTI = hospital $ / TCOC for attributed beneficiaries.
  - MPA Adjustment = Traditional MPA x (1- CTI $ / Traditional MPA $).
  - If CTI Leverage is equal to the MPA Leverage, this would eliminate the traditional MPA adjustment for that hospital.

Example of the CTI Weighting Approach

	Hospital	MPA	CTI
# of Beneficiaries	30k visits	80k attributed	15k captured
Medicare Revenue	$420 mil.	$800 mil.	$400 mil.
Leverage	-	52%	105%
TCOC Savings	-	-$4 mil.	+$10 mil.
Current Policy	-$4 mil. + $10 mil. = $6 mil. Net MPA adjustment		
CTI Weighting	(1- $400 mil. / $800 mil.) x (-$4 mil.) + $10 mil. = $8 mil. Net MPA adjustment		

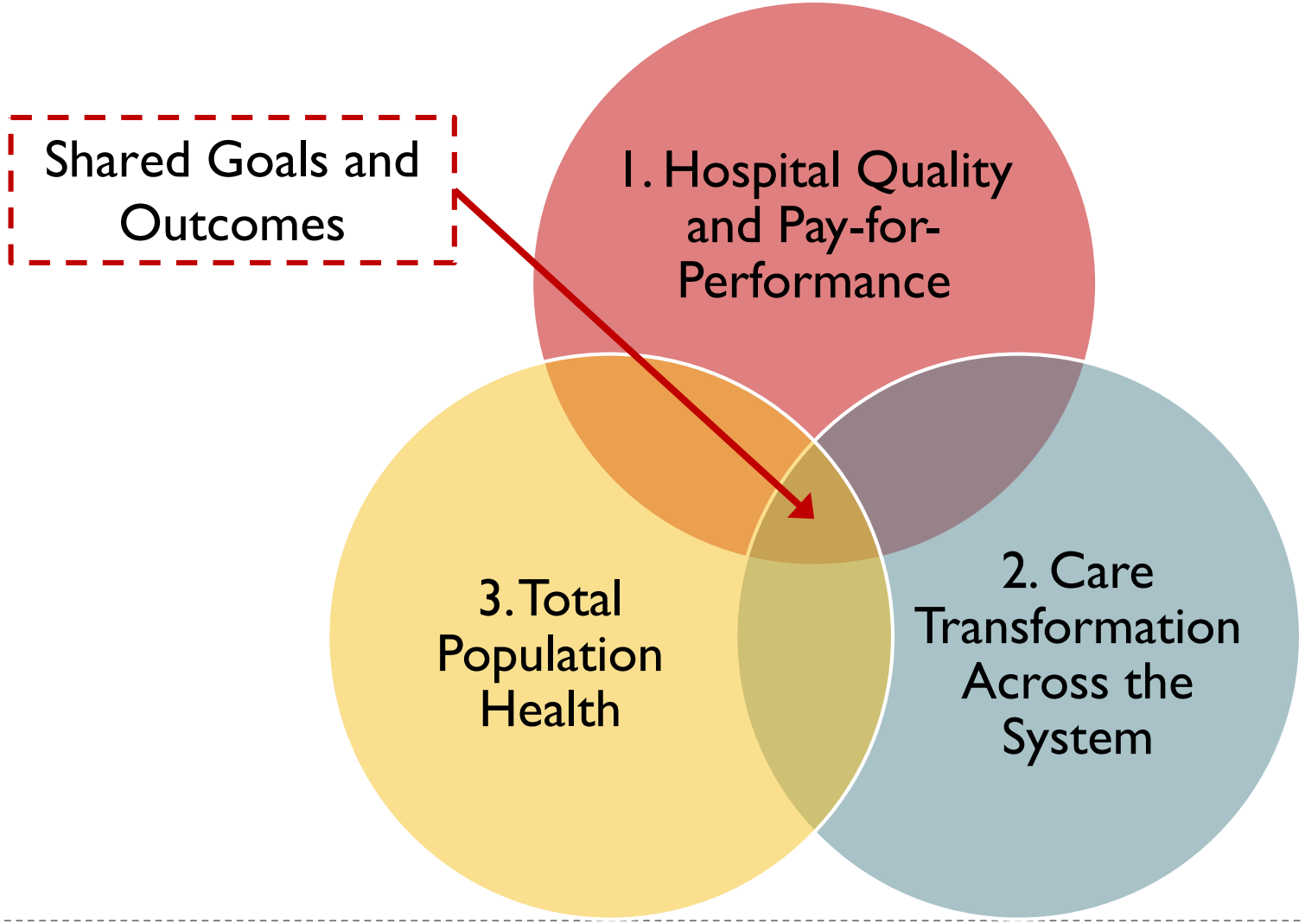
Feedback from the Industry on MPA Options

Discussion: Statewide Integrated Health Improvement Strategy (SIHIS)

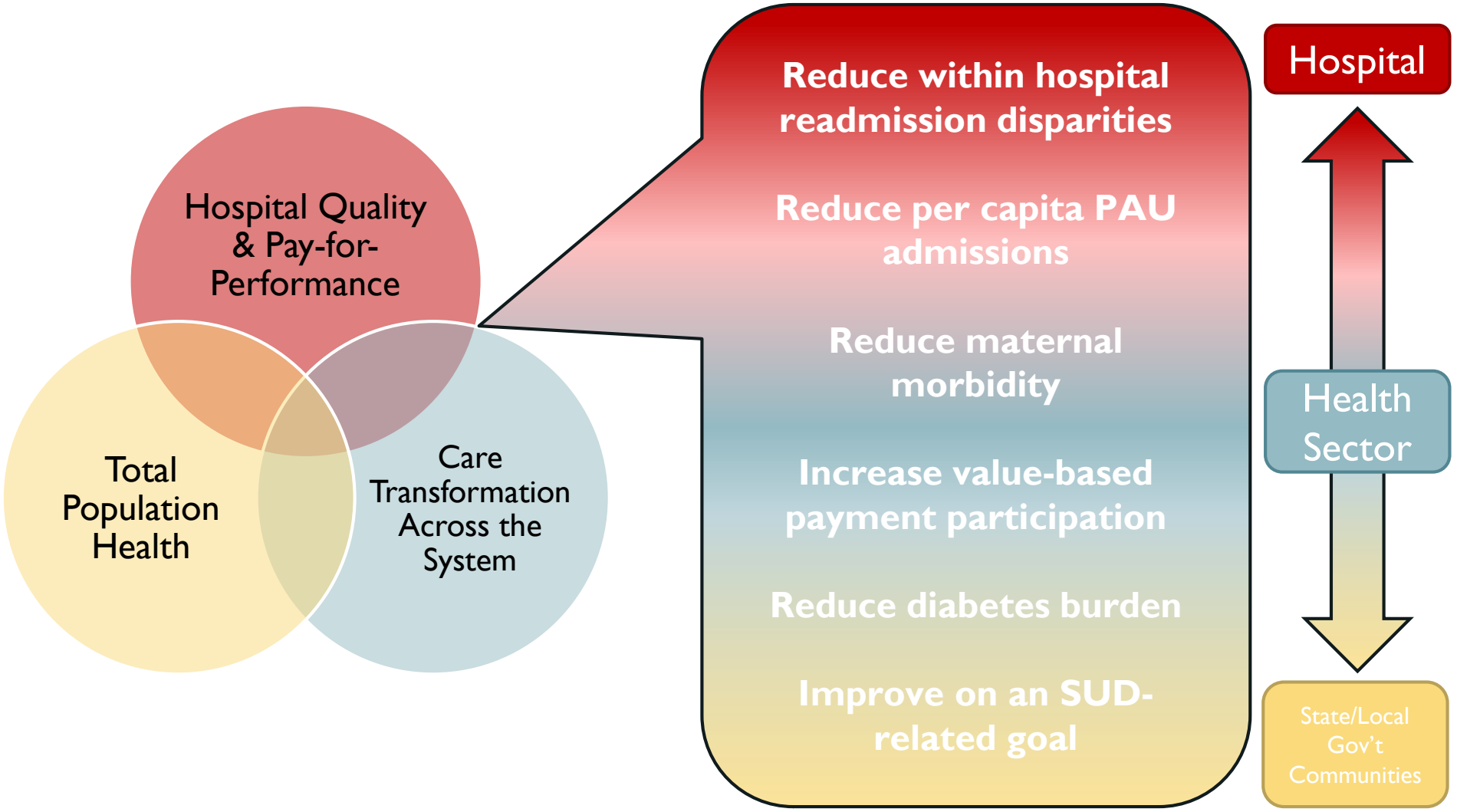
State to set goals for further improvements in quality and population health

- TCOC Contract with CMS requires State to propose new quality targets and population health priorities
- In December 2019, State-CMS signed a Memorandum of Understanding (MOU) to propose goals, measures, milestone and targets in three domains by the end of 2020
- This initiative, referred to as the Statewide Integrated Health Improvement Strategy, engages more state agencies and more private-sector partners than ever before
  - Beyond setting goals and targets
  - Collaborating and investing to further progress to improve health and reduce costs for Marylanders

Domains of Maryland's Statewide Integrated Health Improvement Strategy (non-financial)



Potential examples of Strategy goals



2020 Action Item: State develops and proposes Strategy's milestones and targets

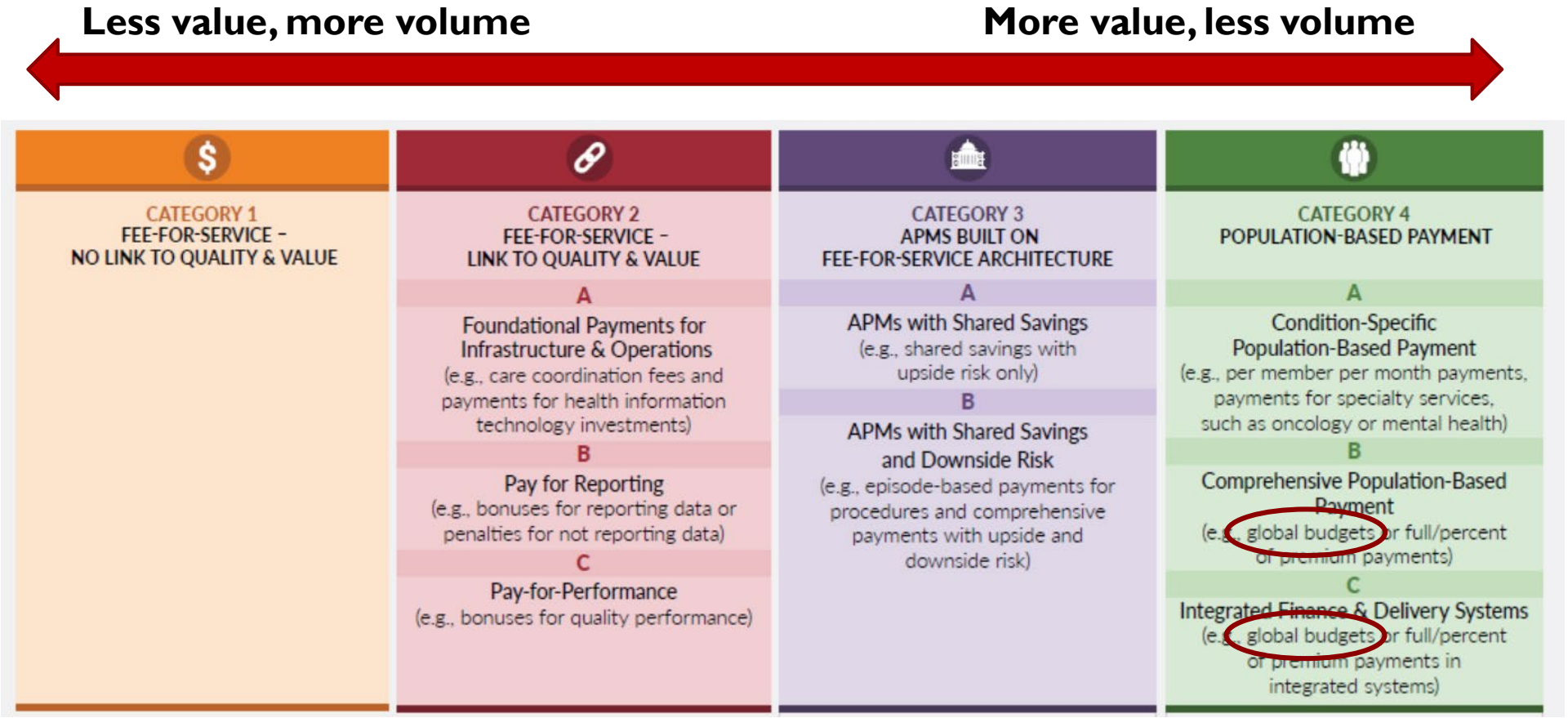
Domain	2021 Milestone	2023 Interim Target	2026 Target
1. Hospital Quality and Pay-for-Performance			
2. Care Transformation Across the System			
3.a. Total Population Health: DIABETES			
3.b. Total Population Health: OUD? Addiction?			

- Already active in all three domains
- Build on our current activities to make further progress through collaboration among Marylanders, providers, payers

Broad work plan

- Domain 1 under development in HSCRC's Performance Measurement Work Group
- Domain 2 under development in
  - HSCRC's Performance Measurement Work Group for measure on "follow-up after discharge"
  - HSCRC's Total Cost of Care Work Group for share of Medicare beneficiaries in value-based framework
- Domain 3
  - Diabetes: MDH
  - Opioids/addiction: OOCC and MDH
  - Other goals? Can be TBD
- State's SIHIS Proposal due by December 31, 2020
  - Must include Milestones, Interim Targets and Targets in all 3 Domains
  - Can add others later, including additional population health goals

Global budgets farthest along Medicare's value-based payment continuum



Source: HCP-LAN Alternative Payment Model (APM) Framework

Discussion question: Where does Maryland stand? What's our goal under TCOC Model?

Our Goal Statement

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models.

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

Source: HCP-LAN Alternative Payment Model (APM) Framework

Proposed Framework for Maryland: Care Transformation Across the System

- Objective: Create measure(s) of progress toward improved statewide outcomes and meaningful development of care transformation in Maryland

Category 1 No change in practice of care	**Category 2** Providers accept value-based payments for patients in their own setting of care	**Category 3** Providers financially accountable for value and care quality for a population regardless of setting
E.g., FFS payments for providers Some link to value and quality of care may be included (e.g., MIPS) but do not fundamentally change the incentives ☹	E.g., Hospitals under global budgets accountable for services in the hospital Moves to value within own setting but little/no financial accountability for outcomes or what happens in other settings 😐	E.g., ACO, ECIP Could be an attribution-based approach (e.g., ACO, ECIP, EQIP) and/or it could include self-defined populations (e.g., hospitals' Care Transformation Initiatives) ☺

9% of Medicare beneficiaries were in Category 3 in 2018

Work plan specific to Domain 2 Framework in TCOC Work Group

- Today: Initial thoughts on framework
- Summer
  - Establishing baseline: Presentation of numbers on number of Medicare beneficiaries in Category 3 in 2019 and projected for 2020
  - Discussion of potential 2021 Milestones, 2023 Interim Targets, and 2026 Targets
- Fall: Staff recommendation to Commission and MDH
  - Tout our success in the Maryland Model as assessed under HCP-LAN (especially with hospital global budgets + MPA)
  - Press toward goals beyond existing frameworks like HCP-LAN
- State submits SIHIS Proposal to CMS by 12/31/2020
- CMS and State agree: Should be stretch goals, but not setting up for failure or automatic success

Discussion questions

- Thoughts on proposed Maryland Framework for Assessing Care Transformation?
  - Programs to be included/excluded?
- Thoughts on work plan, process, and timing?
- What innovations need to be developed to attain more enrollment in Category 3? Some currently under discussion:
  - PACE
  - EMS

Future meetings

- TCOC Work Group meetings
  - March 25, 2020
  - April 29, 2020
- HSCRC Commission meetings
  - March 11, 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
- **Merit-based Incentive Payment System (MIPS):** CMS quality payment incentive program
- **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)
- **Program of All-Inclusive Care for the Elderly (PACE):** provides comprehensive medical and social services to certain frail, elderly people still living in the community
- **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
- **Statewide Integrated Health Improvement Strategy (SIHIS):** sets state-wide goals to improve health and costs for Marylanders