Total Cost of Care Workgroup

January 25th 2017

HSCRC
Health Services Cost Review Commission

Workgroup Charge

The initial charge of the TCOC workgroup is to provide feedback to HSCRC on the development of specific methodologies and calculations while considering implications to avoid cost-shifting for:

1. Hospital-level Medicare TCOC guardrails for the Amendment Care Redesign Programs
2. The Hospital-level Incentive Pool for the Complex and Chronic Care Improvement Program (CCIP)
3. Value-based payment modifiers based on Medicare TCOC
4. The development of a Geographic Population Model (Medicare and potentially others)

Care Redesign Amendment Update

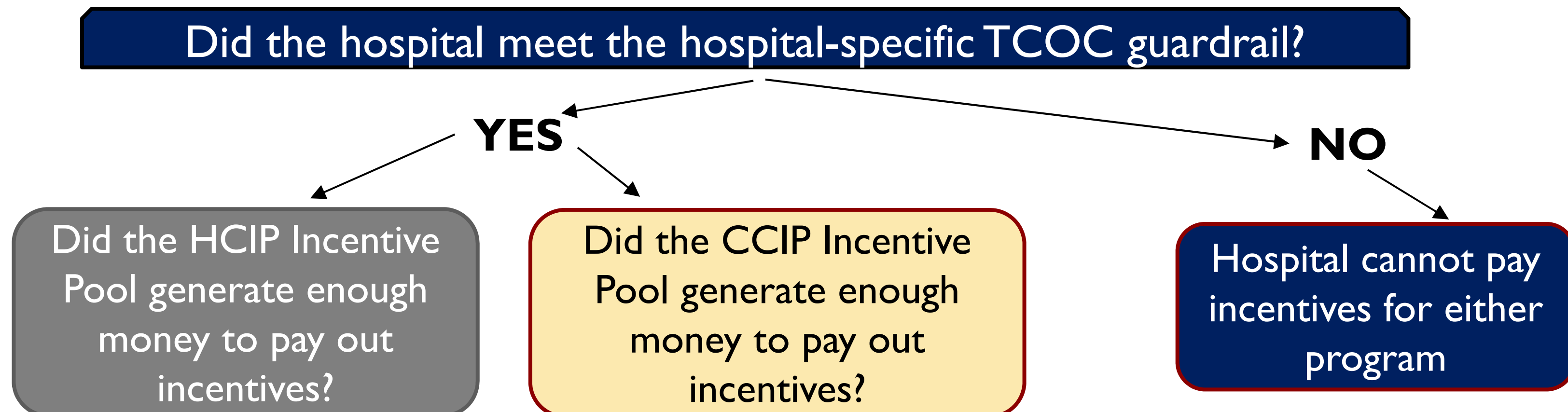
TCOC Workgroup will Focus on Two Elements of the Care Redesign Programs

TCOC Guardrails

- Medicare Hospital-specific TCOC guardrails apply to **both** CCIP and HCIP
- The same Medicare Hospital-specific TCOC calculation will be used for both programs

Incentive Pools

- Physician incentives in both programs are funded out of the hospital GBR, through realized savings
- This workgroup will focus on the **CCIP program only for the incentive pool**



CCIP Incentive Pool

- Determines the amount of money available for a hospital to pay out incentives to providers who meet the thresholds for incentives
- A hospital's Incentive Pool is based on **all Medicare FFS Benes who see the hospital**, not only those enrolled or identified as high or rising need.
- Pool is derived solely from the Participant Hospital's budget and is driven by reductions in Potentially Avoidable Utilization (PAU) for all Medicare Benes
  - 50% of 30-day readmissions (inpatient and observation stays of greater than 23 hours)
  - 100% of Prevention Quality Indicators (PQI)
- Incentive Pool Amount Formula = [(*Standardized Historical Costs of PAU in Base Year – Standardized Current Year Costs of PAU) – Intervention Costs]* 50% Variable cost (VCF)*

Estimating PAU Reduction for CCIP Incentive Pool Payout

- Overall formula to calculate the estimated reduction in PAU necessary to fund a hospital's incentive pool is:

$$\frac{\textit{(Provider Incentive Payments + Intervention Costs) x 2}}{\textit{Incentive Pool Base}}$$

- In the example below, the hospital would need to decrease PAU by 8% in order to fund its Incentive Pool.

Steps	Hospital Example
Calculate Incentive Pool Base	PQIs @ $ 6 million + 50% of Readmissions @ 8 million = $10 million
Estimate Benes: High Need	100 benes
Estimate Benes: Rising Need	500 benes
Calculate Incentive Payments: High Need	Average payment of $1,000 @ 100 benes = $100,000
Calculate Incentive Payments: Rising Need	Average payment of $150 @ 500 benes = $75,000
Add Intervention Costs	200,000
Multiply by 2 to account for Variable Cost Factor*	($100,000 + $75,000 + $200,000) x 2 = $750,000
Divide result by incentive pool base	$750,000 / $10 million = **8%**

*Variable Cost Factor (VCF) assumes hospitals will only save 50 % of the reduced PAU cost due to fixed costs of providing services.

Statewide PAU numbers

- Statewide Medicare FFS Total PAU Charges:
  - 17% of all Medicare FFS Charges in FY15 for a total of ~$1 billion
  - Readmissions = ~$600 million and PQIs = ~$400 million
- State identified high need and rising need benes for FY15 using state definitions.
  - For High Need benes, PAU charges represent 40% of total hospital charges.
  - For Rising Need benes, PAU charges represent 17% of total hospital charges.
  - PAU charges for High and Rising Need benes represent **87%** of Statewide PAU Charges for all Medicare FFS benes.

Medicare FFS FY 15	High Need	Rising Need	Total Rising and High Need	All Medicare FFS
# of Benes	18,000	92,500	110,500	900K
Total Hospital Charges	$1,370,935,217	$1,982,613,559	$3,353,548,776	$5,927,308,998
Total PAU Charges	$545,969,507	$334,016,995	$879,986,502	$1,010,942,639
% PAU in category	40%	17%	26%	17%
% All Medicare FFS PAU	54%	33%	87%	100%

TCOC and MACRA Strategy

TCOC Analytical Steps

- What do we include in the TCOC measurement (numerator) ?
- How do we set benchmarks ?
- How do we structure the payment adjustments?
- How do we qualify clinicians under MACRA ?

MACRA-tizing the Model

- Progression
  - Engaging physicians and other providers in aligned efforts

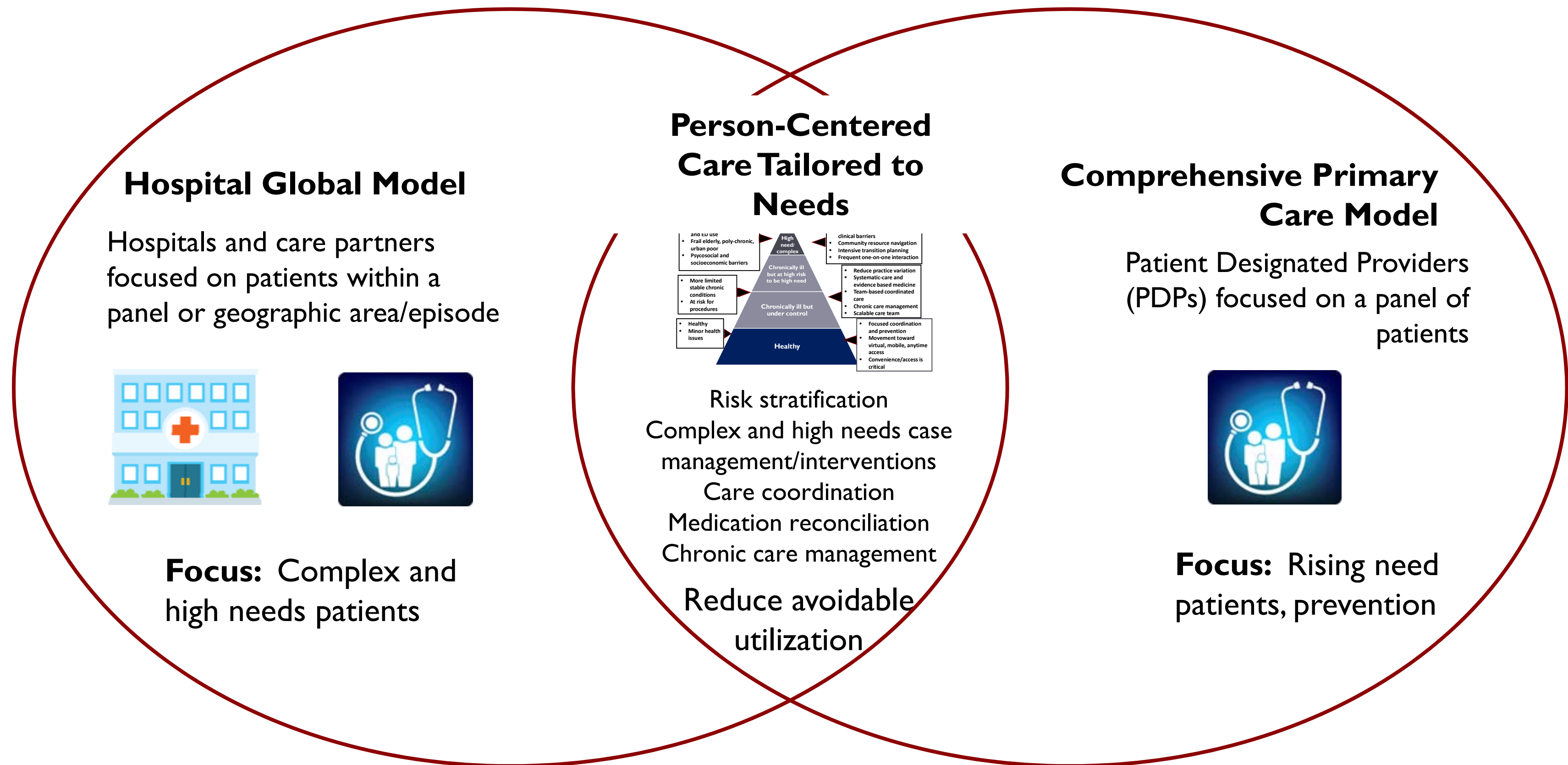
- Key strategies to have the All-Payer Model qualify as Advanced APM:
  - CMS approved Care Redesign Programs to link physicians to the All-Payer Model
  - Hospital global revenues incorporate non-hospital Part B costs through incentives

- Other key approaches to have Advanced APMs in Maryland:
  - Statewide Comprehensive Primary Care Model (CPC+ design)
  - ACOs with downside risk, new Dual Eligible ACOs

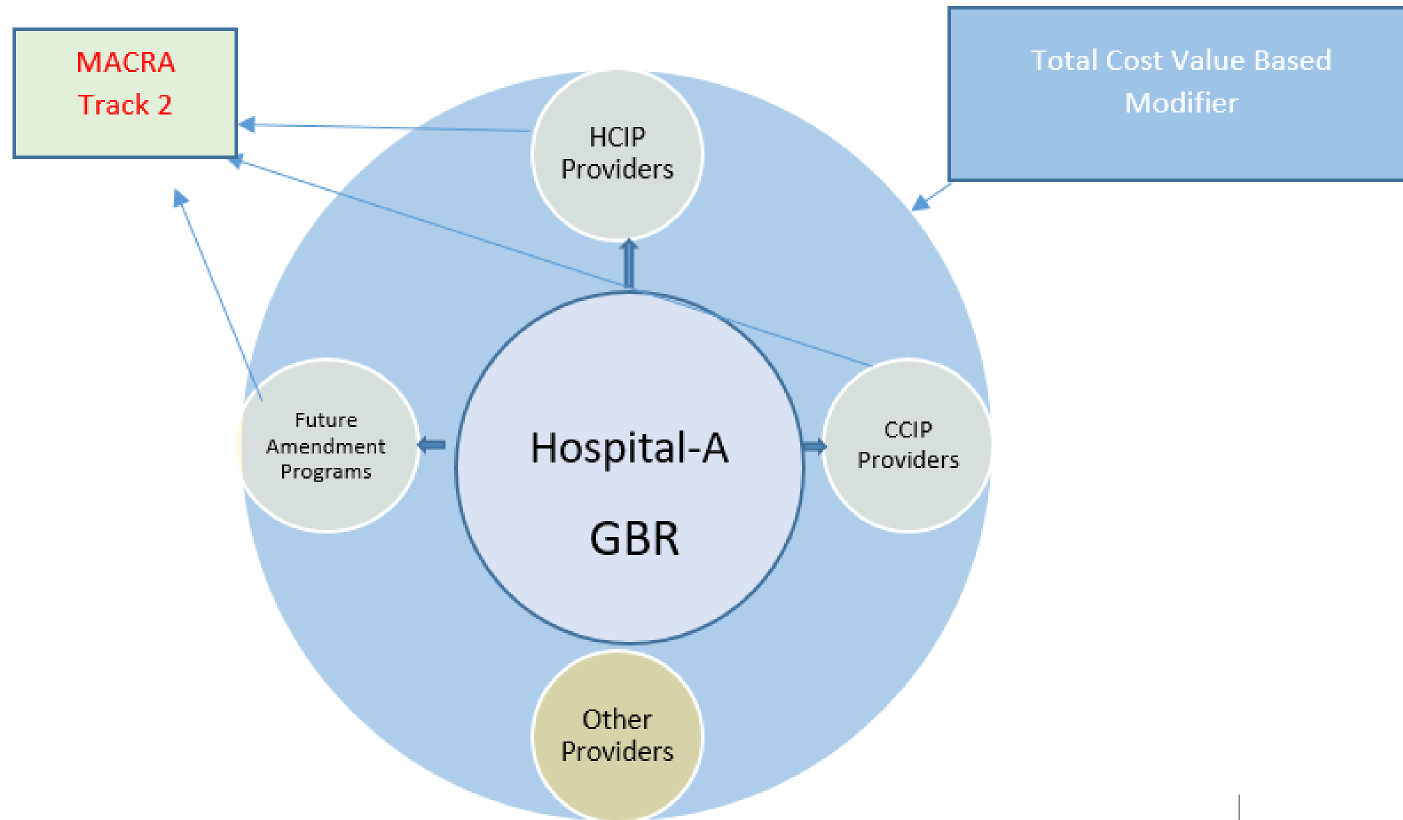
2019 and Beyond—Progression Plan

- Key Components of the Second Term (Starts in 2019):
- Build on global revenue model and continue transformation
- Increase responsibility beyond hospital costs
- Dual Eligibles ACO/Geographic Model
- Comprehensive Primary Care Model
- Other payment and delivery transformation
- Other MACRA-eligible programs

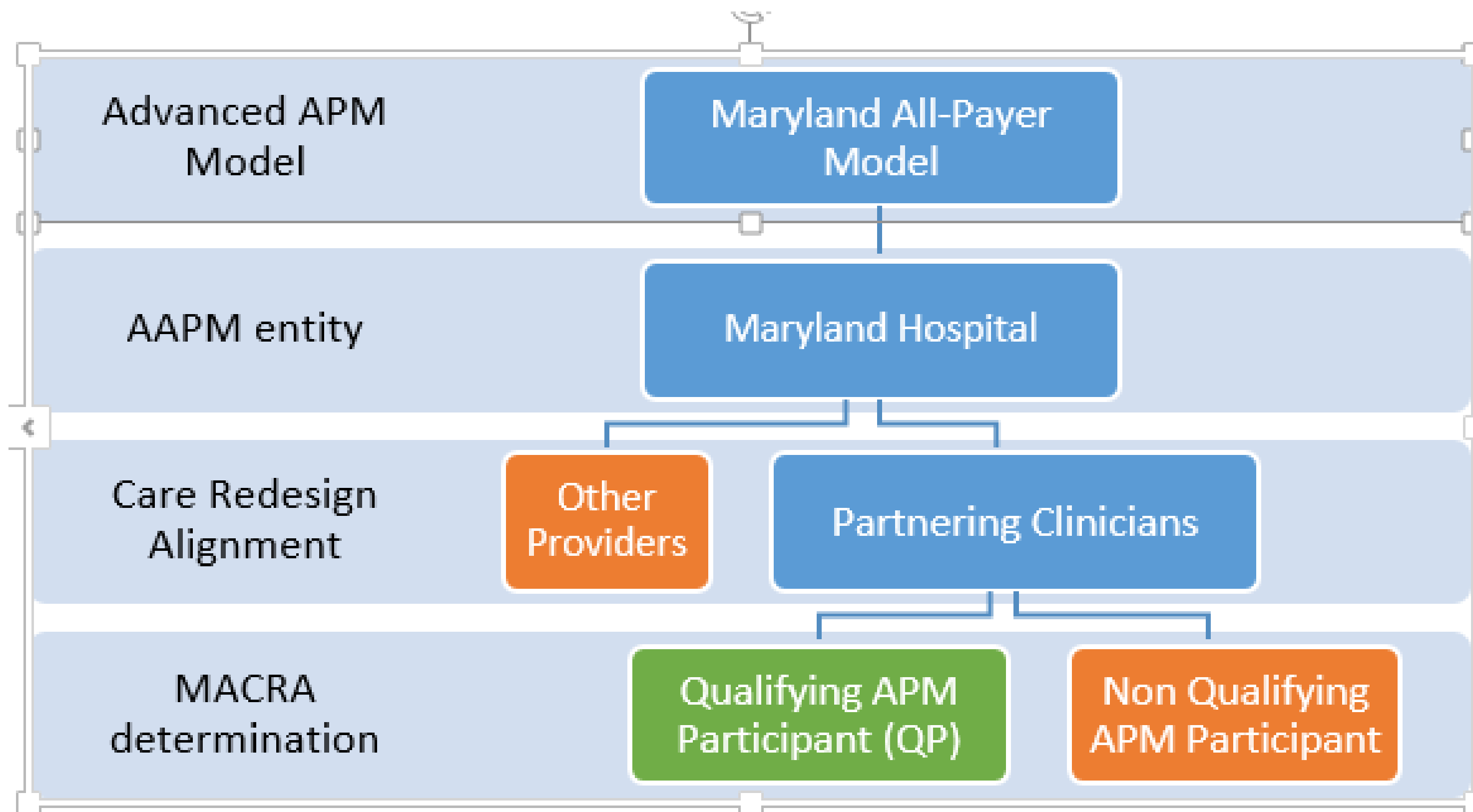
Maryland's Planned Progression: Synergistic Models



Total Cost Value Based Modifier-Framework



TCOC Proposed MACRA Eligibility



Eligible clinicians for 2017 defined as physicians, nurse practitioners, physician assistants, certified nurse specialists, and CRNA

Determining Individual Physician's AAPM eligibility

- Calculations will depend on the structure of the TCOC value based modifier
- Claims run through TCOC measurement is the key:
  - $\% \; Beneficiary = \dfrac{Total \; Provider \; Beneficiaries \; Residing \; in \; Maryland}{Total \; Provider \; Beneficiary \; Count}$
- Or
  - $\% \; Payment = \dfrac{Total \; Provider \; Payment \; for \; Beneficiaries \; Residing \; in \; Maryland}{Total \; Provider \; Payment \; Count}$

Total Cost Value Based Payment Modifier Measurement Options

Guiding Principles from other HSCRC performance measurement policies

- Provide clear incentives and goals.
  - Promote efficient, high quality and patient-centric delivery of care
  - Emphasize value, recognizing that this concept will take some time to develop
  - Promote investments in care coordination
  - Encourage appropriate utilization and delivery of high quality care
  - Set predictable financial impact and targets
  - Hospitals should have the ability to track their progress during the performance period

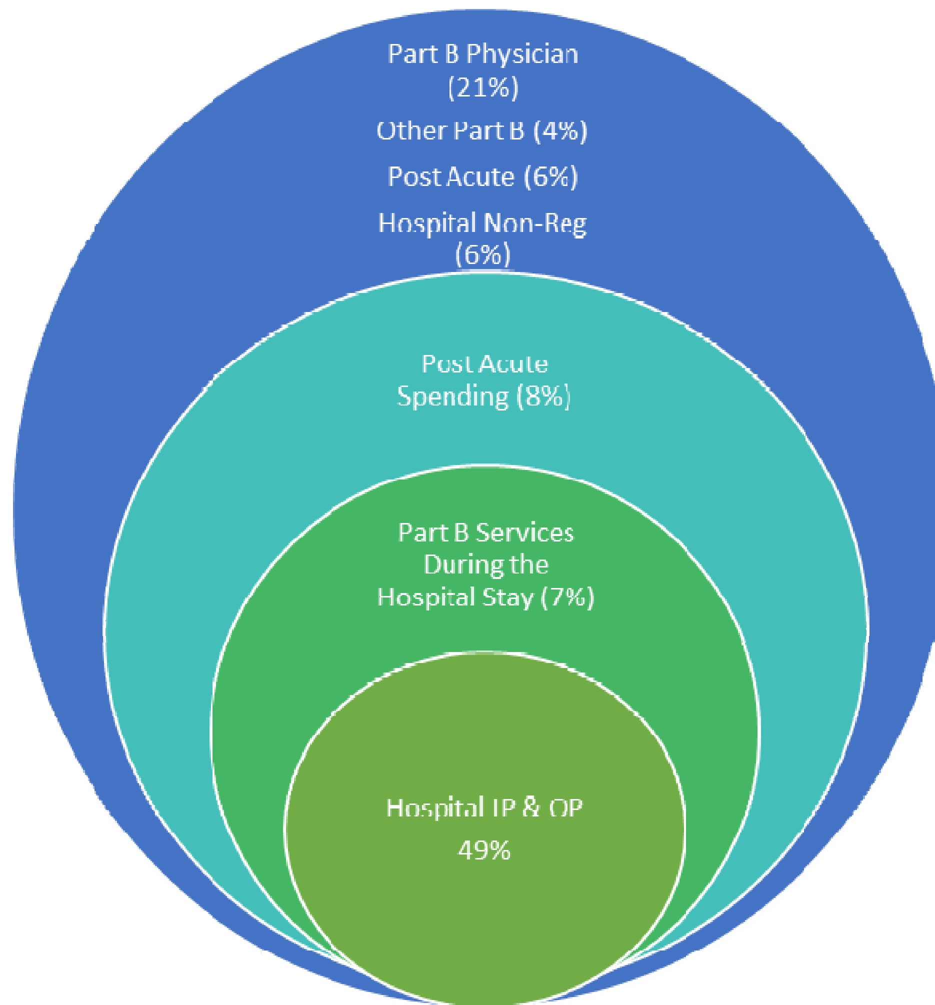
Additional Guiding Principles for TCOC

- Total cost measure should have a broad scope and gradual risk
  - Total cost should include to the extent possible all Part A and Part B costs
  - Measure should be linked to individual hospital performance to the extent possible
  - Measure should reflect both reductions in avoidable utilization (such as preventable admissions) and efficient high quality continuum of care (such as 30 to 90 day episodes of care)
  - Payment adjustments should provide controlled risk

Questions for TCOC Workgroup: Attributing TCOC for VBM

- How to attribute Total Cost of Care (TCOC) to each hospital? Options:
  - (1) Primary Service Area (PSA) – that is, based on the zip codes each hospital has declared as theirs
    - PSAs are more reliable for assigning TCOC in rural areas
    - Where multiple hospitals share PSAs, attributing TCOC becomes more complicated
  - (2) Episodes
    - Based on 48 BPCI episodes used by CMS
    - Captures only a quarter of TCOC
  - (3) Stepwise Approach:
    - Built from hospital utilization, related post-acute and Part B spending – which in total, captures 70-75% of TCOC
    - The remaining could be attributed via market share distributions or PSA

Distribution of TCOC



List of other methodological considerations

- TCOC Performance Year 1 Target= TCOC Base Year * Expected trend factor
- Performance Benchmarks (state, national, best practices etc)
- Population served (denominator)
- Population Risk adjustment (HCCs, Demographics, Socio-economic factors, etc)
- Standardization of charges (Medical education, DSH,etc)
- Annual vs cumulative measurement etc.

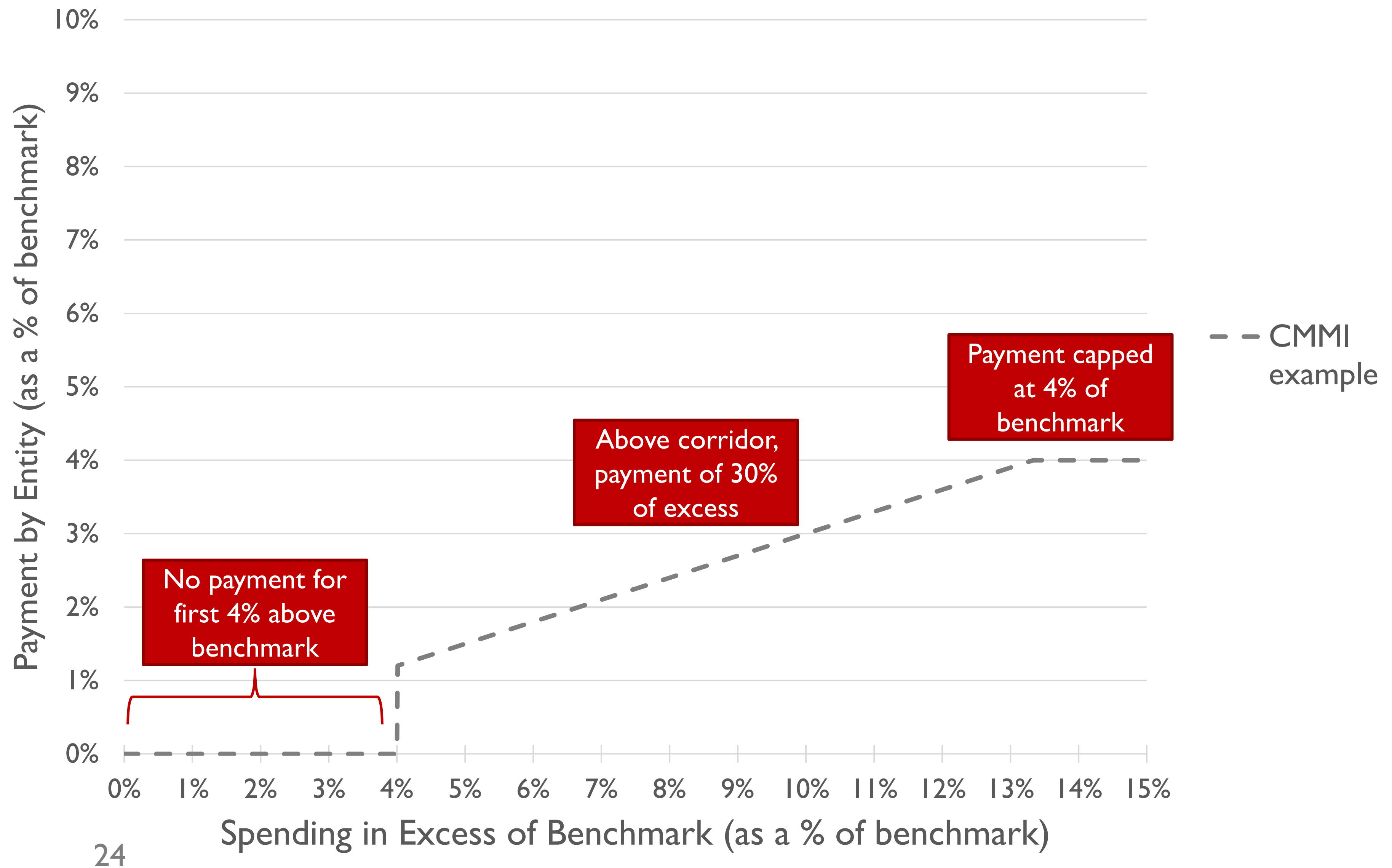
Total Cost Value Based Payment Approach

Questions for TCOC Workgroup: Structuring VBM for Possible Payments and Incentives

- Once TCOC has been attributed to each hospital, what size of payment is appropriate? Options – as illustrated in the following figures:
  - CMMI's Track 1+ ACOs appear to follow draft MACRA regulations, with losses capped at 4% of the benchmark
  - However, Maryland hospitals already face substantial financial responsibility based on their GBRs
  - Concept paper to CMS:
    - Could propose a VBM to make hospitals accountable for TCOC
    - But at levels below Track 1+ ACOs, acknowledging responsibility Maryland hospitals already bear

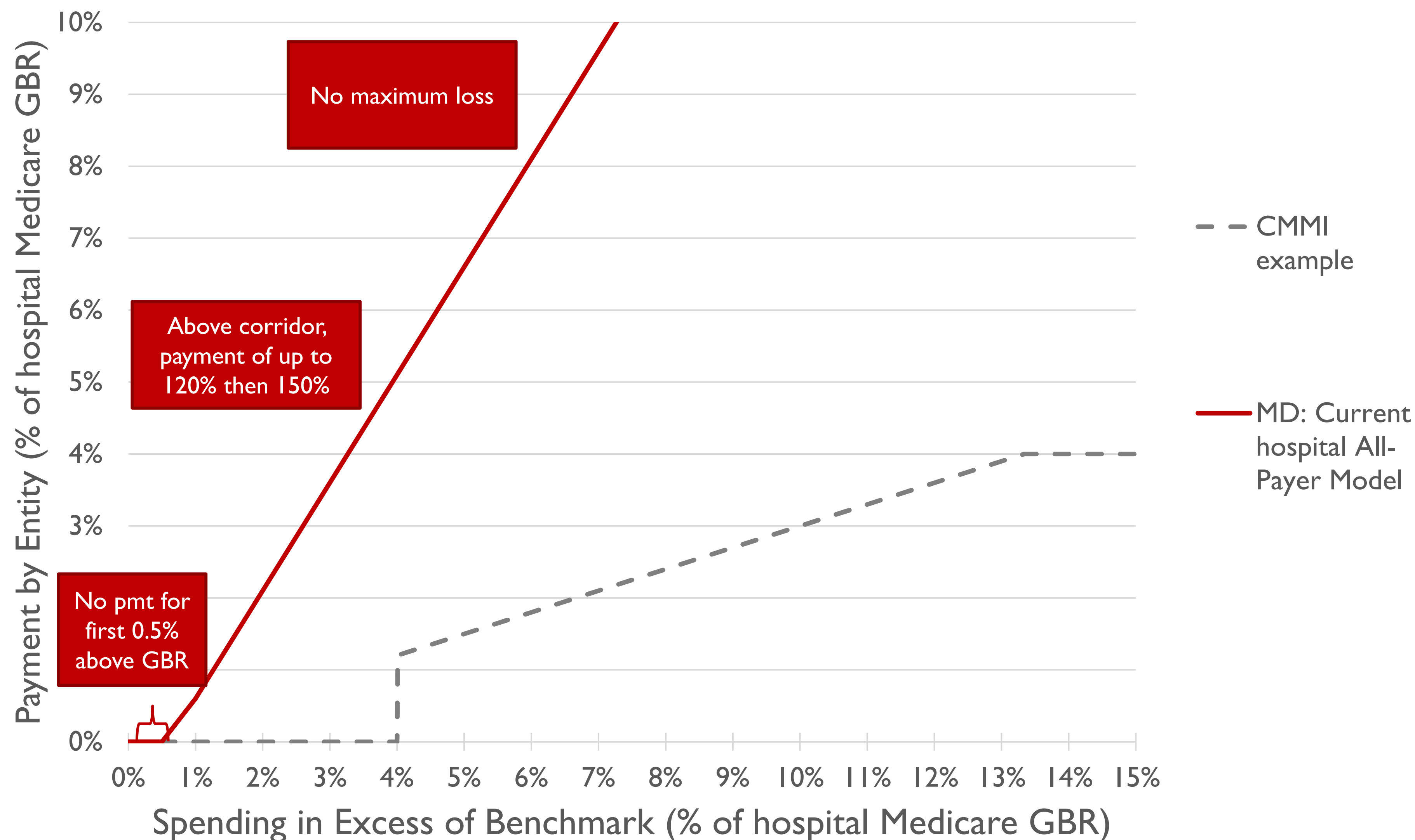
CMMI: Proposed MACRA Rule & Track 1+ ACOs

(Source: Figure D of 81 *Federal Register* 28308. Marginal risk and stop-loss below applies to Track 1+ ACOs)



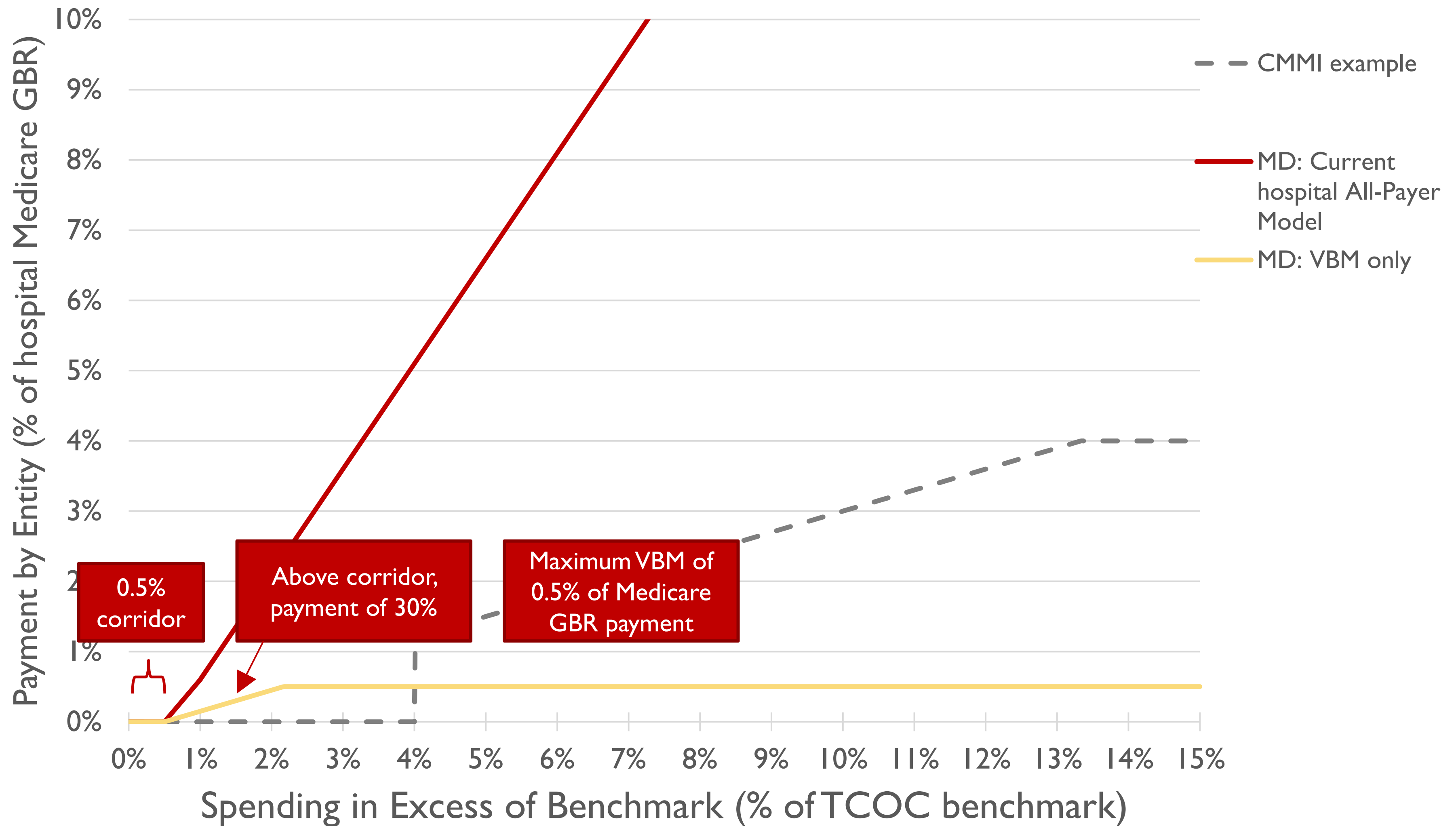
Maryland Hospitals under Global Budget Revenue (GBR)

(Source: GBR Agreements between the state and each Maryland hospital)

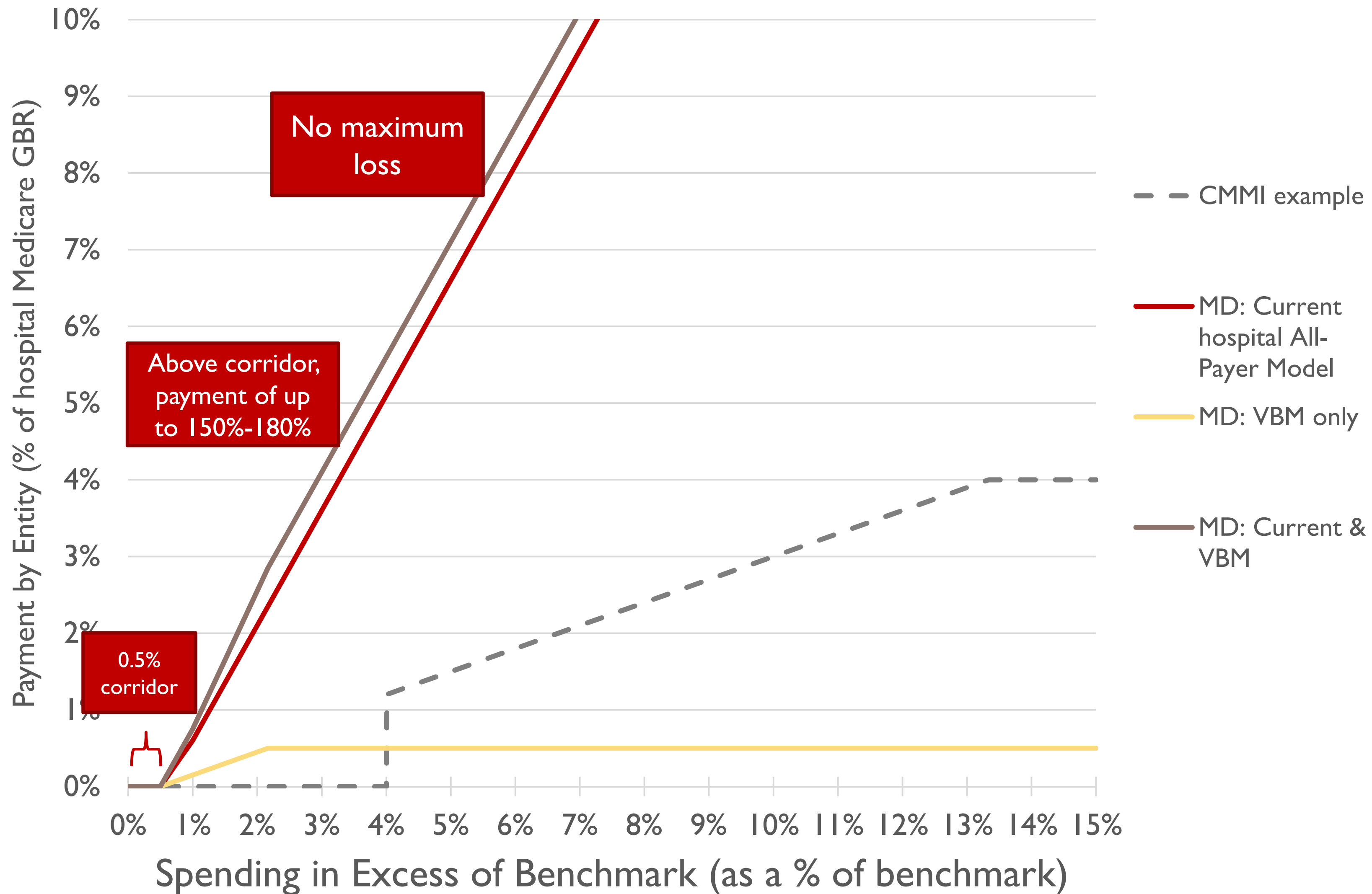


Proposed Value-Based Modifier (VBM)

Based on Total Cost of Care (Parts A&B), including costs of physicians and other clinicians, post acute, etc.



Combined Risk on Maryland Hospitals: All-Payer Model + VBM



Questions for TCOC Workgroup: Possible Incentives under VBM?

- Although the VBM is proposed to satisfy CMMI requirements for financial responsibility on TCOC, should it also permit positive financial payments to hospitals?
- If positive payments are permitted to hospitals under the VBM, should amounts of potential incentives mirror those of penalties (symmetrical)?
- Should positive financial payments be permitted only if hospitals participate in HCIP and/or CCIP?
- Should positive amounts be designated to the CCIP Incentive Pool, for hospitals to potentially pay as gain-sharing to physicians?