Total Cost of Care Workgroup

April 26, 2017

HSCRC
Health Services Cost Review Commission

Agenda

- Updates on initiatives with CMS
- Summary of Medicare Performance Adjustment (formerly VBM)
- Trade-offs in various approaches to assign Medicare TCOC
- Options for assigning TCOC based on geography
- Options for assigning TCOC based on beneficiary attribution

Updates on Initiatives with CMS

Summary of Medicare Performance Adjustment (MPA)

Formerly Value-Based Modifier (VBM)

HSCRC
Health Services Cost Review Commission

Medicare Performance Adjustment (MPA)

- **What is it?**
  - A scaled adjustment for each hospital based on its performance relative to a Medicare Total Cost of Care (TCOC) benchmark

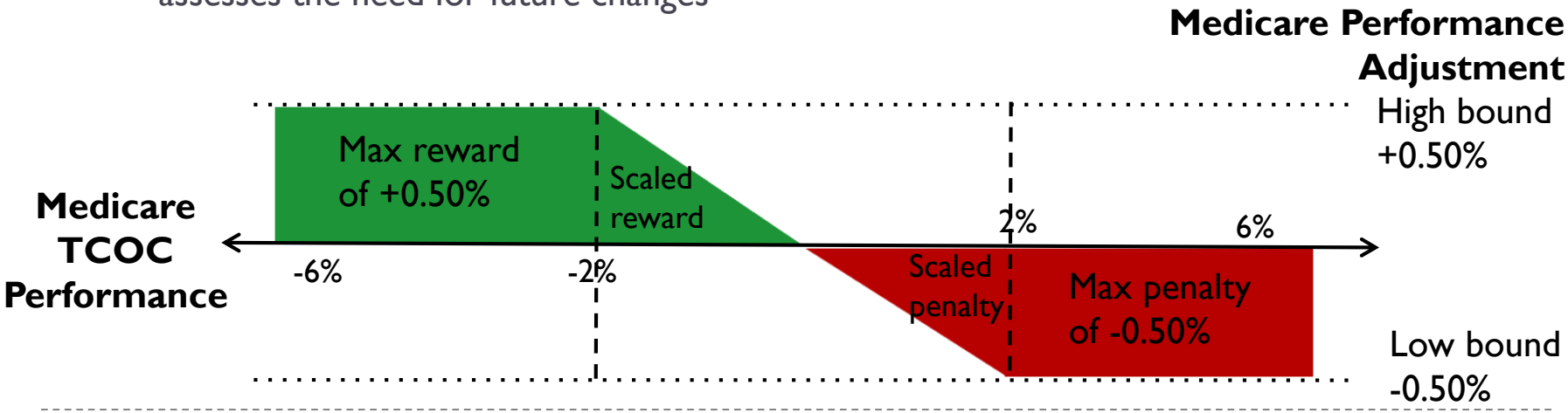
- **Objectives**
  - Allow Maryland to step progressively toward developing the systems and mechanisms to control TCOC, by increasing hospital-specific responsibility for Medicare TCOC (Part A & B) over time
  - Provide a vehicle that links non-hospital costs to the All-Payer Model, allowing participating clinicians to be eligible for bonuses under MACRA

MPA: Design Process

- **Initial staff and stakeholder discussions** (including Advisory Council)
  - Discussed high-level concept
- **Progression Plan** – Key Element
  - Summarized discussions to date under "Key Element 1b: Implement local accountability for population health and Medicare TCOC through the geographic value-based incentive"
- **TCOC Workgroup**
  - Working on MPA conceptual details
- **Other ongoing discussions** with staff, stakeholders, experts, including Mathematica, LD Consulting, Aditi Sen, PhD
  - Preparing materials for TCOC workgroup and vetting concepts

MPA: Current Design Concept

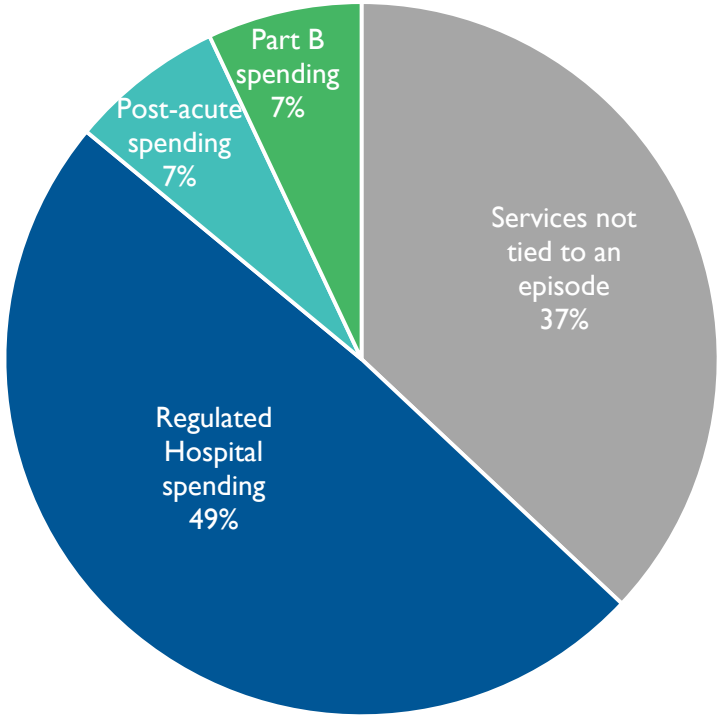
- Based on a hospital's performance on the Medicare TCOC measure, the hospital will receive a scaled bonus or penalty
  - Function similarly to adjustments under the HSCRC's quality programs
  - Be a part of the revenue at-risk for quality programs (redistribution among programs)
  - NOTE: Not an insurance model
- Scaling approach includes a narrow band to share statewide performance and minimize volatility risk
- MPA will be applied to Medicare hospital spending, starting at 0.5% Medicare revenue at-risk (which translates to approx. 0.2% of hospital all-payer spending)
  - First payment adjustment in July 2019
  - Increase to 1.0% Medicare revenue at-risk, perhaps more moving forward, as HSCRC assesses the need for future changes



MPA: Potential Options for Calculation of Hospital-level TCOC

- **A) Geographic Approach**
  - TCOC for Medicare beneficiaries living within a Hospital's geography.
  - PSAs cover ~90% of Maryland Medicare TCOC
- **B) Episode Approach**
  - TCOC for Medicare beneficiaries during and following a hospital encounter for a specified amount of time (i.e. 30 days)
  - Covers ~2/3 of Maryland Medicare TCOC with episodes alone
- **C) Attribution Approach**
  - Assignment based on Medicare beneficiary utilization and residence

Example of Episode Approach: Approx. share of Medicare TCOC included in hospital episodes with 30 days post-acute



Source: Draft analysis by HSCRC of 2015 Medicare FFS claims

MPA: Next Steps

- Receive federal, stakeholder, and HSCRC input on State's proposed concepts to date, including:
  - MACRA qualification
  - Level of revenue at risk, progression
  - TCOC linkage design
- Prepare MPA for Medicare TCOC so it is in place by January 1, 2018
  - Current focus is on the start-up Year 1 (Performance Year 2018, Adjustment Rate Year 2020)
  - MPA calculations modified in future years based on lessons learned and delivery system's increasing sophistication

Tentative Timeline for MPA Analytics and Policy

Date	Topic/Action
April 26, 2017 TCOC Work Group	More in-depth analyses of TCOC potential measures and modeling, including geographic areas besides current PSAs
May 28, 2017 TCOC Work Group	Potential benchmarking methodology (plus follow-up on TCOC measure refinement)
June 28, 2017 TCOC Work Group	Potential financial responsibility and rewards (plus follow-up on benchmark and TCOC refinements)
Additional TCOC WG meetings?	Other follow-ups and outstanding issues
July 2017 – Sept 2017	Continue technical revisions of potential MPA policy with stakeholders
October 2017	Staff drafts RY 2020 MPA Policy
November 2017	Draft RY 2020 MPA Policy presented to Commission
December 2017	Commission votes on Final RY 2020 MPA Policy
Jan 1, 2018	Performance Period for RY 2020 MPA begins

Trade-offs in various approaches to assign Medicare TCOC

Trade-offs in Various Approaches to Assign Medicare TCOC to Hospitals

Approach	Pros	Cons
Geography TCOC for Medicare beneficiaries living within a hospital's geography (to be defined)	• High % of statewide TCOC coverage • Focus on communities • Post-acute and primary care near patient residence • Collaboration between hospitals • Not based on utilization	• Overlapping geographies and large variation in % market share within the same geographies • Specialty cases in another hospital
Episode TCOC for Medicare beneficiaries before and after a hospital encounter (length to be defined)	• Clear single hospital responsibility • Focus on costs directly impacted by a hospital • Encourages on post-discharge care • Holds each hospital accountable for its own significant procedures	• Lower % of statewide TCOC coverage • Based on utilization, which may affect TCOC performance and attribution • Post-acute and primary care may be far from hospital delivering care • Churn: Population attribution dependent on hospital use
Patient Attribution Assignment based on Medicare beneficiaries' utilization of hospital services (to be defined)	• Clear single hospital responsibility • Encourages post-discharge care	• Lower % of statewide TCOC coverage • Based on utilization, which may affect TCOC performance and attribution • Churn: Population attribution dependent on frequency of attribution, dependent on hospital use

Options for assigning TCOC based on geography

MATHEMATICA
Policy Research

Total Cost of Care:

Defining Hospital Service Areas

Preliminary Results Presented to Total Cost of Care Work Group

April 26, 2017

Eric Schone
Fei Xing

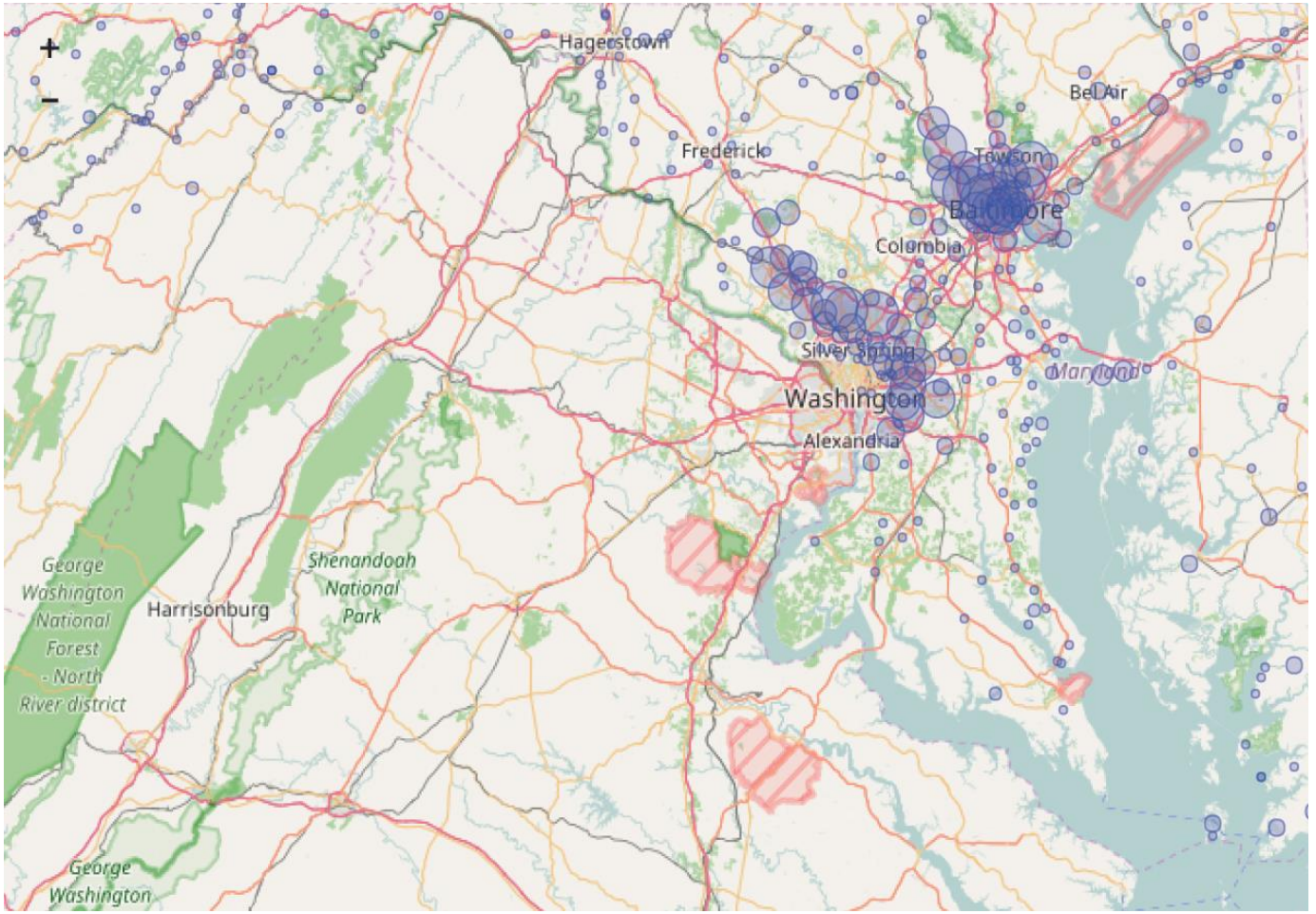
Defining Service Area

- **Primary Service Area (PSA)**
  - Defined by hospital
- **Service Flows**
  - Inflow: share of hospital's services provided to area
  - Outflow: hospital's share of services in area
  - Where hospital has at least designated share of discharges
- **Plurality rule**
  - Dartmouth Atlas approach
  - Where hospital or set of hospitals has higher share of discharges than other hospitals
- **Travel distance (under consideration)**
  - Area within which patients are willing to travel to use a particular hospital

Testing Service Area Definitions: Methods

- One year of Medicare hospital inpatient service records
  - Compare to alternate years (planned)
  - Compare to all payer (planned)
- Assign and compare service areas
  - Based on hospital zip code combinations
  - What is hospital's share of discharges in zip code by PSA and other definitions?
  - What is share of hospital's discharges from zip code by PSA and other definitions?
  - How much overlap?
  - What proportion of costs are assigned (planned)?

PSA zip codes Claimed by Hospitals: Number of hospitals by zip code



PSAs and hospital share of discharges

- Overlap is given by circle size for zip codes
  - About 2/3 of zip codes claimed by only one hospital
- Share of hospitals discharges
  - Share of hospital's discharges in designated PSA ranges from 18.5 percent (JHU) to 93.7 percent (Union of Cecil)
  - Median is 63.9 percent
- Market share within PSA
  - Median is 30.9 percent

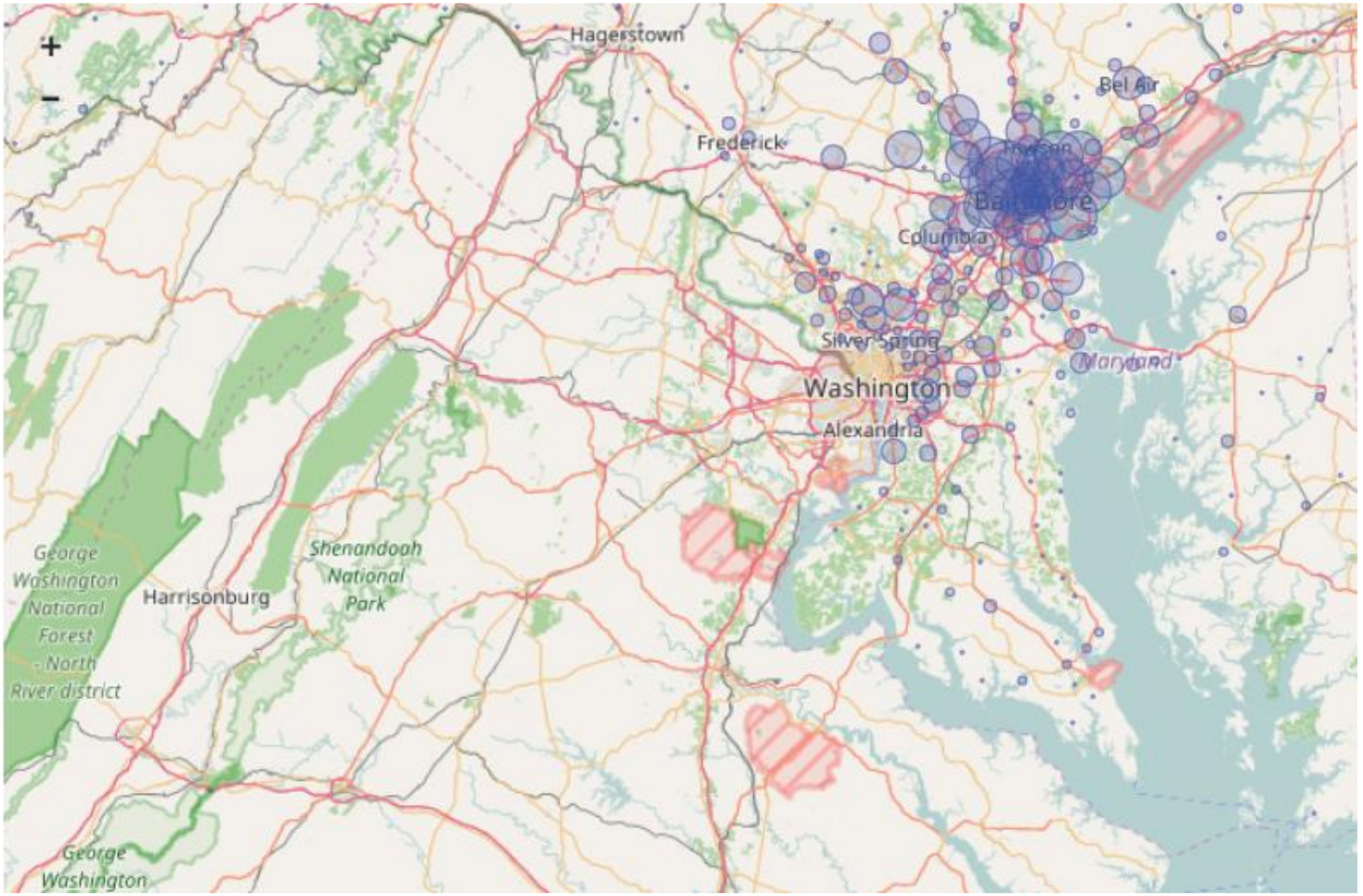
Flow Model

- Service area
  - Hospital has at least 75 percent of all hospitals' discharges in combined zip codes
  - Hospital has at least 75 percent of its discharges from combined zip codes
- Two hospitals with unique service areas
  - Meritus and Western Maryland

Overlapping Service Areas based on Outflows

- Overlapping service areas
  - Zip codes with highest market share making up 75 percent of hospital‘s discharges
- Number of overlapping zip codes is greater than PSA approach
  - 35 percent uniquely assigned

Zip codes making up 75 percent share of hospital discharges: Number of hospitals by zip code



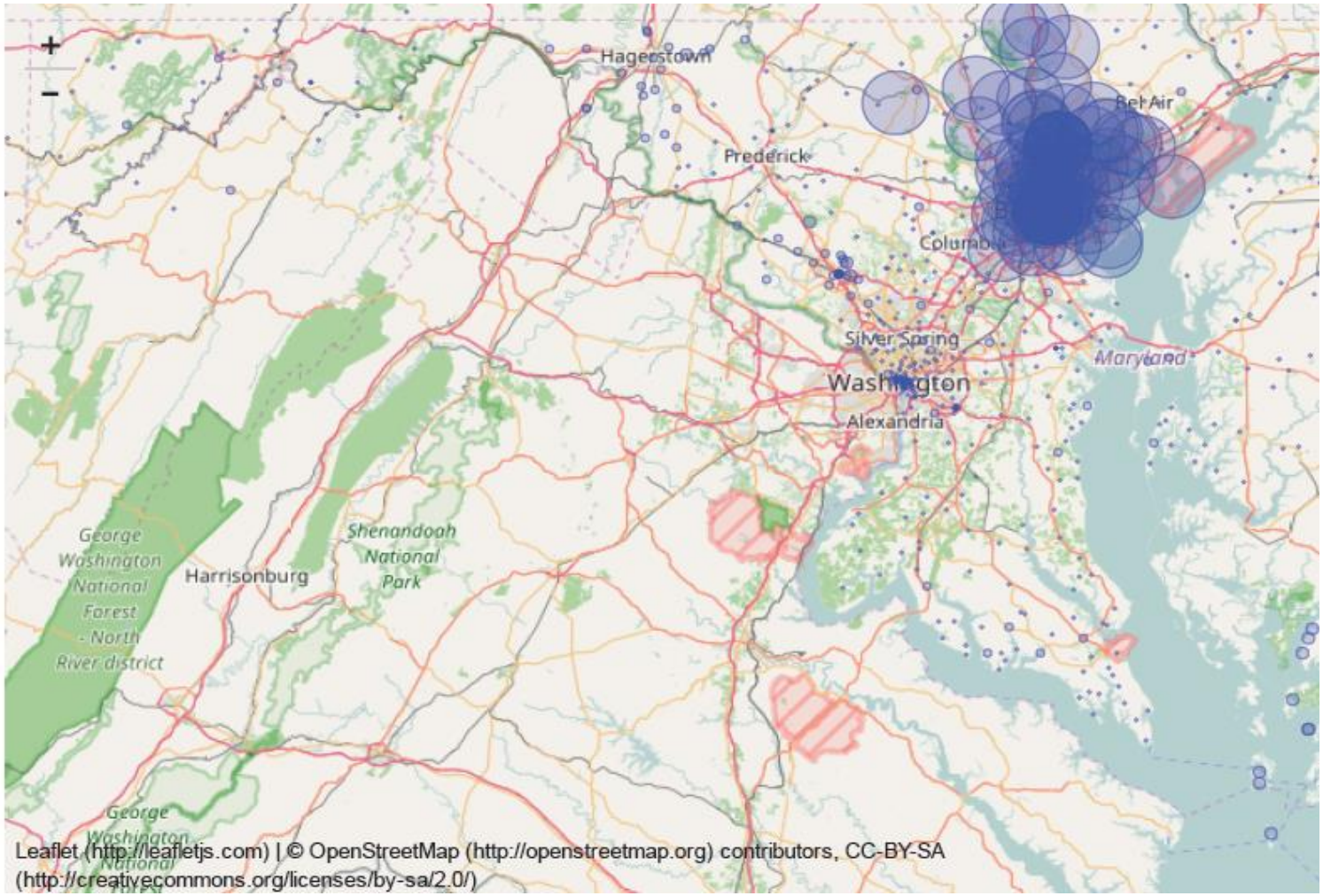
Overlapping Service Areas based on Outflows

- Share of hospital discharges, by definition >75 percent
- Up to 89 zip codes in service area (U MD)
- Minimum market share: 2.7 percent (Bon Secours)
- Median market share: 27.6 percent
- Nine hospitals with market share > 50 percent

Plurality Approach

- Median share of hospital's discharges in service area: 73.6 percent
- Minimum share of hospital's discharges in service area: 30.8 percent (PG County)
- Produces maximum overlap – Baltimore service area contains 16 hospitals, but 2/3 of zip codes are uniquely assigned

Hospital Service Area zip codes



Comments

- Self-designated PSAs account for a lower proportion of discharges compared to other approaches
- PSAs frequently overlap, but less than other approaches
- Flow-based and plurality-based approaches account for more hospital services
- These approaches can produce service areas within which hospital has small role
- Plurality-based approach accounts for more discharges than PSA approach with more focus on hospital served areas than flow approach (except in Baltimore)
- Priorities depend on role of geography in assignment of total cost

Next Steps

- Analyze exclusions
- Assess mixed strategies
- Analyze travel distance approach (optional)
- Compare results across years and data sets
- Perform cost analysis

Options for assigning TCOC beneficiary attribution from hospital use