maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

October 2023

Agenda

1. Administrative updates
2. Revisions to MPA for CY24 & to CTIs for Y2 and beyond
   - Recap of Comment Letters Received
   - Staff Responses
   - Next Steps

Administrative Updates

Changes to Meeting/Management Structure

- Cancelled the CTI Steering Committee and added membership to this meeting
  - Will kick off additional ad hoc series if needed
  - CRISP Learning Collaborative will continue to facilitate information sharing on CTIs
- HSCRC will be looking to fill Deputy Director role to focus on managing MPA, EQIP and CTIs
- Welcome to Lynne Diven

Value-Based Program Timelines

- MPA
  - Draft Y6 (CY24) policy will be submitted to the Commission in December
  - Request to CMS due by 12/31/23
  - Final approval in early 2024
- EQIP
  - Y1 (CY22) payments expected in late October
  - Y3 (CY24) enrollment complete, vetting process ongoing
  - Groups wishing to develop new episodes for Y4 should be contacting HSCRC now
- CTIs
  - Y1 (FY22) settlement in MPA adjustment effective 7/1/23
  - Y2 (FY23) completed 6/30, episode and claims run out to 3/31/24, settlement in Q2 of 2024
  - Y3 (FY24) Enrollment was extended to June 30.
  - Y3 Initial Data available October 27, 2023, covering claims from July to September
  - Hospitals wishing to suggest changes to or addition of thematic areas for Y4 should contact the HSCRC soon

Population Health Spending Diagnostic Tool – Progress Update

Discussed in TCOC May Meeting

- Existing CRS tools in support of Medicare Population Health management tend to be:
  - Program focused (e.g. CTP, SIHIS) or
  - Focused on specific elements of care (MADE)
  - Relies on hospital analysis of the problem (DEX, MPA Sandbox, benchmarking)

- Is there a need/demand for a diagnostic tool that starts at a high level and allows hospitals to identify areas of spending to address
  - Include benchmarks to identify outliers
  - Allow drill down from high level to specific across the total spend
  - See Milliman “ACO Insight” example

Current Status/Next Steps

- Held demos for small industry audiences on two alternative tools in August
- Received positive feedback on the concept
- CRISP will be releasing an RFP soon RFP Released 10/16
  - Will work with CRISP RAC to include hospital representation in the evaluation process
  - Goal will be to award by 12/31 and if acceptable tool is identified, implement by 7/1/24

MDPCP and ACO in MADE and MPA Y6 Reports

- In MPA Y6 All Hospital and Hospital Specific Sandboxes Categories:
  - MDPCP:
    - **Yes**: Beneficiary participates in MDPCP in the current attribution quarter.
    - **No**: Beneficiary does not participate in MDPCP in the current attribution quarter
    - Currently 2023Q3. Will Update to 2023Q4 in November.
  - ACO:
    - **Yes**: Annual calendar year flag from Medicare indicates participation in an ACO.
    - **No**: Annual calendar year flag from Medicare does not indicate participation in an ACO.
- MADE (with beneficiary level information):
  - MDPCP:
    - **Yes**: Beneficiary participates in MDPCP in the current attribution quarter.
    - **Yes (Hospital CTO)**: Beneficiary participates in MDPCP in the current attribution quarter *and* is attributed to a hospital/hospital system-based Care Transformation Organization (CTO).
    - **No**: Beneficiary does not participate in MDPCP in the current attribution quarter.
    - Will Update to 2023Q4 in November.
  - ACO:
    - **Yes**: Annual calendar year flag from Medicare indicates participation in an ACO.
    - **No**: Annual calendar year flag from Medicare does not indicate participation in an ACO.

Comment Letters

MHA
Adventist
UMMS

Recap of Proposal - MPA Revenue At Risk

- In its 2023 MPA Approval Letter, CMS indicated that it expected the State to increase the Revenue at Risk under the MPA in 2024.
  - Staff believe that CMS expects an increasing the revenue at risk to at least 2% of Medicare revenue in 2024 and potentially further increases in the future.
  - *The expectation that the State shift to 2% was cited in CMS' letter waiving the need for a corrective action plan based on 2022 guardrail miss.*
  - Increasing the revenue at risk to 2% would double the revenue at risk under the traditional portion of the MPA.
- The MPA has a 33% marginal savings rate. This means that in order to realize the maximum revenue at risk, a hospital would have to exceed the national growth rate by 6 percentage points.
- Staff believe that increasing the revenue at risk is reasonable but will propose to re-institute the CTI buy out at the same time.

Recap of Proposal - Revisions to CTI Program

- Cap downside risk at 3%
  - Consistent with MPA the quality adjustment would be applied after the cap.
  - Spread impact across all hospitals in order to maintain revenue neutrality
  - Effective impact would be max risk before quality at slightly over 3% (as hospital at max loss of 3% would receive allocation of the offset)
  - Reduce total risk with MPA by re-introducing CTI Buy Out

- Reintroduce CTI Buy Out
  - Under prior buy out a hospitals MPA risk was reduced based on the ratio of CTI impacted beneficiaries to total MPA attributed beneficiaries
    - Recognizes hospital's greater ability to impact CTI populations
    - Combined with higher MPA at risk it focus relief on hospitals pursuing Care Transformation through CTI while leaving inactive hospitals fully exposed.
  - CMS previously did not sign off on the CTI buy out
    - Combination of high MPA exposure and data on actual CTI risk may help reverse that decision.
    - If CMS does not change their position, HSCRC would eliminate the provision of the MPA policy, no other changes would be made.

MHA Summary

- Support Mitigating MPA Risk if Combined with CTI Buy Out
  - Hospital acceptance of the increase to 2% is contingent on implementing CTI Buy Out
  - Concern about geographic attribution under MPA
  - Requests further consideration of the MPA-like impact of the Medicare TCOC measure in the efficiency policy.
- Support Limiting CTI Downside Risk with Additional Cap Analysis
  - Requests further evaluation of 3% cap, including potential formulaic alternatives to set the threshold.
- Quantify Financial Risk in all Policies
  - Requests quantifying the risk and reward of all value-based payment policies, or those that adjust, or potentially adjust, a hospital's all payer rates or Medicare payments, based on total cost of care performance.

Adventist Summary

- Supports focusing risk on populations with whom hospitals have a treatment relationship with
  - Limit focus on the MPA
  - Implement the CTI-buy out
- Has concerns with the nascent CTI payment policy and recommends further study and refinement
- Recommends a comprehensive policy risk assessment considered in setting the CTI loss cap as well as a standard risk framework to assess all policies when contemplating new risk thresholds.
- Supports a CTI downside risk less than 3%, suggest 1% as a transitional approach
- Does not think it is appropriate to solely use Year 1 policy results in setting the stop-loss risk
  - Recommends that risk could be set at a lower threshold and incrementally increased as the CTI payment policy matures

UMMS Summary

- Notes the industry has invested a significant amount of effort into attribution in recent years, and we concur that a geographical approach is the most suitable framework.
  - HSCRC should continue to invest in analytical tools that let hospitals better understand geographically attributed beneficiaries
- HSCRC should evaluate benchmarking targets used in MPA to ensure specific geographies/populations are not disadvantaged by the use of national growth as a benchmark.
- The combination of 33% marginal savings rate and a 2% cap limits a hospital's ability to benefit from/exposure to risk under MPA
  - 33% marginal savings rate creates an effective 6% minimum savings rate for maximum reward of 2%
  - Other programs typically require much lower threshold to achieve savings reward
- Concerned that the population health measure proposed for addition to MPA quality score may need further review
- Support the CTI buy out proposal
- Industry need to better understand the 3% cap for CTIs

Staff Responses

Support for CTI Buy Out (all)

- Staff agree with industry that the buy out is a logical companion to the MPA and CTI policies
- Prior elimination came from CMS. Concerns included:
  - Interaction with TCOC contract that 95% of beneficiaries be attributed under MPA
  - Limits role of MPA in ensuring all Maryland beneficiaries are managed using tools available to hospitals
  - At the time, risk under the CTI policy was an unknown
- HSCRC appreciates input from the industry on how to best address CMS' concerns
  - CTI risk is now quantifiable
  - HSCRC evaluating data on the impact of beneficiary selection in CTIs

Validity of 3% CTI Downside Risk Cap – Level and Basis (all)

CTI Penalties by % for CTI Y1

%	% of hospital below X%
-1.0%	48.8%
-1.5%	27.9%
-2.0%	20.9%
-2.5%	7.0%
-3.0%	2.3%

Cap interpretation:

- A cap of -3.0% would equate to a hospital with no CTI savings reaching the maximum penalty at a statewide gross CTI savings of $150 M, based on Statewide hospital spending of $5.0 Bn.
- Any excess would be redistributed across all hospitals to achieve neutrality, resulting in a practical cap slightly above 3%
- Prior complete calendar year is used in setting the actual amount.

- Staff is willing to consider alternative approaches to calculating a maximum as suggested by industry, although staff is skeptical of the need for added complexity
- Staff believes a maximum of 2.5% may be appropriate shielding the bottom 7% of hospitals in 2023
- Maximum could be revisited after Y2 data is complete and does not have to be fixed for all future years at this time
- Staff does not believe that a cap of 1% is appropriate, even in transition, it would
  - decimate the incentives of the policy
  - penalize hospitals with strong results
  - undermine the argument for the CTI buy out of the MPA.

TCOC Risk Exposure (MHA and Adventist)

	Integrated Efficiency	MPA	CTI's
Evaluation	50% ICC, 25% Medicare TCOC Assessment (TBD), 25% Commercial TCOC Assessment (TBD)	Cumulative TCOC Growth compared to TCOC Target that accounts for historical TCOC effectiveness	Attributed TCOC compared to historical TCOC updated for inflation.
One-time or Permanent	Permanent	One-time	One-time
Potential At-Risk (%)	~75% of Inflation in Update Factor	2% of Medicare Revenue	Share of Statewide CTI Savings less Hospital-specific savings, capped at 3%
Potential At-Risk Assuming Average GBR Size of $300M ($)	$300M X 3% UF X 75% Reduction from IE = $6.75M	$300M X 33% Med FFS Share X 2% MPA Reduction = $2M	$300M X 33% Med FFS Share x 3% = $3 M.
Requirements to Have Potential At-Risk = Realized At Risk	Assuming hospital had worst TCOC performance in the State, it would also need to be at least worse than 20th percentile of ICC performance (rank of 35 out of 43)	The hospital must exceed its Medicare TCOC Target by 6%.	The hospital must have produced no savings in any CTI and the State must have produced at least 3% average.

$11.75M Total Potential At Risk is equivalent to 3.9% (before CTI buy out)

Assessment of Overall Hospital Risk Exposure

- Staff believe TCOC exposure (before CTI buy-out) of ~4% of all payer revenue is appropriate under the TCOC model
  - Maximum exposure results only from very poor hospital performance
  - Combined exposure supports arguments for CTI buy out
- As UMMS notes, MPA policy already includes very dilutive translation of actual results to incentive payments this reduces the practical risk of hospital exposure at the cost of reduced incentives
  - Should the HSCRC argue for a lower MPA cap in exchange for a more direct translation of TCOC trend into incentive payments under MPA?

Other Comments

- Population Health measure (UMMS) – will discuss further at next meeting
- Other CTI provisions (Adventist) – Staff will continue to consider revisions to the CTI program
- Data Analytics (UMMS) – CRISP/HSCRC are continually evaluating ways to expand/enrich data availability
  - Population Health Diagnostic tool
  - Ability to expand access to hospital “touch” patients beyond IP and ED (reach out to CRISP for more information)
  - Exploring CMS capability to share partially adjudicated claims
  - Open to other suggestions, subject to PHI and data timeline limitations
- Benchmarking (UMMS) – Staff are currently planning the scheduled periodic review of the benchmarking methodology starting late next spring using CY22 data
  - Will lay out plan in early CY24 with TCOC Workgroup.
  - Any changes will be implemented for CY23 benchmarking results
  - Revisit of MPA approach will follow that.

Proposed Update to CTI Baselines

- Following slide outlines the currently available CTI baselines and the proposed changes
- Proposal is still be considered and will be finalized in the Spring prior to the next enrollment period
- Further revisions to the baselines may still be considered for all future periods.
- Please contact the HSCRC with questions or thoughts

Proposed Update to CTI Baselines

- Current Baselines:
  - Panel-Based Primary Care: CY19
  - All others: FY17, FY18, FY19
- Proposed Baselines for Y4 (FY25 Performance Year)
  - Panel-Based Primary Care: CY19, CY22
  - All others: FY17, FY18, FY19, FY23
- Proposed Baselines for Y5 (FY26 Performance Year)
  - Panel-Based Primary Care: CY22, CY23
  - All others: FY23, FY24
  - Existing CTIs will be grandfathered into pre-pandemic baseline but any change in the existing CTI parameters will require the creation of a new CTI using a new post-pandemic baseline.

Next Steps

Next Steps

- November meeting moved back to November 29thth at 8AM to avoid Thanksgiving week.
- Staff expects to release draft MPA CY24 recommendation to this workgroup by ~ November 7
- November workgroup agenda:
  - Update on Population Health measure
  - Review of MPA Recommendation
  - Review of data on CTI and EQIP beneficiary selection
  - Review of analysis on site of service shifts from 2018 to 2022

Thank You
Next Meeting: November 29th, 8-10 am