maryland
health services
cost review commission

Care Transformation Steering Committee

May 2022

Agenda

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1. CRP Waiver Issue
2. Supplemental Adjustment Buyout
3. CTI Risk Adjustment

CRP Discussion

Stakeholder Comments on CRP

Several stakeholders provided comments on the CRP changes discussed at the last workgroup.

1. UMMS appreciates the protections of the CMS fraud and abuse waivers, without them they would be limited to more traditional forms of partnership to manage costs outside of the hospital.
2. Luminis asks that Staff to create a workgroup specific to this issue. They believe that CRP has been valuable and recommend that CRP continues functioning in its current form.
   A. They note that hospitals might not earn shared savings through the MPA and might not make incentive payments if they did not earn savings.
   B. Through the waivers and programmatic structure of ECIP, Luminis has been able to invest in data sharing tools, care coordination resources (i.e. providers in SNFs and care management using SNF quality data), and early mobility efforts.
3. MHA recommends HSCRC continue ECIP as currently constructed and allow flexibility to pilot new hospital-led tracks. They also noted:
   A. HSCRC should get an expert legal opinion on the status of the ability for hospitals to provide these incentives without the waivers. Blanket waivers give hospitals the ability to readily extend services to their care partners without needing to evaluate each specific use case.
   B. In national programs, where Maryland historically has been excluded, incentive payments are not required, and the federal government recognizes that provision of non-monetary resources is appropriate.

Staff Responses

Staff recognize the value of the waiver and are committed to supporting the waivers.

- The policy we are proposing is simple: If a hospital uses the waiver (either to share incentive payments or non-pecuniary resources), they may participate in ECIP; if they do not use the waiver, they do not participate in ECIP.
- The ECIP Incentive Payment methodology shares incentive payments to the physicians only if the hospital earned savings.
- We will revise the ECIP implementation protocol so that hospitals can better report their non-pecuniary investments. We only require than something be included here.

Regarding the process, this is the workgroup to discuss CRP issues.

- We do not see the need for another one. We do not believe that a commission recommendation is necessary.
- And we have provided numerous opportunities to “include additional stakeholder input beyond a survey.”

Summary

Beginning in 2023, participants in ECIP must use the Fraud and Abuse wavers.

- This means that participants must either make incentive payments (if there are any savings) to their care partners OR share non-pecuniary resources with their care partners.
- We will ask any participant sharing non-pecuniary resources to provide the fair market value of the resources provided to their care partners.
- Hospitals that do not want to share incentive payments or resources can participate in the CTI program and earn savings that they keep.

We will phase out the HCIP track.

MDPCP Supplemental Buyout

Finalization of the MPA Supplemental Adjustment Buyout

In the previous workgroup meeting we asked for stakeholder's suggestion on MDPCP Supplemental Adjustment 'buyout.' We are finalizing the policy as follows:

- The Buyout will apply to both 2021 and 2022
- We will calculate the number of CTI beneficiaries that are also attributed to the hospital for the MDPCP Supplemental Adjustment.
- We will reduce the magnitude of any MDPCP Supplemental Adjustment by the amount of the overlap.
  - If 25% of a hospitals MDPCP Supplemental population are in a CTI then we will reduce the magnitude of the MDPCP supplemental adjustment by 25%.
  - This applies to both the upside (rewards) and the downside (penalties).
- The care management fee cap will be reduced by the amount of the overlap.
  - The MDPCP Supplemental Adjustment cannot exceed the amount of the care management fees for the attributed population.
  - We will reduce the cap (and thus potentially losses) by the amount of the MDPCP supplemental population who are in the CTI program.

MDPCP Supplemental Buyout

Review of the CTI Risk Adjustment Methodology

During our previous stakeholder meetings, we discussed the CTI Risk Adjustment methodology and its implications for wins / losses.

As a reminder, risk adjustment has 3 steps:

- Step 1: Regress TCOC on the HCC and / or APR-DRG Weights
- Step 2: Risk normalize baseline period target prices
- Step 3: Update the target price with the performance period risk score

The regression is run on the statewide, baseline data for that specific CTI:

$$\text{Total Episode Cost} = \alpha_P + \beta(\text{Risk Score})$$

- α_P captures the unique baseline average cost of the CTI for each provider in the state
- Risk Score is the average HCC score of patients comprising the CTI episodes
- β is the coefficient for each risk score (which equals the average change in total episode cost given a one-unit change in the average risk score)

Analysis of Risk Adjustment Issues

As a consequence of using statewide coefficients, it is possible that a hospitals baseline target price is either higher or lower than its baseline costs.

- Some hospitals raised concerned that a hospital whose target price was less than its baseline period costs would have difficulty beating its target price.
- We used the 6-month ‘measurement period’ to assess whether the target price was above baseline period costs was associated with better or worse performance.

Results

	No Savings (Costs above Target Price)	Savings (Costs below Target Price)	Total	Percent Successful
Target Price Above Baseline	26	18	44	41%
Target Price Below Baseline	34	26	60	43%
Total	60	44	104	42%

Regression Analysis

	(1) % Difference Between Performance Period Cost and Target Price	(2) Probability of "Win"	(3) % Earnings as a share of target price, conditional on "Win"
Final Target Price Below Baseline Average	-2.36 (0.470)	2.42 (0.807)	-2.02 (0.446)

We used a regression analysis to check whether the Final Target Price being above the baseline average is statistically related with the following:

1. The percent by which the performance period costs exceeds the target price;
2. The probability that the performance period costs is less than the target price;
3. The savings if the hospital does succeed at beating the target price.

We saw no statistically significant relationship between earning savings in the CTI and the baseline period target price.

Conclusion

We do not believe that the risk adjustment process systematically penalizes or rewards hospitals. Variation occurs around the statewide mean and a hospital being above / below is not indicative of the following year.

- However, there is some variation inherent in the risk adjustment.
- We believe that this is unavoidable. Even using a ‘straight risk adjustment’ (e.g. dividing the costs by the HCC score) would include an assumption that the relationship between costs and HCC at the hospital is the same as national.

We will continue to examine the CTI and the relationship between costs and risk scores.

Reporting Update

We intend to update the CTP reporting system to show hospitals their risk scores in the baseline and the performance period and the results of the regression analysis.

- This will allow hospitals to calculate the difference between their baseline costs and their target price.
- Additionally, hospitals will be able to track changes in the risk mix of their CTI.

Next Steps

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Next Steps

The next CTI Period begins on July 1st

- Thank you to all hospitals that submitted CTI for the next performance period.
- The HSCRC has begun reviewing the CTI submissions. If there is an issue the HSCRC will reach out to you.
- **You do not need to take any further action unless you hear from us.**

If you have any suggestions / comments on the application process, please let us know.

- We have talked with some hospitals about modifications to the Care Transformation Profiler.
- We would appreciate any additional comments.

As always, if there are additional CTI definitions that you would like to see made available please let us know. We are committed to adding any feasible definitions.