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Total Cost of Care Workgroup

10/26/22

Agenda

- MPA Attribution
- GBR 2.0
- (Medicare) Consumer Benefits

MPA Issues

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Changes to the MPA as of 1/1/23

There are several changes to the MPA that will become effective on January 1st, 2023. Those include:

- Updated ECIP period
- Quality adjustment – consistent with all-payer recommendations
  - RRIP to be implemented at 2x value to adjust in 6 months
  - MHAC will remain at zero
- Implementation of CTI Buyout over last 6 months of the fiscal year
- HSCRC will release updated worksheet in mid to late November

Update to Proposed New MPA Quality Calculation

Base Proposal

- Capture results from new all-payer population health measures
  - Set maximum value to +/- 4% as that sets population health weight equal to the value of traditional programs
  - Exact translation from all-payer population health measures to MPA value of 4% will be determined once measures and scoring are established*.
- Double the quality weighting after adding population health score and apply the quality adjustment after the TCOC cap.
- Proposed MPA Quality Adjustment
  - Step 1: MPA TCOC x 1/3 result subject to +/- 1% cap.
  - Step 2: Step 1 x (1+ 2 x (RRIP + MHAC + Pop Health Reward/Penalty))
  - Where:
    - MPA result is expressed as percentage points above or below target
    - RRIP and MHAC are each up to +/- 2%
    - Population health is worth +/- 4%
    - Calculation is reversed if MPA TCOC result is a penalty
    - Total adjustment can not exceed +/- 1.16% of Medicare payments
  - % of MPA reward at risk for quality = 16%

New

- Staff have proposed and CMS has preliminarily agreed to suspend the population health portion for CY23 while the measure is evaluated. So for CY23 the risk would be 8%.

MPA Attribution

At our previous TCOC Workgroup we asked for comments on the proposed MPA attribution algorithm.

- Reminder: We are proposing to change the hospital's PSAPs for geographic attribution to assign the zip codes comprising 60% of the hospital's volumes. Hospitals then receive their share of the zip code's beneficiaries.
- Most comment letters indicated that they agreed with the proposed attribution algorithm.
- We have received a comment from UMMS indicating a concern with the zip codes attributed to the AMCs.
- We will work with the AMCs to determine which zip codes are attributed to them. This can impact the attribution of other hospitals (by effecting their share in the overlapping zip codes) but we expect the impact to be relatively limited.

Progression Plan

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Progression Plan Development Timeline

Oct 2022-April 2023
- Small Workgroups begin
- Progress Updates to Secretary's Vision Group (SVG)

April 2023
- Small Workgroups Conclude
- Written workgroup recommendations finalized by HSCRC and State staff

May-June 2023
- Draft Progression Plan finalized (May)
- Draft plan circulated to HSCRC Commission and SVG for initial comment (June)

June - Sept 2023
- Draft Progression Plan circulated for public comment
- Socialize with other important stakeholders (elected officials, others as needed)

Oct - Dec 2023
- Public comments reviewed and integrated into final Progression Plan

Dec 2023
- Final Progression Plan submitted to CMMI

Stakeholder Engagement Approach

- HSCRC and other State staff are planning stakeholder engagement meetings to develop content for a written Progression Plan for the expansion of the Model (or a new Model) beyond 2026.
- Small groups will meet on priority topics, October - April 2023.
  - To the extent possible, staff will utilize existing workgroup structures; new groups will be created for select topics
  - Staff leading the small groups will reach out to Commissioners for input
- Progression Plan drafted for review, May-June 2023
  - Commission will receive updates on progress and also view a draft of the Progression Plan before the public comment period.
  - Members of the Secretary's Vision Group (MHA, MedChi, Payers, HFAM/LifeSpan, MHCC, Medicaid, MDH) will also be asked to review and comment.
- Public Comment and Final Submission to CMMI, June-December 2023
  - Public comment period will allow for additional comments from all stakeholders before presented to CMMI
  - Begin negotiation process with CMMI on future of Model based on vision in Progression Plan

Stakeholder Small Group Focus Areas

TCOC Workgroup & Next Steps

The TCOC will focus on two topics:

1. A concept for a GBR 2.0 aligned with suggestion by Meritus.
2. Cost sharing in the future of the Model

We plan on five monthly meetings before finalizing our staff report to the Secretary's Vision Group.

1. October – Socialize design questions & Solicit suggestions from the industry
2. November – Discuss stakeholder suggestions and conceptualize a straw man example
3. December – Discuss stakeholder questions
4. January – Discuss stakeholder questions
5. February – Staff circulates draft recommendation & Solicit stakeholder comments
6. March – Summarize and discuss stakeholder comments

GBR 2.0

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Overview of the GBR 2.0

Under the TCOC Model, hospitals have a GBR that includes only their hospital revenues but are (collectively) accountable for reducing the TCOC in Maryland, but individual accountability is limited. The GBR 2.0 would:

- Expand the GBR to include all (Medicare) physician, post-acute care costs, and other provider costs for an attributed population.
- Give the hospital additional tools to help control the TCOC.

Note: This model will be…

- Voluntary for the foreseeable future
- Medicare for the foreseeable future
- Implemented through the MPA so that only Medicare payments are implicated

Components of the GBR 2.0

In order to specify the GBR 2.0, we will need to define

1. Determining any Excludes Services
2. Attribution of Beneficiaries
3. Setting the GBR
   - Baseline
   - Inflation / Demographic Growth
   - Market Shift
4. Quality programs
5. Additional Flexibilities

Determining Excludes Services

Ideally, the GBR 2.0 would include all costs. However, there may be some services / costs that should be carved out of the GBR because: 1) they are entirely outside the control of the hospital; 2) they are performed only by certain hospitals with the state.

- Burns
- Transplants

Discussion Questions: What rules should be used to determine which services are excluded in the GBR 2.0?

Attribution

The GBR 2.0 will need to attribute all beneficiaries to hospitals within a given area (county, state, service area, etc.). Some options include:

- County / Region
- Attributing rural areas to the nearest hospital.
- Determining service areas based on the zip codes that comprise a certain amount of the hospital's volume (60%, 40%, etc.)
- Service areas defined by the hospital in a proposal to HSCRC

Discussion Questions: What attribution rule should be used to assign beneficiaries to the hospital?

Setting the GBR 2.0

Conceptually, setting the GBR 2.0 is simple. Once the beneficiaries have been assigned to the hospital, the GBR 2.0 should grow no faster than our savings target (e.g. National TCOC growth rate – savings obligation).

- Which baseline should be used to set the GBR 2.0?
- What adjustments should be made for risk / service mix within the attributed population.

Discussion Question: What other adjustments should be made to the GBR 2.0?

Quality Programs

QBP / MHAC / Readmission would apply to the hospital GBR. In addition, the GBR 2.0 would have its own quality adjustment:

- Population Health linked to SIHIS
- Network Adequacy for a certain level of service provided per beneficiary

Discussion: What other quality adjustment should apply to the GBR 2.0.

What flexibilities would be necessary

The GBR 2.0 will hold hospitals accountable for costs that occur in the community. Hospitals will have limited ability to control costs in those settings. Additional flexibilities may be necessary, such as…

1. Fraud and Abuse Waiver
2. Utilization Management
3. Voluntary Partial Capitation for non-hospital providers

Discussion Question: What other flexibilities would be necessary for hospitals under the GBR 2.0?

(Medicare) Consumer Benefits

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Medicare Benefit Design

The Maryland Model changes the payment system for hospitals and thus extends the life of the trust fund. But there are limited benefits to the Medicare consumers and an element of fee-for-service utilization remains. As part of the Phase 3 Waver, we could as for waiver to change:

1. Medicare Benefit Design
2. Cost Sharing Amounts
3. The Medicare Payment Mechanism

Overview of Medicare Benefit Design

We could increase consumer benefits by using excess Medicare savings to enhance the Medicare benefit package by…

1. Reducing cost-sharing in Part B
2. Rebates on Part B premiums
3. Providing additional coverage (vision, dental, etc.)
4. Changing eligibility

Discussion Question: Are there other benefits that could be provided to consumers using excess Medicare savings?

Standardize Cost Sharing Amounts

Under the existing GBR, patient charges will increase or decrease based on the~~y~~ hospital's volume.

- This means that an individual's patient's charge could increase even as total utilization decrease.
- As utilization continues to declines, this problem will grow.

We could solve this problem by…

- Setting a standardized cost sharing based on IPPS/OPPS rates
- Setting a cost sharing schedule for different types of cases

Discussion Question: Are there other proposals to limit consumer cost sharing?

Modifying Payment to Hospitals

Currently, hospitals are paid through the rate setting system. This means that the charge per case must vary so that price x utilization is equal to the GBR. This causes underlying distortions:

- Price corridors are necessary to prevent dumping of services and excessively high charges.
- Indirect financing of hospital fixed costs (e.g. Medical education).
- Rolling over under/overcharges during periods of uncertainty.
- Complexity in both the rate alignment model and the revenue comparison between hospitals.

This could be solved by providing hospitals non-claims-based payments on a biweekly basis. This would allow for…

- A simple and predictable revenue stream.
- A more direct assessment of network adequacy for provided hospital services.
- Site neutral payments for the hospital and nonhospital services.

Discussion Questions: Would changing the hospital payment system be desirable? Are there other policy objectives that could be accomplished through non-claims-based payments.

Next Steps

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Next Steps

Please send any questions and suggestions on the model components to HSCRC staff (Willem.Daniel@maryland.gov). At the next meeting…

- We will discuss a straw man of how a GBR 2.0 and Medicare Benefit Designs could work.
- We will include options based on stakeholders' suggestions.