maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

February 2024

Agenda

1. MPA Updates
    1. Review CMS feedback on MPA
    2. Update on population health measure for inclusion in MPA
2. Update on Care Redesign Activity
3. Overview of Periodic Review of TCOC Benchmarking
4. Reconstitution of TCOC Workgroup
5. Upcoming Dates/Future Meetings

MPA Update

MPA Update

- CMS approved the policy as is except they did not approve the CTI Buy Out:

"CMS requests revision of the PY 2024 MPA proposal to reflect removal of the "CTI Buyout" adjustment to the MPA, which proposes to lower the traditional MPA penalty based on CTI-attributed beneficiaries. The CTI buyout was previously approved for a limited duration, from 7/1/2021-12/31/2021, in order to mitigate some of the attribution limitations of the Traditional MPA prior the Traditional MPA's new geographic attribution methodology which went into effect in CY 2022. With the adaptation of the updated Traditional MPA geographic attribution methodology, CMS continues to view the Traditional MPA as foundational to holding hospitals accountable for all attributed beneficiary total cost of care (TCOC). "

- In the Final Recommendation Staff will remove the CTI buy out.
  - Staff is open to suggestions for alternative approaches to be considered for CY2025 MPA policy. Will revisit in the fall.

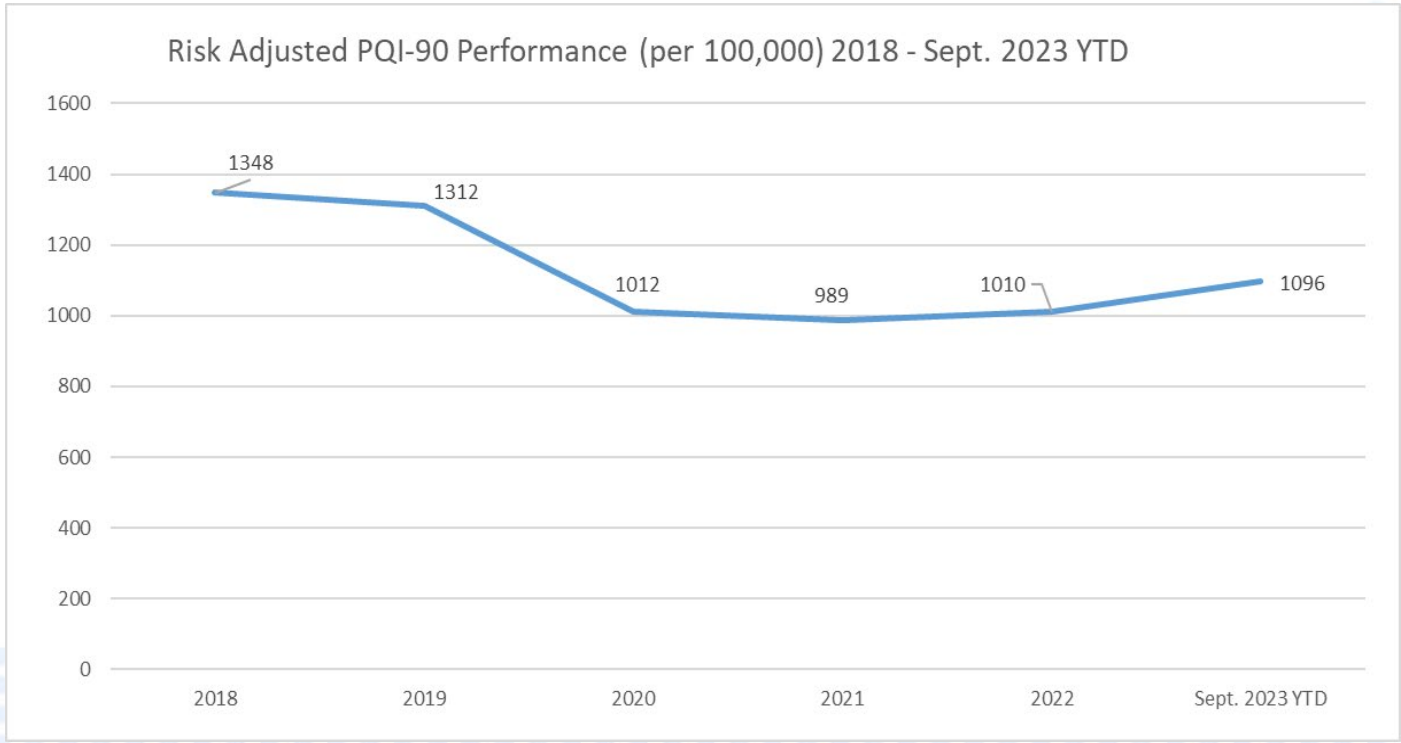
Population Health Metric

- HSCRC staff are required to propose a population health measure as part of the Medicare Performance Adjustment
- Process and measures were discussed in Performance Measurement Workgroup
  - Given the additional development work required of the inpatient diabetes screening measure, staff proposed an alternative existing population health measure
  - Proposal is to use the AHRQ Prevention Quality Indicators
    - CMS signed off on this approach in their MPA response.
    - The AHRQ PQIs are population based indicators that identify hospitalizations that might have been avoided through access to high-quality outpatient care, thus providing insights into the quality of health services in a community
    - There are ten individual PQI measures that are included in the overall PQI composite measure (PQI-90), which is risk-adjusted based on age and sex. (See appendix A listing the 10 PQI measures)
      - These ten measures are also grouped into three other specific composites for
        - Acute composite(PQI 91)
        - Chronic composite (PQI 92)
        - Diabetic-related admissions composite (PQI 93) - can also be included in the chronic composite

AHRQ PQI Performance under SIHIS

- To support Maryland's success under SIHIS, Maryland hospitals are held financially accountable under the TCOC Model for all-payer PQI admissions
  - As of September 2023, Maryland has experienced a 19% percent decrease across all PQIs from the 2018 baseline
    - Current admission rate is 1,096 per 100,000 residents
    - Current PQI rate is -4.4 percent below the 2023 year 5 target rate

Goal: Reduce Avoidable Admissions	
Measure	AHRQ Risk-Adjusted PQIs
2018 Baseline	1,348 admits per 100,000
2021 Year 3 Milestone	8 percent improvement
2023 Year 5 Target	15 percent improvement
2026 Year 8 Final Target	25 Percent improvement



Proposed Measure Structure

- Detail behind the data and target setting was shared in Performance Measurement Workgroup.
- 2023 results below are shown for informational purposes. 2024 is the first performance period.
- Recommend approach was better of improvement or attainment where:

	Minimum (-4% MPA)	←	Threshold	→	Maximum (+4% MPA)
Improvement	Threshold - (Max – Threshold)		Applicable Annual SIHIS improvement goals[1]		2026 SIHIS improvement goal
Attainment	Threshold - (Max – Threshold)		2022 Median + SIHIS improvement target for current year		2026 Median[2] plus equivalent annual improvement
# of Hospitals based 2023 Performance	7	20		3	12

1. 2023 = 3%, 2024 = 7%, 2025 = 10%, 2026 = 13%
2. 2026 Median = 2022 Median less 2026 improvement goal

Update on Care Redesign Activities

Updates

- Discussing potential new CTI focused on Hospital Outpatient Services
  - Working with Mercy and Hopkins on development.
  - Final thematic area will be open to all hospitals.
  - Close to finalizing this month
- EQIP Grouper
  - Evaluating change from Prometheus Grouper to PACES Grouper for CY2025
  - Final decision by end of February, basis for decision:
    - Continuity of results and coverage of key clinical areas
    - Acceptability to critical specialty constituents (series of meetings in February)
- EQIP Primary Care
  - Received 25+ responses to RFI
  - Dedicated working group for this project – first meeting today 11-12

Total Cost of Care Benchmarking – Methodology Review

Benchmarking Goals

- In 2019 HSCRC developed and implemented a process to compare Maryland's total cost of care to like geographies in other states. Goal was stated as:
  - Create a tool to allow the incorporation of Total Cost of Care (TCOC) benchmarks into appropriate methodologies at a granular level and guide the State on areas of strength and weakness in terms of cost and quality.
- Focus on Medicare (MC) fee-for-service and Commercial (CO) benchmarks of people younger than 65.
- Data is used in:
  - ICC and Efficiency Policies
  - Attainment measurement under the MPA
  - Readmission information used in goal setting for quality policies
  - Care analytics and diagnostics

Benchmarking Update

- This year the HSCRC will undertake the periodic review of the benchmarking approach, as outlined in the original process.
- 2022 data will be used to assess modifications and alternative approaches. New approach will be implemented for 2023 data and policies that use that data set.
- Will be coordinated with AHEAD process
- Mathematica has been contracted to support the State, we will present more specifics and discuss opportunities for input in the May TCOC meeting
- CMS used a similar approach in their evaluation of the model[1]. The following slides contrast the current HSCRC approach with approach used in the CMS evaluation

1. https://www.cms.gov/priorities/innovation/data-and-reports/2022/md-tcoc-qor2

Goals Overview, Federal versus State Methodology

- CMS analysis was focused on changed\s during the life of GBRs, State evaluation is focused on a comparison of costs at a point in time which means CMS process requires matching on baseline period characteristics like utilization and health care market characteristics.
- CMS analysis was focused on creating a single estimate of model impact while State is interested in that but also:
  i. Performance by region and hospital
  ii. Placing Maryland performance within a continuum (i.e. calculating top quartile)
- Despite differences, the outcomes of State and Federal approach are similar, in order of magnitude terms (MD 6-8% more expensive).

Comparing state implementation to federal evaluation methodology

Component	State Implementation Methodology	Federal Evaluation Methodology
Geographic Unit	Each Maryland county is matched to 20 (for five large urban counties) or 50 (for all other counties) peer comparison counties outside Maryland. Subsequently, county results are mapped to hospital PSAP using a crosswalk.	Uses Public Use Micro Areas (PUMAs) as the matching unit. PUMAs are non-overlapping, statistical geographic areas that partition states into areas with at least 100,000 people.
Peer Group Selection Algorithm	Counties are stratified into six groups by rurality, population density quartile, and population size quartile. Using the k-nearest neighbor approach, each county is matched to other counties within the same group most similar on county characteristics (e.g., deep poverty, median income)	PUMAs were matched using the SBW method which finds the weights of minimal dispersion across a peer group pool that meets the specified variable balance. PUMAs were matched using more variables than the state implementation methodology, including aggregate Medicare FFS beneficiary characteristics and health market characteristics.
Post matching adjustment	Medicare FFS TCOC goes through a series of adjustments, including 1) removal of medical education costs, 2) risk adjustment by dividing by HCC risk score, and 3) regression adjustment of risk-adjusted costs.	Outcomes were regression-adjusted after matching. A differences-in-differences model was implemented to estimate beneficiary-year level impacts

Main Considerations

- **Geographic Unit**: Within-county variations are notable for larger counties, while estimates for smaller counties may be noisy. PUMAs contain at least 100,000 people, thus reducing statistical noise, but are small enough to break larger counties into several geographic regions. However, PUMAs being statistical constructs may not be useful for hospitals in understanding the geographic location where their performance is measured.
- **Variables**: Using more matching variables could provide a more nuanced perspective but would decrease the likelihood of achieving sufficient balance in all variables.
- **Matching**: Compared to the k-nearest neighbors method, the SBW method is more data-driven because the number of peer comparison counties is determined empirically by how many counties are similar enough to the Maryland county, rather than a pre-fixed number. However, SBW is more challenging to explain and requires researchers to set balance limits on matching variables a priori.
- **Health Equity:** Incorporating quality benchmarks (e.g., 30-day readmissions) into evaluations of racial disparities in healthcare costs could provide a more comprehensive measurement of health equity. Including race/ethnicity in matching variables for peer group selection would facilitate comparisons of within-market disparities and enable more precise measurements of the impact of socioeconomic characteristics (e.g., median household income), but could weaken socioeconomic match because matching algorithm is trying to find a good match on race/ethnicity.

Potential Options

- **Maintain existing benchmarking methodology.** Update data sources. Prioritizes stability and consistency.
- **Methods expansion**. Keep framework unchanged but expand methods such as through adding matching variables or regression variables
- **Framework change.** Change geographic unit to PUMA or directly mapping hospital PSAPs to PUMA or county. Focus on a pure regression approach.

Reconstitution of TCOC Workgroup

Reconstitution

- Purpose
  - The success of the Total Cost of Care Model and the Care Redesign programs will be measured, in part, by reductions in potentially avoidable utilization, readmissions, and ultimately reduced costs due to higher quality healthcare and improvements in patient health. Understanding and managing the drivers of total cost of care and establishing sound approaches to incenting and measuring care transformation activities across the State is essential to ensuring overall success.
  - The charge of the TCOC workgroup is to provide technical feedback to HSCRC on the methodologies and calculations that underpin care transformation and total cost of care management activities.
- Workgroup Membership
  - HSCRC has confirmed most members, waiting to hear back from a handful
  - Will finalize and do introductions in the next meeting.

Current Confirmed Members

- Arin Foreman, CareFirst
- Benjamin Lowentritt, MedChi Representative
- Chad Perman, Maryland Primary Care Program
- David Johnson, Bolton
- Debi Kuchka-Craig, MedStar
- Eric Wargotz, MedChi Representative
- Ed Beranek, Johns Hopkins Health System
- Gene Ransom, MedChi CEO
- Jerry Reardon, Independent Member
- John Colmers, Independent Member
- Kathy Talbot, TidalHealth
- Katie Eckert, Adventist HealthCare
- Kenneth Yeates-Trotman, Maryland Health Care Commission
- Laura Russell, Maryland Hospital Association
- Marcella Bailey, Mercy Medical Center
- Michael Myers, LifeBridge Health
- Mike Wood, MedStar
- Niharika Khanna, University of Maryland School of Medicine
- Padmini Ranasinghe, MedChi Representative
- Paul Miller, LifeSpan
- Ryan Anderson, MedStar
- Shelby Boggs, Frederick Health

Upcoming Dates

Upcoming TCOC Workgroup-Related Dates

- March 13th - Final MPA Recommendation to Commission
- March TCOC workgroup cancelled
- April 1st to May 25th – MATT open for CY25.
  - Hospitals can establish treatment relationships for PHI access
  - Lists must be re-entered annually
  - New CFO certification is required
  - HSCRC will send out information memo in March
- Early April – CTI Enrollment Meeting for FY25 – CRISP will host, to be scheduled.
- April 24th - TCOC workgroup
  - Agenda TBD
  - Possibly cancelled – holding for now
- May 22nd - TCOC workgroup
  - Will release memo teeing up benchmarking process in early May
  - Update on benchmarking process
  - Check in on CTIs
- Early June – Hospitals can access CY25 MPA reports in CRS

Thank You
Next Meeting (Tentative): April 24th, 8-10 am