maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

May 2024

Agenda

- TCOC Workgroup Introduction & Overview of Major Topics
- 2025 and 2026 MPA Priorities
- Introduction to Benchmarking Process
- Future Meetings

TCOC Workgroup

Confirmed Workgroup Members

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

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.

Introduction to Major Areas of Focus

- Medicare Performance Adjustment
- Care Transformation Initiatives (CTIs)
- Monitoring of TCOC results under the model
- Benchmarking

MPA Overview

Introduction to MPA Policies

- The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for Medicare FFS total cost of care (TCOC) in Maryland.
- MPA includes three components:
  1. Traditional Component – Holds hospitals accountable for Medicare TCOC of an attributed patient population
  2. Reconciliation Component – Rewards hospitals for the care redesign interventions
  3. Savings Components – Allows the Commission to adjust hospital rates to achieve the Medicare TCOC savings targets
- The traditional components is governed via annual updates to the MPA policy adopted to the Commission, while reconciliation and savings components are governed via the MPA Framework.
- These three components are added together and applied to the amount that Medicare pays each respective hospital.
  - The MPA is applied as a discount to inflator to the amount that Medicare pays on each claim submitted by the hospital.
- Commission recommendation governing the MPA Framework can be found here: MPA Framework

Recap of current traditional MPA

1. Attribute Medicare FFS beneficiaries to hospitals on a geographic basis
    1. AMCs have extra layer focused on high-acuity individuals
2. MPA penalizes or rewards hospitals based on a subtracting:
    1. The cumulative growth since 2019 in their attributed per capita TCOC from
    2. Cumulative national growth in per capita TCOC less a hospital specific growth rate adjustment
3. Each hospital's growth rate adjustment is set based on their position versus target in 2019.

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1st Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2nd Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3rd Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4th Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5th Quintile (+21% to +28% Relative to Benchmark)	-1.00%

4. The result is then multiplied by 0.33 and capped at 2% of Medicare revenue then adjusted for quality to derive the final value.

Recap of Recent Changes - MPA Revenue At Risk

- Increase revenue at risk to 2%
  - In its 2023 MPA Approval Letter, CMS indicated that it expected the State to increase the Revenue at Risk under the MPA in 2024.
    - Revenue at risk increased to 2% of Medicare revenue in 2024 and CMS may potentially request 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% doubles 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.
- Add Population Health Measure with weight of 4% of bonus/penalty
  - Consistent with prior recommendation, adds to 4% currently at risk for RRIP and MHAC
  - Quality values are doubled so total quality risk to 16% of penalty/bonus (total risk = ±2.32%)

CTI Overview

History of the Care Transformation Initiatives (CTI)

- Since early in the All-Payer Model, the HSCRC attempted to develop ‘alignment programs’ which encourage hospitals to partner with non-hospital providers to reduce TCOC.
- These early programs did not work for a variety of reasons:
  - There was a disconnect between hospital’s clinical efforts and programs developed by the HSCRC.
  - Hospitals had to earn substantial savings before they receive a reward and it is costly for hospitals to manage TCOC effectively.
  - Thus the ROI for participation was highly uncertain.
- The CTI program overcomes these problems by:
  - Allowing hospitals to define their own populations to focus on.
  - Providing all hospitals with ‘first dollar’ savings.
  - Distributing savings in a net neutral manner, so hospitals that do not participate (or do not make a successful effort) in care transformation are penalized.
- See https://www.crisphealth.org/learning-system/cti/ for more information

Recap of CTI Methodology

- Hospitals can design their own population target based on the parameters within each Thematic Area. Each Thematic Are provides a menu of selection options.
  - For example: in the Care Transitions Thematic Area beneficiaries are attributed to the hospital where they are discharged from. The hospital can limit the CTI population based on DRGs, chronic conditions, number of prior hospitalizations, etc.
  - There are five thematic areas: Care Transitions, Palliative Care, Primary Care, Geographic, and ED Care.
  - New thematic area for FY2025: Hospital Outpatient Services
- Each CTI has a target price that is based on the TCOC of the beneficiaries attributed to the CTI in the baseline period.
  - Baseline period costs are updated for inflation and risk adjusted.
  - This compares hospitals to their own historical performance. In other words, this is an improvement only program.
  - Baseline periods can be set back as far as FY17 to try and recognize early adopters.
- Hospitals earn savings if their performance period costs are less than the target price.
  - Hospitals earn 100% of the savings they achieve that exceed a Minimum Savings Rate. This ensures that all payments are made for savings that are statistically significant.
  - All shared savings payments are offset on a statewide basis. Hospitals that are less successful in the CTI will pay for the savings of those hospitals that were successful in the CTI.
  - Bonuses and penalties are applied via MPA Reconciliation Component.
  - This ensures that Medicare continues to benefit from care transformation and that hospitals which are not engaged in successful care transformation pay their fair share of meeting the statewide savings target.

Data Source

CTI episodes are constructed from the Maryland All-Payer Model (MDAPM) Claim and Claim Line Feed (CCLF) data.

- Medicare final action claims for all Part A and Part B services received by Maryland residents, regardless of service location.

***Excluded* Beneficiaries:**

- Non-Maryland residents
- Managed care enrollees
- ESRD patients

***Excluded* Claims:**

- Non-final Action
- Unpaid/Denied
- Substance Abuse and Mental Health Service Association (SAMHSA)

Episode versus Panel-Based CTIs

Episode-Based CTIs

- "Triggered" by a specific type of medical encounter and a specific patient profile.
- Episodes are attributed to providers involved in the medical encounter.
- Episodes begin on any date during the performance year and end after a specified length of time.

Panel-Based CTIs

- Patients meeting a specific patient profile are attributed to providers based on a
  - History of medical encounters between them (e.g., Primary Care)
  - Specified provider service area (e.g., Community Based Care)
- Patients are attributed to a provider for the full performance year.

Future CTI thematic areas could use a hybrid approach to attribute patients to providers.

- For example, a patient is attributed to a provider on any date and the episode spans the rest of the performance period.

Calculation of Target and Performance Cost

- Identify all relevant episodes for Part A and B beneficiaries, calculate total costs during the episode window,[1] then implement the following (for baseline and performance period episodes):

Step	Comment
Eliminate Excluded Costs	Exclusions are small and primarily relate to highly technical items.
Complete Claims	3-months run out is allowed for each claim and a completion factor is applied based on the claim type
Standardize Costs	Inpatient claims are standardized based on base period CMS standardization
Inflate Costs	Costs are inflated using the relevant update factor (HSCRC for hospitals and CMS for all others)
Renormalize Costs	Claims are restated in real dollars based on the ratio of real to standard costs in the base period.
Risk-Adjust Costs	Costs are risk adjusted to predict episode spending during the performance period. Risk adjustment is based on a combination of HCC and APR-DRG depending on the type of CTI.
The difference between the target price and total episode costs is the savings achieved for that episode.	

1. Claims with lengths of stay that go beyond the episode window are pro-rated.

Calculation of Final Savings Amounts and Offsets

- Only positive savings are considered
- To be counted savings must meet a minimum savings threshold (MSR)
  - MSR is hospital specific and depends on the nature of the CTI and total episode volume
  - Hospitals are assigned separate MSRs for episode- and panel-based CTIs
  - Multiple similar CTIs can be combined to attain a lower MSR
  - If MSR is met, all savings are credited from first dollar
- Total positive savings are aggregated, and each hospital gets:

  \+ Hospital specific savings

  \- Hospital share of CTI statewide savings

  (hospital % of Medicare spending x statewide CTI savings)

  < *[Starting with FY23 Results]* Hospital impact limited to 2.5% of Medicare Spending (before redistribution of excess offset)

2025 and 2026 MPA Priorities

MPA/CTI Considerations 2025

- Intent is to make minimal changes as we expect to be focused on AHEAD related items
- Potential Revisions:
  - CTI Risk Cap, change to 2.5%
  - Alternative to CTI Buy Out
- Further discussions later in the year, stakeholders should consider areas upon which they want to focus

Changes for 2026 - Attribution under the MPA

- The State believes that CMS wishes to retain the MPA as is under AHEAD but their may be some opportunity for revisions
- Under the current TCOC Model aggrement, the State's Medicare Beneficiary Attribution Algorithm requires attribution to one or more Regulated Maryland Hospitals of at least **95 percent** of Maryland Medicare Beneficiaries who are enrolled in both Part A and Part B for purposes of inclusion in the MPA calculation for those Regulated Maryland Hospitals.
  - Previously this required minimum attribution has been a limitation on flexibility in attribution under the traditional MPA
  - Consider revisiting the 95% requirement? Base on dollars or lower the threshold
- Do stakeholders have other suggestions for revision to MPA policies as part of a future agreement?

Introduction to Benchmarking Process

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
- Results through 2019 and more information can be found under benchmarking on this page: TCOC Workgroup
- 2021 results will be added shortly, Staff can provide this data upon request in the mean time. 2022 results will be added over the summer.

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

Benchmark Approaches

Methods differ as the goals of each approach is different.

State's TCOC Benchmarks	Federal Evaluation (Model impact)	Federal Estimates of switching Maryland to Prospective payment system (added this year)
Comparable areas to measure Hospital performance on TCOC relative to "national results"	Impact of the model on TCOC "Difference in difference" methods	Comparable areas to estimate statewide TCOC under PPS
Constructing national benchmarks by matching county's that are similar to Maryland on socio-demographics. Did not include any health care specific variables as these factors may be impacted by the all-payer rate setting.	Match Maryland to a comparison group with similar outcome trends from 2011 to 2013, the comparison group is designed to reflect the path that Maryland would have been on if it had not introduced any of the changes starting in 2014—the counterfactual.	Constructing national benchmarks by matching PUMAs that are similar to Maryland on some characteristics, such as health status and demographics, and intentionally not matching on characteristics likely to change as a result of switching to PPS, such as the outcomes we examine.

Comparing state implementation to federal evaluation methodology

Component	State Implementation Methodology	Federal PPS 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. Each Maryland PUMA was matched to eight to 20 benchmark PUMAs (on average, 13).
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)	Each one of 44 Maryland PUMA was matched to PUMAs most similar on matching characteristics using the optimal N:1 matching (with replacement). Calipers were imposed by requiring that matching PUMAs differ from the Maryland PUMA by less than a minimum value for each characteristic and excluding potential matches that do not. Matched PUMAs were used to create high- and low-spending benchmarks.
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.	Adjusts the final comparison based on risk and demographics for the effect of both area-level and beneficiary-level characteristics on beneficiary-level spending and then aggregating to the PUMA level.

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.
- **Inclusion/exclusion:** Consider if we should continue to use enrolled in both part A and B beneficiaries. Add non-claim based payments to TCOC estimates.
- **Variables**: The federal evaluation methodology includes a similar number of matching variables but fewer area-level population variables and more characteristics of Medicare beneficiary variables compared with the state implementation methodology.
- **Matching**: Compared to the k-nearest neighbors method, the N:1 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, the N:1 method yielded as few as eight matched PUMAs, which may be sub-optimal for constructing high- and low-spending benchmarks matched PUMAs.
- **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.

Options

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

Next steps - Benchmarking

- Memo comparing state and federal methods is provided for review
- Feedback during the next TCOC meeting to develop a workplan
  - Feel free to provide written comments or ask questions prior to that meeting.
  - In next meeting Staff will discuss the various considerations in more detail

TCOC Workplan for Upcoming Months

- Next combined HSCRC TCOC Workgroup/H-TAC Meetings is June 24
- May have an H-TAC meeting in the interim
- TCOC Workgroup Priorities – Approximate timeline (will vary with AHEAD-related needs)
  - June to August – focus on benchmarking review
  - July – Update on TCOC results
  - September to October – discuss changes to the MPA policy
  - November – draft MPA recommendation to commission for CY2025
- Other TCOC Related dates:
  - MATT – Hospitals to submit care coordination lists by 5/24/24 in order to have access to beneficiary level claims data via attested arrangements with providers in June release of CY2024 data (2023 Attestations do not carry over).
  - Traditional MPA – Final results now available for CY24
  - MPA – FY25 Impact Spreadsheet to be released by HSCRC around 5/27, hospitals will have a week to review.
    - Will include FY23 CTIs, CY23 MPA, ECIP final for 6 months ended 12/31/22.
    - MPA – Correction to FY24 impact that used the estimate of hospital base that excluded out of state – immaterial for most hospitals.
  - CTI – FY25 programs, due by June 28th.
  - CTI - FY23 final data available May 24th

Thank You
Next Meeting June 24, 8-10 am