



maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

June 26, 2024

Agenda

- Update on AHEAD
- AHEAD Terms Discussion
 - Terms Overview
 - Review of MPA Comment Letters
- Benchmarking
 - Process and timelines
 - PUMAs vs Counties
 - Review of Variable Options
- Next Steps and Future Meetings

Update on AHEAD

- Waiting on official NOFO Response
- Expecting additional feedback on contractual terms and savings target in July
- Today's meeting will focus on known terms for discussion, other items to be discussed in future forums

AHEAD Terms Discussion

Areas of Focus

- Finalize Savings Setting Approach Position
- Share of Spending Under GBRs
- MPA-Related Terms

Current Target Setting Approach

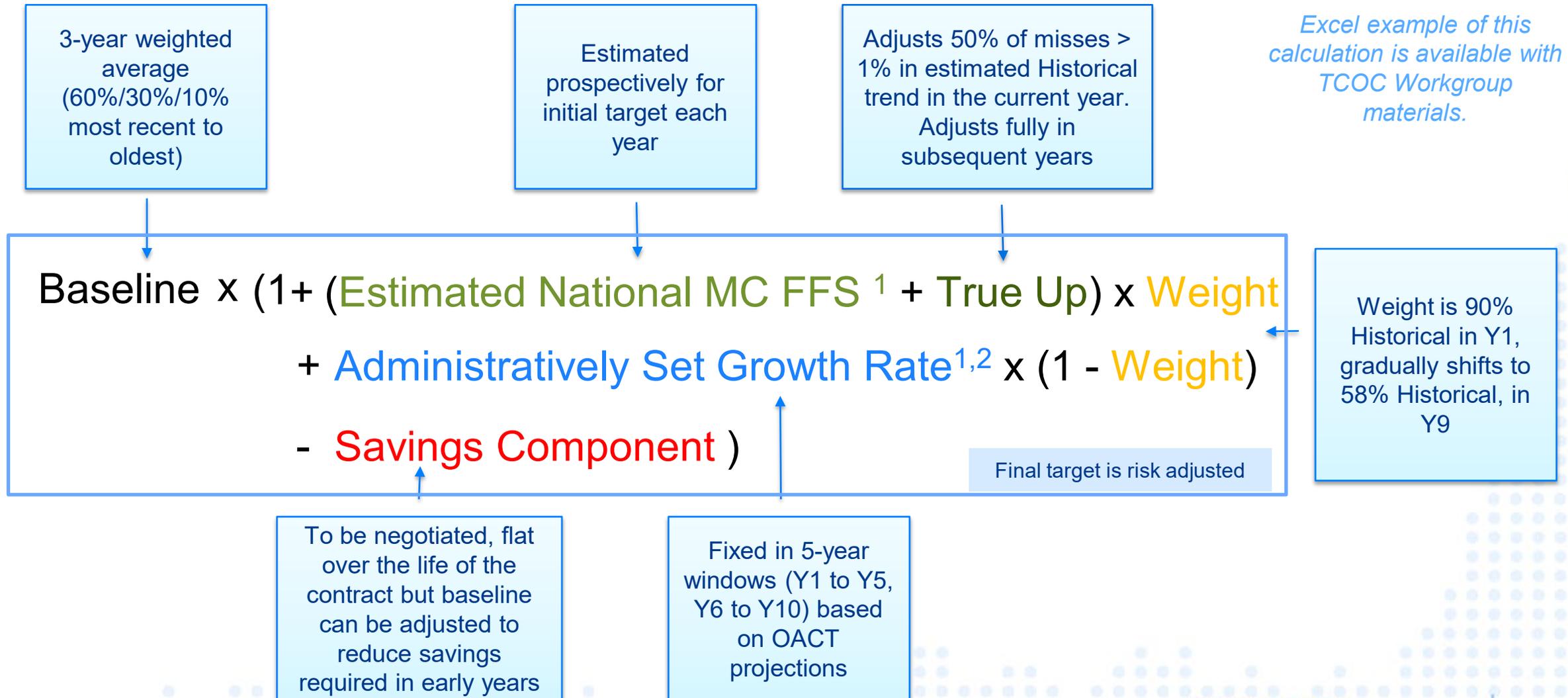
Target is set based on concurrent national trends. State holds estimation risk each year as trends are unknown until the year is complete.

$$\text{Baseline} \times (1 + \text{Actual National MC FFS}) \times \text{Beneficiaries} \\ - \text{Savings Component in \$}$$

Because target is set in \$ terms, State can gain or lose on beneficiary growth¹

1. Risk for shift to Part C is not completely open-ended there is accommodation for current year changes.

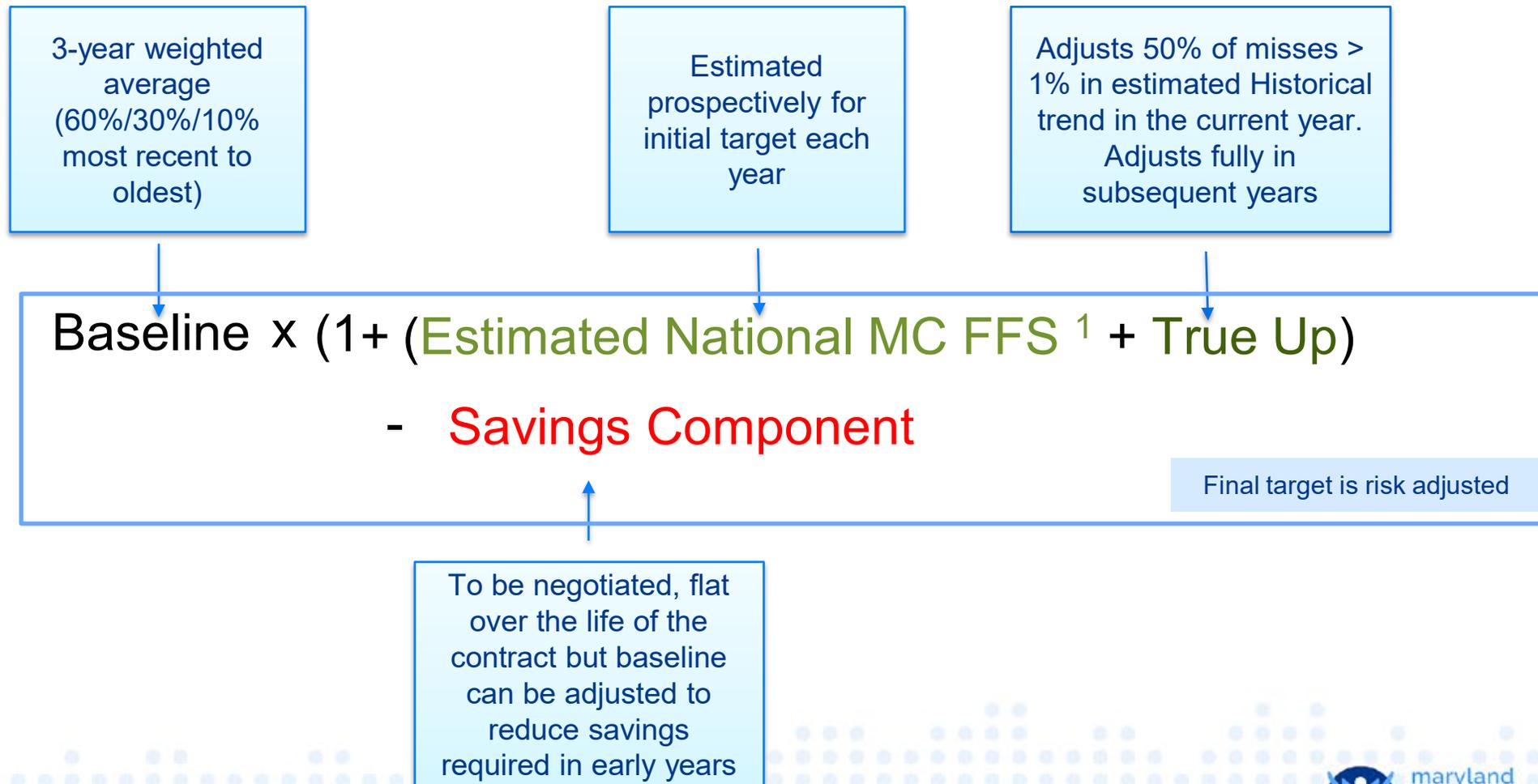
Current Understanding of Proposed AHEAD Expenditure Target



1. 33% of both trends are calculated against national \$ and added to MD \$ instead of applying trend to MD Base \$.

2. "For any award recipients with statewide all-payer rate setting authority, the award recipient will have the option to use only the USPPC without ACPT blend." (NOFO pg. 117 Appendix XI)

Current Understanding of Proposed AHEAD Expenditure Target (without Administratively Set Growth Rate) (option 2)



1. 33% of both trends are calculated against national \$ and added to MD \$ instead of applying trend to MD Base \$.

Proposed Position

- Select Option 2 – No administratively set growth rate
- Pursue extension of first year true up to a 2- or 3-year phase in (see example in appendix)

Share of Spending under GBRs

- Current contract requires 95% of all payer costs to be included in a population-based methodology
 - High-cost drugs are the only current exemption.
 - While there is a program around quaternary care it is still prospective in nature and not scored as an exemption.
 - Excluded costs still count against the savings test.
- Opportunity is to either (a) revise 95% and/or (b) pursue an alternative approach around specific exceptions
 - Staff favors option (a) but State will need to justify size based on potential areas of exemption.
 - Areas for evaluation proposed by stakeholders: high-cost drugs, high-cost supplies, obstetrics, behavioral health, quaternary care, trauma.
 - Exclusion amount should assume higher than average trend in excluded areas.

High-Cost Drugs

- Rationale:
 - Drug prices are outside the control of hospitals and subject to rapid growth
 - High-Cost drugs are currently the only exception
- Share: \$390M or 2.1% (Drugs currently on CDS-A list)
- Considerations:
 - Exemption is calculated based on drug cost from the survey, plus mark up, (not charges) as related overhead costs are not reimbursed on a volume variable basis
 - CDS-A policy is to be revised later this year, but Staff do not anticipate this will impact the exemption, it will continue to be required at approximately current levels.
 - CDS-A list could be expanded to cover more drugs although that is not Staff's current bias

High-Cost Supplies

- Rationale:
 - A High-Cost Supply exemption would be justified on the same logic as the drug exemption – hospital's lack of control of external pricing
- Share: \$300M or 1.6% (estimated supply cost on selected high supply cost IP and OP DRGs/EAPGs)
- Considerations:
 - HSCRC does not have an equivalent to the CDS-A reporting for supplies nor are their ASP prices for supplies making “cost” harder to capture
 - Supplies has not typically been cited by hospitals as a driver of cost concerns
 - Innovation policy already covers some high-cost supplies

Quaternary Care

- **Rationale:**
 - Highly complex care may not be avoidable through the tools assumed under GBRs
 - Desirable Clinical innovation is limited by the GBRs
 - Innovation policy currently reimburses care provided mostly at academic medical centers differently, but this adjustment is not considered an exemption from GBRs as it is still prospective.
- **Share: \$510M or 2.7% (Innovation and Categorical Exclusions)**
- **Considerations:**
 - Expanding the definition of quaternary care or including non-academic medical centers is a possibility although Staff believe the current approach is appropriate.
 - A larger exemption threshold would allow the adoption of a simpler approach counting this care against the exemption, instead of the current, more complex, prospective approach.

Obstetrics

- Rationale:
 - Birth rates are outside the control of hospitals and given not all hospitals provide OB the demographic adjustment is likely not sensitive to hospitals with higher than anticipated births.
- Share: \$1,190 M or 6.4% (OB/GYN + Neonatology Service Lines)
- Considerations:
 - While the number of births are not subject to control, OB and Neonatology services can vary in acuity within the control of the hospital. Exempting hospitals completely for financial risk around birth complications is inconsistent with a population health approach.
 - OB would not necessarily be expected to grow faster than average, so the risk is primarily related to the distribution of growth
 - OB may be attractive for a hybrid approach – e.g. a risk-adjusted episode rate. Such approach may not be scored fully against a GBR exemption.
 - Estimate of \$1.19B includes some GYN services unrelated to births and therefore is overstated.

Behavioral Health

- Rationale:
 - Need to expand behavioral capacity may challenge GBR norms
- Share: \$600 M or 3.2% (IP + ED with Primary BH/SUD dx, need to add OP)
- Considerations:
 - Inpatient behavioral health treatment should typically be a last resort and therefore exempting services from the GBR may not be the appropriate long-term strategy.
 - Capacity could be expanded through targeted initiatives rather than removing the spending from the GBR.

Trauma

- Rationale:
 - Costs are unpredictable and beyond hospital control and may fall unevenly across institutions
- Share: \$?, multiple potential approaches to define
- Considerations:
 - Separating trauma from non-trauma ED may be subjective
 - Depending on the definition, some trauma care is subject to public health initiatives
 - Trauma costs would not necessarily be expected to grow faster than average, so the risk is primarily related to the distribution of growth
 - Much of the challenge from trauma costs relates to physician coverage, which is already outside the GBR.

MPA Contractual Revisions

- Most aspects of MPA are governed by CMMI-approved MPA policies and not contractual provisions
 - HSCRC expects MPA to continue under AHEAD
 - Most changes may be achievable through MPA policy (rather than in the contract)
 - Obtaining CMS buy-in during the contracting process would improve chance of success (particularly items which have previously been points of difference – CTI Buy out)
- Staff believes CMS' core goals for the MPA are that it:
 - Ensure all beneficiaries are being managed.
 - Places hospitals at risk for total cost of care performance.
 - Incorporates quality metrics in line with qualifying hospitals as AAPM entities.

MPA Comment Letters

- Following slides review comment letters received
- Focus today will be on items with potential contractual implications
- MPA and CTI changes that are manageable within HSCRC framework and will be deferred to the fall for discussion and inclusion in:
 - 2026 MPA Policy
 - FY2025 and forward CTI scoring methodology
 - FY2026 CTI approach

MPA & CTI Comment Letters

- **University of Maryland Medical System**
 - Concerned about discrepancy between Statewide Medicare savings performance and MPA adjustment (MPA Policy)
 - Concerned about the process of obtaining beneficiary detail on hospital attributed populations (Contract Negotiation/HSCRC PHI Policy)
- **Mercy Medical Center**
 - Concerned about the current attribution of patients in the MPA policy (Contract Negotiation/MPA Policy)
 - CTI savings calculation – Limit any individual hospital savings Medicare revenue (MPA Policy/CTI Program Design)
- **Johns Hopkins Health System**
 - Institute a coding intensity adjustment cap from the baseline to the performance period (CTI Program Design)
 - Utilize a panel-based measurement approach rather than intent to treat (CTI Program Design)
 - Reduce the amount of Medicare FFS revenue subject to the CTI savings pool (CTI Program Design)

MPA & CTI Comment Letters

- Adventist

- Concerned about different results between the Model TCOC savings test and the MPA policy calculation (MPA Policy)
- Concerned CTI policy is improvement only (MPA Framework/CTI Program Design)
- Recommends:
 1. Align MPA and CTI TCOC savings calculations with the Model TCOC savings test. There should only be one mathematical calculation for TCOC savings to ensure alignment and clarity across policies and eliminate the current dissonance.
 2. Incorporate improvement and attainment into TCOC savings policies.
 3. Adapt policies on a regional basis to ensure adequate access and funding for care.

- MHA

- Concerned about disconnect between MPA results and Medicare savings (MPA Policy)

MPA Opportunities – Lower Minimum Threshold

- Currently: MPA requires 95% of beneficiaries to be attributed
- Challenge: Requires attribution of new, low-cost beneficiaries who promote instability and often have no data history from which to manage
- Opportunity: Lower threshold or switch to a \$-based rather than beneficiary-based threshold

MPA Opportunities – Expand Data Sharing

- Currently: HSCRC shares maximum allowable amount of beneficiary data under “treatment relationship” paradigm
- Challenge: Limits share of beneficiaries where data can be shared and requires administrative process to document “treatment relationship”
- Opportunity: Contractual provision that deems CMMI-approved MPA attribution sufficient to merit full data sharing.

MPA Opportunities – Revise MPA Attribution to Acknowledge Hospital Relationship

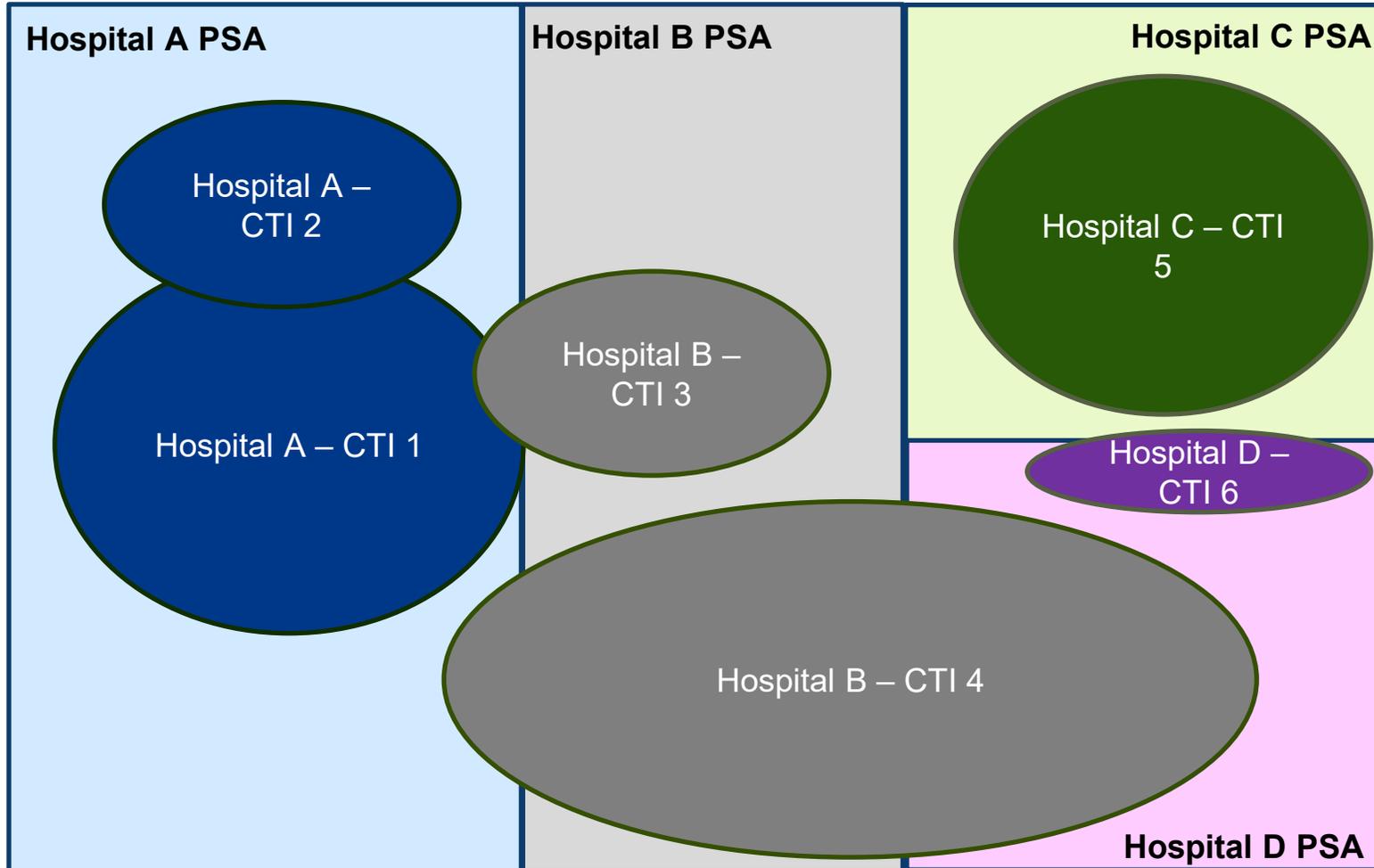
- Currently: MPA attribution is one size fits all and must address 95% of beneficiaries
- Challenge:
 - Attempts to adopt comprehensive primary care-driven approach to MPA attribution resulted in unstable attribution and significant administrative burden
 - Geographic approach prevents tight alignment between hospital initiatives and measured populations
 - CMS has rejected approaches to “buy out” of MPA downside based on CTI involvement

MPA Opportunities – Revise MPA Attribution to Acknowledge Hospital Relationship (Cont.)

- Opportunity: Incorporate more flexible attribution approaches into contractual provisions, for example:
 - Step 1: Hospitals establish panel and/or geography based CTIs
 - Has to be CTIs with TCOC accountability (e.g. not Care Transitions)
 - Could be scored both as a CTI and for MPA or just for MPA (hospital decision)
 - If scoring as a CTI is elected all normal CTI rules and scoring apply (e.g. hospital selected baseline, comparison to hospital history as target)
 - For MPA scoring standard Statewide rules apply (e.g. 2019 baseline, comparison to national growth target)
 - Step 2: HSCRC aggregates all MPA-responsive CTIs
 - CTIs must be relevant to the hospital's service area
 - Step 3: Any beneficiaries not accounted for in a hospital CTI are attributed using geographic approach until minimum attribution level is reached
 - Results are weighted between CTI and Geographic attribution based on # of beneficiaries covered
- Contract would only need to contain broad commitments to an approach like this, details could be devised in the normal MPA policy process

Illustration and Considerations for CTI-Based MPA Attribution

PSA = Primary Service Area



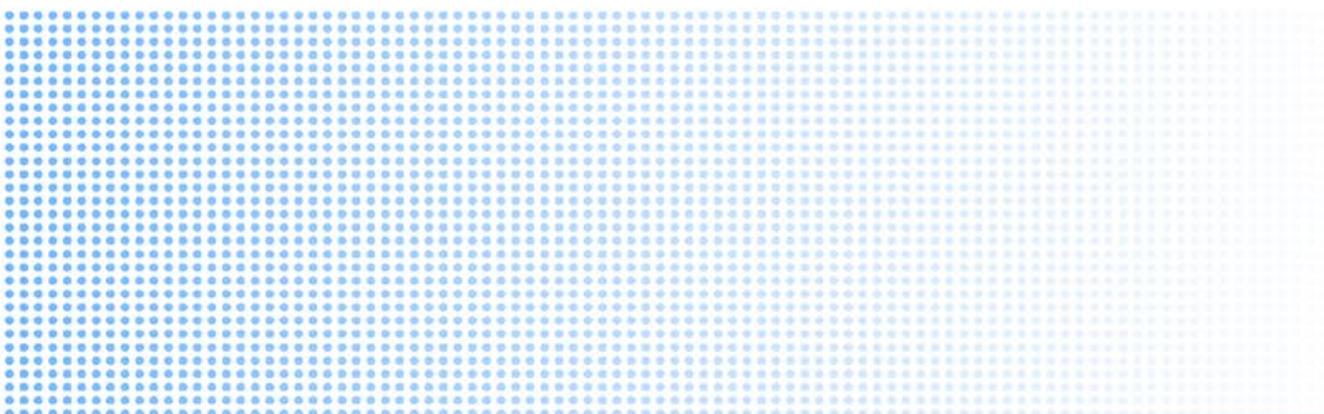
Standard Approach

- Hospital A gets all beneficiaries in their CTIs (dark green) plus all beneficiaries in the blue box not in another hospital’s CTI.
- Key issues:
 - Do beneficiaries in overlapping CTIs for the same hospital (CTI 1 vs 2) count twice?
 - What about between hospitals (CTI 1 vs 3)
 - Is it acceptable for Hospital B CTI 4 to “claim” many beneficiaries outside their PSA, thereby diluting the influence of their PSA?
 - Is it acceptable for Hospital D to “claim” a limited number of beneficiaries due to their small CTI and Hospital B’s large CTI?

NOTE: A hospital’s risk is 2% of their delivered care not their attributed care, therefore the size of attribution impacts the value of the care scored but not the size of the risk.

Next Steps

- Refine positions on Global Budget and MPA contractual provisions
- Surface additional topics for discussion based on AHEAD NOFO feedback
- May need extra July meeting of the TCOC Workgroup



Benchmarking

Benchmarking Timeline

- Data Releases
 - 2021 data for Medicare and Commercial now available on the website.
 - 2022 Medicare data available upon request.
 - Full 2022 package should be available in late summer/early fall.
 - 2023 Medicare data available upon request later this summer.
- Refresh Process
 - Begin review of key decision areas today
 - Provide comments on the selection of geography by July 12th.
 - Staff is inclined to keep county level analysis
 - Other comments welcome
 - Continue to receive feedback on high-level approach on July 24th
 - Factors to consider in benchmarking:
 - Population and rurality
 - Social and economic factors
 - Medicare beneficiary characteristics
 - Review preliminary results from baseline model on August 28th (this meeting may need to be rescheduled)

Benchmark Approaches

Methods differ as the goals of each approach is different.

State's TCOC Benchmarks	Federal Estimates of switching Maryland to Prospective payment system (added this year)
Comparable areas to measure Hospital performance on TCOC relative to "national results"	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.	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	<p>Each Maryland county is matched to 20 (for five large urban counties) or 50 (for all other counties) peer comparison counties outside Maryland.</p> <p>Subsequently, county results are mapped to hospital PSAP using a crosswalk.</p>	<p>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.</p> <p>Each Maryland PUMA was matched to eight to 20 benchmark PUMAs (on average, 13).</p>
Peer Group Selection Algorithm	<p>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)</p>	<p>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.</p>
Post matching adjustment	<p>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.</p>	<p>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.</p>

Options

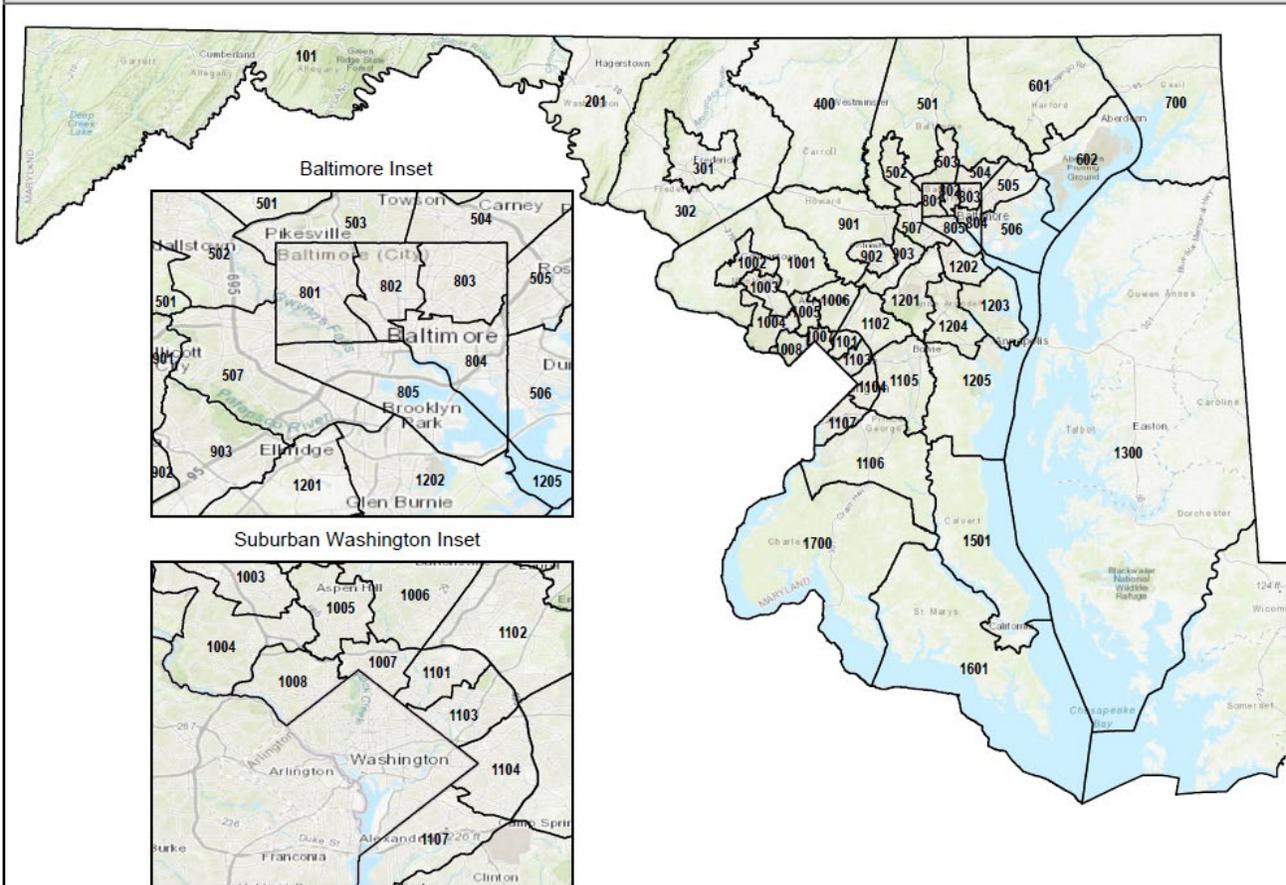
1. **Maintain existing benchmarking methodology.** Update data sources. Prioritizes stability and consistency.
2. **Methods expansion.** Keep framework unchanged but expand methods such as through adding matching variables or regression variables
3. **Framework change.** Change geographic unit to PUMA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

Public Use Micro Areas (PUMAs)

- PUMAs are geographic units of at least 100,000 people which helps limit statistical noise in cost and outcome metrics as well as demographic and socioeconomic characteristics.
 - Based on census tracts and/or whole counties serve as the geographic foundation for PUMAs.
 - Only measures from American Community Survey (Population, income, poverty) are available at PUMA level.
 - Medicare beneficiary and costs can be calculated with mapping beneficiary detailed address to PUMAs.
 - Other measures, such as labor cost, regional price parity etc. are not available at PUMA level.

Geography

Maryland PUMAs and Counties



PUMAs Consolidate More than Counties in Rural Areas

PUMA 101 will combine three different counties and create a single benchmark for hospitals serving these communities.

County	Deep Poverty Percent		Median Income		Demographic Adjusted TCOC	
	MD County	Benchmark Average	MD County	Benchmark Average	MD County	Benchmark Average
Allegany	7.01	7.11	\$47,020	\$49,484	\$14,262	\$11,834
Garrett	3.77	4.39	\$51,661	\$53,868	\$12,277	\$12,723
Washington	5.37	5.20	\$61,026	\$68,760	\$12,416	\$11,374

Primary service area distributions for counties.

- Western Maryland Hospital: Allegany=95%, Garrett= 5%
- Garrett County Memorial Hospital: Garrett= 98% , Allegany= 2%
- Meritus Hospital: Washington= 98% , Frederick= 2%

PUMA will produce a single comparison benchmark for these hospitals. Regression adjustments for TCOC based on hospital's patient population may adjust for some differences but not be adequate for an accurate benchmark result.

Eastern Shore : PUMA will combine five counties

Queen Anne's and Talbot have fairly different geographic profile than the other three counties

County	Deep Poverty Percent		Median Income	
	MD County	Benchmark Average	MD County	Benchmark Average
Caroline	8.32	7.64	\$59,817	\$50,446
Dorchester	8.46	7.47	\$54,320	\$49,839
Kent	6.82	6.55	\$62,566	\$54,052
Queen Anne's	3.13	3.85	\$99,918	\$80,133
Talbot	3.66	4.03	\$75,351	\$61,103

Matching and Adjustment Variables

Area level population characteristics

	State Implementation Methodology	Federal methodology
Area-level population characteristics	<ul style="list-style-type: none">• Population density - population per square mile• Total population estimate• Rural/urban continuum code• Median household income• % population in deep poverty• Regional purchasing parities• % uninsured adults in 2015 (test-only)• % 65 and older (test-only)• % all adults with diabetes (test-only)• % non-Hispanic Black (test-only)• Bureau of Labor Statistics (BLS) wage all industry, all ownership type (test-only)• BLS wage for all industries, private ownership (test-only)• BLS wage for ambulatory healthcare service, private ownership (test-only)	<ul style="list-style-type: none">• Regional purchasing parities• Median household income categories• % below federal poverty level, adjusted for cost of living• Log population density• % Hispanic

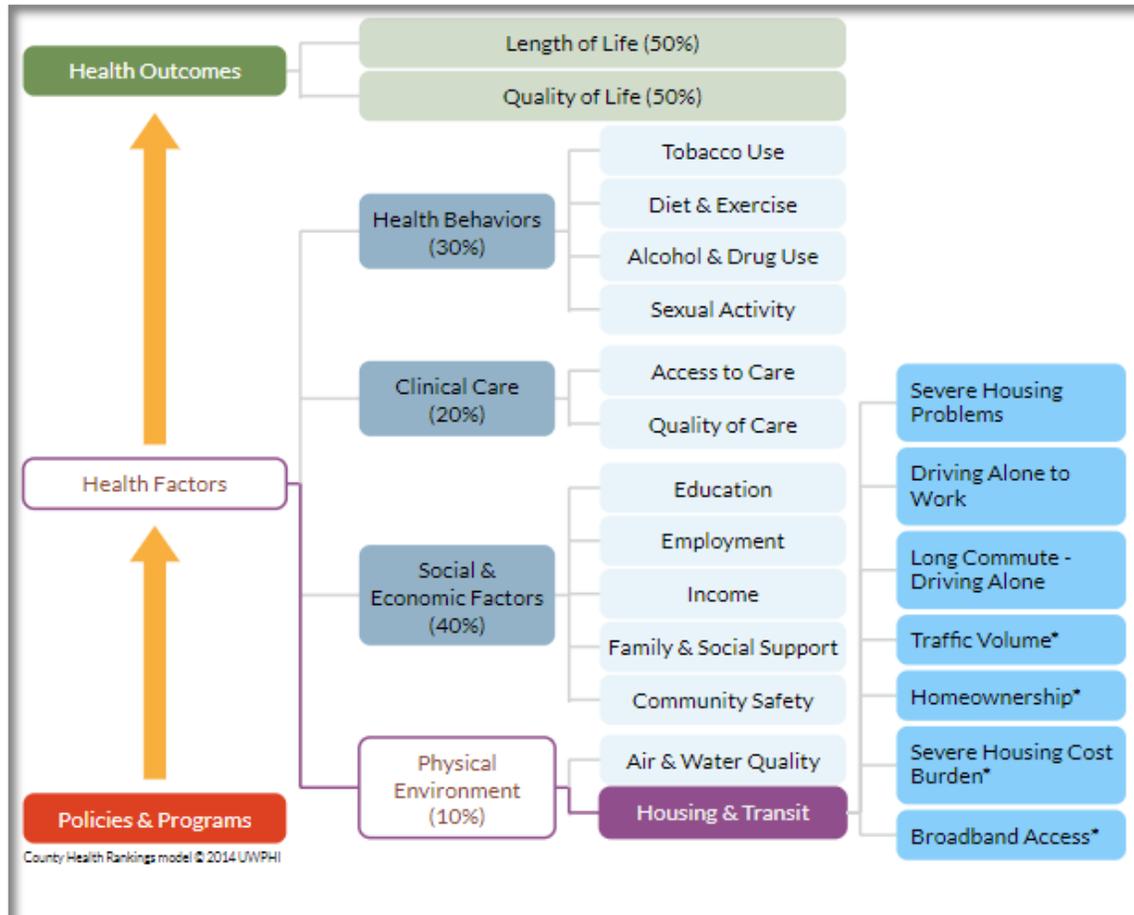
Matching variables

Beneficiary Level Characteristics

	State Implementation Methodology	Federal methodology
Characteristics of Medicare Beneficiaries	<ul style="list-style-type: none">• % Medicare beneficiaries eligible for Medicaid (test-only)• Average Hierarchical Condition Category (HCC) Score	<ul style="list-style-type: none">• Average age• % Black, 4-category distribution• % non-Hispanic White• % female• Average % of the population living in a rural area in the PUMA, calculated based on Medicare beneficiaries' zip code and census urban and rural classification by ZCTA.• % original reason for Medicare entitlement: disability, ESRD• Average HCC risk score
Characteristics of the healthcare system and insurance market		<ul style="list-style-type: none">• Number of primary care providers (PCPs) per 1,000 Medicare beneficiaries

Potential new measures: Health Factors

Benchmarking metrics are chosen to control for social and economic factors. For health factors, state methodology tested percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted).



Health Outcomes

Length of Life	Premature Death
Quality of Life	Poor or Fair Health
	Poor Physical Health Days
	Poor Mental Health Days
	Low Birthweight

Health Factors

Health Behaviors

Tobacco Use	Adult Smoking
Diet and Exercise	Adult Obesity
	Food Environment Index
	Physical Inactivity
	Access to Exercise Opportunities
Alcohol and Drug Use	Excessive Drinking
	Alcohol-Impaired Driving Deaths
Sexual Activity	Sexually Transmitted Infections
	Teen Births

Social & Economic Factors

Education	High School Completion
	Some College
Employment	Unemployment
Income	Children in Poverty
	Income Inequality
Family and Social Support	Children in Single-Parent Households
	Social Associations
Community Safety	Injury Deaths

Physical Environment

Air and Water Quality	Air Pollution - Particulate Matter
	Drinking Water Violations
Housing and Transit	Severe Housing Problems
	Driving Alone to Work
	Long Commute - Driving Alone

<https://www.countyhealthrankings.org/health-data/county-health-rankings-measures>

Potential new measures

- A composite measure of social and economic drivers of health in addition or to replace median income and deep poverty
 - Area deprivation index
 - CMMI uses this measure for payment adjustments
 - Social vulnerability index
 - Federal evaluation used this measure
 - Social deprivation index
 - Child opportunity index
 - Structural racism effect index

<https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00659>

Exhibit 4 Explanatory power of the Structural Racism Effect Index (SREI) and other indices for predicting census tract-level variation in disease prevalence, 2020

	Prevalence, %	R ²				
		SREI	ADI	SVI	SDI	COI
Poor mental health	14	0.73	0.53	0.51	0.58	0.67
Poor physical health	13	0.71	0.53	0.55	0.48	0.65
Diabetes	11	0.57	0.42	0.44	0.35	0.54
High blood pressure	31	0.35	0.39	0.15	0.09	0.27
Asthma	10	0.48	0.37	0.34	0.37	0.54

SOURCES All health outcomes are from the Centers for Disease Control and Prevention's (CDC's) PLACES Project (see note 29 in text), data for 2020. Self-reported disease prevalence data are from the CDC Behavioral Risk Factor Surveillance System, and small-area estimates are from the CDC's PLACES Project. The SREI was calculated by the authors, using data from the sources listed in the exhibit 1 notes, which correspond to a full list of sources in supplement 2 in the appendix (see note 23 in text). The Area Deprivation Index (ADI) was calculated at the census tract level by the authors using Census Bureau American Community Survey 2015–19 5-year estimates. The Social Vulnerability Index (SVI) is from Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry. CDC/ATSDR Social Vulnerability Index [Internet]. Atlanta (GA): CDC; [last reviewed 2023 Jul 12; cited 2023 Aug 26]. Available from: <https://www.atsdr.cdc.gov/placeandhealth/svi/>. The Social Deprivation Index (SDI) is from Robert Graham Center. Social Deprivation Index (see note 16 in text), data for 2019. The Child Opportunity Index (COI) is from diversitydatakids.org. Child Opportunity Index (COI) [Internet]. Waltham (MA): Brandeis University; c 2023 [cited 2023 Aug 25]. Available from: <https://www.diversitydatakids.org/child-opportunity-index>. NOTE The unit of analysis is the census tract.



Next Steps

TCOC Workplan for Upcoming Months

- Next combined HSCRC TCOC Workgroup/H-TAC Meetings is July 24th
 - May schedule an additional meeting in the interim
- TCOC Workgroup Priorities – Approximate timeline (will vary with AHEAD-related needs)
 - July – Update on TCOC results, continue Benchmarking discussion
 - September to October – Finalize benchmarking, discuss changes to the MPA policy
 - November – draft MPA recommendation to commission for CY2025
- Other TCOC Related dates:
 - CTI – Reviewing FY24 and FY25 programs for overlap, will reach out soon
 - CTI – FY25 programs, due by June 28th
 - EQIP Enrollment – Now expected to start in mid-July

Thank You
Next Meeting July 24, 8-10 am

Appendix

Example of Proposed True Up and Alternative

- Example assumes option 2 with no Administrative Set Growth Rate

Scenario	Expected National Trend Y1	Initial Target Y2	Actual National Trend Y1	Adjustment to Expected Trend	Final Target Trend Y1	Expected National Trend Y2	Initial Target Y2
Formulas	A	B = A	C	$D = (C - B - 1\%) / 2$	$E = C + D$	F	$G = (1 + F) \times (1 + C)$
Actual National Trend is higher than Expected by > 1%	3.00%	3.00%	4.50%	0.25%	3.25%	3.00%	7.64%
Actual National Trend is lower than Expected by > 1%	3.00%	3.00%	1.50%	-0.25%	2.75%	3.00%	4.54%

Requires State to incorporate 1.5% lower than expected trend in Y2.

Potential Alternative True Up

- Staff believe the State may wish to push for a longer return to national trend where the miss is phased back into the target over 2 years.
- Year 1 target would not change from original proposal

Scenario	Expected National Trend Y2	50% Phase in of Y1 Expected Trend Miss	Initial Target Y2
Formulas	F	$F1 = (C-B)/2$	$G = (1 + F) \times (1 + B + F1)$
Actual National Trend is higher than Expected by > 1%	3.00%	0.75%	6.86%
Actual National Trend is lower than Expected by > 1%	3.00%	-0.75%	5.31%

Y2 Target only includes 50% of the difference between Y1 Expected and Actual (rather than 100% in base model). Y3 would introduce actual Y1 Trend

Was 7.64%, State is more limited in its ability to return to national trends (but can plan knowing it has additional room in the next year)

Was 4.54%, State does not need to as rapidly incorporate lower than expected trends in the Y1.