

Agenda

- AHEAD Update
- January MPA Application Update
- New Paradigms & High Value Care Plans
- MPA Attribution Tracking Tool (MATT)
- Benchmarking
- Next Steps & Upcoming Meetings





AHEAD Update



January MPA Application Update



New Paradigms & High Value Care Plans



Update

- New Paradigms in Care Delivery
 - Hospital submissions received
 - 16 submissions from 11 entities
 - Staff is in the process of reviewing and discussing proposals.
 - HSCRC may reach out with questions.
 - Hospitals will be notified in early June if they have been chosen.
 - Funding will be put into rates in July.
- High Value Care Plans
 - All hospitals completed submission requirement.
 - Staff is in the review process and will notify hospitals in May or June if there are any issues with their submission.
 - Any applicable penalties will be applied to rates in July.



MPA Attribution Tracking Tool (MATT)





- The MPA Attribution Tracking Tool is now available for hospitals to upload their provider partners for CY 2025.
- Hospitals should submit lists of MPA Y8 Clinical and Facility Partners and confirm their CTO Partners before May 25th, 2025 to be reflected in MADE and DEX for June release.
- New Option: Hospitals that are part of a health system have a new option this year to designate the health system's CFO as their representative.
 - This requires that the health system representative completes and signs the appropriate attestation prior to the first MATT submission of the year. *This process change is captured in the next workflow slide.*



Current Workflow

This entire workflow occurs once MATT opens



This attestation accompanies the update provided in the MPA Attribution Tracking Tool (MATT) on 03/27/2025 for Calendar Year 2024. With these changes in the 2024 Provider List, the following Care Coordination Relationship Attestation is agreed:

Purposes of the CFO Certification:

- 1. Assignment of the MATT proxies (those MATT users who are allowed to submit on behalf of the CFO)
- 2. First time attestation for the year that their partners are correct

3. Providing a signature of the CFO

"The Hospital certifies that it has a Business Associate Agreement (BAA), as such term is defined by 45 CFR §164.504, or other such agreement (employment contract, ACO Agreement, etc.) that allows data sharing under HIPPA, with each Medicare-enrolled practitioner on the attached list to receive Protected Health Information (PHI) for healthcare operations and for voluntarily coordinating or managing health care and related services in a manner allowable under 45 CFR §§164.501, 164.502, and 164.504. The Hospital agrees to hold harmless the State, the HSCRC, and CRISP and to defend and indemnify these parties, individually or collectively, from any actions arising from a false certification made herein."

In addition, the following individuals are duly authorized representatives and may attest to additions to this list related to Calendar Year 2024, going forward.

Userld	Name
kjohns46@jhmi.edu	Kevin Johnson
jmayger1@jhmi.edu	Joyce Maygers

□ I hereby certify that I have reviewed this list of providers, its accuracy, and am submitting all information applicable for Johns Hopkins Bayview Medical Center - 210029.

Signature		
Print Name		
Title		
03/27/2025		

Updated Workflow for Hospitals and System Representatives

Hospital

CRISP

System





Benchmarking Medicare and Commercial Methods Evaluation Results



Input Updates

Demographic data is updated to 2019-2022 survey for both methods

- Medicare TCOC
 - Regional Price Parity is based on county level
 - current methods used regional estimates
 - A few MD counties changed the rural/urban status

- Commercial TCOC
 - Updated risk adjustment and benefit level adjustments
 - Risk adjustment model includes
 pharmacy costs
 - Geographic boundaries of MSAs changed over time for national benchmarks
 - The pool of MSAs available for matching changed due to data availability
 - No changes in county to region mapping for Maryland



Medicare recap: Build models to test each variable and combinations, as well as models using regression approach to select matching variables.

Model	Description	Rationale
Original	Original: Median household income (MIncome), % deep poverty (DPP), regional price parities (RPP), average HCC score (HCC)	
Refreshed	Refreshed: Same as Original, updated to 2022 data	Census updates
Model-2	Original + % Black or African American	Health equity and ability to analyze results by race
Model-4	Original + BLS health care wage index	Additional economic inputs
Model-5	Original + BLS health care wage index -MIncome	(wage index)
Model-6	Original + CDC Social Vulnerability Index (SVI)	Consider different measures of social-
Model-7	Original + CDC SVI - MIncome- % DPP	economic-demographic measures
Model-1	Original + % Diabetes	
Model-9	Original + % Adult smoking	Consider bootth factors
Model-10	Original + % Adult obesity	
Model-11	Original + Food Environment Index	
Model-13	Empirical	Test parsimonious modes against the empirical selection of factors
	Replacement: Original+ % Black or African American + SVI –	
Model-14	MIncome - % DPP	Test replacement of current factors
Model-16	Combined: Original+ % Black or African American + SVI	Test addition of new factors yland health service

3

Commercial recap: Tested most promising models assessed for Medicare methodology and commercial empirical models.

Model	Description
Refreshed	Same as original (Median Income, % Deep Poverty, RPP)
M2	Refreshed + % Black
M13	Variables selected by Medicare empirical model
M14	Refreshed + %Black + SVI – Median Income -%Deep Poverty
M16	Refreshed + %Black + SVI
M17	Refreshed + %Black + SVI + RPP
M18	Refreshed + RPP
M20	Used an empirical stepwise regression model to determine which variables to include in normalization regression and peer group selection. The stepwise regression model started with variables used for Medicare stepwise regression.
M21	Same as M20 but removed highly correlated variables from the starting point of stepwise regression



Final Model Considerations: Regional Price Parity and % Black

Model Name	Variables used
	Matching: Median household income (MIncome), % deep poverty (DPP), regional price parities (RPP), average HCC score (HCC)
Original	Regression: Mincome, DPP
Refresh	Refreshed: Same as Original, updated to 2022 data
Refresh+ RPP in regression	Same as original + added RPP to regression
Model-2	Same as original + % Black or African American in matching and regression

Medicare TCOC Adjustment Regression Coefficients

	Original	Refresh	Refresh + RPP in regression	Refresh+% Black
(Intercept)	7,560.16*	6,139.12*	2,184.06*	6,497.81*
Median Income	0.032*	0.045*	0.018*	0.044*
Deep Poverty	181.714*	385.12*	264.23*	309.80*
Regional Price Parity	/		<mark>68.821*</mark>	
% Black				<mark>685.792</mark>
Adjusted R Square	0.133	0.167	0.196	0.173

Commercial TCOC Adjustment Regression Coefficients

Variable	Original	Refresh	Refresh + RPP in regression	Refresh+% Black
(Intercept)	168.4	241.28*	323.45*	317.69*
Median Income	0.002*	0.002*	0.002*	0.01
Deep Poverty	105.0	165.27	193.28	0.99
Regional Price Parity			<mark>-1.187</mark>	0.0
% Black				<mark>-123.30</mark>
Adjusted R Square		0.153	0.146	0.058



Final Model Considerations: Regional Price Parity and % Black

Medicare TCOC Demographic Adjusted, PMPY			Co	mmercial TCO	C Demographic	Adjusted, PMPY	,		
	Original	Refresh	Refresh + RPP in regression	Refresh+% Black		Original	Refresh	Refresh + RPP in regression	Refresh+% Black
Statewide average	\$12.746.36	\$13.543.31	\$13.607.38	\$13.418.44	Statewide average	\$3,218.00	\$3,491.00	\$3,751.53	\$3,469.09
Benchmark average	\$11,657.24	\$12,214.54	\$12,196.34	\$12,232.40	Benchmark average	\$3,863.77	\$4,560.37	\$4,711.96	\$4,562.53
Difference	9.3%	10.9%	11.6%	9.7%	Difference	-16.7%	-23.4%	-20.4%	-24.0%
Adjusted R-Square	0.13	0.17	0.19	0.17	Adjusted R-Square		0.15	0.15	0.06

health services



County Rankings

Original vs. Data Refresh

Medicare TCOC			
			Impact of Data
County	Original	Refresh	Updates on Ranking
Montgomery	1	1	0
Garrett	2	3	1
Calvert	3	4	1
Charles	4	5	1
Prince George's	5	9	4
Howard	6	2	-4
St. Mary's	7	6	-1
Frederick	8	7	-1
Dorchester	9	18	9
Anne Arundel	10	8	-2
Caroline	11	24	13
Washington	12	10	-2
Kent	13	20	7
Somerset	14	12	-2
Queen Anne's	15	14	-1
Cecil	16	11	-5
Carroll	17	16	-1
Wicomico	18	15	-3
Allegany	19	22	3
Harford	20	17	-3
Worcester	21	21	0
Talbot	22	13	-9
Baltimore	23	19	-4
Baltimore City	24	23	-1

Commercial TCOC			
			Impact of Data
County	Original	Refresh	Updates on Rankings
Calvert	1	1	0
Howard	2	4	2
Prince Georges	3	8	5
Anne Arundel	4	2	-2
Somerset	5	6	1
Montgomery	6	13	7
Charles	7	9	2
Frederick	8	11	3
Saint Mary's	9	13	4
Harford	10	12	2
Carroll	11	10	-1
Wicomico	12	7	-5
Baltimore City	13	23	10
Baltimore	14	16	2
Queen Anne's	15	3	-12
Cecil	16	15	-1
Allegany	17	19	2
Washington	18	17	-1
Worcester	19	5	-14
Talbot	20	18	-2
Kent	21	21	0
Dorchester	22	20	-2
Caroline	23	22	-1
Garrett	24	24	0



17

ission

County Results- Difference from Benchmarks

Original vs. Data Refresh

Medicare TCOC Adjusted % Difference from Benchmarks					
County	Original 2022 Difference from Benchmark	Refresh 2022 Difference from Benchmark	Percentage Point Impact of Data Updates		
Montgomery	-9.0%	-3.2%	5.7%		
Garrett	-4.7%	-1.6%	3.1%		
Calvert	0.1%	-1.1%	-1.2%		
Charles	0.8%	1.8%	1.1%		
Prince George's	1.2%	8.3%	7.1%		
Howard	2.6%	-1.8%	-4.3%		
St. Mary's	4.0%	5.6%	1.6%		
Frederick	4.9%	5.7%	0.8%		
Dorchester	6.2%	20.7%	14.6%		
Anne Arundel	6.6%	8.2%	1.6%		
Caroline	8.9%	27.5%	18.7%		
Washington	9.0%	9.2%	0.1%		
Kent	9.0%	22.6%	13.6%		
Somerset	11.9%	11.7%	-0.2%		
Queen Anne's	14.2%	13.4%	-0.8%		
Cecil	15.5%	10.7%	-4.8%		
Carroll	15.8%	15.2%	-0.6%		
Wicomico	16.9%	13.6%	-3.2%		
Allegany	18.8%	23.6%	4.7%		
Harford	19.0%	16.3%	-2.6%		
Worcester	22.6%	22.8%	0.2%		
Talbot	23.2%	12.9%	-10.2%		
Baltimore	23.8%	21.7%	-2.0%		
Baltimore City	26.4%	24.8%	-1.5%		

Commercial ICOC Adju	sted % Differe	nce from Bench	nmarks	
	Original 2022	Refresh 2022	Percentage Point	
	Difference	Difference	Impact of Data	
	from	from	Updates	
County	Benchmark	Benchmark		
Calvert	-27.0%	-36.3%	-9.3%	
Howard	-25.2%	-30.7%	-5.5%	
Prince Georges	-24.7%	-27.7%	-3.0%	
Somerset	-24.5%	-30.3%	-5.8%	
Anne Arundel	-23.0%	-32.8%	-9.8%	
Montgomery	-19.5%	-21.4%	-1.9%	
Charles	-18.2%	-26.8%	-8.6%	
Frederick	-18.2%	-25.9%	-7.7%	
Saint Mary's	-16.6%	-21.4%	-4.8%	
Wicomico	-16.4%	-29.1%	-12.7%	
Queen Anne's	-13.4%	-30.8%	-17.4%	
Harford	-12.5%	-22.6%	-10.1%	
Carroll	-11.7%	-26.3%	-14.6%	
Baltimore City	-11.4%	-12.0%	-0.6%	
Baltimore	-9.2%	-18.0%	-8.8%	
Worcester	-8.6%	-30.5%	-21.9%	
Allegany	-8.6%	-17.2%	-8.6%	
Washington	-7.6%	-17.8%	-10.2%	
Cecil	-6.9%	-20.1%	-13.2%	
Talbot	-0.6%	-17.3%	-16.7%	
Kent	0.0%	-15.4%	-15.4%	101
Dorchester	0.1%	-15.6%	-15.7%	
Caroline	0.1%	-14.2%	-14.3%	land
Garrett	7.4%	-4.3%	-11.7%	attn ser

18

ces

Adding RPP or % Black affected small number of counties. Commercial model shows more significant changes with % black.

Medicare TCOC		Change in Rankings Compared to Refresh	
County	Refresh	Refresh + RPP in regression	Refresh+% Black
Montgomery	1	0	1
Howard	2	1	-1
Garrett	3	-1	2
Calvert	4	0	0
Charles	5	0	-2
St. Mary's	6	5	0
Frederick	7	-1	0
Anne Arundel	8	1	1
Prince George's	9	-1	-1
Washington	10	-3	0
Cecil	11	2	0
Somerset	12	-2	6
Talbot	13	1	2
Queen Anne's	14	-2	-1
Wicomico	15	0	-3
Carroll	16	0	0
Harford	17	0	0
Dorchester	18	0	-4
Baltimore	19	1	0
Kent	20	3	2
Worcester	21	0	-1
Allegany	22	-3	-1
Baltimore City	23	-1	0
Caroline	24	0	0

		i i	
	Change in Rankings		
Commercial TCOC		Compared	to Refresh
		Refresh + RPP	Refresh+%
County	Refresh	in regression	Black
Calvert	1	0	0
Anne Arundel	2	0	0
Queen Anne's	3	1	3
Howard	4	-1	1
Worcester	5	-1	-1
Somerset	6	0	6
Wicomico	7	0	3
Prince Georges	8	2	7
Charles	9	-1	5
Carroll	10	-1	-7
Frederick	11	0	-3
Harford	12	1	-3
Montgomery	13	2	5
Saint Mary's	13	-1	-2
Cecil	15	-1	-8
Baltimore	16	0	1
Washington	17	0	-1
Talbot	18	0	1
Allegany	19	0	-6
Dorchester	20	0	2
Kent	21	1	0
Caroline	22	-1	-2
Baltimore City	23	0	1
Garrett	24	0	-2

9

Model Results Summary

- Both Medicare and Commercial results show the largest change due to demographic changes.
- Adding RPP to the regression:
 - Small variations in county rankings for both Medicare and Commercial models
 - A negative coefficient for the Commercial model (not statistically significant).
 - A positive coefficient for the Medicare model (statistically significant).
- Adding % black to the models:
 - Some changes in the commercial results, with a negative coefficient (not statistically significant).
 - Minor changes the rankings for the Medicare models, with a positive coefficient (not statistically significant).





 Based on balancing Medicare and Commercial model results, and additional considerations, staff proposes to keep the model variables the same and only refresh data inputs.





Next Steps



TCOC Workplan for Upcoming Months

- Upcoming TCOC Workgroup Dates
 - May 28
 - 2025 Meeting Dates (Tentative) posted on <u>TCOC Workgroup Webpage</u>
- Future Meetings Topics
 - May
 - High Value Care Plans and New Paradigms Recap
 - June
 - Semi-Annual TCOC Update



Upcoming Important CTI and EQIP Dates

- CTI
 - CTI Enrollment
 - Enrollment Webinar: March 19th Recording posted on <u>CRISP Learning System</u>
 - Open Enrollment: March 31st
 - CTI Learning Collaborative: May 2nd at 12PM <u>Registration Link</u>
 - Enrollment Close Date: May 30th
 - 2027 Program Change Discussion August 2025
- EQIP
 - EQIP Enrollment
 - Enrollment Webinar: June 18th at 12pm <u>Registration Link</u>
 - Open Enrollment Begins: July 1st
 - Enrollment Close Date: August 29th
 - EQIP Subgroup Meetings
 - May 16th, Jul 18th, Sep 19th, Nov 21st



CRISP User Summit 2025

May 13th, 8:45 am to 4pm

We're excited to give attendees the opportunity to participate in live, interactive programming from the comfort of their own space. This event will showcase insightful sessions and presentations from industry professionals, offering valuable knowledge and perspectives on CRISP tools and services.

A complete agenda and session descriptions will be available in the coming weeks.

Register Now!



Thank You Next Meeting May 28, 8-10 am

