maryland
health services
cost review commission

Total Cost of Care Workgroup

August 2021

Agenda

1. Stakeholder Comments and Responses on the MPA
2. Next steps on the MPA

Stakeholder Comments on the MPA

Overview of Stakeholder Response

	Attribution	CTI Buyout	PSAP Definitions	Miscellaneous
Maryland Hospital Association	The impact of changing the attribution should be examined.	The CTI Buyout should remain.	The definition of the PSAPs should be standardized.	Additional stakeholder accountability needs to be added & year over year changes inhibits strategic planning.
University of Maryland	The impact of the attribution approaches should be examined.		Hospitals should be allowed to redesign their PSAPs.	TCOC Benchmarking should be rerun using a larger claims sample and results should be vetted with the industry.
Johns Hopkins	Analyze the overlap between touch and primary care attribution methodologies.	The CTI Buyout should remain.	Use a consistent methodology to designate the PSAPs.	Getting access to beneficiary level data is important.
MedStar Health	Hospitals should have a clinical relationship with the beneficiaries attributed to them.	The CTI Buyout should remain. New CTI should be delayed.		Getting access to beneficiary level data is important.

Attribution Comments

Stakeholders expressed a concern that the attribution of beneficiaries to hospitals should follow clinical relationships. Additionally, stakeholders were concerned that:

- Under a geographic approach hospitals would be accountable for beneficiaries that do not have an established clinical relationship with that hospital.
- The geographic approach would not work well for urban hospitals with overlapping service areas.

Stakeholders requested that HSCRC analyze the overlap between the existing attribution of beneficiaries and the geographic attribution of beneficiaries.

Analysis of Beneficiary Attribution under Different Methodologies

Staff analyzed the number of beneficiaries attributed to each hospital under the existing attribution and the number of beneficiaries attributed under geographic attribution.

- On average, 43% of the beneficiaries attributed under the existing attribution are retained by the hospital under the geographic attribution.
- This ranges from a high of 91% to a low of 7% (excluding the AMCs).
- In general, rural hospitals retain more beneficiaries than the urban hospitals.
- The results of the retention analysis is provided in the attached excel files.

Attribution Churn

Staff also analyzed the ‘churn’ from one year to the next. About 70% of beneficiaries attributed under the existing algorithm are retained by the hospital from one year to the other.

- The MPA attribution assigns beneficiaries to the hospital based on their claims history over the prior two years.
- Over two years, hospitals retain only 50% of beneficiaries under the primary care-based attribution.
- Shifting to geographic attribution will be a one-year reduction in beneficiary retention but will lead to better retention over time.

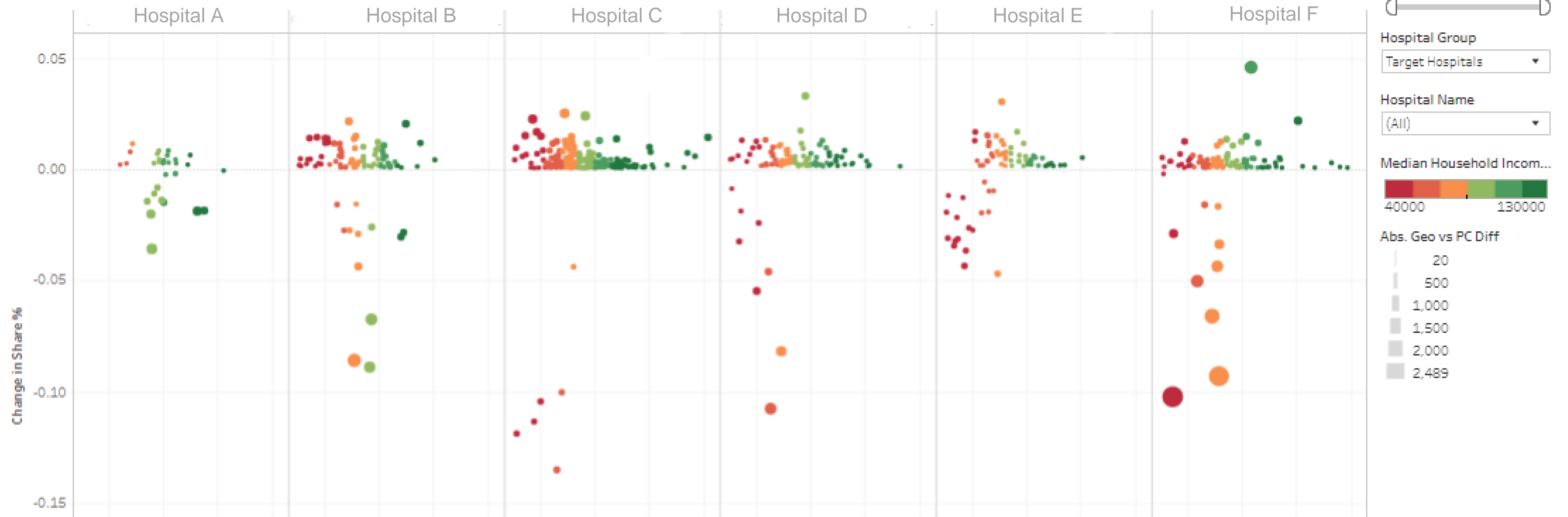
Staff Responses

Staff do not agree with the concerns about moving to geographic attribution for two reasons:

1. The MPA only imperfectly captures the existing relationship between hospitals and the beneficiaries that they choose.
2. CTI provide a much better match between hospital's clinical efforts and attributed beneficiaries.
3. Primary care attribution dilutes the focus on urban beneficiaries. Hospitals' primary care networks are concentrated in suburban geographies.
   - Using primary care attribution results in proportionally fewer beneficiaries being attributed from low-income zip codes and proportionally more beneficiaries being attributed from richer zip codes.
   - The lack of a clinical relationship between beneficiaries and the hospital reflects an under investment in urban primary care networks.

Shifting Focus Under Primary Care

Each point represents one zip code, negative %'s indicate less share of total hospitals beneficiaries under Primary Care-based attribution, zip code income increase from left to right and from red to green



- For many hospitals (D, E and F), primary care-based network shift focus towards more affluent communities.
- Hospitals "pick their patients" rather than vice versa.

CTI Buyout Comments

Stakeholders suggested that the CTI Buyout remain.

- CTIs better capture beneficiaries served by hospital-based programs.
- One stakeholder suggested that new CTIs be delayed until the CTI buyout policy is resolved.

Staff agree that the CTI Buyout should be maintained and will include it in the State's submission to CMMI.

- Staff do not agree that new CTI should be delayed until the buyout is resolved.
- Hospitals should get credit for their CTI interventions regardless of the CTI buyout policy.
- Both the CTI buyout and the CTI themselves incentivize greater participation. The lack of the CTI buyout should not change the financial incentives for hospitals.

PSAPs

Stakeholders suggested that HSCRC adopt a standard, industry wide, PSAP definition.

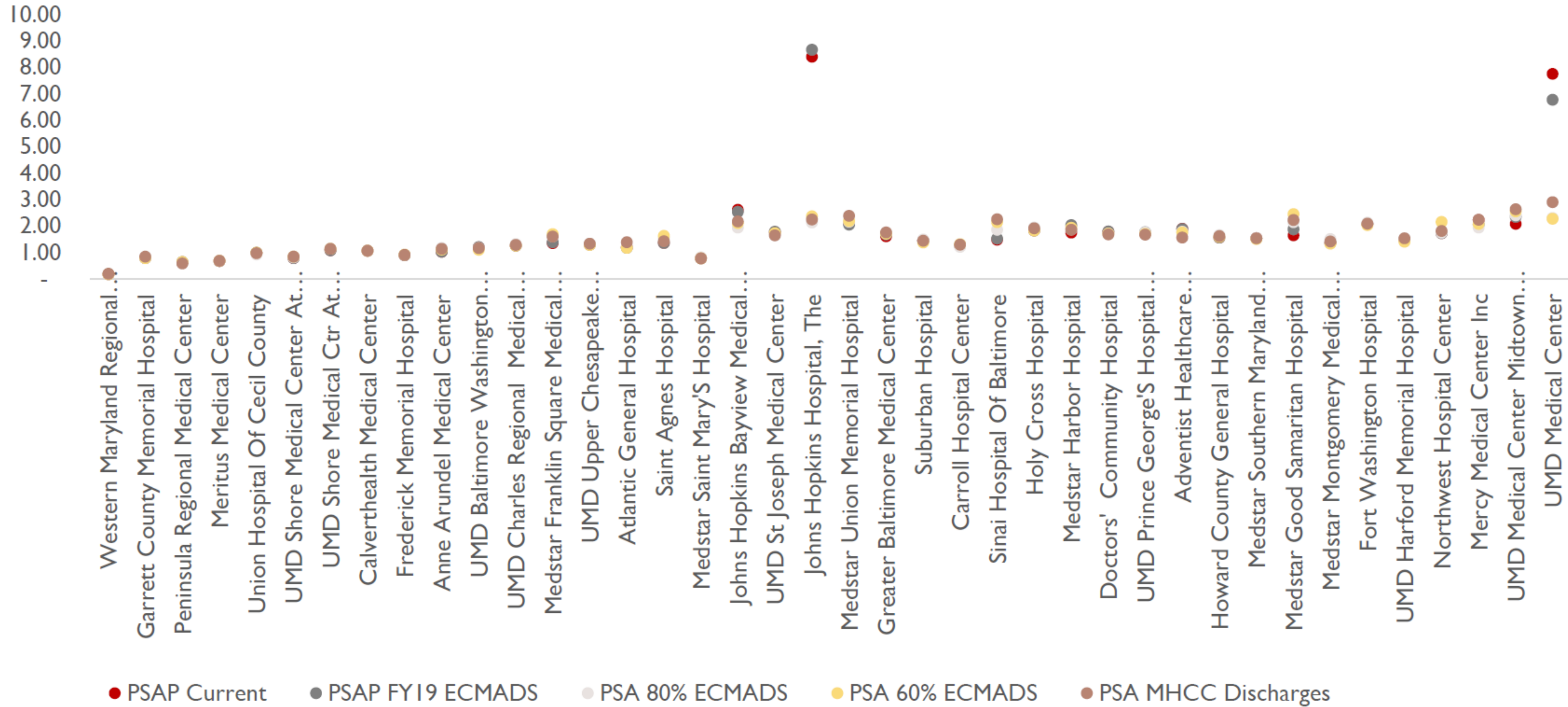
- PSAP definitions vary from hospital to hospital.
- They are old and may not reflect existing service areas.

Staff agree that the PSAP should be updated.

- Staff intend to work with the industry throughout the winter and spring to agree on a standard definition of PSAPs.
- These will be used in the MPA, benchmarking, and other policies based on hospital service areas.
- As a reminder, Staff analyzed alternative attribution approaches an found little difference for the MPA.

Alternative Geographic Attribution

Results are very similar except formula-based methods attribute more to academics lowering their leverage



Miscellaneous comments

The MHA suggested that the HSCRC partner with other state agencies to expand responsibility for managing the total cost of care.

- Staff agree that the responsibility for TCOC needs to be expanded to other care partners.
- Staff have the developed regional partnerships, EQIP, etc.
- Staff are also interested in hospital's efforts to align their physician networks with reducing the TCOC since they have more formal levers over nonhospital costs than the HSCRC.
- Similarly, hospitals spend significant money on their community benefit programs that could be aligned with the TCOC model.

Miscellaneous comments

The MHA commented that frequent changes to the MPA inhibits strategic planning. MHA believes that changes to the MPA policy have resulted in beneficiary churn.

- Staff agree that stability in the MPA is desirable and will propose a multi-year recommendation.
- Last year, staff proposed simplifying and stabilizing the MPA. At MHA's request, we delayed changing the attribution algorithm until this year, even though that added a year of change to the MPA.
- Staff believes that churn is inherent in a primary care-based attribution approach.
    - Beneficiaries change physicians frequently
    - Physicians are frequently changing practices
    - Maintaining the complex algorithms requires frequent changes
- Staff believe that geographic attribution will reduce the need for changes and substantially limit the churn in the beneficiary attribution.

Miscellaneous comments

The University of Maryland suggested that Staff rerun the benchmark with more data than the 5% sample and vet the results with the industry.

- HSCRC does not have access to the full Medicare data.
- CMS releases the 5% sample because its sample size is sufficiently large for most analytics tasks.
- The benchmarking has already been incorporated into the numerous HSCRC policies.

Miscellaneous comments

Johns Hopkins and Medstar emphasized the need for more data access in order to manage the TCOC.

- Staff agree that data access is important. Our intention is to expand data access. Moving to a geographic attribution does not inhibit expanding access.
- Staff intend to explore more expansive attribution approaches. For example, we could provide data for any beneficiary provided a service by the physician. Currently, we provide data for any beneficiary provided the plurality of their services by the physician.

Next Steps

MPA Proposal

Staff intends to present the Draft Recommendation to the Commission in September.

- We intend to propose moving to geographic attribution for the MPA
- We intend to submit the MPA proposal to CMS prior to a final MPA recommendation.

Over the winter and spring we will work with the industry to update the geographic service area definitions.