maryland
health services
cost review commission

Total Cost of Care Workgroup

November 2021

Agenda

1. MPA Proposal to CMS
2. Revision to the PSAP
3. MPA Data Sharing
4. MDPCP Savings Estimate

MPA Proposal to CMS

CMS Responses to the MPA Proposal

CMS has approved the State's MPA proposal for CY 2022. However:

- CMS rejected the State proposal for the 'CTI buyout.' This means that hospitals will receive the full MPA amount regardless of their CTI participation.
- Staff are disappointed, as we continue to believe that the traditional MPA is not as well targeted to the hospital's actual care management programs as the CTI.

CMS indicated a desire to see two additional changes in the future:

- Strengthening the MPA quality measures.
- An increased Revenue at Risk in the traditional MPA.

MPA Quality Adjustments

The MPA current uses the readmissions reductions and MHAC quality adjustments. MPA payments are multiplied by the quality adjustment.

- E.g. a +5% quality adjustment would result in the hospital receiving 105% of its unadjusted MPA adjustment.
- The quality adjustment was originally included in the MPA to qualify the MPA under the QPP program.

Staff believe that quality programs should be implemented on an All-Payer basis.

- Quality programs are more effective when the same measures are used across all patient groups.
- Adjustments on an All-Payer basis have more revenue at risk and thus (presumably) get more attention from hospitals.

Next Steps

Staff intend to the develop additional quality measures based on the SIHIS goals.

- This measure will hold hospitals accountable for helping to meet the SIHIS goals.
- Since the SIHIS goals benefit all populations, our intention is to work on develop an all-payer quality program to include whatever measures are developed.

Staff will be working with the industry in 2022 to develop new quality measures.

- Staff expect this work to occur between Spring and Fall of 2022.
- Staff intend to develop measures by October of 2022 in time for the CY 2023 MPA submission.
- Members that are interested in the workgroup should let staff know and will receive an invite to a workgroup in the new year.

Revised PSAP Definition

Primary Service Area Plus – Revised Definition

- During draft MPA proposal, stakeholders recommended that the Commission revise its definition of the primary care service areas.
  - Staff have analyzed the impact of the service area definitions.
  - Analytic file provided to the TCOC workgroup
- Options:
  1. Current method based on PSAs in original GBR
  2. Automated PSA assignment based on zip codes making up X% of a hospital's ECMAD volume
     - Data provided shows results for X from 40% to 80%
- In both option:
  - Zips in multiple PSAs are split based on ECMADS
  - Unassigned remainder allocated based on driving distance as in current PSAP
- Staff bias is to the "60%" method where PSAs are assigned based on zips that make up 60% of a hospital's ECMADS (similar to standard MHCC approach)
  - Medicare ECMADS to be used in MPA
  - Method would be applied to other policies (e.g. benchmarking, PAU per capita)
  - Staff bias is not strong if stakeholders prefer a different approach
  - Need comments by 12/31 in order to finalize approach for FY22 reporting.
- Appendix includes data run previously showing the impact of different PSA assignments using the metrics developed to capture effectiveness of different MPA approaches
  - Outcomes are similar across most methods except Option 2 approaches increase scores for Academics by increasing their geographic exposure relative to their total spend.

MPA Data Sharing Options

Background

MPA attribution is shifting from Primary Care based to Geographic

Geographic attribution does not support specific PHI relationships as Primary Care did.

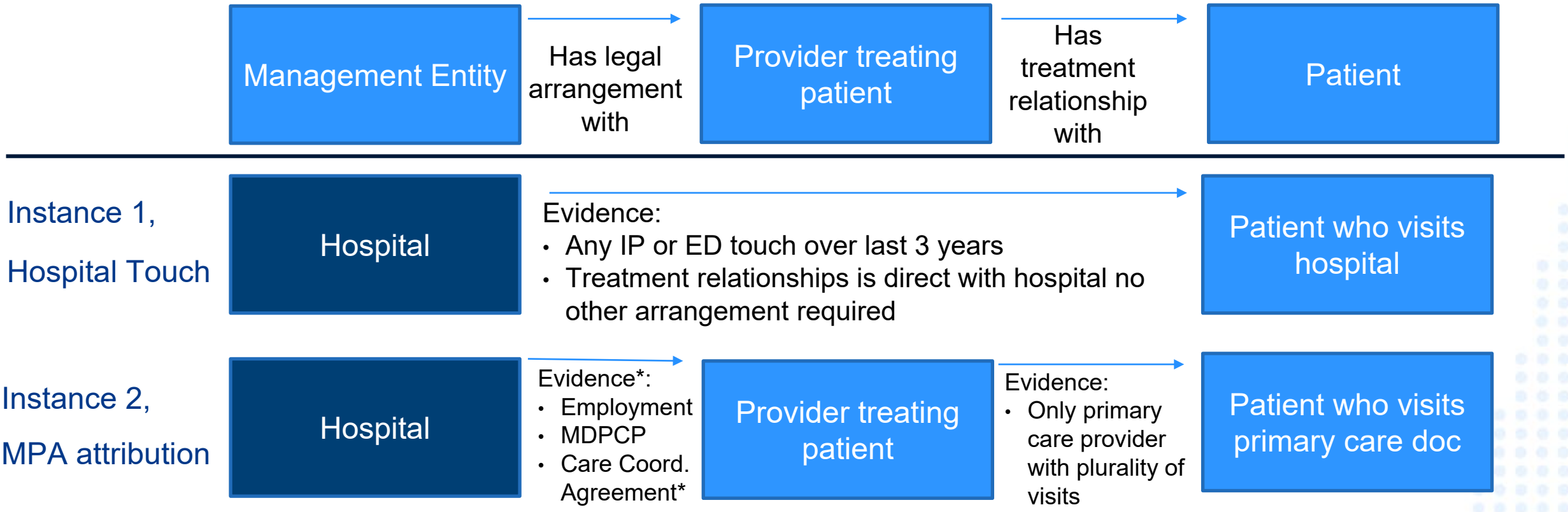
HSCRC is separating PHI data sharing rules from MPA and creating a PHI "attribution" that will be used expressly to facilitate PHI data sharing within the relevant compliance rules

- Will replace MPA primary care attribution in controlling downstream PHI access with more flexible algorithm
- Touch attribution unchanged.
- Remainder of this presentation focuses on the HSCRC's proposed new approach.

MPA Access Tracking Tool (MATT) will be revised with a primary focus on collecting attestations on treatment relationships to support data sharing.

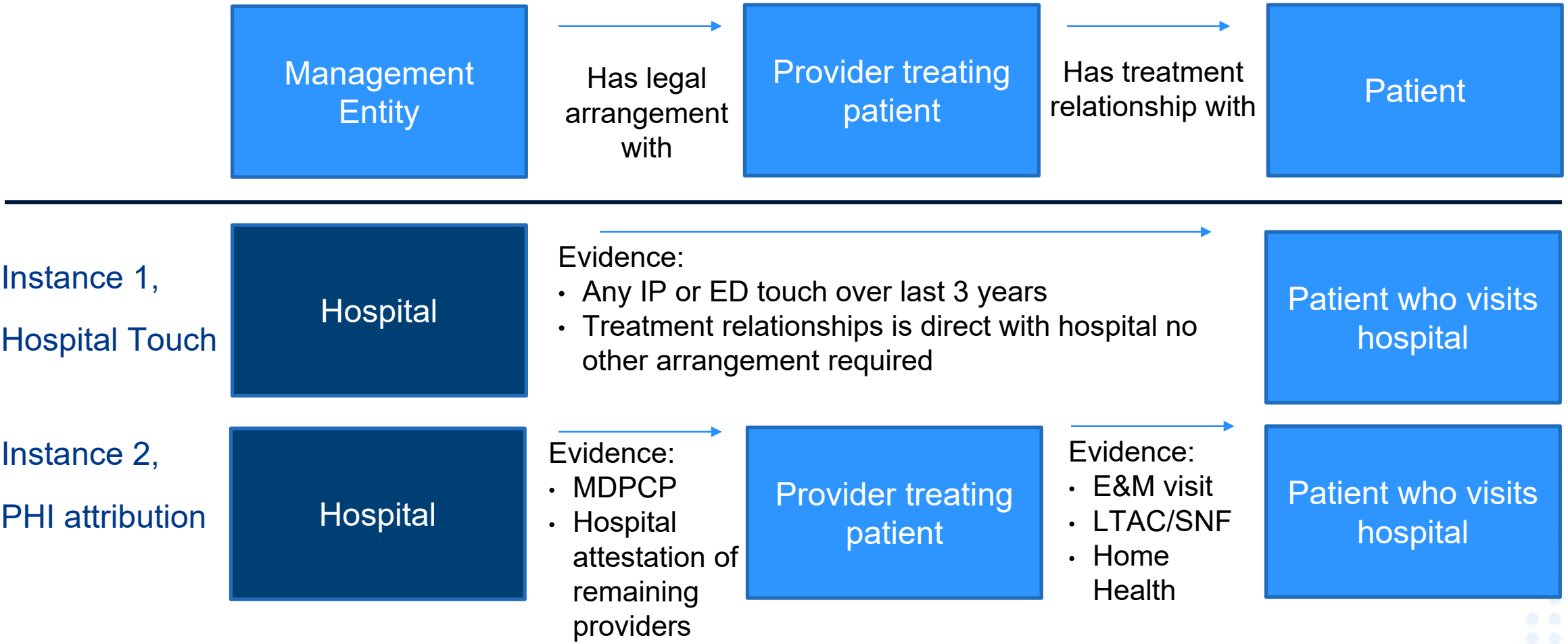
Establishing a Treatment Relationship and Documenting Contractual Access

Current Scenarios



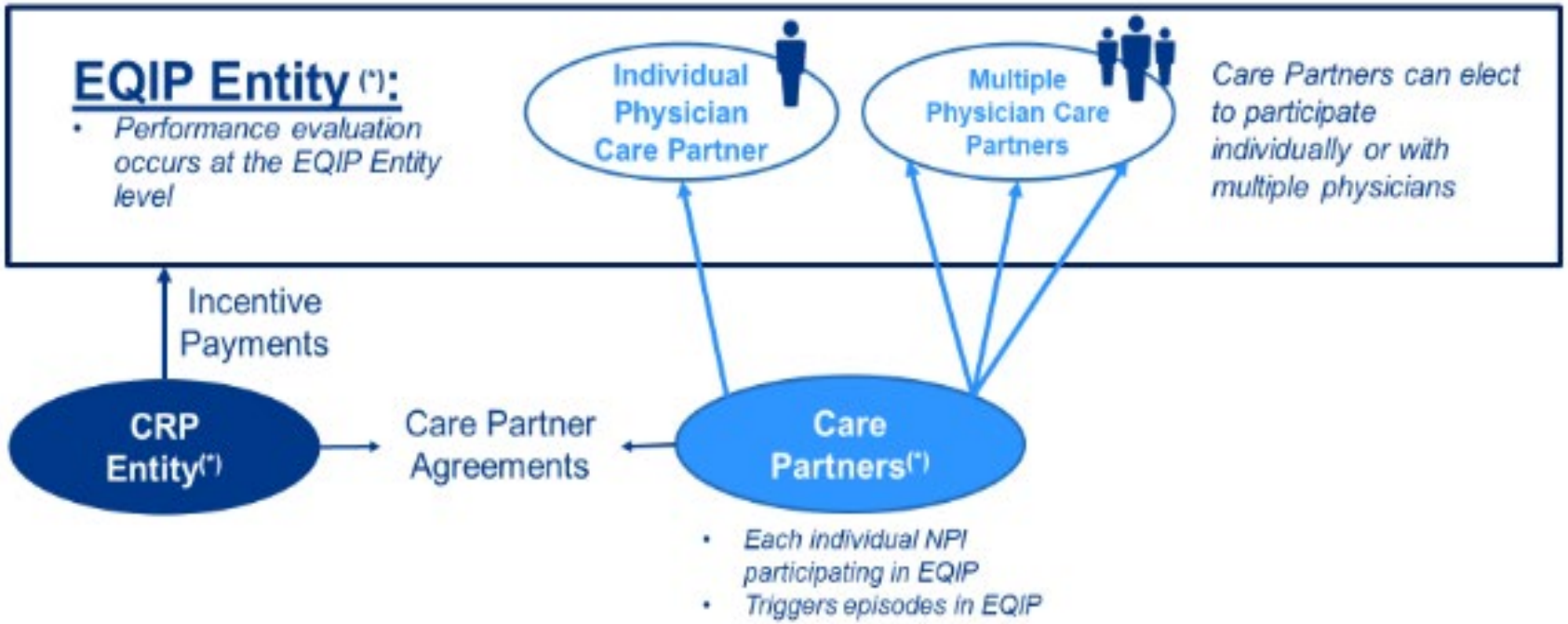
*HSCRC currently requires the assertion that a relationship exists, not any tangible evidence of the relationship, although for MDPCP we have validation via CMS. HSCRC does not plan to change that approach.

Future Scenarios – Hospital Based

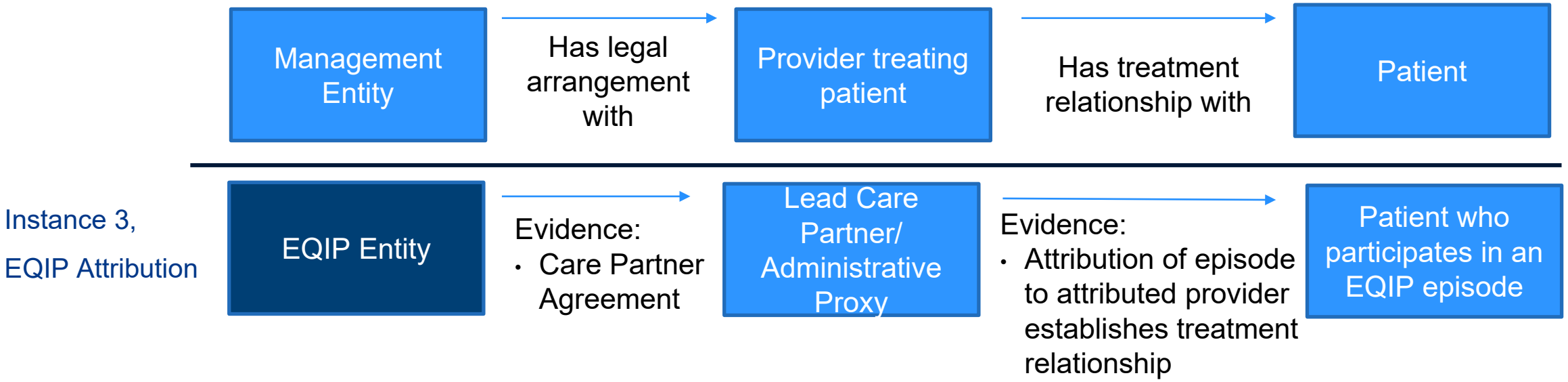


EQIP Relationships

Exhibit 2. The Three Parties Involved with EQIP



New Scenarios – EQIP



- EQIP entity can designate administrative proxies.
- The lead care partner can share PHI data with NPIs at their discretion.

Terminating PHI Access

Treatment Relationships

- Currently:
  - Touch attribution is updated monthly based on newest CCLF file
  - MPA attribution is determined annually when MPA attribution is complete
  - A treatment relationship is deemed to have terminated when these attributions change and the attribution is no longer made OR when hospital notifies HSCRC of a terminated relationship via MATT

- Future:
  - Touch attribution as above
  - MPA attribution will be geographic so annual data collection won't be required for that BUT
    - HSCRC will require complete reset of attribution attestations to ensure ongoing treatment relationships
  - Monthly update on termination of relationships, other than MDPCP, will also be required (via MATT)

Next Steps

Would like to receive industry feedback by the end of year

Final decision and review and approval by HSCRC/CRISP legal and compliance team in January

CRISP/hMetrix will begin making changes to MATT once decisions are finalized

PHI attestations submitted by hospitals in March/April 2022

Changes will be effective with implementation of MPA reporting on CY22 in the June 2022 data release

Estimate of MDPCP Savings

Staff Analysis of the MDPCP Savings

Staff conducted an analysis of the MDPCP program to assess whether the program has produced savings.

- The report was requested by the legislature and is available here: http://dlslibrary.state.md.us/publications/JCR/2021/2021_119b_2021.pdf
- This estimate is different than the supplemental MDPCP adjustment. Savings are estimable relative to a comparison group of non-MDPCP beneficiaries and not relative performance.

Staff found that MDPCP produced approx. $16 million in savings.

- Savings are net of the care management fees.
- Savings are estimated relative to the 2019 baseline.

Staff consider this to be a positive result but urge stakeholders to be cautious in interpreting the results.

- Savings have been relatively volatile (savings in year 1 were negative and positive in year 2).
- COVID is a potential confounder.

Savings Calculation

	Year	RA TCOC per Capita	MDPCP $ Fees	RA TCOC Per Capita + Fees	Growth Rate	Compound Growth
Par	2018	$ 10,379		$ 10,379		
Par	2019	$ 10,522	$ 206	$ 10,728	3.36%	
Par	2020	$ 9,875	$ 381	$ 10,256	-4.41%	-1.19%
Non-par	2018	$ 10,477		$ 10,477		
Non-par	2019	$ 10,727		$ 10,727	2.39%	
Non-par	2020	$ 10,402		$ 10,402	-3.03%	-0.72%

	Period	Growth Rate		Per Capita $	Per Capita Savings	Aggregate Savings
Diff-in-Diff	2019/2018	0.97%	**Benchmark**	$ 10,627	$ (101)	$ (30,177,365)
	2020/2019	-1.37%		$ 10,403	$ 147	$ 47,613,126
	2020/2018	-0.48%		$ 10,305	$ 49	$ 15,992,920

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Next Steps

Next Steps

- Staff will be presenting the final MPA Recommendation to the Commission in December.
- Staff would appreciate workgroup members thoughts by the end of the year regarding:
  - The PSAP definition.
  - The MPA data sharing rules.
  - Thoughts should be sent to HSCR.TCOC@Maryland.gov.
- Next TCOC Meeting will discuss Staff responses to workgroup comments.
  - The December meeting will be canceled considering the holidays.
  - The next workgroup meeting will be in January.
- Staff will convene a workgroup in 2022 to begin discussing the quality measures for the MPA / SIHISS.

Appendix Slides

Alternative Geographic Approaches (From July 2020 TCOC Mtg)

- Alternative Geographic Approaches – No Duplication (shared zip codes are allocated)
  - Based on original Hospital Identified Service Areas
    - **PSAP Current**– Baseline current zips and current weights based on FY14/FY15 ECMADS
    - **PSAP FY19 ECMADS** – PSAP current zips with weights based on FY19 Medicare ECMADS
  - Based Formulaically Derived Service Area
    - **PSA based on 60% ECMADS** – Top 60% cumulative FY19 ECMADS with weights based on FY19 Medicare ECMADS
    - **PSA based on 80% ECMADS** – Top 80% cumulative FY19 ECMADS with weights based on FY19 Medicare ECMADS
    - **PSA based on MHCC Discharge Methodology** – MHCC Algorithm on FY19 discharges with weights based on FY19 Medicare ECMADS

Comparison of Impact by Attribution Approach

Metric	Purpose	Calculation	Meaning
Leverage	How much leverage does a hospital get for good or bad MPA results	Delivered $ over Attributed $	High value indicates the hospital's reward or penalty multiplied across much larger base than it was calculated on
Significance	How significant is attributed care in terms of all care delivered by a hospital	Attributed and Delivered $ over Delivered $	High value means a hospital is working for their own attributed beneficiaries more
Control	How much direct control does a hospital have over its MPA results	Attributed and Delivered $ over Attributed $	A high value indicates a hospital delivers more of its attributed care
Hospital Control	How much direct control does a hospital have over the hospital-driven portion of its results	Attributed and Delivered $ over Attributed $ that were delivered at a hospital	A high value indicates a hospital delivers more of its attributed hospital care
Combined Evaluation	Combines Leverage, Significance and Hospital Control into a single measure	Abs(0.5 – Leverage) * 2 + (1-Significance) + (1-Hospital Control)	Lower score indicates more appropriate leverage and higher hospital control and significance. A value of 0 indicates 50% leverage, 100% significance and 100% hospital control.

Combined Score Under Each Methodology

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