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Total Cost of Care Workgroup

August 2022

Overview

- MPA Proposed Changes and Stakeholder Responses:
  - Elimination of MDPCP Supplemental Adjustment
  - Addition of Population Health Measure and Increase in Quality Weights
  - Change to Primary Service Area Plus (PSAP) Attribution
- Analysis of Medicare utilization

Timeline

- **July:** HSCRC proposed detail on MPA changes for the upcoming year
- **August**: The HSCRC received two comment letters (MHA & JHHS) on the proposed changes in this package
- **August 31st:** TCOC workgroup– Review these changes to MPA and any industry comments
- **September/October:** Population Health Quality Metrics Workgroup concludes on all-payer measures and scoring mechanism
  - CMS is requiring inclusion of the Population Health measures in the MPA for CY2023 so Staff will select these measures even if workgroup can't reach broader consensus
- **October**: HSCRC shares draft MPA recommendation with stakeholders
- **November**:
  - Preliminary recommendation amending MPA policy submitted to Commission
  - MPA approval letter submitted to CMS
- **December**: Final recommendation amendment to MPA submitted to Commission

Proposed Changes for the MPA

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Elimination of MDPCP Supplemental Adjustment

- Given that Track 3 is approved, Staff anticipate eliminating the supplemental adjustment.
  - Hopkins supported the removal of the supplemental adjustment.
  - Staff did not receive additional comments on the Supplemental Adjustment.

Current Quality Calculation and Proposed Revisions

- Current MPA Quality Adjustment =
  - MPA TCOC result ***x*** *1/3** ***x*** (1**+** RRIP **+** MHAC Reward/Penalty)
    - Subject to +/- 1% cap applied at the end of the calculation.
  - Where:
    - MPA result is expressed as percentage points above or below target
    - RRIP and MH are each up to +/- 2%
    - Calculation is reversed if MPA TCOC result is a penalty
    - Total adjustment can not exceed +/- 1.0% of Medicare payments
  - % of MPA reward at risk for quality = 4%
- CMS has requested the State include Population Health goals in the MPA quality component and increase the aggregate at risk for quality.
- Staff have committed to mirroring all payer quality programs in the MPA to avoid creating competing incentives

*A hospital receives a 1% bonus/penalty by beating/exceeding national trend by 3% resulting in the 1/3rd translation
** The payment model workgroup will be reviewing all-payer related rewards and penalties

Proposed New MPA Quality Calculation

- Capture results from new all-payer population health measures
  - Set maximum value to +/- 4% as that sets population health weight equal to the value of traditional programs
  - Exact translation from all-payer population health measures to MPA value of 4% will be determined once measures and scoring are established*.
- Double the quality weighting after adding population health score and apply the quality adjustment after the TCOC cap.
- Proposed MPA Quality Adjustment
  - Step 1: MPA TCOC x 1/3 result subject to +/- 1% cap.
  - Step 2: Step 1 x (1+ 2 x (RRIP + MHAC + Pop Health Reward/Penalty))
  - Where:
    - MPA result is expressed as percentage points above or below target
    - RRIP and MH are each up to +/- 2%
    - Population health is worth +/- 4%
    - Calculation is reversed if MPA TCOC result is a penalty
    - Total adjustment can not exceed +/- 1.16% of Medicare payments
  - % of MPA reward at risk for quality = 16%

*The payment model workgroup will be reviewing all-payer related rewards and penalties for the selected population health measures within the base HSCRC quality program. The MPA will use the same measures, but the penalty/reward will be applied to the MPA, as defined in the MPA recommendation, regardless of the application in the quality program.

Comments on the Quality Adjustment

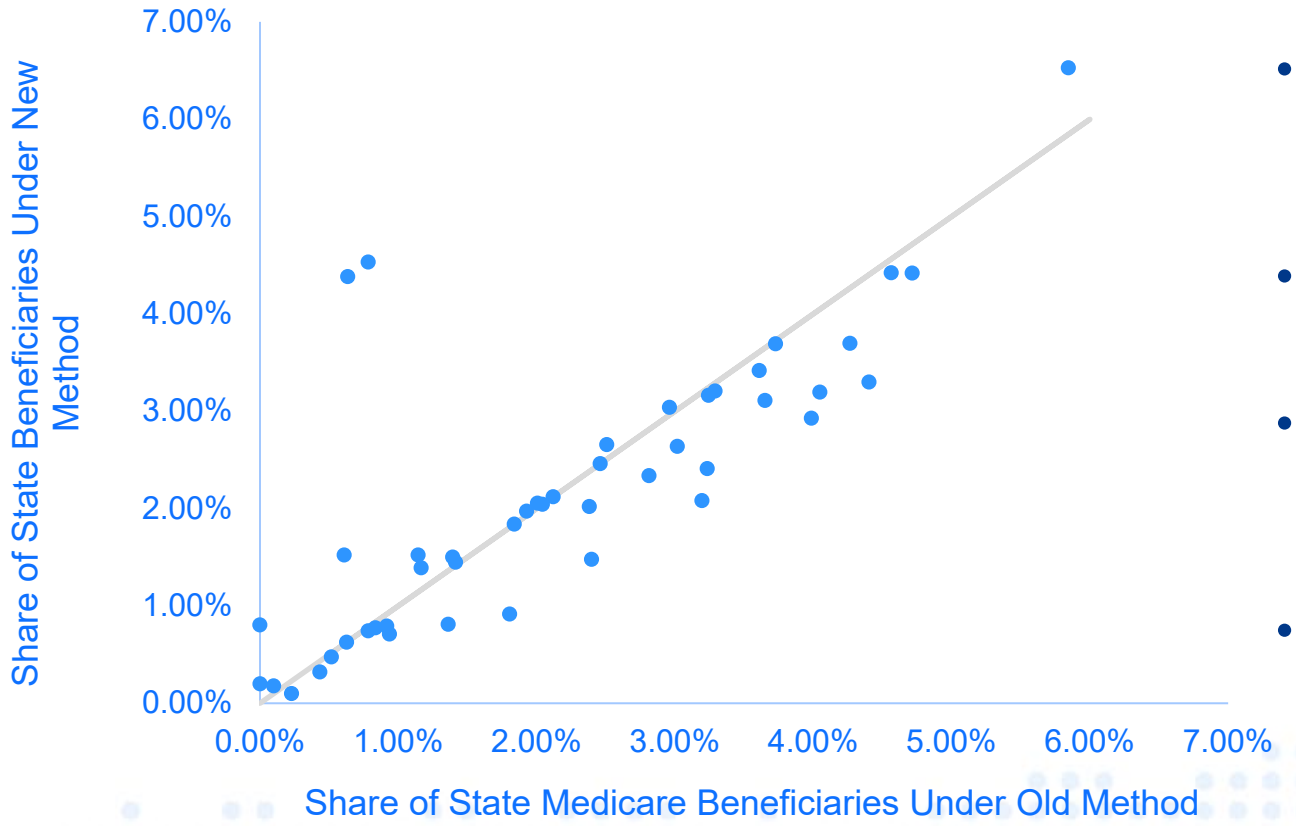
- MHA commented that HSCRC should explain the weighting of the population health measures.
  - Staff response: They are weighted equally. The hospitals performance is additive.
- MHA commented that HSCRC should only adjust the quality measures after “reviewing and aligning HSCRC policies”.
  - Staff response: We don’t know what this means. Hospitals can review and comment on HSCRC policies through the workgroup.
- MHA commented that staff should start with reporting and monitoring the measure for at least a year before imposing “real consequences.”
  - Staff response: We are working with CMS on a measurement strategy. They have been consistent that the Maryland Model focus on outcomes not just process.
- MHA does not support holding hospitals accountable for activities that happen outside of the hospital (e.g. DPP).
  - Staff response: This is contrary to the purpose of the TCOC Model and the MPA which holds hospitals and the State accountable for the total cost of care, not just hospital costs / service.
- JHHS commented that there is an overlap with the All-Payer quality programs and that hospitals will be doubling rewarded / penalized.
  - Staff Response: This is true. We believe that all quality measures should be developed on an all-payer basis. CMS has insisted that we have some Medicare specific measures in the MPA. We have duplicated the rewards / penalties of the All-Payer programs to minimize the measures hospitals must pay attention too.

New PSAP Algorithm, Effective 1/1/23

- **Current**: Primary Service Areas (PSAs) are determined based on zip code in GBR agreements
- **New**: Based on MHA feedback, PSAs to be determined mathematically as those zip codes which account for 60% of a hospital's FY19 ECMADs when sorted from highest to lowest volume
- Remaining zip codes are then assigned, and shared zip codes are split to create the PSAP, no change to this process except FY19 ECMADs will now be used.
- Other HSCRC processes will follow this change on the same timeline: PQIs, Benchmarking etc.
- Also attached in this package
  - Detail on revised approach (same file distributed late last year)
  - Attribution memo for CY2022 (Y5) and draft for CY2023 (Y6)

Impact of Change on Share of MC FFS Beneficiaries by Hospital

- Change is small for most hospitals. Academic Medical Centers add significant share with the offset coming from other Baltimore area hospitals



- Each point indicates a hospital, grey line indicates where there is no change in share
- AMCs are the two points well above the line on the left
- Nearly all hospitals with share loss (below grey line) are in the Baltimore area.
- Detail in attached file

Comments on the Attribution Methodology

JHHS supports the change to the attribution methodology and emphasizes that a period of stability is necessary to allow hospitals to adapt.

- Staff response: We will try to keep the MPA as stable as possible. Staff do not intent to make major changes. However, CMS has requested modification to the MPA and may do so again.

There were no further comments on the attribution methodology.

Analysis of Maryland Utilization vs the Nation

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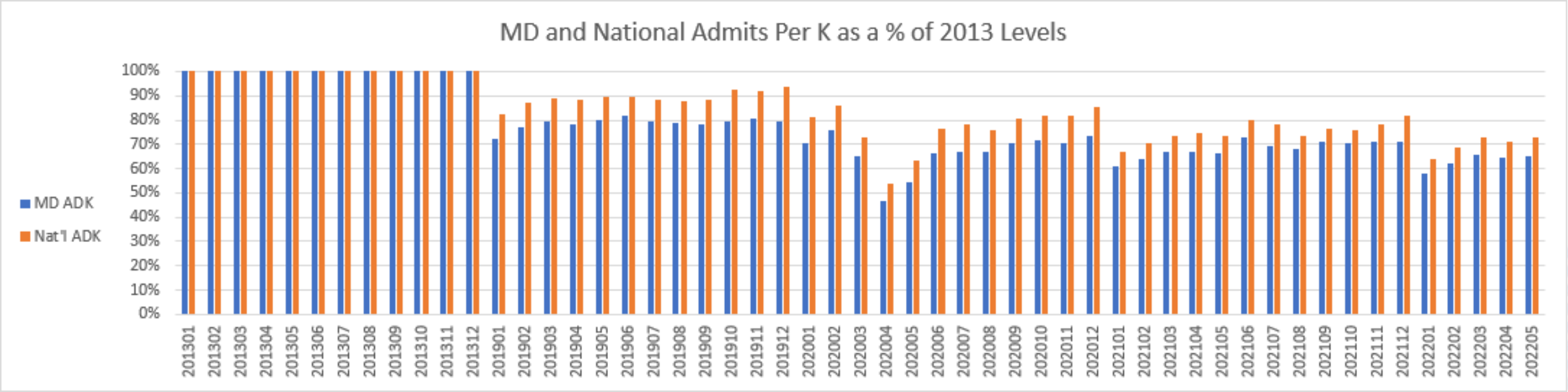
Overview

We have started to an analysis of Medicare utilization vs the Nation as part of our annual examination of our Medicare savings drivers. There are some concerning trends:

- Both Maryland and National utilization remain very depressed versus pre-pandemic levels. However, our utilization is lower by less, which has resulted in a deterioration of our utilization relative to the nation.
- As a results our admits per K advantage has shrunk, in addition, our LOS disadvantage has increased, resulting in IP utilization levels that are higher than the nation compared to a 2013 base

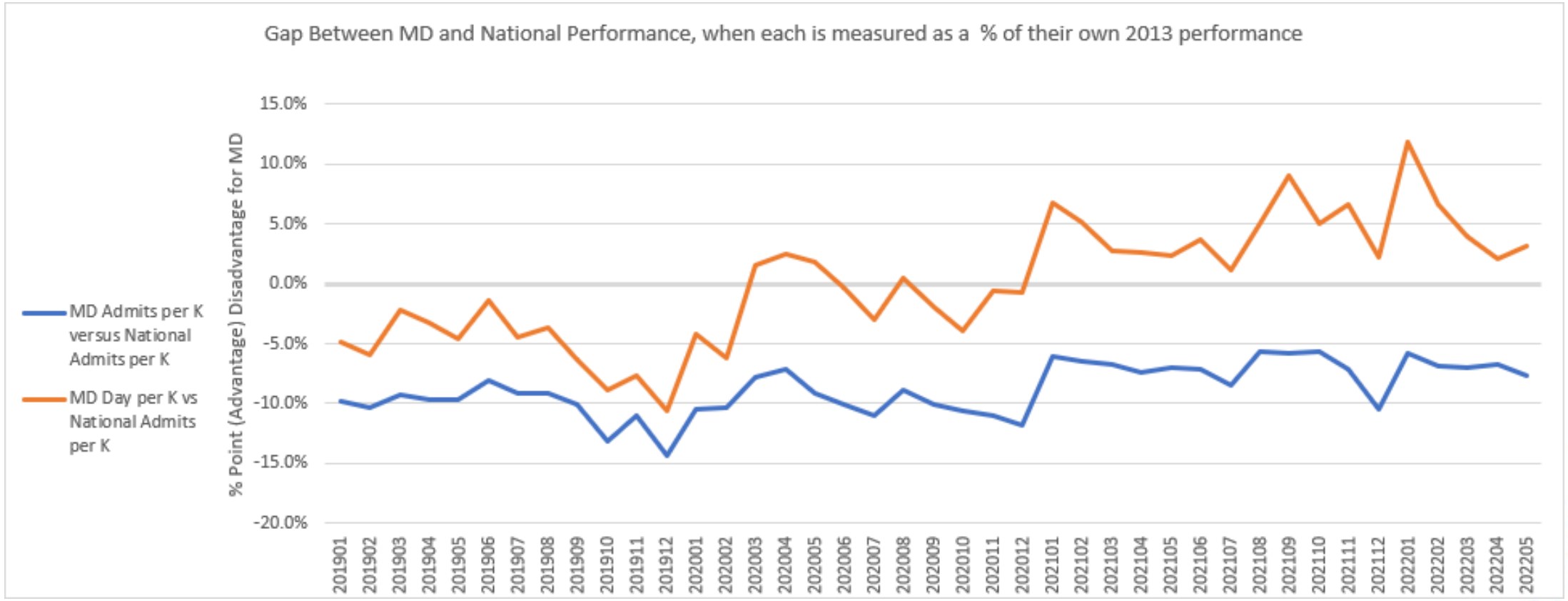
Analysis of Overall Utilization



Both MD and the Nation remain significantly below Pre-pandemic levels.

- In 2019 MD was around 80% of the 2013 level utilization, the nation around 90%.
- YTD 2022 the nation is below the 70% and MD almost 60%.

Comments on the Attribution Methodology



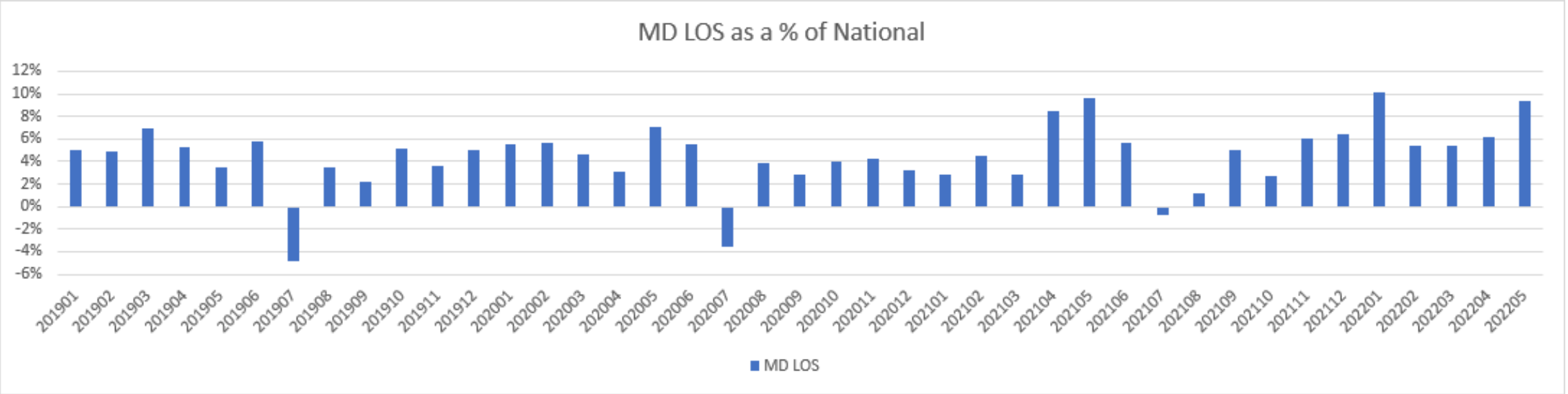
Utilization Analysis

Maryland's utilization advantage relative to the nation has deteriorated since the beginning of the pandemic.

- Maryland's admits advantage has shrunk, and when days are considered, it has reversed into a disadvantage.
- Since MD is paid on days, not admits like the nation, the relevant measure that impact our savings test is Days per K for MD and this should be compared to Admits per K for the nation.

Starting at exactly the time of the pandemic, and escalating since, the Maryland's LOS disadvantage has erased gains from having fewer admits.

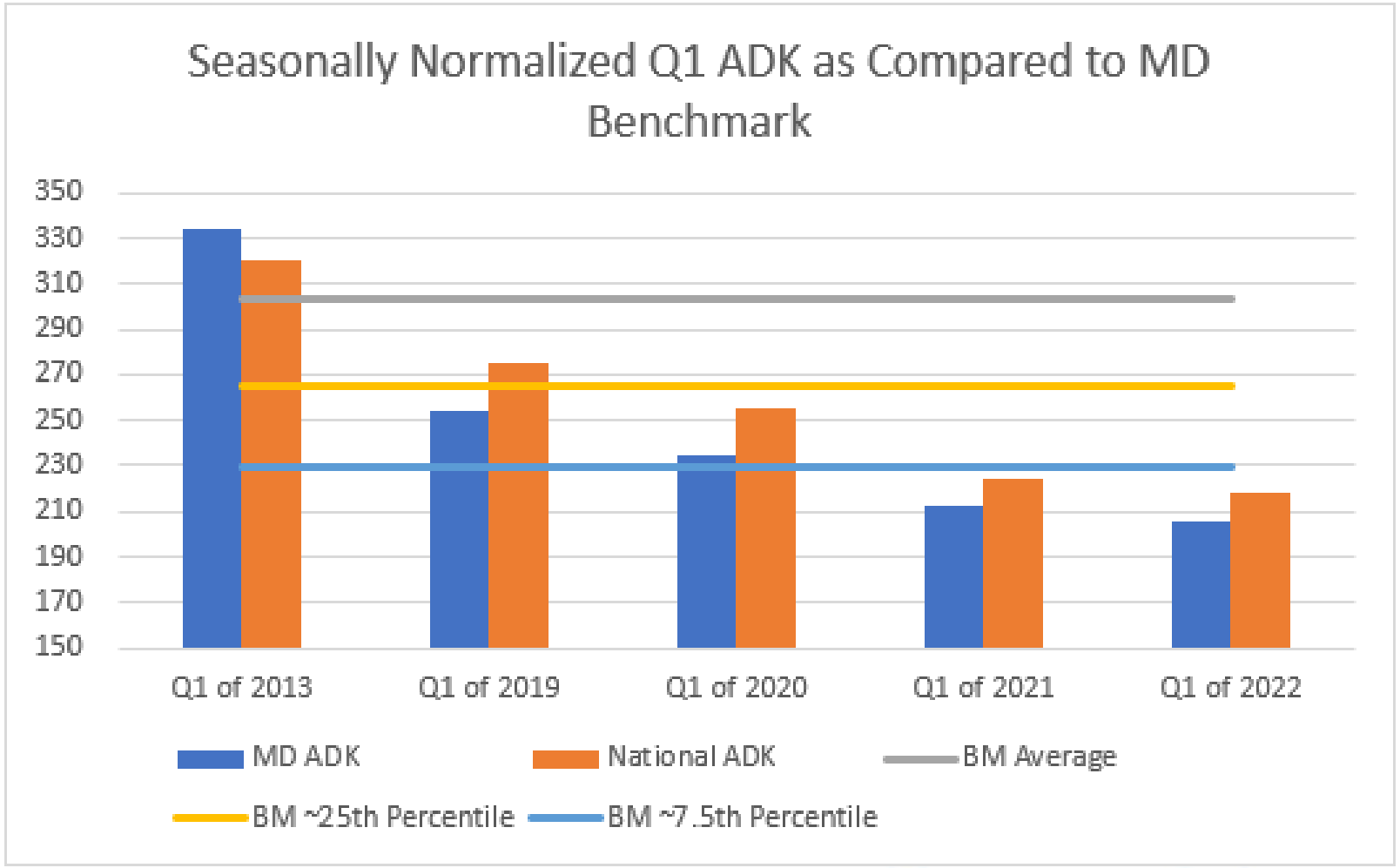
Comments on the Attribution Methodology



Maryland's utilization advantage relative to the nation has deteriorated since the beginning of the pandemic.

- This graphic shows MD LOS as a % of National.
- Consistent with the previous graph the gap has noticeably grown in 2021 and 2022. The gap ran from 4-6% in 2019, went down a little through March 2021 but since then has regularly been above 6%.
- On a rolling basis we have added about 5% to our overage versus the nation from early 2021 to May of 2022.

Comments on the Attribution Methodology



Overall Conclusion

The deterioration in Maryland utilization is concerning. However, the impact of the pandemic remains significant.

- The previous chart shows current utilization relative to the 2019 benchmarking utilization.
- It shows both Maryland and the nation remain below 7.5% of national counties in 2019.
- This makes it difficult to determine why Maryland's performance has deteriorated.

We will continue to analysis the utilization drivers as the pandemic (hopefully) resolves.

Next Steps

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Next TCOC Meeting

The next TCOC Meeting will be in October.

- We intend to continue discussing the update to the quality measures, as the population health workgroup finishes its work.
- We will also be discussing the next phase of the Model and, specifically, additional Medicare flexibilities that may be necessary.