



# Total Cost of Care (TCOC) Workgroup

July 29, 2020



# Agenda

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1. Maryland Total Cost of Care Performance
2. MPA Policy Review
  1. Evaluation of MPA Attribution Options
  2. Attainment Options for the Medicare Performance Adjustment
  3. CTI and MPA Weighting Options
3. Next Steps

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Drivers of Maryland FFS Medicare Savings, CY  
2018 to CY 2019 And Recap of Savings Since 2013

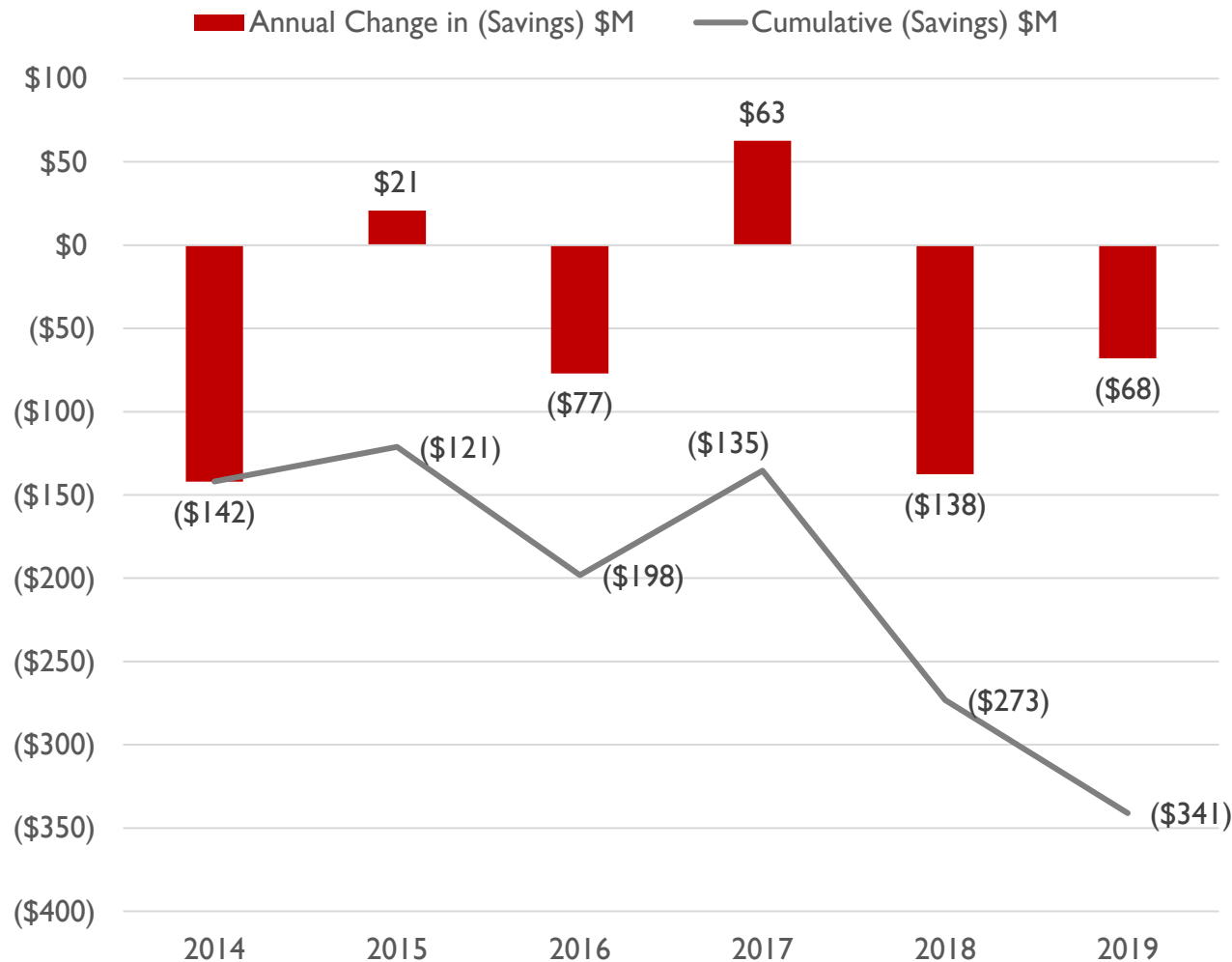


# Background

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- ▶ Analysis reflects through CY 2019 with 3 month run out
- ▶ Analysis based on comparison of Maryland trend to US trends of 5% sample in each cost bucket. This differs from the \$335 M disclosed in Commission reporting"
  - ▶ Impact of differing MD versus National mix between cost buckets is not shown
  - ▶ 5% sample does not tie to CMMI true national numbers used in overall scorekeeping
- ▶ Comparison is to US total with no risk adjustment or modification - reflects overall scorekeeping approach
- ▶ Visit counts are based on a count of services and are intended as approximations
- ▶ IP reflects patient day count, except where noted

# Run Rate (Savings) by Year



- ▶ Maryland's results have typically fluctuated by year.
- ▶ 2019 results are favorable compared to other odd years
- ▶ We exceeded our run rate requirement from CMS in 2019
- ▶ This slide is based on CMMI national reporting and will not tie to other slides in this presentation.

# Savings, 2013 to 2018 vs 2018 to 2019

	2013 to 2018, Average		2018 to 2019	
	Average Run Rate (Savings) Cost \$ M	% of Savings	Run Rate (Savings) Cost \$ M	% of Savings
Inpatient Hospital	(\$31)	56.9%	(\$58)	175.7%
SNF	(\$6)	10.6%	(\$6)	18.6%
Home Health	\$9	-16.8%	(\$1)	2.1%
Hospice	\$7	-13.3%	(\$19)	56.2%
<b>Total Part A</b>	<b>(\$20)</b>	<b>37.4%</b>	<b>(\$83)</b>	<b>252.6%</b>
Outpatient Hospital	(\$57)	106.4%	(\$12)	35.6%
ESRD	(\$2)	3.7%	(\$3)	8.6%
Outpatient Other	(\$3)	5.2%	(\$6)	19.3%
Clinic	\$0	-0.1%	(\$1)	1.8%
Professional Claims	\$28	-52.6%	\$72	-217.9%
<b>Total Part B</b>	<b>(\$34)</b>	<b>62.6%</b>	<b>\$50</b>	<b>-152.6%</b>
<b>Total</b>	<b>(\$54)</b>		<b>(\$33)</b>	
OP Hospital Net of Professional	(\$29)		\$60	

- ▶ Part A savings, from IP hospital costs in particular, helped to offset growing Part B costs in 2019
- ▶ Professional claims grew at the fastest rate resulting in net increases in Part B costs in 2019
- ▶ MDPCP fees cause larger than normal increase in Professional Claims (~\$67 million). Adding back this increase puts professional in line with historical run rate

Note: amounts above reflect change in each individual bucket, mix impact of different shares of each bucket would also impact overall savings, also amounts represent 5% sample data. Therefore will not tie to total actual 2019 savings of \$62 million.

# Overview of Savings, growth rates

	% of MD Spend	MD CAGR 2013-18	MD CAGR 2018-19	National CAGR 2013-18	National CAGR 2018-19
Inpatient Hospital	37.6%	-0.6%	0.9%	0.2%	2.5%
SNF	6.3%	-2.1%	-2.1%	-1.3%	-1.1%
Home Health	3.2%	2.2%	0.0%	-0.9%	0.2%
Hospice	2.4%	5.2%	-1.9%	1.7%	5.9%
<b>Total Part A</b>	49.6%				
Outpatient Hospital	16.9%	3.3%	3.6%	6.7%	6.2%
ESRD	2.4%	1.4%	1.2%	2.3%	2.4%
Outpatient Other	1.3%	4.9%	3.1%	7.1%	8.0%
Clinic	0.2%	9.5%	4.0%	9.1%	8.9%
Professional Claims	29.7%	3.1%	8.1%	2.0%	5.5%
<b>Total Part B</b>	50.4%				

- ▶ Maryland IP hospital growth rate increased, but much less than the 2.5% national rate
- ▶ Maryland OP hospital growth rate continues to grow much more slowly than the national rate, although the gap shrunk slightly
- ▶ Maryland Home Health and Hospice growth trailed the nation in 2019
- ▶ When excluding MDPCP fees from Professional Claims, the MD 2018-19 CAGR still increases to 6.0%

# Inpatient Savings Drivers

Area	Metrics: 2013 to 2019			Savings In \$M		
	Metric	MD Impact	National Impact	2013 to 2018	2019	2013 to 2019
				Savings (Dissavings)	Savings (Disavings)	Total Savings (Dissaving)
Admits	Decrease in Admits per 1000	(69.0)	(35.5)	\$321	\$85	\$406
Length of Stay (Acuity Normalized)	Decrease in Acuity Normalized LOS	(0.24)	(0.71)	(\$228)	(\$54)	(\$282)
Unit Cost	Increase in Cost/Day	\$429	\$549	\$122	\$31	\$153
Acuity (MS-DRG weights)	Increase in CMI	0.18	0.17	(\$54)	(\$5)	(\$58)
Mix Impact				(\$9)	\$1	(\$8)
			<b>Total</b>	<b>\$153</b>	<b>\$58</b>	<b>\$211</b>

- ▶ MD's IP advantage is driven by decreasing IP admits almost twice as fast as national. MD also has tighter control of cost per day.
- ▶ These savings are offset by smaller decreases in LOS.
- ▶ 2019 saw a similar but slightly accelerated pattern versus the prior 5 years.

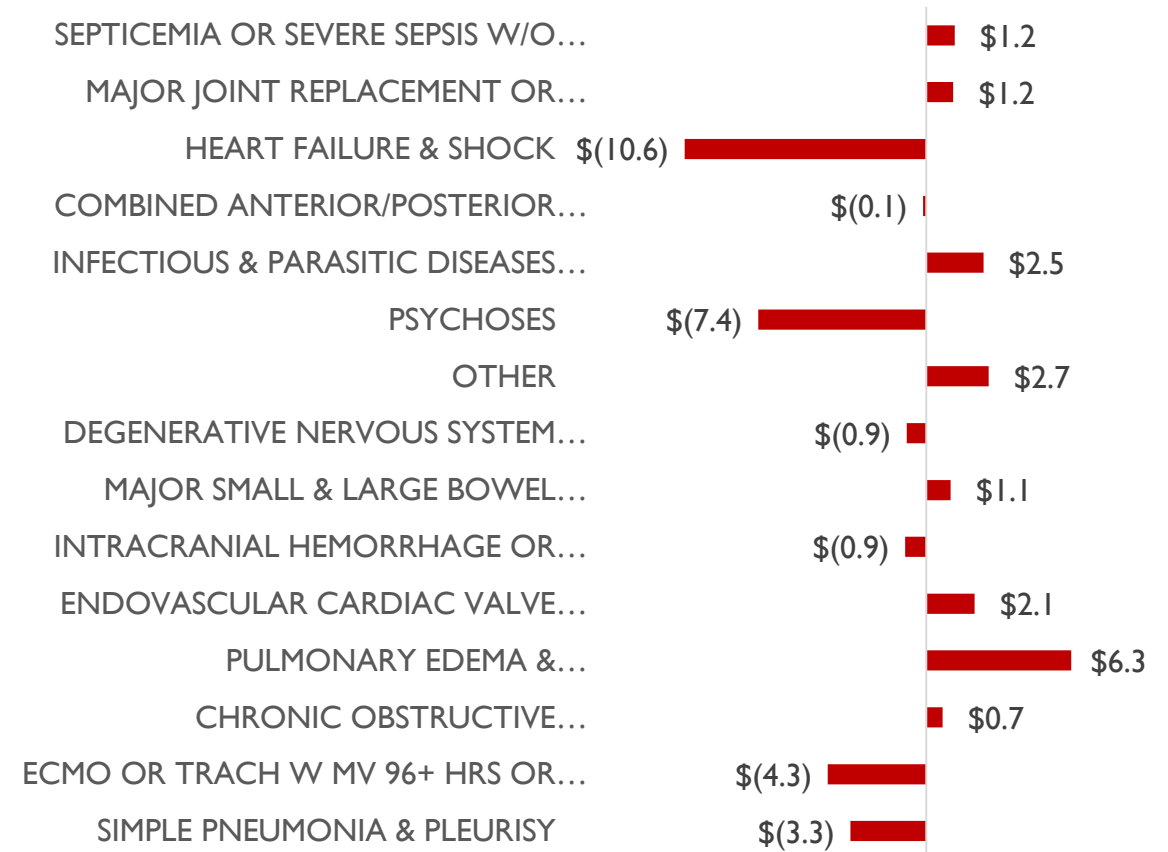


# Impact by DRG, 2018 to 2019

- ▶ For 2019, savings were distributed across many DRGs likely reflecting the broad incentives of the model. Maryland fared poorest on higher volume DRGs.
- ▶ For 2018 vs 2017, Major Joint Replacement drove significant MD savings (\$28M) due to quick adoption of OP opportunity, but impact was much less in 2019 (\$1.0M).

% of Spend Category	% of Spend	% of Savings
Greater than 2.5% of Spend (5 DRGs)	19%	-14%
1.5% to 2.5% of Spend (9)	17%	-1%
0.5% to 1.5% of Spend (38)	33%	62%
Less than 0.5% of Spend (329)	30%	53%
<b>Total</b>	<b>100%</b>	<b>100%</b>

- ▶ Maryland savings, in millions, versus national trend by DRG for DRGs accounting for more 1.5% of spend:



# MD vs Nation, OP Hosp. CAGR, '18 to '19

2013 to 2019 Cumulative (Savings) Costs \$M	2018 to 2019 % of Nat. Spend	MD Above (Below) National CAGR			Run Rate (Savings) Cost, \$M	% of Savings	
		Utilization	Unit Cost	Total			
(\$112.5)	Part B Rx	20.7%	4.4%	-11.6%	-6.9%	(\$19.5)	165.7%
(\$23.9)	Imaging	12.6%	-1.1%	-2.4%	-3.5%	(\$5.9)	50.1%
(\$73.3)	E&M - ER	10.2%	3.0%	-7.7%	-4.1%	(\$6.3)	53.3%
(\$9.8)	Proc-Major Cardiology	10.1%	-2.4%	5.1%	1.8%	\$1.2	-10.5%
(\$28.9)	Proc-Minor	8.8%	1.7%	-7.4%	-5.5%	(\$5.9)	50.5%
(\$55.8)	E&M - Other	6.9%	-9.3%	10.4%	-3.0%	(\$5.8)	49.3%
(\$1.3)	Proc-Major Other	5.9%	1.8%	-4.5%	-2.5%	(\$1.3)	11.0%
(\$7.6)	Proc-Endocrinology	5.4%	0.9%	-2.2%	-1.1%	(\$0.6)	5.1%
\$58.1	Lab	4.9%	-0.6%	2.0%	1.3%	\$2.1	-18.3%
(\$13.2)	Proc-Ambulatory	4.6%	0.9%	4.6%	5.6%	\$2.8	-23.9%
(\$15.5)	Proc-Oncology	3.8%	-1.9%	3.5%	1.6%	\$1.5	-12.6%
\$2.3	Proc-Major Orthopaedic	2.8%	3.0%	-2.4%	1.2%	\$0.3	-2.2%
(\$6.6)	Proc-Eye	1.7%	-5.7%	2.5%	-3.6%	(\$0.6)	4.8%
\$3.5	Other Professional	1.4%	1.6%	13.4%	14.3%	\$27.5	-234.1%
(\$1.5)	DME	0.2%	-4.2%	2.1%	-2.6%	(\$1.5)	12.5%
\$0.1	Proc-Dialysis	0.0%	-1.4%	13.9%	13.4%	\$0.1	-0.8%

- ▶ Part B Rx stands out as the most significant driver of cost savings
- ▶ 2019 National ER unit cost trended up at 10% (versus ~2.5%) in MD, driving MD's advantage. Due to change in use of EMTALA codes in MD in 2019, ED is adjusted to a visit rather than E&M count
- ▶ Approximately \$12.0 M savings in 2019 Imaging and Minor Procedures, which tend to include low value care (only \$0.4 M increase in professional)



# MD vs Nation, Professional CAGR, '18 to '19

2013 to 2019 Cumulative (Savings) Costs \$M	2018 to 2019 % of Nat. Spend	MD Above (Below) National CAGR			Run Rate (Savings) Cost, \$M	% of Savings	
		Utilization	Unit Cost	Total			
\$3.6	E&M - Specialist	19.3%	0.4%	-1.5%	-1.1%	(\$6.4)	-8.9%
\$65.3	Part B Rx	16.2%	-0.3%	0.9%	0.6%	\$3.0	4.2%
\$79.4	E&M - PCP	11.7%	1.6%	17.3%	19.3%	\$66.7	92.8%
\$12.3	Lab	9.0%	1.7%	-1.3%	0.4%	\$1.1	1.6%
\$9.4	Imaging	7.2%	-0.7%	0.9%	0.2%	\$0.6	0.8%
\$9.9	Other Professional	7.0%	0.0%	-0.6%	-0.6%	(\$0.9)	-1.3%
(\$0.9)	DME	6.3%	-0.2%	-1.1%	-1.3%	(\$1.9)	-2.6%
\$5.9	Proc-Minor	6.0%	0.2%	-0.3%	-0.1%	(\$0.2)	-0.2%
(\$4.5)	ASC	3.8%	-1.2%	2.8%	0.8%	\$1.0	1.4%
(\$5.3)	Proc-Ambulatory	3.0%	-3.4%	3.4%	-0.1%	(\$0.1)	-0.1%
\$2.7	Proc-Major Other	2.1%	-2.0%	0.8%	-1.2%	(\$0.8)	-1.1%
(\$2.2)	Proc-Eye	1.7%	-0.1%	0.3%	0.2%	\$0.1	0.1%
\$24.1	Proc-Major Cardiology	1.7%	0.3%	15.0%	15.1%	\$11.0	15.3%
(\$2.3)	Proc-Endocrinology	1.5%	1.0%	-1.8%	-0.9%	(\$0.3)	-0.4%
(\$1.6)	Proc-Major Orthopaedic	1.5%	-3.7%	2.9%	-0.9%	(\$0.4)	-0.5%
\$9.6	Proc-Oncology	1.4%	1.0%	-2.4%	-1.5%	(\$0.7)	-0.9%
(\$0.7)	Proc-Dialysis	0.7%	-3.0%	3.0%	-0.1%	(\$0.0)	0.0%

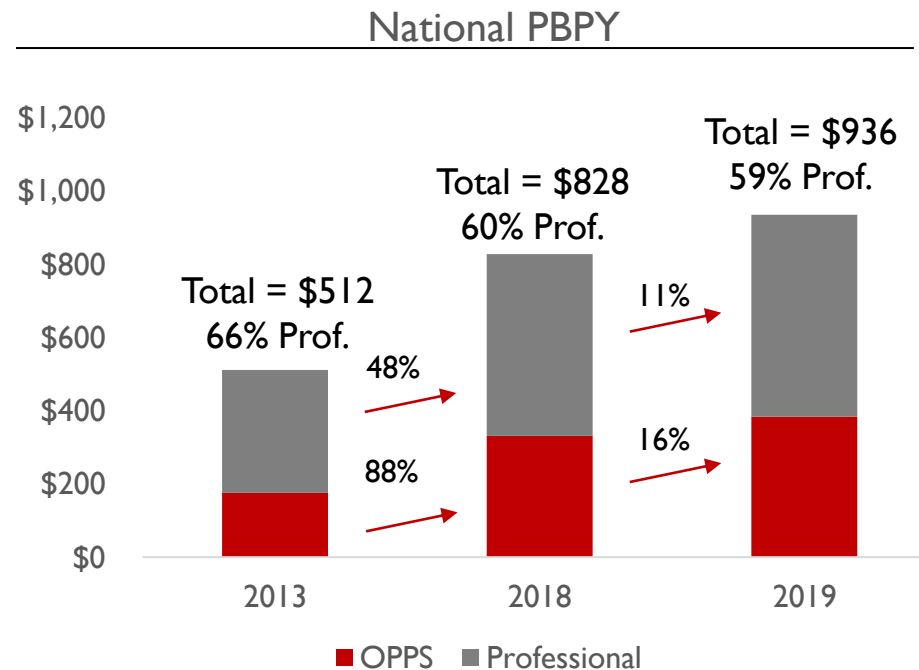
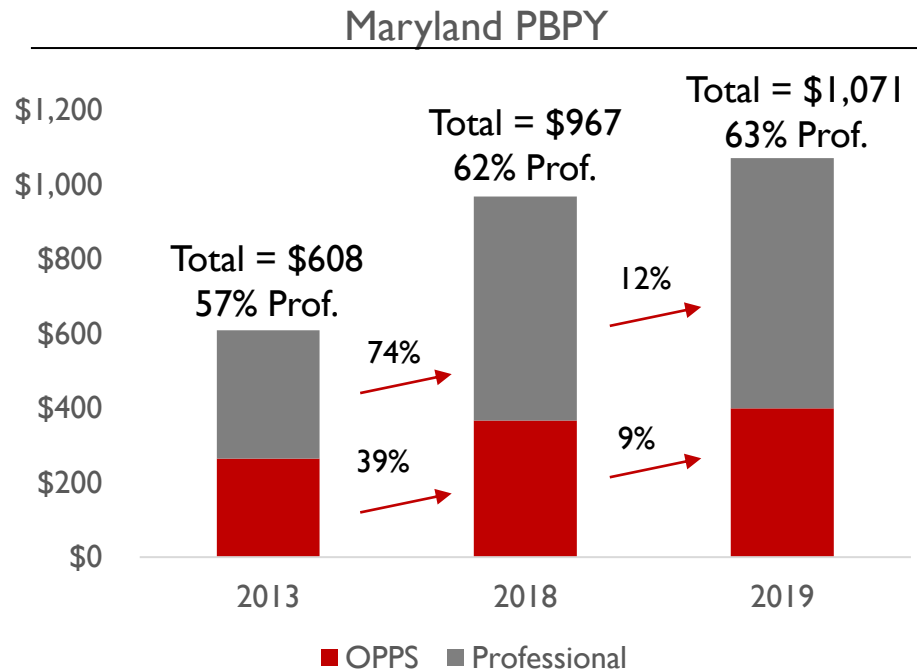
- ▶ E&M PCP account for the MDPCP fees and largely explain the Professional Claim increases from 2018 to 2019
- ▶ Major Cardiology is also a significant driver, with big increases in unit costs vs the nation
- ▶ Specialists and DME are the only meaningful drivers of Professional Claims savings vs the nation

▶ || % of spend reflects 2019 US amounts

Additional OP trend analysis on prior periods can be found in the appendix.

# Mix of Part B Drug Spending

- ▶ Throughout 2018 Maryland was successful in shifting Part B Rx to the professional setting, going up from 57% professional to 62% professional while the nation dropped from 66% to 60%. Maryland also had a lower total CAGR: 9.7% versus 10.1%.
- ▶ 2019 continued the pattern, as MD went to 63% professional while national dropped to 59%. Maryland's CAGR advantage increased half a point to 9.9% versus 10.6% nationally.



# High Level Summary of Savings Impact

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- ▶ Since 2013 Maryland has generated approximately \$340 M of savings compared to the national run rate. While there are various ways to calculate and allocate savings, savings can generally be attributed to the following (\$ in M):

<b>IP:</b> Reduced IP admits and cost per day somewhat offset by higher LOS	\$210
<b>OP Hospital (excl. ED):</b> Reductions in imaging, minor procedures, hospital clinics, offset in Other Prof.	\$115
<b>ED:</b> Reduction in ED per Visit Costs	\$75
<b>Part B Drugs:</b> Shift to lower cost, office POS	\$45
<b>Other</b>	\$45
<b>MDPCP Fees</b>	(\$65)
<b>Other Professional:</b> Some additional Primary Care plus increase in other professional categories	(\$85)
<b>Net Savings</b>	<b>\$340</b>



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# MPA Attribution Approaches – Geographic Options



# 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

1. All data based on 2018 CCLF. Certain very small facilities were excluded in calculating the median and percentile values.
2. For MPA leverage UMMC is an extreme outlier on this measure at 684%, reflecting the very small attribution to the main campus.
3. For PSAP leverage both UMMC and Hopkins are significant outliers at ~390%.



# Conclusions

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- ▶ **The concurrent touch attribution works the best of all options. But...**
  - ▶ The attribution is unstable from year to year
  - ▶ Touch attribution alone does not meet the MPA attribution threshold
  - ▶ Concurrent touch attribution will overlap substantially with the Care Transitions CTI
- ▶ **Based on this analysis:**
  - ▶ CTIs may be an accurate way of measuring improvement
  - ▶ CTIs are less desirable for attributing the entire population
  - ▶ Geographic attribution will be necessary
- ▶ **Potential options for modifications:**
  - ▶ Simplify the MPA to geographic and add an attainment measure
  - ▶ Blend attainment and improvement using the CTI



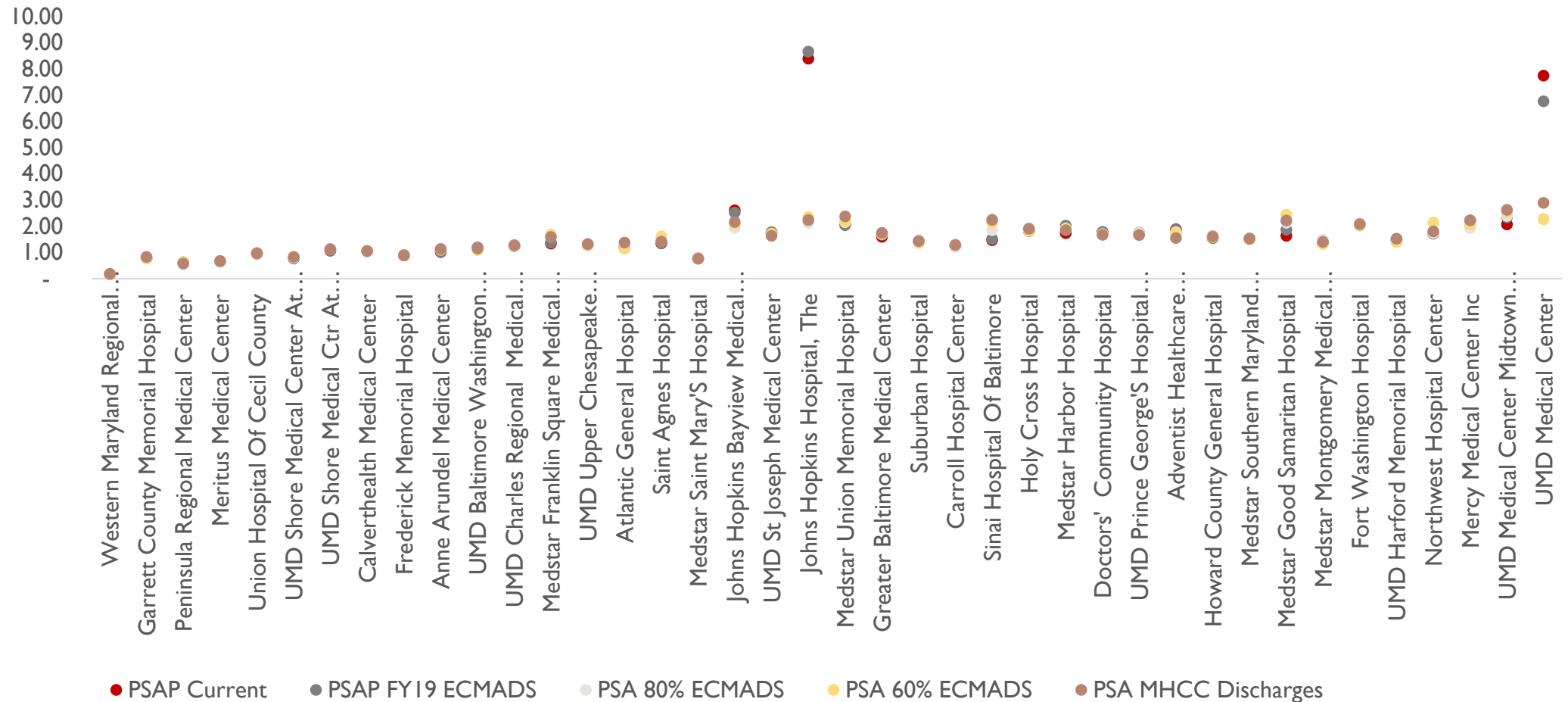
# Alternative Geographic Approaches

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- ▶ **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
- ▶ All above could be run with duplication
- ▶ All could be run using all-payer data

# Combined Score Under Each Methodology

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



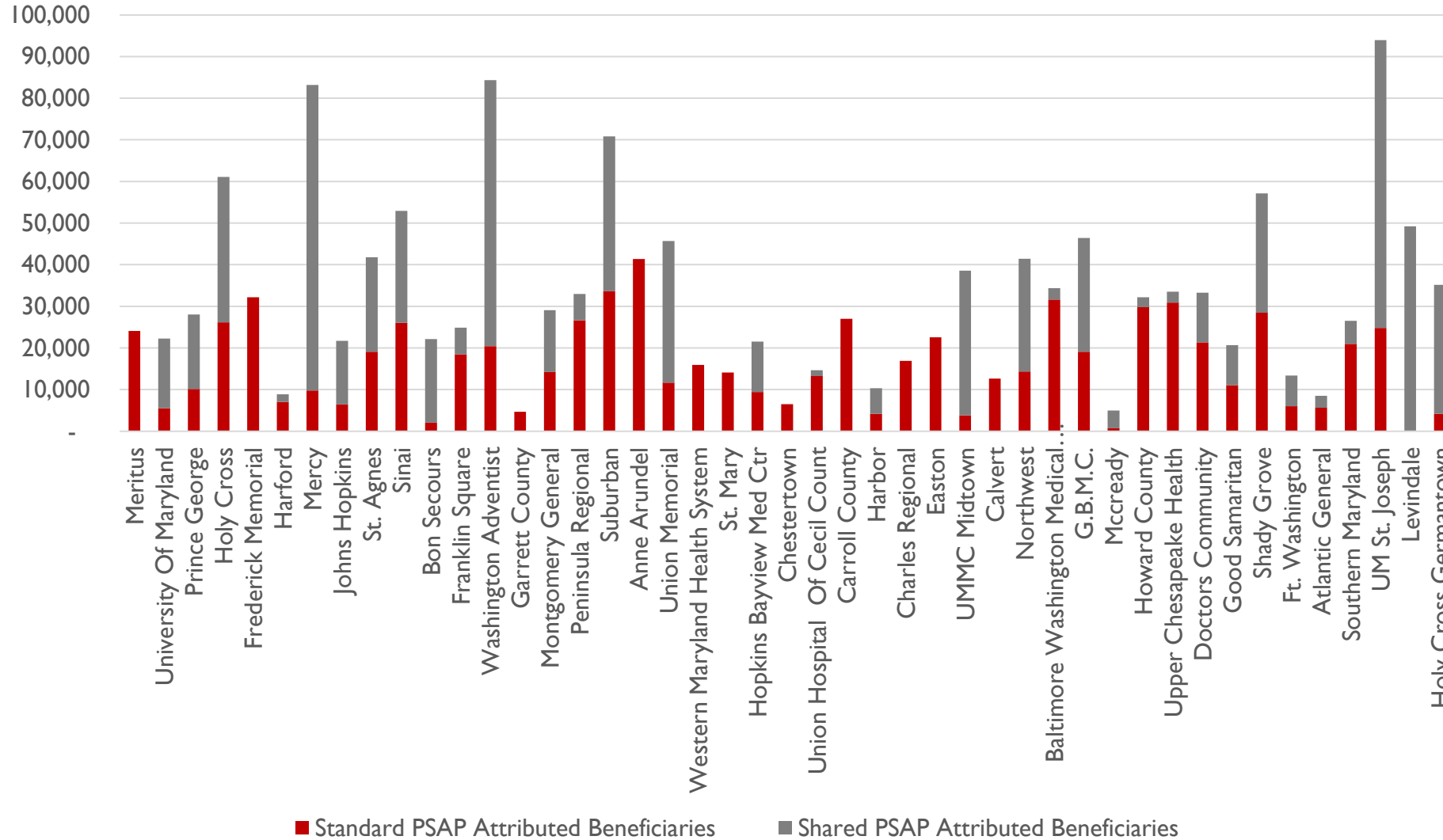
# Comparison of PSAP Methods Impact on Academics

		Leverage	Significance	Hospital Control
Hospital Id'd	<b>PSAP Current</b>			
	Johns Hopkins	387.4%	5.1%	30.5%
	UMMC	350.3%	3.9%	23.0%
	<b>PSAP FY19 ECMADS</b>			
Johns Hopkins	400.0%	4.7%	29.5%	
UMMC	301.8%	4.4%	22.5%	
Formulaic	<b>PSA 80% ECMADS</b>			
	Johns Hopkins	69.5%	11.2%	15.6%
	UMMC	76.1%	9.5%	13.7%
	<b>PSA 60% ECMADS</b>			
	Johns Hopkins	81.8%	11.6%	17.0%
	UMMC	75.5%	10.7%	14.6%
	<b>PSA MHCC Discharges</b>			
Johns Hopkins	76.0%	11.8%	16.5%	
UMMC	105.7%	7.7%	14.5%	

- ▶ The formulaic methods attribute more to the academics resulting in lower leverage.
- ▶ However additional care does generate major increases in the significance and results in the hospital controlling a smaller percentage of attributed care.
- ▶ PSA based on zip codes contributing 60% of ECMADS appears to generate best combination.
- ▶ Separate approach still required for academics.



# Impact of Allowing Duplication – Shared PSAP



Medians	Current PSAP	Shared PSAP
Leverage	36.8%	28.7%
Significance	45.7%	65.9%
Hospital Control	39.6%	37.3%
Proximity Score	1.45	1.51

- ▶ Allowing duplicate attribution means each hospital is judged on a larger allocation of care which increases how much of their own care is attributed to them.
- ▶ However, eliminating unique attribution complicates attribution outcomes.



# Staff Recommendations

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- ▶ **Primary MPA attribution should be geographic based**
  - ▶ Simpler and more stable than primary care or touch based
  - ▶ No submission of provider lists, except to maintain care coordination relationships for the purpose of data sharing
- ▶ **Current PSAP method should be maintained as switching geographic approaches does not yield sufficient benefit to outweigh complexity and rework required**
  - ▶ May need to update allocation ECMAD period in the future
- ▶ **Next Steps - Basic geographic approach should be combined with:**
  - ▶ Alternative academic approach
  - ▶ Use of CTIs to increase direct accountability

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# Attainment Options for the MPA



# Medicare TCOC Attainment in the MPA

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- ▶ Stakeholders have suggested moving the MPA to an attainment standard rather than an improvement standard. Staff sees two options...
  1. Directly link the MPA performance to a Medicare benchmark.
    - ▶ Under this option, the hospitals' MPA benchmarks would be equal to the weighted average of the Medicare county level benchmarks.
    - ▶ Potentially scale the MPA reward / penalty based on the difference between their actual total cost of care and the benchmark.
  2. Use the hospital's performance on the Medicare benchmarking to determine the TCOC growth rate adjustment for the MPA performance target.
    - ▶ Under this option, the hospital receives a performance target equal to prior year's target x (the national Medicare growth rate – TCOC growth rate adjustment).
    - ▶ The TCOC growth rate adjustment would be based on the hospitals' TCOC performance relative to the Medicare benchmark.

# Example of Option 1 for MPA Attainment

- ▶ The MPA benchmark would be equal to the hospital's Medicare benchmark.
  - ▶ Prince George's County example:
    - ▶ Medicare costs were ~1% below its comparison group.
    - ▶ The MPA benchmark would be equal to 101% of Prince George's County TCOC.
  - ▶ Caroline County example:
    - ▶ Medicare costs were ~10% above its comparison group.
    - ▶ The MPA benchmark would be equal to 90% of the Caroline County TCOC

	CY 2017 Commercial % Over (Under) Benchmark Demographic- Adjusted Total Cost of Care	CY2018 Medicare % Over (Under) Benchmark Risk-Adjusted Total Cost of Care	Commercial Relative Rank	Medicare Relative Rank		CY 2017 Commercial % Over (Under) Benchmark Demographic- Adjusted Total Cost of Care	CY2018 Medicare % Over (Under) Benchmark Risk-Adjusted Total Cost of Care	Commercial Relative Rank	Medicare Relative Rank
24027 Howard	-30.7%	8.6%	1 ●	4 ●	24045 Wicomico	-22.5%	22.6%	6 ●	20 ●
24003 Anne Arundel	-23.6%	8.4%	5 ●	3 ●	24013 Carroll	-18.0%	19.0%	11 ●	17 ●
24009 Calvert	-25.1%	9.1%	4 ●	5 ●	24021 Frederick	-13.5%	12.7%	19 ●	10 ●
24031 Montgomery	-20.9%	1.9%	9 ●	2 ●	24025 Harford	-21.2%	23.4%	8 ●	22 ●
24033 Prince Georges	-17.3%	-0.9%	13 ●	1 ●	24043 Washington	-14.9%	15.4%	17 ●	14 ●
24035 Queen Anne's	-21.4%	11.4%	7 ●	7 ●	24023 Garrett	-0.2%	11.4%	24 ●	8 ●
24510 Baltimore City	-25.7%	15.0%	3 ●	13 ●	24029 Kent	-12.4%	15.9%	20 ●	16 ●
24011 Caroline	-17.3%	10.0%	14 ●	6 ●	24001 Allegany	-15.2%	23.3%	16 ●	21 ●
24039 Somerset	-29.1%	19.7%	2 ●	18 ●	24041 Talbot	-6.3%	15.7%	23 ●	15 ●
24019 Dorchester	-17.7%	11.8%	12 ●	9 ●	24015 Cecil	-9.7%	19.9%	22 ●	19 ●
24017 Charles	-19.8%	13.8%	10 ●	12 ●	24047 Worcester	-14.4%	26.0%	18 ●	24 ●
24037 Saint Marys	-15.5%	13.3%	15 ●	11 ●	24005 Baltimore County	-10.2%	24.8%	21 ●	23 ●



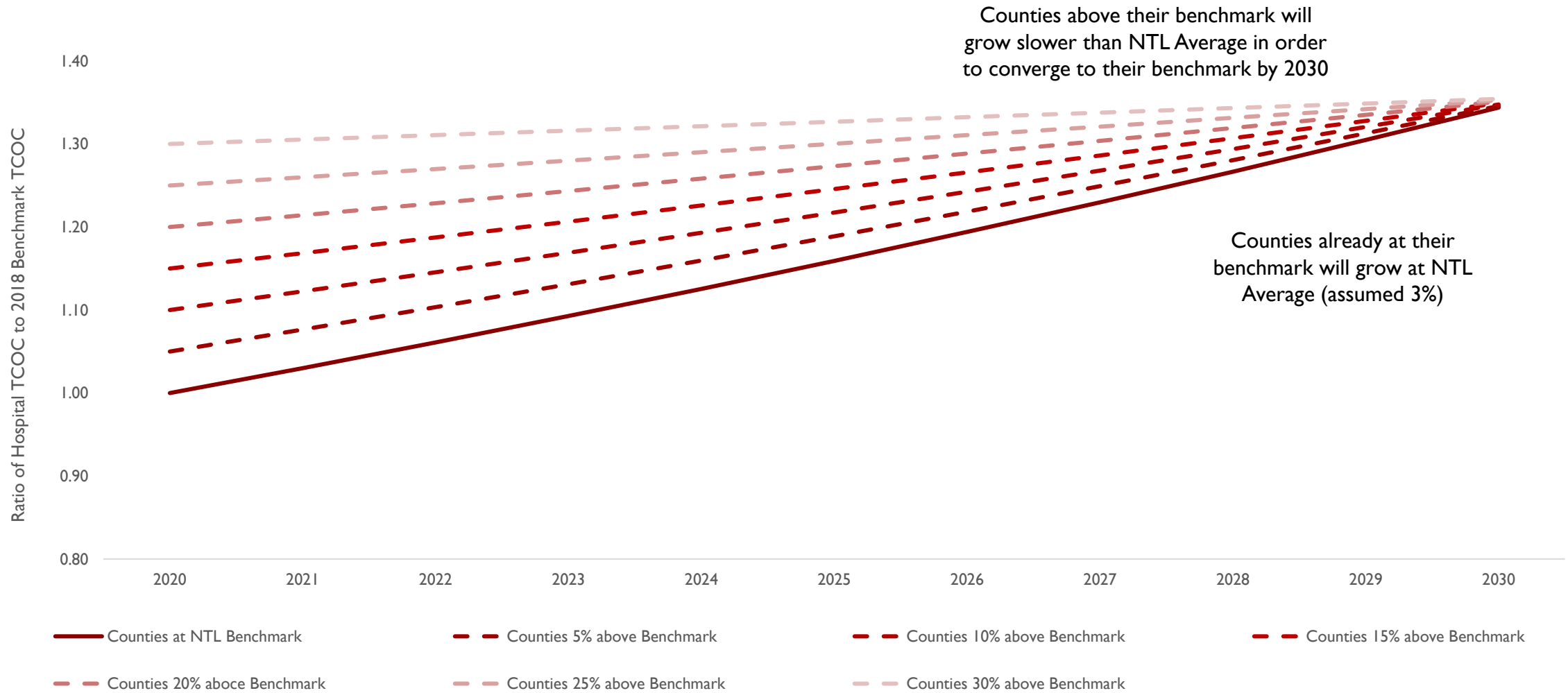


# Example of Option 2 for MPA Attainment

- ▶ Hospitals' MPA performance target would be set so that hospital converge to their benchmark by 2030.
- ▶ The hospitals' performance target for each year is equal to their 2018 TCOC times a compounded trend factor.
  - ▶ The compounded trend factor is equal to the national growth rate + the TCOC growth rate adjustment.
  - ▶ HSCRC will re-evaluate the hospitals' TCOC costs relative to the benchmark every 3 years.
  - ▶ The TCOC growth rate adjustment may change based on the hospital's updated performance relative to their new benchmark.

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
<0%	-0.0%
0-5%	-0.5%
5-10%	-1.0%
10-15%	-1.4%
15-20%	-1.8%
20-25%	-2.2%
25-30%	-2.6%

# Cumulative Growth in Benchmark



# Discussion

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- ▶ **Given Maryland's high level of Medicare TCOC, Option 1 (pure attainment) would likely lead to most hospitals receiving the maximum penalty.**
  - ▶ Hospitals would be unlikely to see any reward even if they reduced their TCOC from one year to the next.
  - ▶ This would likely discourage hospitals from trying.
- ▶ **Option 2 (gradually phasing in the benchmarks), would give hospital achievable annual TCOC targets and set expectations for the long-run growth trajectory.**
- ▶ **HSCRC staff welcomes comments and suggestions on this approach including:**
  - ▶ The speed of the convergence (i.e. is 10 years too fast or slow).
  - ▶ The level of revenue at risk to attract meaningful efforts by the hospitals.
  - ▶ The achievability of the growth targets among high-cost of care outliers.

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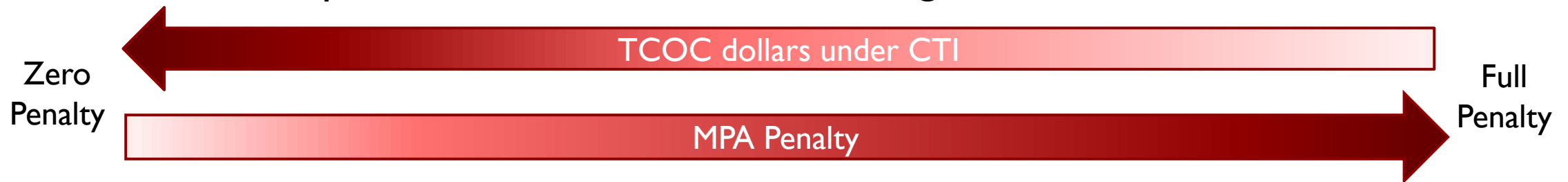
# Options on CTI Weighting



# Impact of Proposed Weighting

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- ▶ The Traditional MPA and the CTI reflect different types of performance.
  - ▶ The MPA (under and attainment approach) reflects a hospital's targeted level of costs but may not pick up the hospital's costs improvement in the short-run.
  - ▶ The hospitals' CTIs are intended to capture the hospitals short-run improvement in the TCOC of care.
- ▶ Combining the MPA and the CTI would allow hospitals to focus on improvement or attainment dependent on their individual strategies.



- ▶ CTIs would require validation as “real” (e.g. the hospital must report some spending on that CTI on the cost report).
- ▶ Rewards for CTIs under the MPA-Reconciliation Component would be unchanged

# Potential Option: MPA Attainment & CTI Improvement

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- ▶ Assume the Traditional MPA score is initially calculated 100% based on attainment
  - ▶ If a hospital has a positive score, the Final Traditional MPA = Initial Value
  - ▶ If a hospital has a negative traditional MPA Score:
    - ▶ Hospital can reduce negative initial value based on investments in CTIs
    - ▶ Final Traditional MPA = Blend of MPA initial attainment and no penalty, weighted based on level of TCOC dollars in CTIs
- ▶ The weight put on the traditional MPA would be reduced by the ratio of the attributed TCOC and the attributed CTI dollars.
  - ▶ E.g. Traditional MPA Weight =  $1 - (\text{CTI } \$ / \text{Traditional MPA } \$)$ .
  - ▶ A lower weight would reduce the penalty caused by the traditional MPA.

# Example of the CTI Weighting Approach

	Hospital	MPA	CTI
# of Beneficiaries	30k visits	80k attributed	15k captured
Medicare Revenue	\$420 mil.	\$800 mil.	\$400 mil.
Weighting	-	50%	50%
TCOC Savings	-	-\$4 mil.	+\$10 mil.
Current Policy	-\$4 mil. + \$10 mil. = \$6 mil. Net MPA adjustment		
CTI Weighting	$(1 - \$400 \text{ mil.} / \$800 \text{ mil.}) \times (-\$4 \text{ mil.}) + \$10 \text{ mil.} = \$8 \text{ mil.}$ Net MPA adjustment		

# Discussion

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- ▶ This approach would balance attainment (Traditional MPA) with improvement (CTI).
  - ▶ A hospital whose TCOC is high relative to its MPA benchmark would normally be penalized.
  - ▶ Alternatively, the hospital could increase its participation in CTIs in order to reduce its MPA penalty.
- ▶ This approach would give hospitals the ability to choose which population their performance is judged on.
  - ▶ A hospital can choose their CTI population.
  - ▶ A population that had broad enough CTI participation would have an MPA adjustment solely based on the population that they selected.
- ▶ The CTI weighting option allows hospitals to ‘buy’ their way out of a negative attainment adjustment on the traditional MPA by investing in CTI.
  - ▶ CTI weighting would reduce a negative attainment adjustment.
  - ▶ Creates options for hospitals to improve relative to a difficult attainment benchmark.



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Next Steps



# Maryland Primary Care Program Costs

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- ▶ CMMI indicated to HSCRC that the MDPCP costs should be included in the MPA for 2020.
  - ▶ Based on stakeholder comments, HSCRC requested that MDPCP costs be excluded for the CY 2020 Performance Year. CMMI rejected this request.
  - ▶ For hospitals' CY2020 MPA performance, MDPCP Care Management Fees (CMF) will be included only for those clinicians who participated in MDPCP in both CY2019 (base period) and CY2020 (performance period).
  - ▶ This is approximately a \$30 million increase in statewide TCOC.
- ▶ Some hospitals have requested more information about the MDPCP attribution tier in the MPA and of MDPCP costs & savings generally.
- ▶ If there is interest from stakeholders, the TCOC workgroup will discuss an approach to evaluating the MDPCP costs & savings.

# August TCOC Workgroup Meeting Agenda

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- ▶ **Final Benchmarking Analysis**
- ▶ **Staff proposal for the MPA overhaul**
  - ▶ Proposal for CY2021 MPA Attribution
  - ▶ Potential Alternatives for AMC Attribution
- ▶ **CTI 'Revenue at Risk'**
  - ▶ Revenue at Risk
  - ▶ Risk Adjustment
  - ▶ Minimum Savings Rates
- ▶ **MDPCP Costs**
  - ▶ Discussion of MDPCP Evaluation Criteria
  - ▶ Cost growth for MDPCP Attributed Practices

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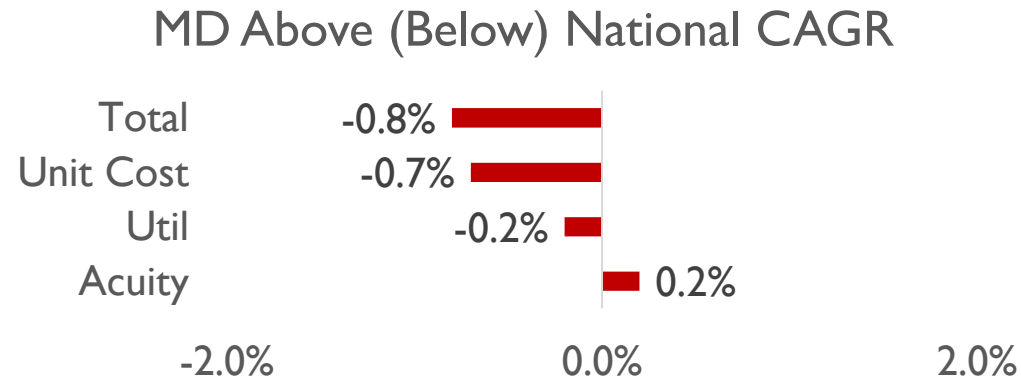
# Appendix



# Inpatient Cost Variation by Source

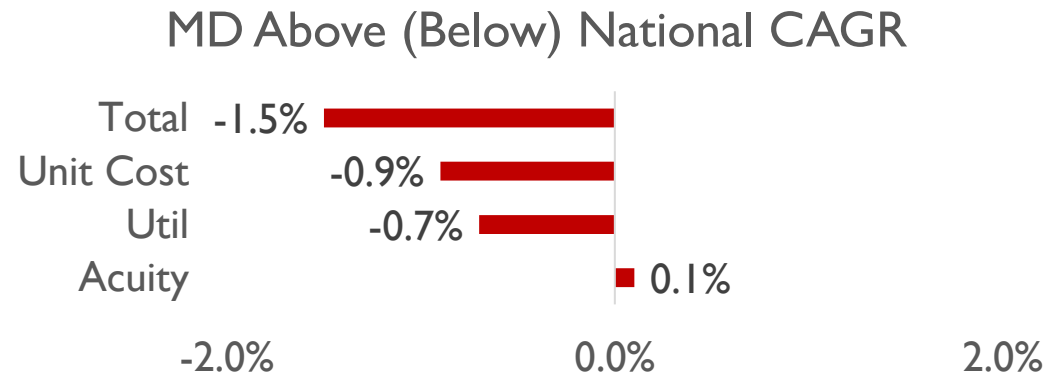
(View 1: Units = Days, No acuity, as presented previously)

## 2013 to 2018 CAGR, IP Utilization and Cost per Day



CAGRs	Utilization	Unit Cost	Total
MD	-2.9%	2.4%	-0.6%
National	-2.8%	3.1%	0.2%
<b>MD Above/Below National</b>	<b>-0.2%</b>	<b>-0.7%</b>	<b>-0.8%</b>

## 2018 to 2019 CAGR, IP Utilization and Cost per Day



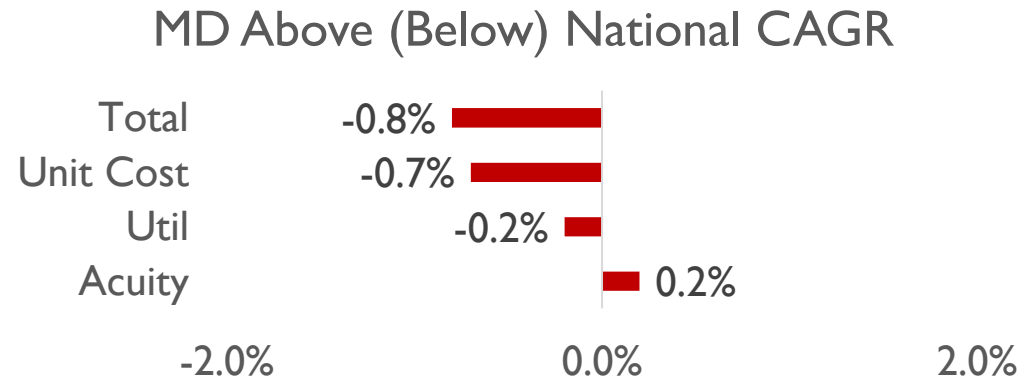
CAGRs	Utilization	Unit Cost	Total
MD	-2.8%	3.8%	0.9%
National	-2.1%	4.7%	2.5%
<b>MD Above/Below National</b>	<b>-0.7%</b>	<b>-0.9%</b>	<b>-1.5%</b>

▶ Trends in 2013-18 and 2018-19 appear similar, with stronger utilization performance in 2018-19

# Inpatient Cost Variation by Source

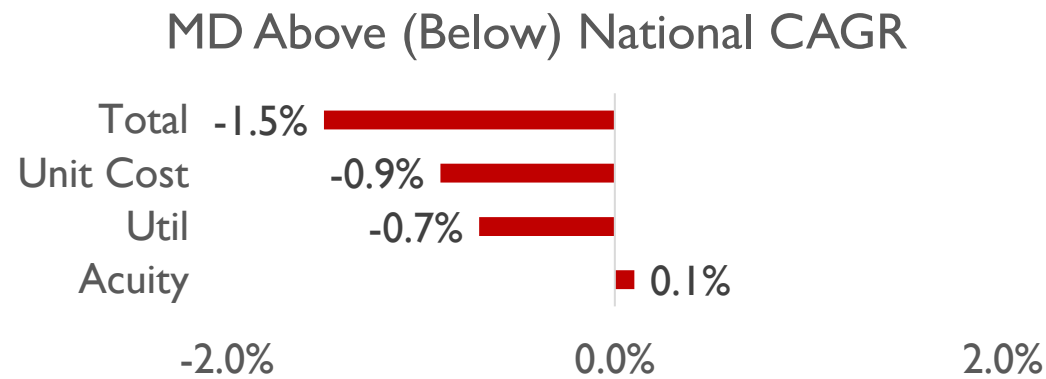
(View 2: Units = Days, Acuity Adjusted with MS-DRG wts)

## 2013 to 2018 CAGR, IP Utilization and Cost per Day



CAGRs	Utilization	Unit Cost	Acuity	Total
MD	-2.9%	0.4%	2.0%	-0.6%
National	-2.8%	1.3%	1.8%	0.2%
<b>MD Above/Below National</b>	<b>-0.2%</b>	<b>-0.9%</b>	<b>0.2%</b>	<b>-0.8%</b>

## 2018 to 2019 CAGR, IP Utilization and Cost per Day



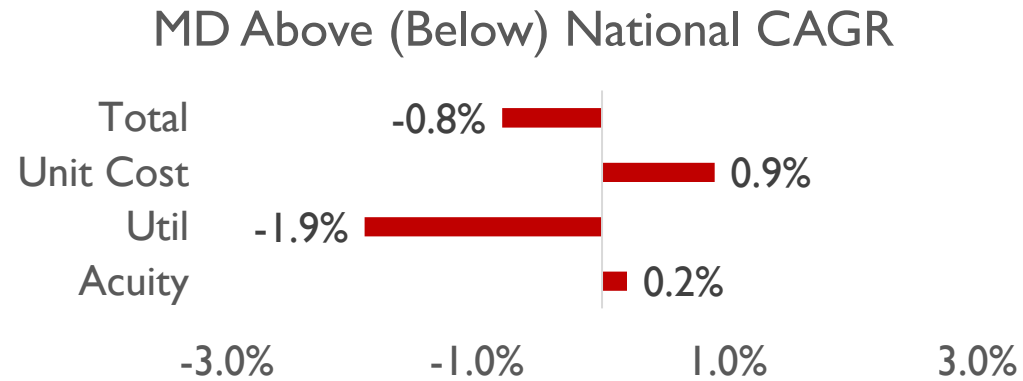
CAGRs	Utilization	Unit Cost	Acuity	Total
MD	-2.8%	2.6%	1.3%	0.9%
National	-2.1%	3.5%	1.1%	2.5%
<b>MD Above/Below National</b>	<b>-0.7%</b>	<b>-1.0%</b>	<b>0.1%</b>	<b>-1.5%</b>

► Trends in 2013-18 and 2018-19 appear similar, with stronger utilization performance in 2018-19

# Inpatient Cost Variation by Source

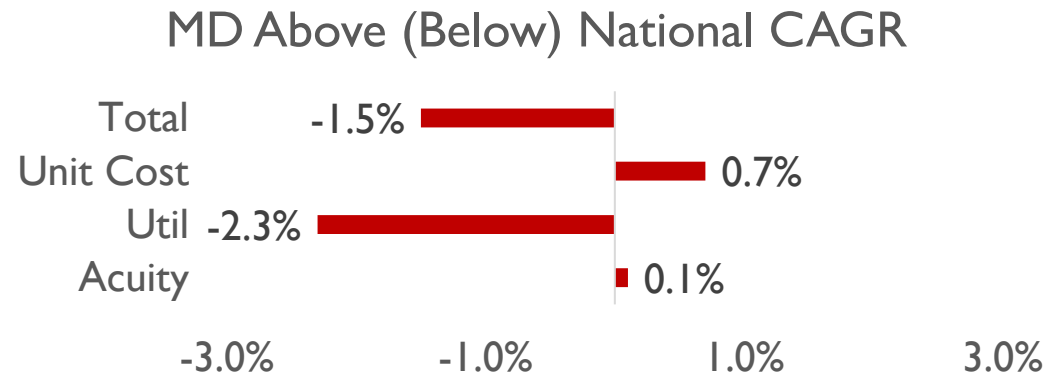
(View 3: Units = Admits, Acuity Adjusted with MS-DRGs)

## 2013 to 2018 CAGR, IP Utilization and Cost per Admit



CAGRs	Utilization	Unit Cost	Acuity	Total
MD	-3.9%	1.4%	2.0%	-0.6%
National	-2.0%	0.5%	1.8%	0.2%
<b>MD Above/Below National</b>	<b>-1.9%</b>	<b>0.9%</b>	<b>0.2%</b>	<b>-0.8%</b>

## 2018 to 2019 CAGR, IP Utilization and Cost per Admit



CAGRs	Utilization	Unit Cost	Acuity	Total
MD	-4.0%	3.8%	1.3%	0.9%
National	-1.7%	3.1%	1.1%	2.5%
<b>MD Above/Below National</b>	<b>-2.3%</b>	<b>0.7%</b>	<b>0.1%</b>	<b>-1.5%</b>

▶ Trends in 2013-18 and 2018-19 appear similar, with stronger utilization performance in 2018-19



# MD vs Nation, OP Hosp. CAGR, '13 to '17

	2013 to 2017	MD Above (Below) National CAGR			Run Rate (Savings) Cost, \$M	% of Savings
	% of Spend	Utilization	Unit Cost	Total		
Part B Rx	19.0%	4.1%	-9.6%	-6.1%	(\$67)	36.3%
Imaging	12.4%	-1.3%	0.6%	-0.7%	(\$5)	2.7%
Proc-Major Cardiology	11.1%	-0.4%	-1.2%	-1.7%	(\$5)	2.5%
E&M - ER	10.6%	-0.2%	-9.9%	-10.3%	(\$63)	34.4%
Proc-Minor	8.6%	-1.3%	-2.3%	-3.7%	(\$16)	8.6%
E&M - Other	7.1%	-3.1%	-1.7%	-5.0%	(\$37)	20.3%
Proc-Major Other	5.9%	3.3%	-2.3%	1.0%	\$2	-0.9%
Proc-Endocrinology	5.4%	-0.8%	-0.4%	-1.2%	(\$2)	1.3%
Lab	5.2%	-1.1%	12.1%	11.0%	\$61	-33.6%
Proc-Ambulatory	4.7%	-4.6%	-0.3%	-4.9%	(\$11)	6.0%
Proc-Oncology	3.8%	-3.1%	0.9%	-2.2%	(\$8)	4.3%
Proc-Major Orthopaedic	2.4%	5.3%	-3.2%	2.1%	\$1	-0.4%
Proc-Eye	1.8%	-8.8%	2.8%	-6.4%	(\$5)	2.6%
Other Professional	1.7%	-4.5%	4.3%	-0.2%	(\$2)	0.8%
DME	0.2%	4.7%	-18.6%	-14.3%	(\$28)	15.1%
Proc-Dialysis	0.0%	-0.7%	8.2%	7.3%	\$0	-0.1%

▶ ~ \$172 M total with mix

▶ From 2013 to 2017 material hospital OP savings accrued in Part B Rx (unit cost), ER (unit cost), Other E&M (Both) and DME (unit cost)

▶ Only in Lab did MD cost growth outstrip US to a material degree

% of spend reflects 2018 MD amounts.





# MD vs Nation, OP Hosp. CAGR, '17 to '18

	2017 to 2018	MD Above (Below) National CAGR			Run Rate (Savings) Cost, \$M	% of Savings
	% of Spend	Utilization	Unit Cost	Total		
Part B Rx	19.0%	-4.8%	-4.2%	-9.3%	(\$26)	28.6%
Imaging	12.4%	-8.9%	0.6%	-7.7%	(\$13)	14.7%
Proc-Major Cardiology	11.1%	-5.9%	-2.6%	-8.4%	(\$6)	6.4%
E&M - ER	10.6%	-17.3%	15.8%	-3.0%	(\$4)	4.9%
Proc-Minor	8.6%	-9.9%	3.3%	-6.1%	(\$7)	7.4%
E&M - Other	7.1%	-11.1%	3.4%	-7.2%	(\$13)	14.9%
Proc-Major Other	5.9%	-11.8%	7.3%	-4.6%	(\$2)	2.4%
Proc-Endocrinology	5.4%	-10.5%	1.1%	-9.2%	(\$5)	5.4%
Lab	5.2%	-8.1%	4.4%	-3.1%	(\$5)	5.8%
Proc-Ambulatory	4.7%	-15.6%	5.4%	-10.3%	(\$5)	5.9%
Proc-Oncology	3.8%	-14.7%	3.9%	-10.1%	(\$9)	10.3%
Proc-Major Orthopaedic	2.4%	17.6%	-9.8%	8.0%	\$1	-0.9%
Proc-Eye	1.8%	-15.7%	9.6%	-6.0%	(\$1)	1.1%
Other Professional	1.7%	-8.4%	-3.4%	-12.7%	(\$22)	24.9%
DME	0.2%	1.0%	54.8%	63.0%	\$28	-31.8%
Proc-Dialysis	0.0%	-27.5%	13.6%	-15.8%	(\$0)	0.1%

- ▶ ~\$114 M total with mix
- ▶ From 2017 to 2018, the savings were more widely distributed across different areas, and improved utilization versus national played a larger role
- ▶ Part B Rx, and E&M Other continued to be significant drivers, while Other Professional, Imaging and Cardiology also contributed
- ▶ DME unit cost variance reversed eliminating gains prior years; this reflects changes in national DME reimbursement in 2018

% of spend reflects 2018 MD amounts.



# MD vs Nation, Professional CAGR, '13 to '17

	2013 to 2017 % of Spend	MD Above (Below) National CAGR			Run Rate (Savings) Cost, \$M	% of Savings
		Utilization	Unit Cost	Total		
ASC	3.7%	-1.0%	-0.8%	-1.8%	(\$8.04)	-8.5%
Proc-Ambulatory	2.9%	-2.7%	0.7%	-1.9%	(\$5.58)	-5.9%
DME	6.4%	0.5%	-0.9%	-0.4%	(\$2.16)	-2.3%
Proc-Endocrinology	1.5%	-0.5%	-0.5%	-1.1%	(\$1.55)	-1.6%
Proc-Eye	1.7%	-0.7%	-0.2%	-0.8%	(\$1.40)	-1.5%
Proc-Major Orthopaedic	1.5%	0.7%	-1.2%	-0.6%	(\$0.86)	-0.9%
Proc-Dialysis	0.7%	-0.4%	-0.3%	-0.7%	(\$0.56)	-0.6%
E&M - Specialist	19.6%	-0.6%	0.7%	0.1%	\$1.38	1.5%
Proc-Major Other	2.1%	0.4%	1.6%	2.0%	\$4.61	4.9%
Proc-Minor	5.8%	0.1%	0.8%	0.9%	\$5.76	6.1%
Imaging	7.2%	0.4%	0.2%	0.7%	\$6.49	6.8%
Proc-Major Cardiology	1.7%	-1.0%	3.9%	2.7%	\$6.51	6.9%
Proc-Oncology	1.4%	2.7%	2.0%	4.7%	\$6.75	7.1%
Other Professional	7.4%	1.6%	-0.2%	1.4%	\$8.47	8.9%
Lab	9.1%	1.0%	0.1%	1.1%	\$10.95	11.5%
E&M - PCP	11.9%	0.9%	0.1%	0.9%	\$12.35	13.0%
Part B Rx	15.3%	0.9%	2.8%	3.8%	\$51.69	54.5%

% of spend reflects 2018 MD amounts.

# MD vs Nation, Professional CAGR, '17 to '18

	2017 to 2018	MD Above (Below) National CAGR			Run Rate (Savings) Cost, \$M	% of Savings
	% of Spend	Utilization	Unit Cost	Total		
Proc-Major Other	122.6%	-1.9%	0.1%	-1.8%	(\$1.15)	-3.0%
Proc-Eye	83.6%	-0.6%	-1.4%	-2.0%	(\$0.87)	-2.3%
Proc-Endocrinology	84.6%	-1.0%	-0.2%	-1.2%	(\$0.42)	-1.1%
Proc-Major Orthopaedic	105.1%	-1.1%	0.3%	-0.9%	(\$0.32)	-0.8%
Proc-Dialysis	53.4%	-0.7%	0.1%	-0.6%	(\$0.12)	-0.3%
Lab	59.6%	-0.5%	0.6%	0.1%	\$0.20	0.5%
E&M - PCP	11.9%	-1.5%	1.6%	0.1%	\$0.33	0.9%
Proc-Ambulatory	79.6%	0.8%	-0.3%	0.5%	\$0.35	0.9%
Proc-Minor	78.2%	0.5%	-0.2%	0.2%	\$0.37	1.0%
Imaging	79.2%	0.0%	0.9%	0.9%	\$2.29	6.0%
Other Professional	102.7%	-3.1%	4.9%	1.5%	\$2.31	6.1%
ASC	57.5%	3.3%	-1.9%	2.2%	\$2.53	6.6%
DME	109.9%	-1.3%	4.3%	2.8%	\$3.20	8.4%
Proc-Oncology	90.5%	5.3%	3.4%	8.9%	\$3.57	9.4%
Proc-Major Cardiology	57.9%	-1.8%	12.5%	10.4%	\$6.56	17.3%
E&M - Specialist	165.0%	-0.5%	2.1%	1.6%	\$8.57	22.5%
Part B Rx	78.0%	1.0%	1.6%	2.7%	\$10.60	27.9%

