



maryland
health services
cost review commission

Total Cost of Care Workgroup

July 2021

Agenda

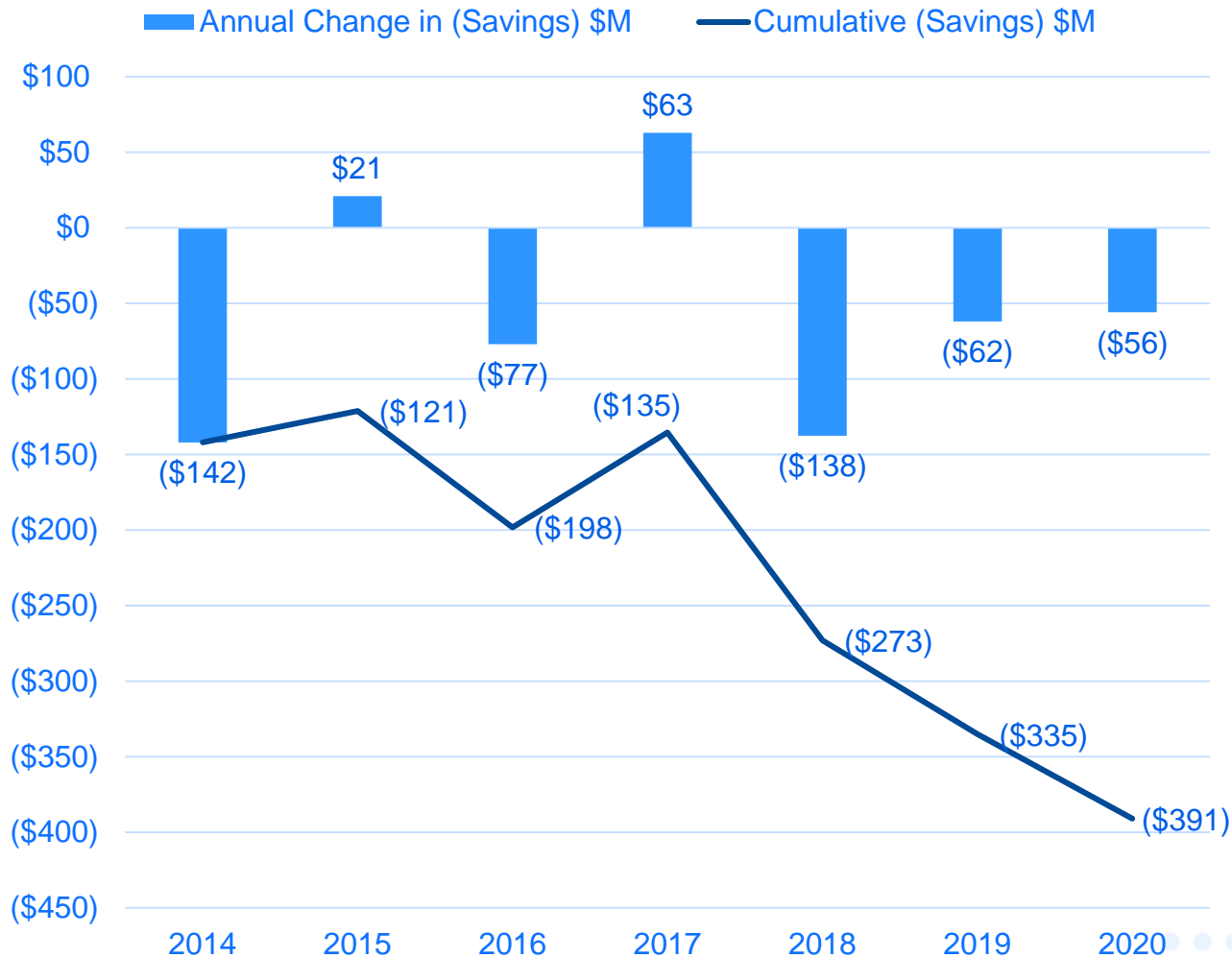
1. Drivers of Maryland FFS Savings
2. Overview of the CY22 MPA Recommendation
3. MDPCP Performance

Drivers of Maryland FFS Medicare Savings, CY 2019 to CY 2020 And Recap of Savings Since 2013

Background

- Analysis reflects through CY 2020 with 3 months' run out.
- Analysis based on comparison of Maryland trend to US trends in 5% sample in each cost bucket and differs from the \$391 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.

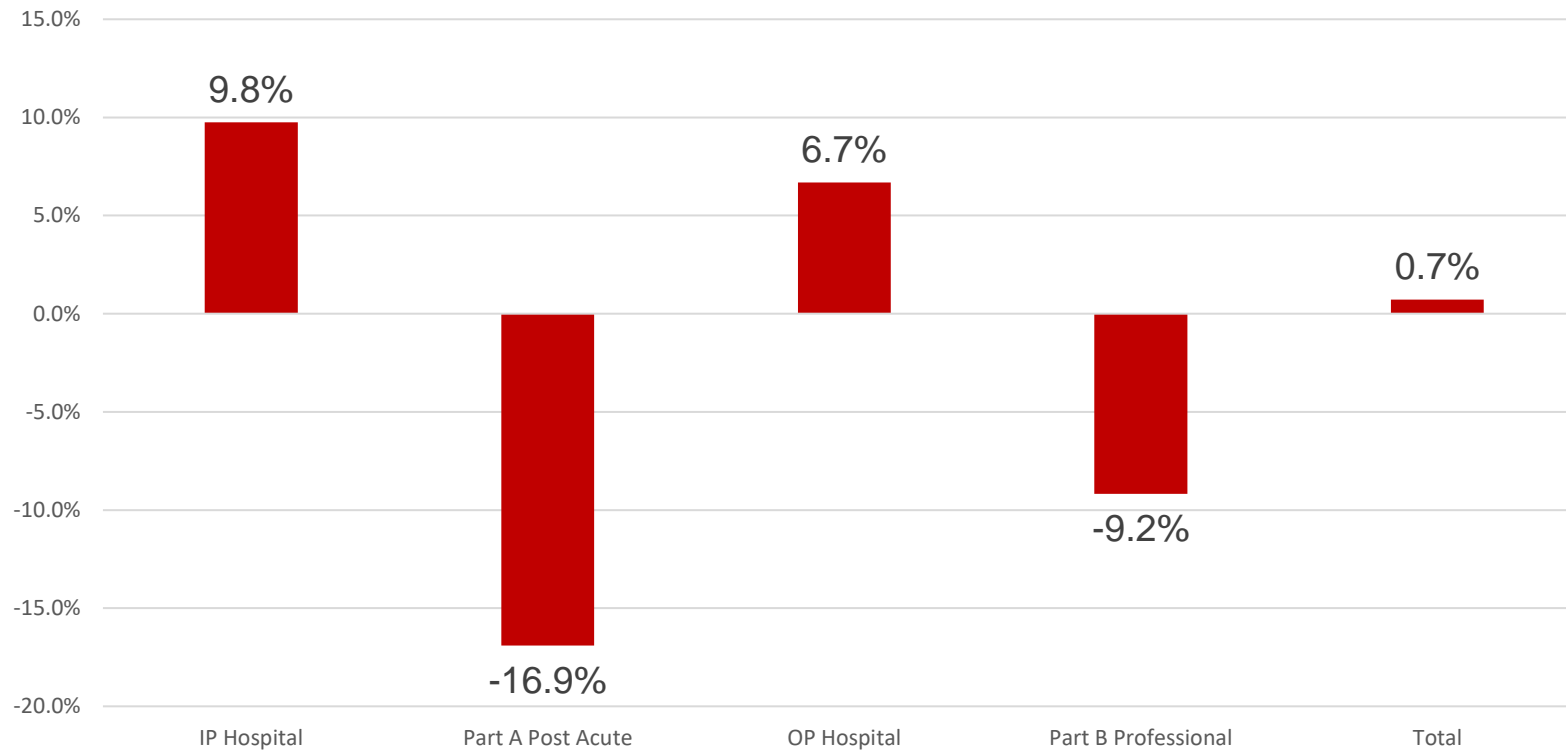
Run Rate (Savings) by Year



- For the first 5 years MD's results fluctuated by year, 2020 results are favorable for the 3rd straight year.
- Approximately \$32 M of 2020 savings relates to the initial recognition of national non-claims-based payments for MSSP.
- We exceeded our run rate requirement from CMS in 2020.
- This slide is based on CMMI national reporting and will not tie to other slides in this presentation.

2020 COVID-19

2020 Covid Diagnosis TCOC per Capita
MD Over/(Under) US



- 4.0% of 2020 MD TCOC per Capita was from Claims with Covid-19 diagnosis versus 4.6% nationally.

Savings, 2013 to 2019 vs 2019 to 2020



















	2013 to 2019, Average		2019 to 2020	
	Average Run Rate (Savings) Cost \$ M	% of Savings	Run Rate (Savings) Cost \$ M	% of Savings
Inpatient Hospital	(\$35)	572.1%	\$174	
SNF	(\$6)	13.0%	(\$56)	
Home Health	\$7	-15.0%	(\$7)	
Hospice	\$4	-7.4%	(\$8)	
Total Part A	(\$31)	62.7%	\$103	-5,745%
Outpatient Hospital	(\$46)	94.0%	(\$71)	
ESRD	(\$2)	4.5%	(\$4)	
Outpatient Other	(\$4)	7.4%	(\$13)	
Clinic	(\$0)	0.1%	\$0	
Professional Claims	\$34	-68.7%	(\$17)	
Total Part B	(\$18)	37.3%	(\$105)	5,846%
Total	(\$49)		(\$2)	
OP Hospital Net of Professional	(\$12)		\$87	

- Part B savings, OP hospital costs in particular as well as Part A Post-Acute Care helped to offset growing IP costs in 2020.
- Inpatient Hospital claims grew at the fastest rate resulting in net increases in Part A costs in 2020.
- ~\$62M Increases in MDPCP fees were offset by decreases in 2020 Professional Claims relative to US (net ~(\$17) million).
- Excludes national non-claims-based spending for MSSP. CPC+ is included as it is a match to MDPCP.

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 2020 savings.

Amounts may not add up due to rounding.

Overview of Savings, growth rates

	% of MD Spend	MD CAGR 2013-19	MD CAGR 2019-20	National CAGR 2013-19	National CAGR 2019-20
Inpatient Hospital	38.3%	-0.4% 	0.4%	0.6% 	-4.1%
SNF	6.1%	-2.2% 	-1.8%	-1.2% 	7.2%
Home Health	3.1%	1.8% 	-5.8%	-0.7% 	-3.6%
Hospice	2.4%	4.0% 	1.9%	2.4% 	5.2%
Total Part A	49.9%				
Outpatient Hospital	16.1%	3.3% 	-7.7%	6.6% 	-5.3%
ESRD	2.4%	1.4% 	-2.7%	2.3% 	-0.9%
Outpatient Other	1.2%	4.5% 	-10.2%	7.2% 	-0.3%
Clinic	0.1%	8.5% 	-8.7%	9.1% 	9.5%
Professional Claims	30.3%	3.6% 	-3.6%	2.7% 	-4.7%
Total Part B	50.1%				

- Maryland's IP Hospital growth rate increased slightly while the national rate fell by over 4%.
- Maryland OP hospital continues to grow much more slowly than the nation.
- MD 2020 OP Hospital trend was 2.5% favorable to the national rate.
- National 2020 growth in SNF was 7.2% vs -1.8% in MD.

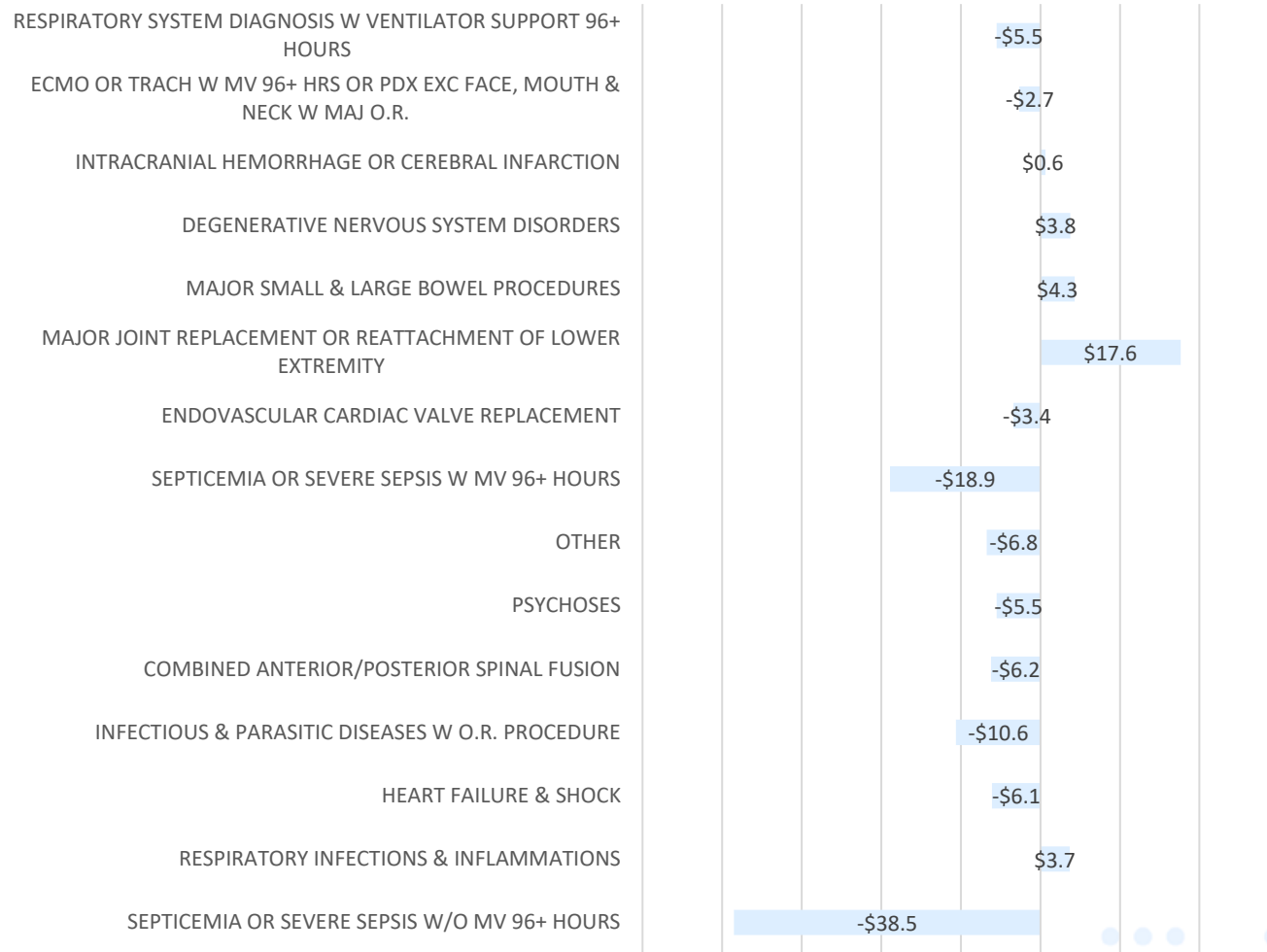
CAGR = Compound Annual Growth Rate, amounts may not add up due to rounding. % of spend reflects 2020 values.

Inpatient Savings Drivers

Metrics: 2013 to 2020				Savings In \$M		
				2013 to 2019	2020	2013 to 2020
Area	Metric	MD Impact	National Impact	Savings (Dissavings)	Savings (Dissavings)	Total Savings (Dissavings)
Admits	Decrease in Admits per 1000	109.0	74.1	\$396	\$51	\$405
Length of Stay (Acuity Normalized)	Decrease in Acuity Normalized LOS	0.17	0.61	(\$262)	\$6	(\$256)
Unit Cost	Increase in Cost/Day	\$787	\$714	\$158	(\$227)	(\$69)
Acuity (MS-DRG weights)	Increase in CMI	0.27	0.25	(\$67)	(\$9)	(\$77)
Mix Impact				(\$7)	\$6	(\$6)
			Total	\$218	(\$174)	\$44

- MD's IP Savings through 2019 deteriorated in 2020 mostly due to Unit Cost increases relative to US. Extended corridor relief to offset Covid-19 related volume reductions was the main driver of MD unit cost increases.

2020 over 2019 Savings (in millions) – Top 15 MS-DRGs



- Continue to see large savings in Major Joint Replacement as services are moved to lower cost of care venues.
- Approximately \$57.5M Dissavings due to Septicemia/Sepsis; ~\$24M due to Utilization and ~\$33.5M due to Unit Cost.

MD vs Nation, OP Hosp. CAGR, '19 to '20

2013 to 2020		2019 to 2020						
		MD Above (Below) National CAGR						
Cumulative (Savings) Costs \$M		% of Nat. Spend	Utilization	Unit Cost	Total	Run Rate (Savings) Cost, \$M	% of Savings	
(\$159.1)	Part B Rx	23.60%	-4.21%	1.33%	-2.94%	(\$9.9)	14.02%	
(\$30.1)	Imaging	11.72%	-6.57%	2.40%	-4.32%	(\$6.8)	9.61%	
(\$12.3)	Proc-Major Cardiology	10.09%	-4.42%	-1.22%	-5.58%	(\$3.6)	5.04%	
(\$34.8)	Proc-Minor	8.41%	-4.50%	-1.37%	-5.81%	(\$5.9)	8.36%	
(\$58.0)	E&M - ER	8.36%	-5.32%	10.29%	4.42%	\$5.4	-7.29%	
(\$3.4)	Proc-Major Other	5.81%	-11.04%	8.22%	-3.73%	(\$1.9)	2.65%	
\$53.2	Lab	5.26%	-6.02%	0.32%	-5.72%	(\$10.1)	14.28%	
(\$11.2)	Proc-Endocrinology	5.08%	-5.52%	-1.52%	-6.96%	(\$3.5)	4.90%	
(\$19.9)	E&M - Other	4.96%	-0.25%	18.15%	17.86%	\$23.6	-33.39%	
(\$2.9)	Proc-Major Orthopaedic	4.79%	-3.77%	-14.95%	-18.16%	(\$7.9)	11.14%	
(\$16.3)	Proc-Ambulatory	4.48%	-11.14%	8.24%	-3.82%	(\$2.0)	2.77%	
(\$20.5)	Proc-Oncology	4.01%	-9.62%	8.10%	-2.30%	(\$2.3)	3.28%	
(\$32.7)	Other Professional	1.71%	-8.32%	-9.58%	-17.10%	(\$39.6)	56.14%	
(\$6.8)	Proc-Eye	1.46%	-16.56%	5.87%	-11.66%	(\$1.5)	2.07%	
\$7.8	DME	0.23%	-13.88%	8.15%	-6.86%	(\$4.4)	6.29%	
\$0.1	Proc-Dialysis	0.01%	-15.91%	-0.12%	-16.01%	(\$0.1)	0.14%	

% of spend reflects 2020 US amounts.

- Part B Rx stands out as the most significant driver of cost savings and continues in 2020.
- Approximately \$15.8 M savings in 2020 Imaging and Minor Procedures, which tend to include low value care (\$16.0 M savings in professional).
- Approximately \$40.0 M savings in Other Professional driven by MD reductions in rotary wing air transport and basic life support ambulance in MD relative to the nation.

MD vs Nation, Professional CAGR, '19 to '20

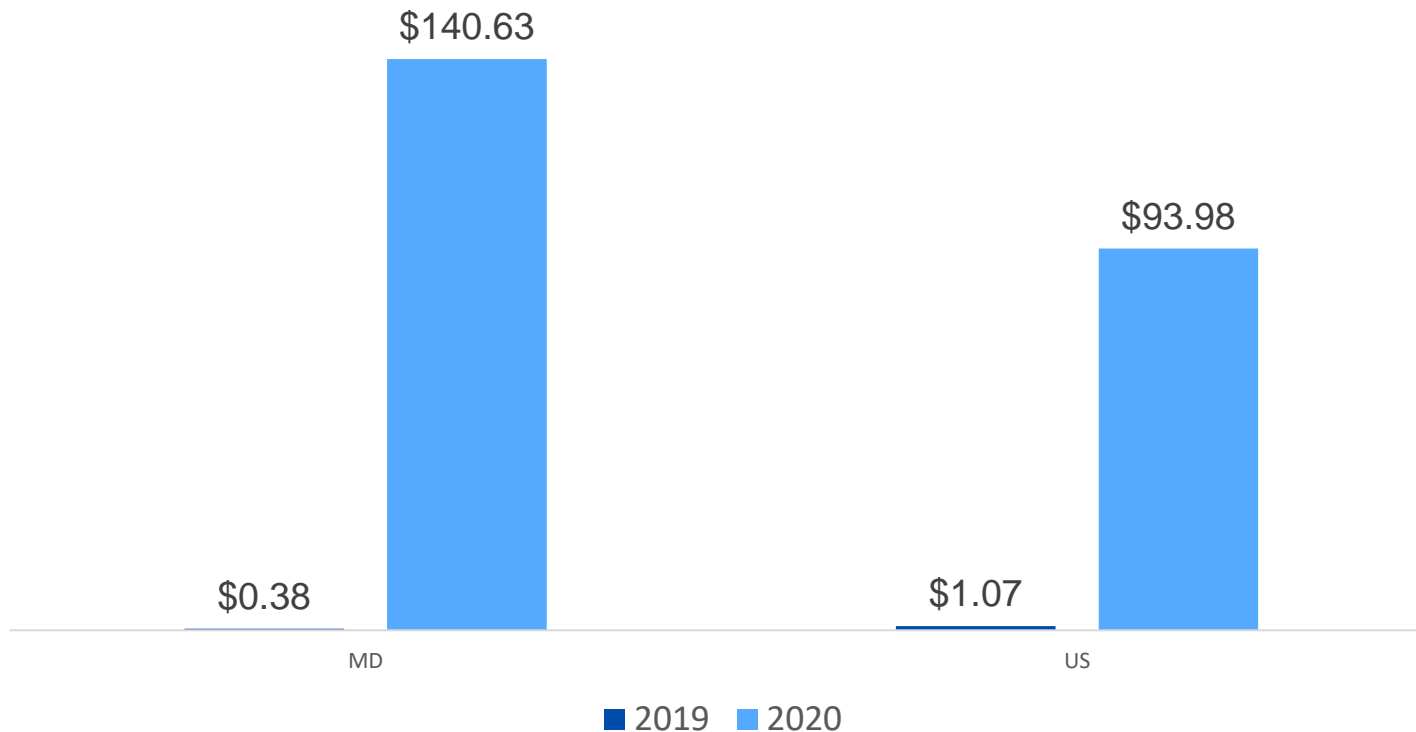
2013 to 2020		2019 to 2020						
Cumulative (Savings) Costs \$M		% of Nat. Spend	MD Above (Below) National CAGR			Run Rate (Savings) Cost, \$M	% of Savings	
			Utilization	Unit Cost	Total			
(\$5.46)	E&M - Specialist	18.49%	-3.05%	1.41%	-1.68%	(\$9.39)	56.22%	
\$91.24	Part B Rx	18.15%	1.15%	-0.64%	0.50%	\$2.84	-16.98%	
\$104.67	E&M - PCP	11.88%	1.76%	11.60%	13.56%	\$52.91	-316.87%	
\$5.87	Lab	9.21%	-2.80%	0.03%	-2.77%	(\$7.89)	47.22%	
(\$6.59)	DME	6.78%	-0.55%	-3.34%	-3.88%	(\$5.75)	34.42%	
\$3.37	Other Professional	6.75%	-4.96%	0.93%	-4.08%	(\$6.17)	36.94%	
\$1.29	Imaging	6.72%	-2.26%	-0.97%	-3.21%	(\$8.09)	48.44%	
(\$3.07)	Proc-Minor	5.46%	-6.65%	1.29%	-5.45%	(\$9.20)	55.12%	
(\$8.10)	ASC	3.70%	-4.38%	2.62%	-1.87%	(\$2.47)	14.78%	
(\$10.87)	Proc-Ambulatory	2.89%	-10.47%	4.42%	-6.51%	(\$5.10)	30.54%	
\$0.82	Proc-Major Other	1.99%	10.61%	-12.67%	-3.41%	(\$2.18)	13.03%	
\$15.33	Proc-Major Cardiology	1.69%	-3.35%	-7.52%	-10.62%	(\$9.02)	54.01%	
(\$3.45)	Proc-Major Orthopaedic	1.45%	-6.59%	1.54%	-5.16%	(\$1.93)	11.57%	
\$10.70	Proc-Oncology	1.40%	0.90%	-0.23%	0.66%	\$0.30	-1.81%	
(\$3.81)	Proc-Eye	1.38%	-3.76%	-1.75%	-5.45%	(\$1.97)	11.83%	
(\$5.29)	Proc-Endocrinology	1.29%	-8.02%	-1.83%	-9.70%	(\$3.16)	18.93%	
(\$1.17)	Proc-Dialysis	0.76%	-3.17%	1.26%	-1.95%	(\$0.44)	2.62%	

% of spend reflects 2020 US amounts

- E&M PCP account for the MDPCP fees and largely explain the Professional Claim increases from 2019 to 2020.
- All other Professional categories are generating savings in 2020 with the exception of Part B Rx and Oncology.

2020 Telehealth Trend, MD vs US

TCOC per Capita Trend for Telehealth Services

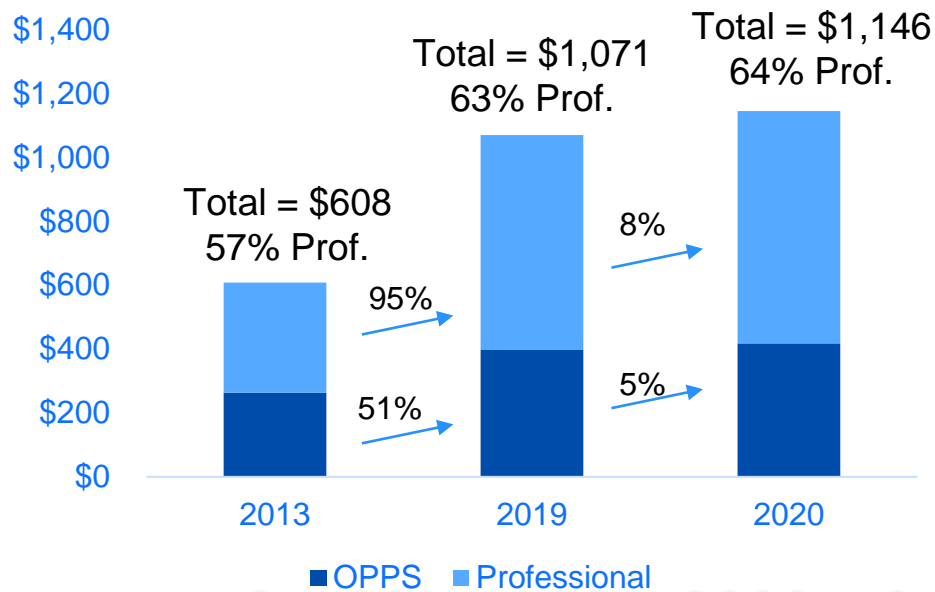


- MD ranked 4th in Telehealth Cost per Capita.
- Telehealth was 1.2% of MD TCOC per Capita in 2020, 0.9% nationally.

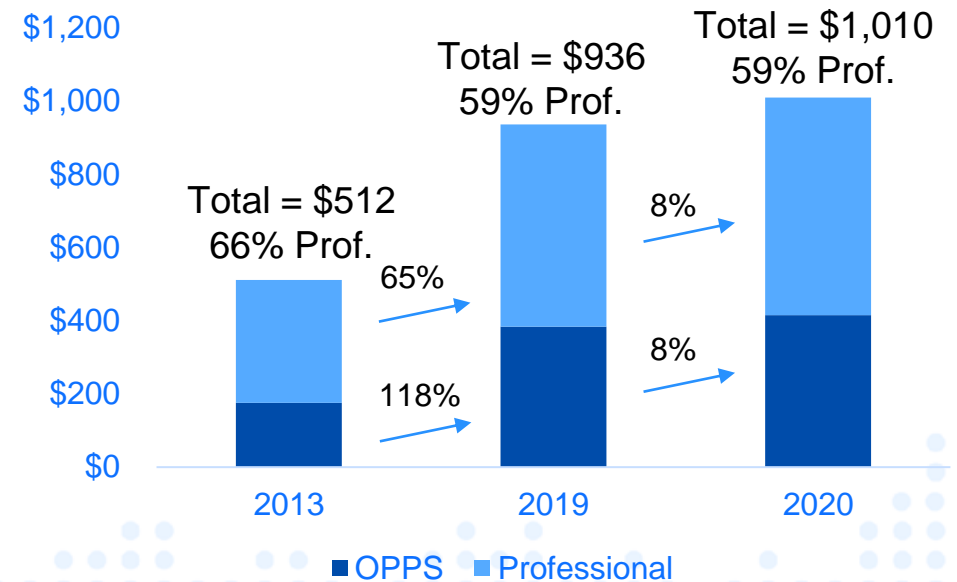
Mix of Part B Drug Spending

- Through 2019 Maryland was successful in shifting Part B Rx to the professional setting going up from 57% professional to 63% professional while the nation dropped from 66% to 59%. Maryland also had a lower total CAGR: 9.9% versus 10.6%.
- 2020 continued the pattern, as MD went to 64% professional while national stayed at 59%. Maryland's CAGR advantage maintained at 9.5% versus 10.2% nationally.

Maryland PBPY



National PBPY



High Level Summary of Savings Impact

Area	Savings
IP: Reduced IP admits and cost per day somewhat offset by higher LOS	\$64
OP Hospital (excl. ED & Part B Rx): Reductions in imaging, minor procedures, hospital clinics	\$164
PAC: Skilled Nursing, Home Health & Hospice	\$43
ED: Reduction in ED per Visit Costs	\$58
Part B Drugs: Shift to lower cost, office POS	\$68
Other Professional: Lower professional growth, previously a hit to Maryland but reversed during COVID	\$40
Other	\$48
MDPCP Fees	(\$126)
MSSP: National growth from Medicare Shared Savings Program Performance	\$32
Net Savings	\$391

Since 2013 Maryland has generated approximately \$391 M of savings compared to the national run rate. While there are varying ways to calculate and allocate savings, savings can generally be attributed as shown at left (\$ in M).

This slide is adjusted to tie to validated savings of \$391 M and may not tie exactly to other analyses derived from the national 5% savings.

Medicare Performance Adjustment Calendar Year 2022

CY 22 MPA Recommendation

Staff are planning on a draft recommendation on the MPA for the commission in September of 2021.

- Staff will submit the Recommendation and the MPA proposal to CMS in September.
- The final draft will be submitted to the commission after receiving CMMI's feedback on the MPA.
- Staff decided to advance the MPA recommendation to September in order to get CMMI's approval prior to the start of the calendar year and prior to final Commission sign off.

Staff would like comments on the MPA policy by August 13 in order to include those comments in the draft recommendation. Comments should be sent to hscrc.tcoc@maryland.gov.

CY 2021 MPA Recommendation

During 2019/2020 the TCOC Workgroup completed a review of the MPA policy. Based on that review, Staff considered several changes to the MPA

1. Attribution

- A. Staff proposed moving to a geographic attribution methodology for the MPA.
- B. Based on comments from the industry, Staff delayed that recommendation for a year.

2. Financial Methodology

- A. The MPA will use a long-term attainment target rather than a year-over-year target.
- B. The hospital's attainment target will be scaled based on the hospital's performance compared to its benchmark region.

3. Supplemental Adjustments

- A. Staff proposed creating a 'CTI Buyout' for the traditional MPA based on CTI performance.
- B. The MPA will include a new 'Supplemental Adjustment' for the hospital's performance in the primary care program.

CY 2022 MPA Recommendation

Staff will propose moving to a geographic attribution for the MPA.

1. Staff believe that the current MPA attribution is overly complex and reduces the validity of the TCOC measurement.
 - There is substantial churn in the attributed beneficiaries from one year to the next.
 - The hospital's MPA results can be driven by changes in the attribution, rather than in actual improvement in TCOC management.
2. Additionally, the MPA attribution algorithm is operationally complex (multiple NPI lists / CFO Attestations).
 - Hospitals are required to submit lists of NPIs for their employment, MDPCP, and ACO relationships so that HSCRC can attribute beneficiaries to the hospital.
 - Hospitals also must submit lists of NPIs that have a 'care coordination relationship' with the hospital for the purpose of sharing PHI data.
 - Using a geographic approach will allow us to build a PHI access methodology that is as efficient and complete as possible for that purpose (could be expanded to non-primary care relationships)
3. Staff believe moving to geographic attribution would be more stable and simpler.

Revised Attribution Methodology for CY 2022

The revised attribution algorithm for CY 22 will include two changes:

- All Medicare beneficiaries that reside within the hospital's PSAP service area will be attributed to the hospital.
 - Beneficiary duplication will be allowed for zip codes that are shared between hospitals will be attributed to both hospitals.
 - Any zip code that is not in some hospital's PSAP will be assigned to a hospital by the HSCRC.
- Academic Medical Centers will have an alternative attribution.
 - The PSAP attribution results in "too few" dollars being attributed to the AMCs.
 - As an alternative, HSCRC intends to work with the AMCs to create an alternative attribution for the two AMCs.
 - The AMC attribution will be based on a hospital "touch" attribution for beneficiaries with CMI above 1.5.

Additional Changes

In the CY 2020 MPA proposal, HSCRC recommended a “CTI Buyout” for the MPA.

- Under the CTI Buyout, any MPA penalty will be scaled based on the ratio of attributed TCOC dollars to CTI dollars.
- For example, if the hospital’s CTI is equal to 50% of the hospital’s attributed TCOC under the MPA, then any MPA penalty will be reduced by 50%.

CMS approved the CTI Buyout for CY21 only. CMS expressed concern about the CTI Buyout reducing the hospital’s accountability for TCOC management.

- Staff continue to believe that the CTI is a better tool than the traditional MPA.
- The magnitude at risk under the CTI is larger than the MPA and the CTI are better targeted.
- Staff will continue to include the CTI Buyout in the MPA proposal.

The MPA proposal will include several miscellaneous updates for the MPA:

- The recommendation will include the EQIP adjustment
- The attribute for the MDPCP Supplemental Adjustment will be dynamically attributed for each period.

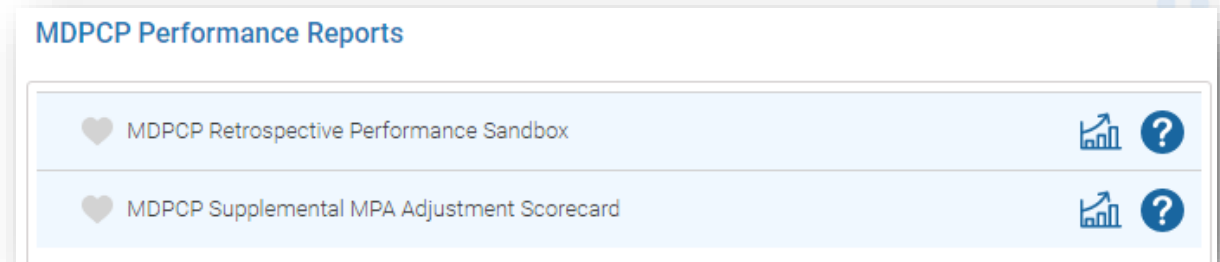
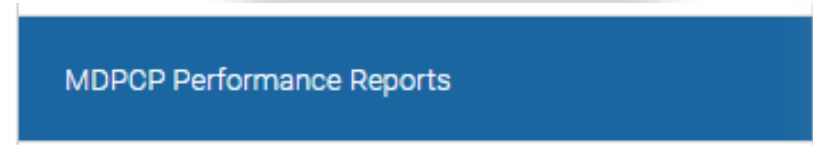
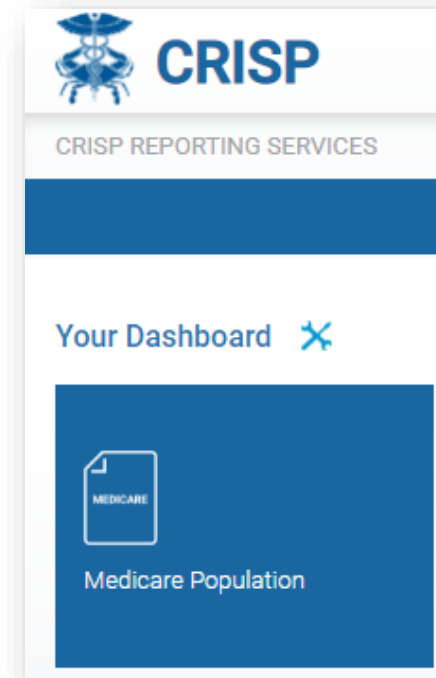
MDPCP Performance Reports

Goals of MDPCP Performance Reports

- Allow CTO and affiliated-hospital users to monitor MDPCP utilization and payment performance over time on a retrospective basis
- Provide MDPCP performance using dynamic attribution in order to improve functionality for use in retrospective trend analysis
- Provide official scorekeeping for the MDPCP MPA Supplemental Adjustment, based on an identified set of “affiliated” providers
- Two Reports:
 - MDPCP Retrospective Performance Sandbox
 - MDPCP Supplemental MPA Adjustment Scorecard

Getting Started

- MDPCP Performance Reports are accessible through a modern browser
 - Google Chrome 59 or higher
 - Internet Explorer 11 or higher
 - Firefox 52 or higher
- Access the Medicare Reports card from the CRS Reports Portal
 - <https://reports.crisphealth.org/>



Beneficiary Attribution

- **CRISP MDPCP Reports** present utilization measures and trends for the selected quarterly attribution population, as provided by CMS
 - Data over time is presented for the *static population*

BUT

- **MDPCP Performance Reports** present utilization measures and trends for a *dynamically-attributed* population
 - CRISP & hMetrix replicated CMS's MDPCP attribution logic but apply it separately to each period
 - Physician and practice participants were identified for CY 2021 (based on Q1); attributed beneficiaries were identified for both 2021 and 2019 based on the respective lookback period
 - This results in better insight into trends because beneficiaries who die in the base period are not automatically excluded

Comparison Populations

- **MDPCP Statewide**
 - All beneficiaries attributed to MDPCP participating NPIs and practices according to Q1 2021 Attribution files; beneficiaries attributed to base and comparison group using respective lookback period
- **CTO Average**
 - MDPCP beneficiaries attributed to practices participating in a CTO in Q1 2021
- **No CTO MDPCP**
 - MDPCP beneficiaries attributed to practices not participating in a CTO in Q1 2021
- **Statewide FFS Population**
 - Maryland's Medicare fee-for-service beneficiary population with both Part A and B coverage regardless of MDPCP participation

Comparison Populations (cont'd)

- **Statewide Non-Participating Population**
 - All beneficiaries eligible for MDPCP and able to be attributed to physician, but the attributed NPI did not participate in MDPCP in Q1 2021
- **Equivalent Non-Participating Population**
 - Subset of the Statewide Non-Participating Population that is demographically matched to the statewide participating population based on the distribution of age band, race, gender, dual eligibility, and county of residence

Part 1: Retrospective Performance Sandbox

- Allows CTOs to compare their overall and practice-specific performance from 2019 (baseline) to 2021 (performance year)
- Key differences from MDPCP Dashboard:
 - Intended for retrospective analysis not operational support
 - Not tailored to a specific quarterly attribution
 - Fixed time period (2019 vs 2021; YTD or CY)
 - Includes risk-adjusted values
 - Dynamic Attribution

Part 1: Retrospective Performance Sandbox (cont'd)

- CTO or Practice Views
 - CTO-level data are available to all users
 - Practice-level data are only available to CTO or hospital users' specific practices
 - Practices are accessible via the Category drop down selector
- Base Year Time Period is defaulted to complete 2019 Calendar Year
 - Can be converted to YTD
- Measure Year Time Period is always YTD
- Numerous total cost and utilization measures

Part 2: Supplemental MPA Adjustment Scorecard

- Developed as the official scorekeeper of the MPA MDPCP Supplemental Adjustment policy
- Universe based on hospital-owned practices, as identified by users through CRS MPA Attribution Tracking Tool's (MATT) "Affiliated Providers"
- HSCRC applied logic to ensure each practice is fully (un)attributed based on the plurality of physicians identified as "hospital-owned"
 - Example: If 3 of the 5 MDPCP participating NPIs in a practice are identified as "hospital-owned," all NPIs are included and deemed "hospital-owned"
- Report is static with no drill-throughs
- Performance data are available to all users, regardless affiliation

Part 2: Supplemental MPA Adjustment Scorecard (Cont'd)

- Shows year-to-date performance by hospital according to affiliated MDPCP participating practices
- Statewide MPA TCOC per Beneficiary measures will not directly correspond to PMPM in the Retrospective Performance Sandbox due to claim exclusions according to MPA Y4 policy
 - Supplemental MPA Adjustment Scorecard uses MPA TCOC definition (exclusions)
 - MDPCP Retrospective Sandbox uses MDPCP TCOC definition (no exclusions)

User Roles and Permissions

- Available to:
 - MDPCP CTO users
 - Hospital users with MDPCP attributed beneficiaries under MPA
- Retrospective Performance Sandbox
 - Everyone can see everyone else's CTO-level results
 - CTO/hospital users can only see their affiliated practices, consistent with MDPCP Reports
- Supplemental MPA Adjustment Scorecard
 - Everyone can see everyone else's results
 - No Practice-level detail available

Future Enhancements

- Hospital MPA Affiliated Provider Sandbox
 - Analogous report to Retrospective Performance Sandbox
 - Same measures, but coded consistently with Scorecard
 - i.e. TCOC per beneficiary month in place of PMPM in order to tie directly to Scorecard
 - Uses affiliated provider to hospital roll up
 - View practice level performance for your hospital(s)



Questions?

Next Meeting

The next meeting of the TCOC Workgroup will be held on August 25.

- This meeting will be in person.
- There will be an option for remote participation.

Staff will discuss responses to the MPA comments.