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Total Cost of Care Workgroup

November 2022

Agenda

1. Draft MPA Recommendation
2. Drivers of Medicare Savings, through June 2022
3. MHA Presentation on Future of the Model

Draft MPA Recommendation

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CY23 Draft Recommendation

Staff will submit the CY23 Draft Recommendation to the Commission at the December Meeting. Simultaneously, Staff will submit the MPA proposal to CMS. The Draft Recommendation is mostly unchanged from prior years. Staff are proposing only three changes:

1. Formalizing the geographic attribution methodology;
2. Eliminating the MDPCP Supplemental Adjustment;
3. Slightly increasing the Quality Adjustment.

New PSAP Algorithm

- **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.

Elimination of MDPCP Supplemental Adjustment

- Given that Track 3 is approved, Staff anticipate eliminating the supplemental adjustment.

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.

Analysis of Maryland Utilization vs the Nation

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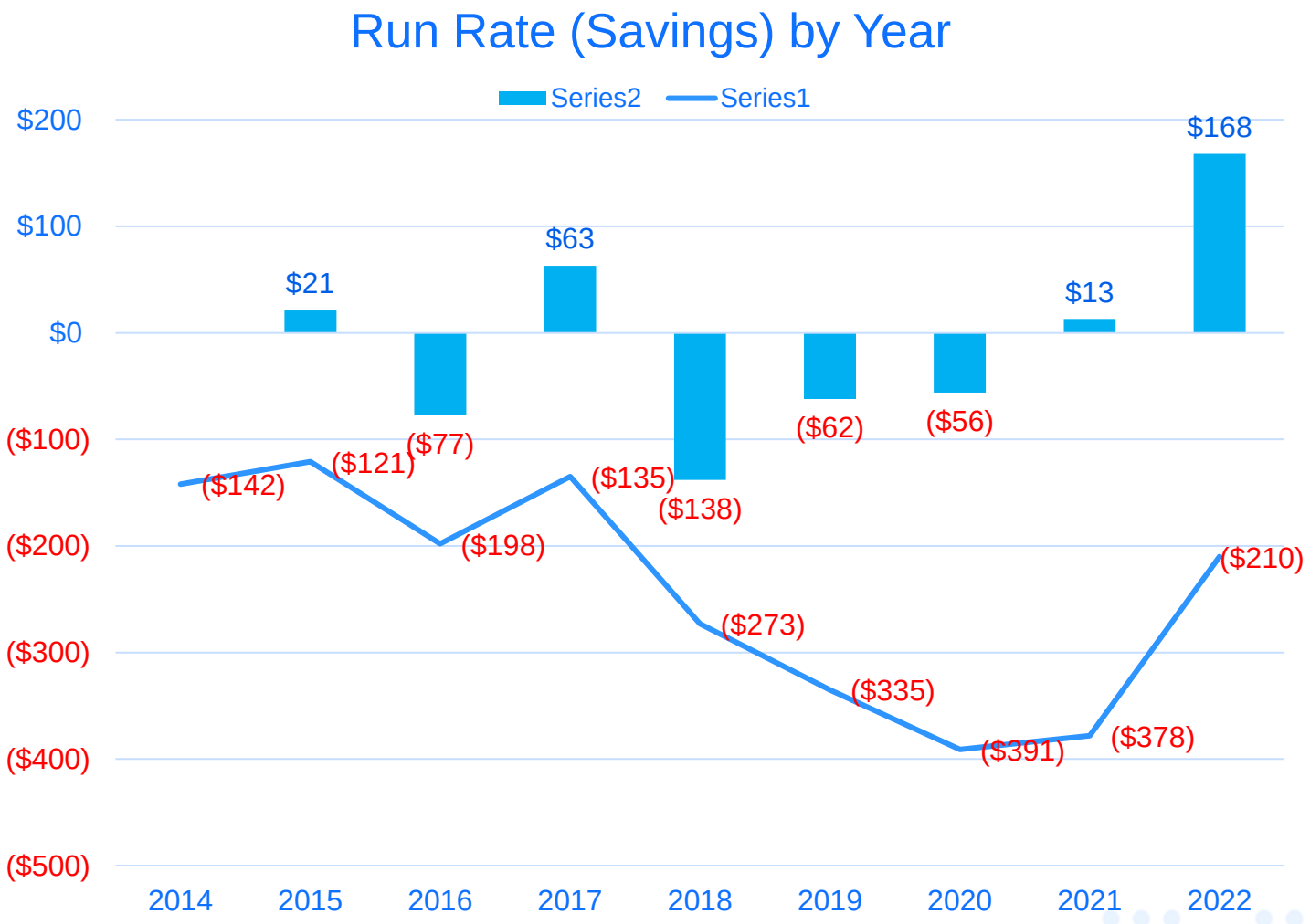
Presentation Context

- Presentation attached is a brief overview of changes in Maryland Medicare Total Cost of Care in the first half of CY2022.
  - Considerable volatility in TCOC in 2020, 2021, and 2022 makes 2022 analysis over any period complex.
    - 2022 MD Hospital Costs had significant increases in Feb & March due to one-time recoupment of undercharges not expected to repeat in the second half of the year
    - US claims' utilization has been historically low in 2022 and well under any forecasts (e.g. OACT)
- HSCRC still will provide an update on the full year 2022 in comparison to prior years in mid 2023
  - Staff believe focusing on the change from 2019 to 2021 in addition to 2021 to 2022 is the best way to focus on the sustained trends.

Background

- Analysis reflects through 1st Half CY 2022 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 $210 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

Run Rate (Savings) by Year



- Maryland's results have typically fluctuated by year for the first 5 years. 2019 was the first two-year gain in Savings. Then Covid-19 impacts to Utilization led to further volatility
- 2022 results are historically unfavorable
- We expect to fail our run rate requirement from CMS in 2022 of $267M potentially by over $100M; additionally expect YOY guard-rail well over US by 2+%
- This slide is based on CMMI national reporting and will not tie to other slides in this presentation.

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TCOC Savings, 2013 to 2019 vs 2019 to 2021 vs 2021 to 2022 (1st Half CY)

	2013 to 2019, Average		2019 to 2021, Average		2021 to 2022	
	Average Run Rate (Savings) Cost $ M	% of Savings	Average Run Rate (Savings) Cost $ M	% of Savings	Run Rate (Savings) Cost $ M	% of Savings
Inpatient Hospital	($12)	56%	$40	-2968%	$112	60%
SNF	($2)	11%	($6)	443%	$13	7%
Home Health	$4	-18%	($1)	42%	$2	1%
Hospice	$2	-12%	($6)	467%	($6)	-3%
Total Part A	($8)	37%	$27	-2015%	$122	66%
Outpatient Hospital	($27)	128%	($47)	3453%	$32	17%
ESRD	($1)	5%	$3	-195%	$3	2%
Outpatient Other	($2)	11%	($4)	258%	$1	1%
Clinic	($0)	0%	($0)	17%	($1)	0%
Professional Claims	$17	-82%	$19	-1419%	$28	15%
Total Part B	($13)	63%	($29)	2115%	$64	34%
Total	($21)		($1)		$186	

- Hospital Claims are driving 77% of Total Excess Cost in 2022
- ~$13M of the ~$28M 2022 Professional Claim Incremental Cost is due to increases in the MDPCP Program Cost
- 2022 is the first year of the model where Outpatient Hospital is contributing to Excess Cost

Amounts may not add up due to rounding.

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 2022 dis-savings of $168 million.

IP Savings, 2013 to 2019 vs 2019 to 2021 vs 2021 to 2022 (1st Half CY)

	2013 to 2019, Average		2019 to 2021, Average		2021 to 2022	
	Avg Run Rate (Savings) Cost $ M	Avg Growth Rate, MD vs US	Avg Run Rate (Savings) Cost $ M	Avg Growth Rate, MD vs US	Run Rate (Savings) Cost $ M	Growth Rate, MD vs US
Admits per K	($31)	-1.9%	$10	0.6%	($1)	0.0%
Avg Case Mix Index	$5	0.2%	$8	0.4%	($10)	-0.5%
Cost per Day	($12)	-0.6%	$19	1.1%	$86	4.3%
ALOS (CMI Adj)	$20	1.7%	($2)	-0.1%	$36	1.9%
Mix Impact	$6		$5		$0	
Total Inpatient	($12)		$40		$112	

- Cost per Day is driving dis-savings since 2019
- Admits per K reductions have driven savings during the first 6 years but has since been relatively flat relative to US
- 2022 Case-Mix Adjusted Average Length of Stay is the secondary driver of dis-savings

Amounts may not add up due to rounding.

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.

OP Savings, 2021 to 2022 (1st Half CY)

Cumulative (Savings) Costs $M	2021 to 2022	% of US Spend	MD Above (Below) National CAGR Util.	Unit Cost	Total	Run Rate (Savings) Cost, $M	% of Savings
($107.43)	Part B Rx	22.04%	4.84%	-4.29%	0.35%	$0.53	1.66%
($19.35)	Imaging	11.59%	-5.05%	7.76%	2.32%	$1.90	5.94%
($7.49)	Proc-Major Cardiology	10.07%	-2.54%	11.42%	8.59%	$2.95	9.23%
($23.16)	Proc-Minor	8.04%	3.27%	5.11%	8.54%	$4.06	12.69%
($34.49)	E&M - ER	7.78%	-6.99%	4.74%	-2.58%	($1.56)	-4.89%
($3.96)	Proc-Major Orthopaedic	7.52%	16.02%	-10.06%	4.34%	$1.22	3.81%
($3.22)	Proc-Major Other	6.00%	5.55%	7.16%	13.11%	$3.60	11.25%
($7.06)	Proc-Endocrinology	5.25%	-0.21%	8.42%	8.20%	$2.14	6.68%
$28.41	Lab	5.22%	-4.82%	9.03%	3.77%	$3.46	10.82%
($20.55)	E&M - Other	5.10%	-3.59%	7.42%	3.57%	$2.90	9.08%
($8.72)	Proc-Ambulatory	4.44%	1.47%	7.56%	9.14%	$2.58	8.08%
($14.50)	Proc-Oncology	3.54%	-2.96%	6.45%	3.30%	$1.51	4.72%
$7.55	Other Professional	1.57%	-3.00%	-1.07%	-4.03%	($5.02)	-15.72%
($4.29)	Proc-Eye	1.49%	-6.72%	9.50%	2.15%	$0.14	0.43%
($1.53)	DME	0.37%	11.94%	-29.18%	-20.72%	($9.89)	-30.94%
$0.00	Proc-Dialysis	0.01%	12.75%	28.92%	45.35%	$0.10	0.31%

- Year-over-year dis-savings in most categories and generally due to unit cost increases

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.

Professional Savings, 2021 to 2022 (1st Half CY)

	2021 to 2022		MD Above (Below) National CAGR				
Cumulative (Savings) Costs $M		% of US Spend	Util.	Unit Cost	Total	Run Rate (Savings) Cost, $M	% of Savings
$49.22	Part B Rx	18.62%	19.25%	-12.38%	4.49%	$13.74	48.54%
$6.53	E&M - Specialist	18.45%	11.16%	-9.87%	0.19%	$0.56	1.99%
$70.38	E&M - PCP	11.64%	9.24%	-1.63%	7.46%	$18.33	64.78%
$13.33	Lab	9.55%	-0.84%	-2.72%	-3.54%	($5.75)	-20.33%
$5.01	Imaging	6.57%	0.25%	-0.27%	-0.02%	($0.02)	-0.09%
($5.95)	DME	6.42%	-0.93%	2.02%	1.07%	$0.77	2.73%
$6.63	Other Professional	6.13%	44.72%	-27.26%	5.27%	$3.94	13.93%
($0.24)	Proc-Minor	5.82%	0.49%	-0.82%	-0.33%	($0.30)	-1.07%
($1.24)	ASC	4.38%	3.76%	-2.72%	0.94%	$0.80	2.83%
($4.29)	Proc-Ambulatory	2.99%	-0.04%	-1.54%	-1.58%	($0.66)	-2.34%
$1.44	Proc-Major Other	1.87%	-0.42%	-2.81%	-3.22%	($1.02)	-3.61%
$7.19	Proc-Major Cardiology	1.50%	1.01%	-4.29%	-3.33%	($1.18)	-4.17%
($1.90)	Proc-Eye	1.46%	-1.78%	1.41%	-0.39%	($0.08)	-0.28%
($1.72)	Proc-Major Orthopaedic	1.41%	1.58%	1.46%	3.06%	$0.58	2.03%
($2.51)	Proc-Endocrinology	1.30%	1.89%	0.27%	2.16%	$0.35	1.23%
$5.29	Proc-Oncology	1.27%	1.28%	0.96%	2.26%	$0.50	1.76%
$0.23	Proc-Dialysis	0.61%	4.34%	2.18%	6.62%	$0.68	2.39%

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.

- PCP Visits are the main driver of Professional dis-savings followed closely by Part B Rx
- Specialist visits are also substantially up relative to US offset by RVU mix reduction

Amounts may not add up due to rounding.

PCP Compound Growth Rates, Visits and Cost per Visits (1st Half CY)

2013 to 2019		6-Year Ave, MD Above (Below) Nat'l CAGR				
	% of US Spend	Utilization	Unit Cost	Total	Run Rate (Savings) Cost, $M	% of Savings
E&M – PCP	11.32%	-0.64%	1.08%	0.41%	$6.35	-31.13%

2019 to 2021		2-Year Ave, MD Above (Below) Nat'l CAGR				
	% of US Spend	Utilization	Unit Cost	Total	Run Rate (Savings) Cost, $M	% of Savings
E&M - PCP	11.72%	-3.44%	7.20%	3.38%	$23.41	-517.15%

2021 to 2022		1-Year Ave, MD Above (Below) Nat'l CAGR				
	% of US Spend	Utilization	Unit Cost	Total	Run Rate (Savings) Cost, $M	% of Savings
E&M - PCP	11.64%	9.24%	-1.63%	7.46%	$18.33	64.78%

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.

Amounts may not add up due to rounding.

- PCP Visit Utilization was decreasing prior to 2022, on average, relative to the US growth rate
- Alternatively, Unit Cost for PCP Visits was increasing prior to 2022 relative to the US growth rate mainly due to MDPCP.
- 2022 negative unit cost trend would be more negative if MDPCP were excluded. Resulting in an outcome more similar to specialty on prior slide
- Movement to and from telehealth is likely confounding recent trends.

Future Model Design Concepts

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DISCLAIMER

THE CONCEPTS REFLECTED IN TODAY'S MATERIALS ARE FOR DISCUSSION PURPOSES. THEY ARE TO IDENTIFY AND DISCUSS DIFFERENT OPTIONS AMONG WORK GROUP MEMBERS. MHA'S GOVERNANCE COUNCIL HAS NOT REVIEWED THESE CONCEPTS OR **OTHERWISE TAKEN ANY FINAL POSITION ON POLICY DETAILS**.

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ADD-ON BENEFITS FOR MEDICARE FFS BENEFICIARIES

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Use of additional savings

How is savings defined?

- Previous recommendation to retain 50% of benchmark for population health
- Retain any savings above annual target

How do we address savings fluctuations?

- Allow 1-2 years to capitalize?

Potential Payment mechanisms

Option	Pros	Cons
1. The Centers for Medicare and Medicaid Services (CMS) to directly pay providers who furnish the benefits	• Less administrative burden on State, hospitals and providers	• CMMI may be unlikely to approve given administrative burden
2. Medicare refunds savings to the state to establish a state-wide funding pool	• Similar funding mechanism as regional partnership grants	• Need administrator to pass payments to providers • Need to determine how payments are allocated
3. Provide pass through funding through the Medicare Performance Adjustment Reconciliation (MPA-RC) component	• Already used for Episodes of Quality Improvement Program	• Same as above
4. Allow hospitals to raise prices to reduce the savings closer to the intended target	• GBR provides mechanism	• Impact of price variation on consumers • Need to establish different rate thresholds

STANDARDIZING CONSUMER COST SHARING

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Hospital Field considerations

Does the proposal apply to Medicare only, or all-payer?

- Commission should perform a cost analysis of two recommended options
- Who will pay the remaining balance to hospitals?

Is the priority only to stabilize price sharing?

- If so, consumers avoid individual price variation, resulting in aggregate payment limit, but may still face higher premiums
- If not, how do we limit impact on consumers? MIA could explore placing limits on deductibles, maximum out of pocket costs, actuarial values, and cost sharing
- Would the expected difference be offset against Maryland's savings performance?

How to pay for fixed costs?

- Does the periodic interim payment (PIP) proposal fix the cost share and determine a fixed monthly payment that is settled compared to actual experience at the end of a defined period?
- Is CMS likely to approve this payment mechanism?

GBR 2.0

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Components of the GBR 2.0

Discussion Topic	Proposed Ideas / Questions from TCOC WG	MHA Position
1. Determining Excluded Services	Exclude services from GBR because: *1) they are entirely outside the control of the hospital* *2) They are performed only by certain hospitals within the state.* Examples: Burns & Transplants	MHA agrees with the HSCRC that certain services and costs should be excluded. In addition to burns and transplants, the HSCRC should consider trauma and oncology-related services.
2. Attribution of Beneficiaries	Proposed Options: *a) County / Region* *b) Attributing rural areas to the nearest hospital.* *c) Based on the zip codes that comprise a certain amount of the hospital's volume.* *d) Service areas defined by the hospital in a proposal to HSCRC*	MHA agrees with HSCRC's approach to applying a geographic attribution for GBR 2.0. However, because GBR 2.0 is voluntary, MHA strongly encourages HSCRC to allow hospitals and their care partners flexibility to define their own attributed populations.

Components of the GBR 2.0 (cont.)

Discussion Topic	Proposed Ideas / Questions from TCOC WG	MHA Position
3. Setting the GBR 2.0	HSCRC questions for work group members: • *Which baseline should be used to set the GBR 2.0?* • *What adjustments should be made for risk / service mix within the attributed population?*	MHA suggests that HSCRC evaluate using a multi-year average from 2018-2022. Post-pandemic years should be normalized. Options could include: *a. Replace 2020 with multi-year average* *b. Normalize using risk-adjusted scores*
4. Quality Programs	QBR / MHAC / Readmission would apply to the hospital GBR. Additionally, the GBR 2.0 would have its own quality adjustment: *a) Population Health linked to SIHIS* *b) Network Adequacy for a certain level of service provided per beneficiary*	MHA also suggests including value-based components centered around preventative care and targeted interventions. *Examples: Annual wellness visits, A1C screenings, immunizations, pre-natal screening, etc.* A health equity component should also be considered.

Other Thoughts / Considerations

- Medicare vs All-Payer
- GBR 2.0 vs existing programs
  - How do we differentiate GBR 2.0 from the existing CRP tracks and the MPA if Medicare Only?
- Generating savings in GBR 2.0
  - Will the savings target be a rate of change or an absolute value?

Next Steps

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TCOC Workgroup & Next Steps

The TCOC Workgroup will focus on two topics:

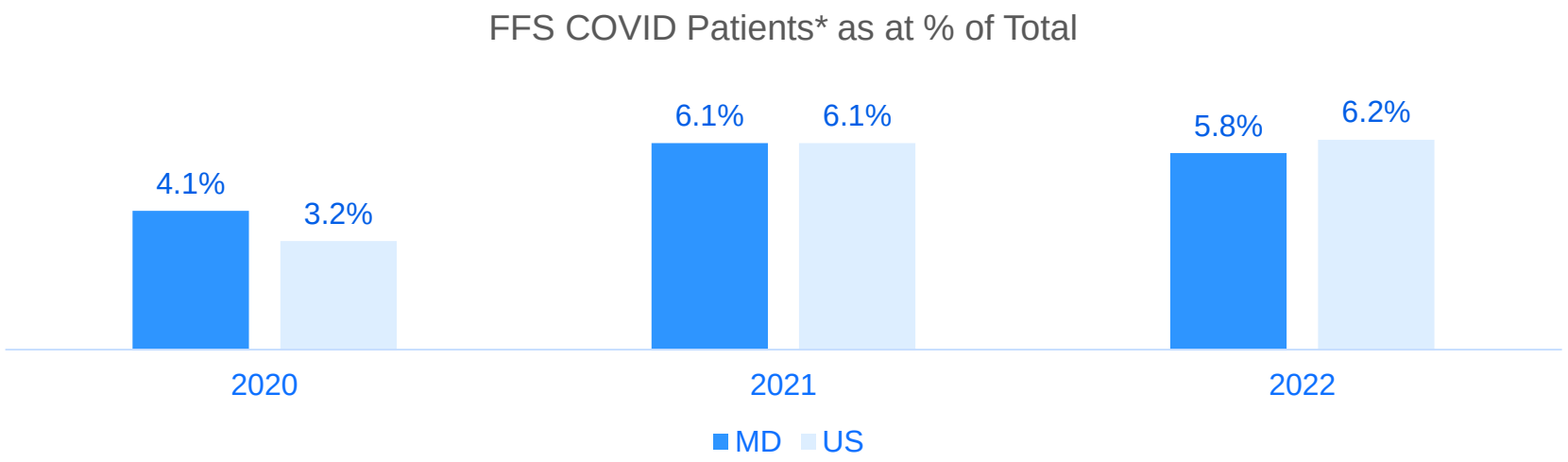
1. A concept for a GBR 2.0 aligned with suggestion by Meritus.
2. Cost sharing in the future of the Model

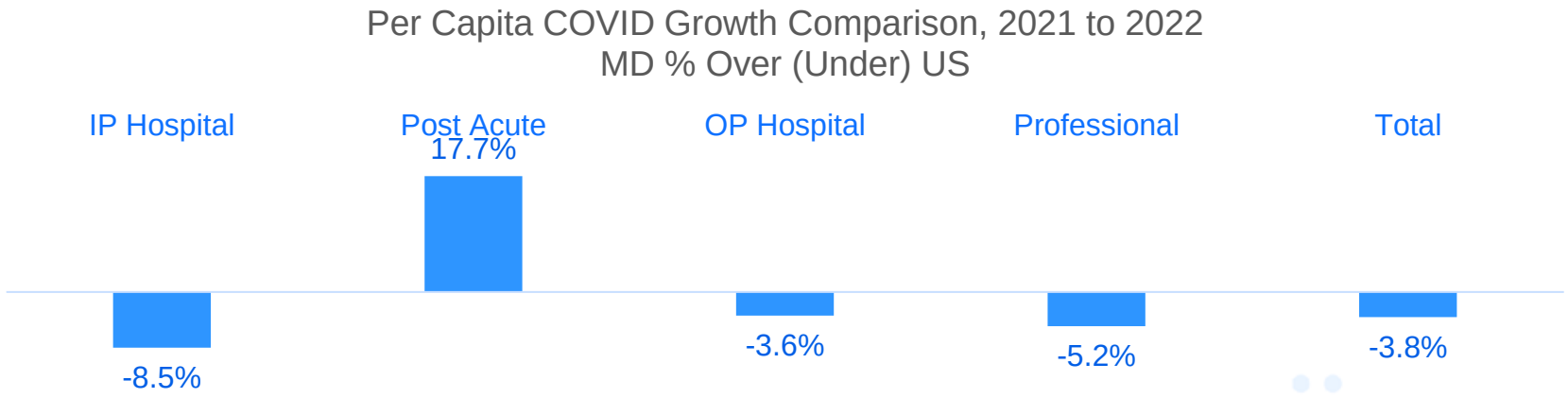
We plan on five monthly meetings before finalizing our staff report to the Secretary's Vision Group.

1. October – Socialize design questions & Solicit suggestions from the industry
2. **November – Discuss stakeholder suggestions**
3. December – Discuss stakeholder questions and conceptualize a straw man example
4. January – Discuss stakeholder questions
5. February – Staff circulates draft recommendation & Solicit stakeholder comments
6. March – Summarize and discuss stakeholder comments

Appendix

2022 COVID-19 Medicare Spending

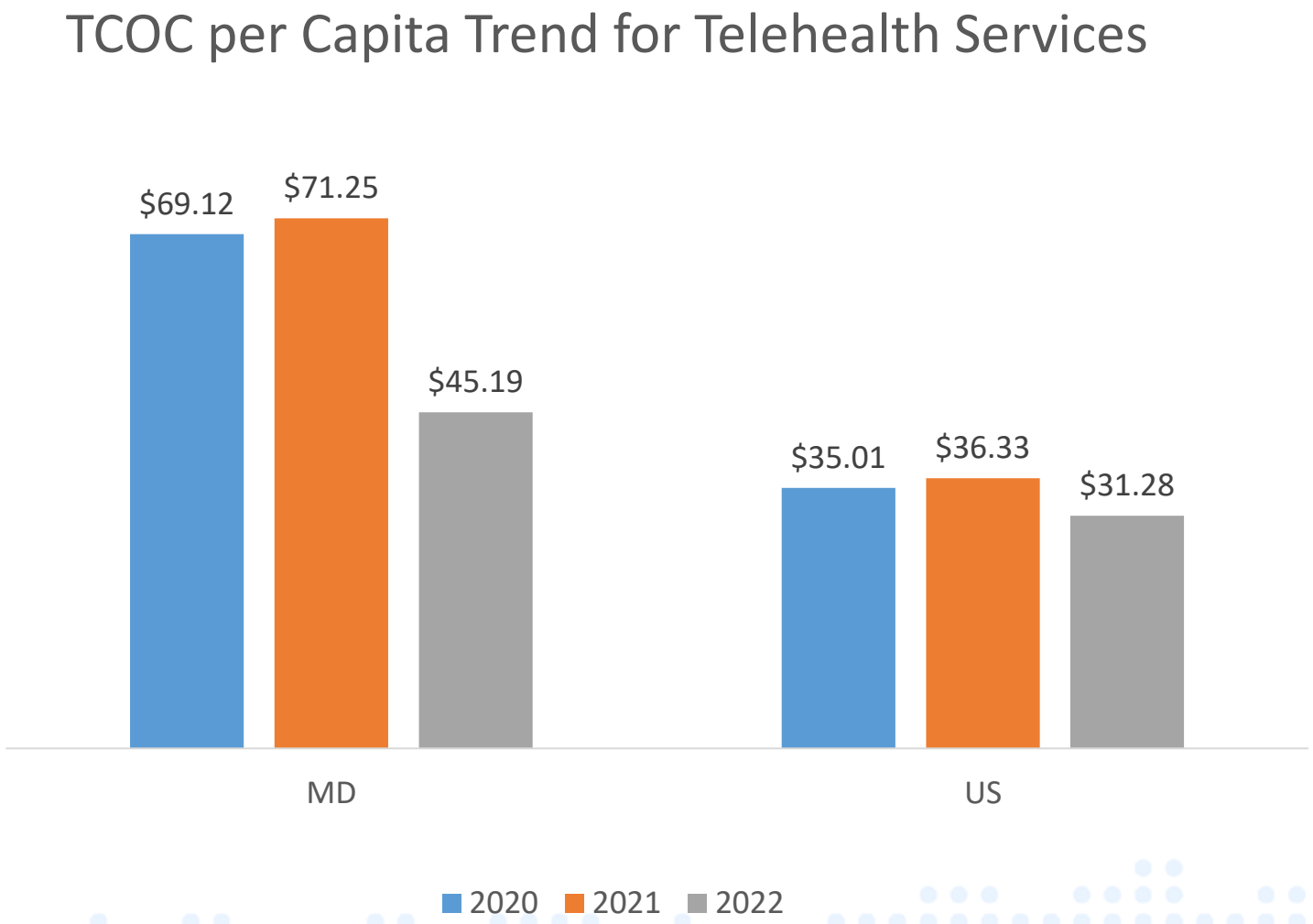




- In 2022H1, 5.8% of MD TCOC per Capita was from Claims with Covid-19 diagnosis (0.4% below US).
- 2022 Post Acute Covid-19 Excess Cost is driven by large savings in previous years

* Includes all patients with a confirmed COVID Dx for IP and Post Acute and all Patients with a confirmed COVID Dx or COVID Exposure for OP and Professional. COVID exposure only accounts for about 12% of 2020 spending and 7% of 2021 COVID spending.

2021 Telehealth Trend, MD vs US



- MD ranked 7th in Telehealth Cost per Capita for 2022H1 vs 5th in 2021H1
- Telehealth was 0.7% of MD TCOC per Capita in 2021, 0.6% nationally

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