



maryland
health services
cost review commission

Total Cost of Care Workgroup

June 2023

Agenda

1. Medicare Performance Adjustment Update
2. Drivers of Medicare Savings
3. Drivers of CTI Performance

Administrative Update

- The MPA was submitted to CMS and will be effectuated on July 1st.
 - This adjustment will be in effect for July – January.
 - A new adjustment will be distributed, which includes midyear adjustments to some programs and the expiration of the savings component.
- An updated (and final) version of the MPA adjustment was distributed with these meeting materials.
 - In this version applies the quality adjustment to the CTI adjustment.
 - The impact of this is extremely small.

Drivers of Maryland FFS Medicare Savings

CY 2021 to CY 2022 and Recap of Savings Since 2013

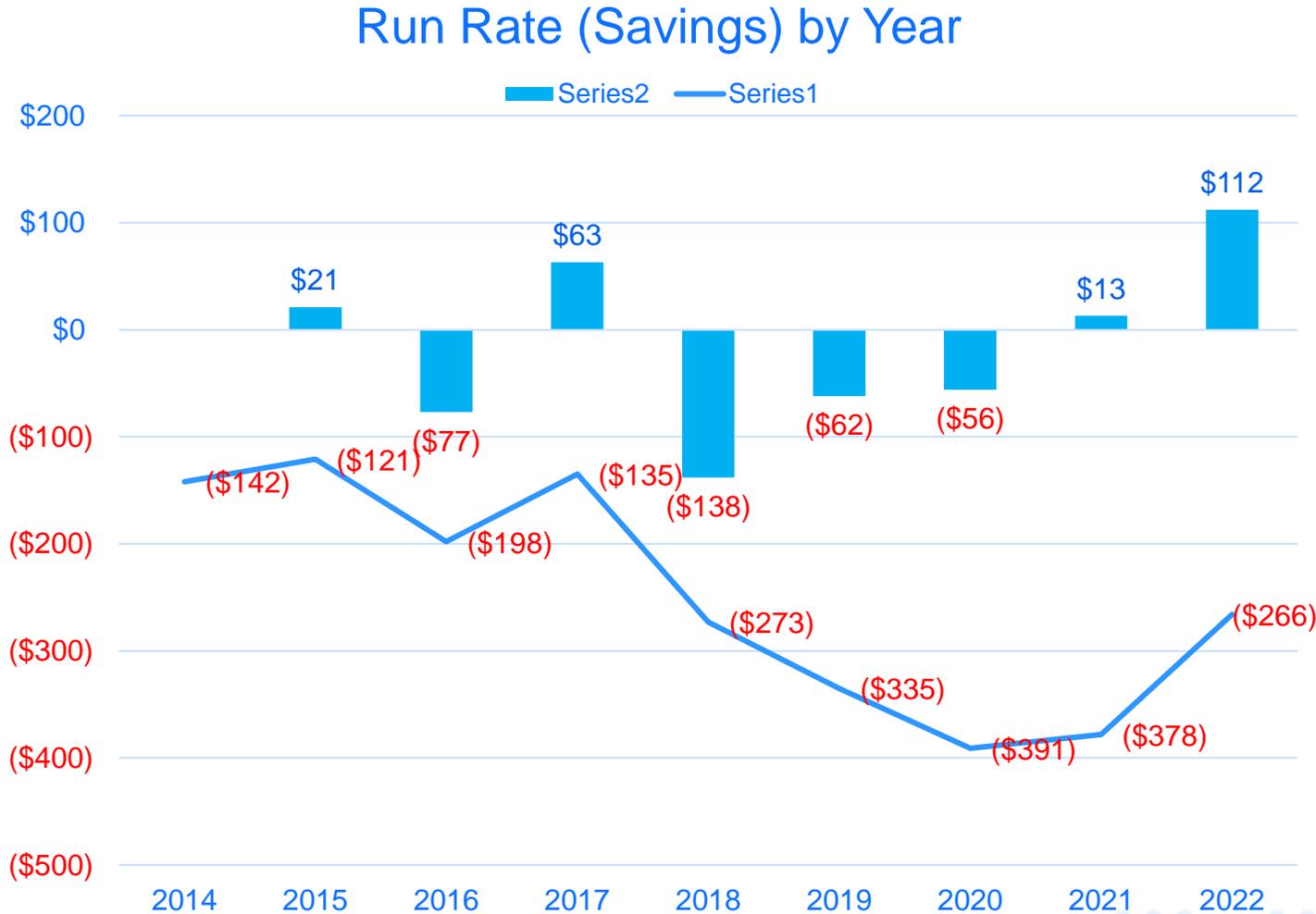
Presentation Context

- Presentation attached is a brief overview of changes in Maryland Medicare Total Cost of Care in 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
 - US Inpatient Hospital and SNF claims' cost has been historically low in 2022 and well under any forecasts (e.g. OACT)
 - Non-Claims-Based Payments (NCBP) from various CMMI AAPM programs (i.e. Shared Savings, Population-Based Payments, etc...) and the extent they are allowed to be counted in TCOC calculations continues to grow every year. HSCRC Staff has continued to advocate for full inclusion of all Non-Claims-Based Payments with CMMI for FFS beneficiaries

Background

- Analysis reflects through 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 \$266 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
 - Non Claims-Based payment (NCBP) program additions not counted in previous years added approximately \$51M in Savings Run-Rate
- 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
- \$51 M in Non-claims-based payments were scored for the first time in 2022, without this addition savings erosion would have been \$163 M
- MD has come close to our 2022 Savings Run-Rate Target of \$267M
- YOY guard-rail TCOC per Capita growth rate in MD failed to be below the US growth rate for two straight years
- This slide is based on CMMI national reporting and will not tie to other slides in this presentation.

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

	2013 to 2019, Average		2019 to 2021, Average		2021 to 2022		2013 to 2022
	Average Run Rate (Savings) Cost \$ M	% of Savings	Average Run Rate (Savings) Cost \$ M	% of Savings	Average Run Rate (Savings) Cost \$ M	% of Savings	
Inpatient Hospital	(\$37)	59%	\$80	284%	\$185	127%	\$126
SNF	(\$6)	9%	(\$4)	-16%	\$10	7%	(\$34)
Home Health	\$8	-12%	(\$1)	-2%	\$2	2%	\$47
Hospice	\$3	-5%	(\$11)	-37%	(\$12)	-8%	(\$13)
Total Part A	(\$31)	51%	\$65	228%	\$185	127%	\$126
Outpatient Hospital	(\$59)	95%	(\$115)	-405%	(\$35)	-24%	(\$617)
ESRD	(\$2)	4%	\$8	27%	\$5	4%	\$7
Outpatient Other	(\$4)	6%	(\$5)	-17%	\$6	4%	(\$26)
Clinic	(\$0)	0%	(\$1)	-2%	(\$2)	-1%	(\$3)
Professional Claims	\$34	-55%	\$76	269%	(\$14)	-9%	\$343
Total Part B	(\$31)	49%	(\$36)	-128%	(\$39)	-27%	(\$295)
Total	(\$62)		\$28		\$146		(\$170)

- Inpatient Hospital Claims are driving 97% of Total Excess Cost in 2022
- Outpatient Hospital Savings are less in 2022 vs 2021 than in previous years
- MDPCP, PCF & CPC+ payments are included in Professional Claims; Other AAPM Payments totaling ~ \$95M are excluded (e.g. MSSP, NGACO, AIPBP, etc...)

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

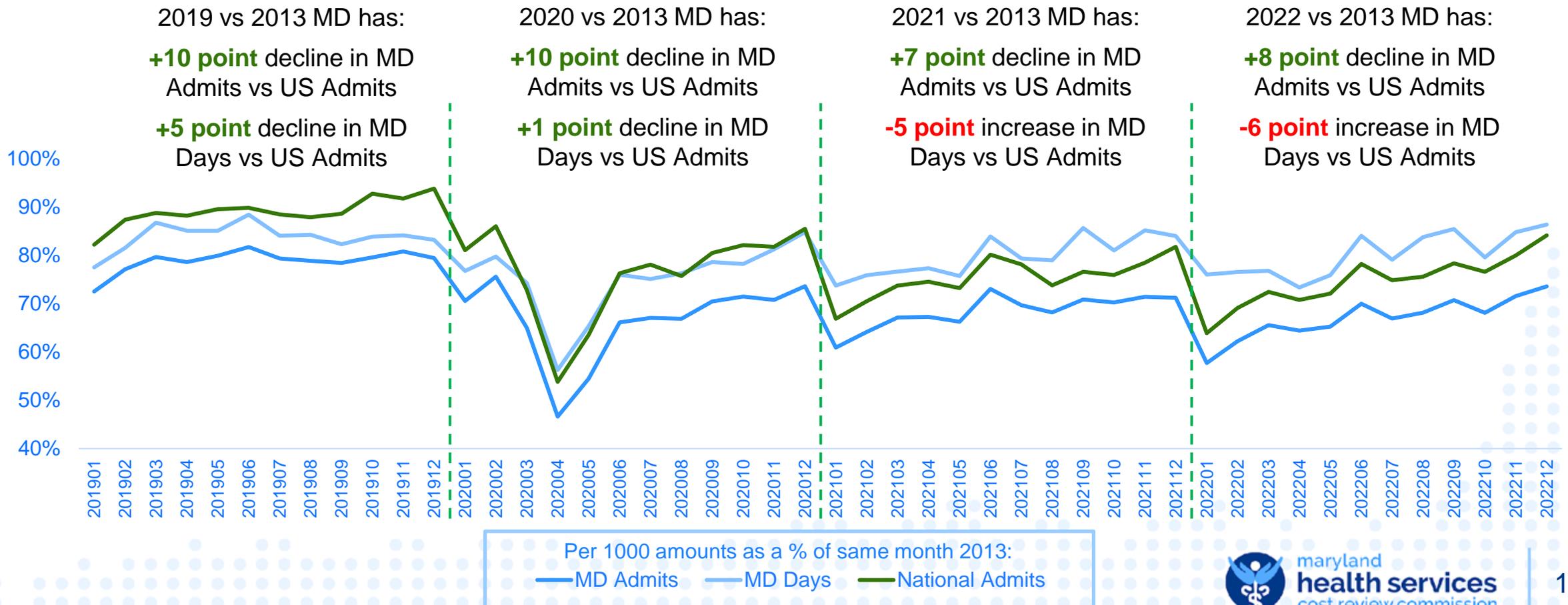
	2013 to 2019		2019 to 2021		2021 to 2022	
	Avg Run Rate (Savings) Cost \$ M	Avg Growth Rate, MD vs US	Avg Run Rate (Savings) Cost \$ M	Avg Growth Rate, MD vs US	Avg Run Rate (Savings) Cost \$ M	Avg Growth Rate, MD vs US
Admits per K	(\$66)	-2.0%	\$39	1.1%	(\$28)	-0.7%
Avg Case Mix Index	\$44	0.2%	\$7	0.1%	\$87	0.5%
Cost per Day	(\$26)	-0.7%	\$19	0.5%	\$102	2.6%
ALOS (CMI Adj)	\$11	1.6%	\$5	0.2%	\$21	2.4%
Mix Impact	\$1		\$8		\$1	
Total Inpatient	(\$37)		\$79		\$183	

- Cost per Day is driving dis-savings since 2019
- Admits per K reductions have driven savings during the first 6 years but have since been increasing or flat relative to US
- 2022 Case-Mix Index as a measure of acuity of cases is the secondary driver of Dissavings as MD Admits per K fall relative to US (calculation assumes case mix is 100% associated with ALOS)

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.

MD and National IP Trends as a % of 2013 Values

- IP admissions have dropped significantly during the pandemic and so far have not rebounded. Maryland was able to maintain most of its admissions advantage, but in terms of days per 1000, Maryland now has a deficit.
- Apparent rebound in latter half of 2022 is due to lower utilization in the 2nd half of 2013 (denominator) rather than any recovery in 2022 values (prior years show similar pattern).



OP Savings, 2021 to 2022 (CY)

Cumulative (Savings) Costs \$M	2021 to 2022		MD Above (Below) National CAGR			Run Rate (Savings) Cost, \$M % of Savings	
		% of US Spend	Utilization	Unit Cost	Total		
(\$281.65)	Part B Rx	24.16%	-1.16%	-5.94%	-7.03%	(\$8.94)	25.50%
(\$41.19)	Imaging	11.37%	-3.79%	6.44%	2.40%	\$1.48	-4.23%
(\$7.58)	Proc-Major Cardiology	9.54%	-1.81%	9.94%	7.95%	\$2.06	-5.89%
(\$44.59)	Proc-Minor	7.85%	-2.69%	8.12%	5.22%	\$1.89	-5.39%
(\$79.88)	E&M - ER	7.73%	-5.64%	2.59%	-3.20%	(\$1.48)	4.21%
(\$12.04)	Proc-Major Orthopaedic	7.26%	4.58%	-4.13%	0.26%	\$0.06	-0.16%
(\$0.20)	Proc-Major Other	5.74%	-0.79%	7.38%	6.53%	\$1.40	-4.00%
(\$48.70)	E&M - Other	5.10%	-4.08%	5.88%	1.57%	\$0.97	-2.77%
(\$12.56)	Proc-Endocrinology	5.00%	0.08%	5.01%	5.10%	\$1.01	-2.87%
\$52.44	Lab	4.93%	-4.90%	5.17%	0.02%	\$0.01	-0.04%
(\$12.17)	Proc-Ambulatory	4.19%	1.96%	6.17%	8.25%	\$1.75	-5.00%
(\$30.45)	Proc-Oncology	3.43%	-11.83%	12.43%	-0.88%	(\$0.30)	0.87%
(\$68.39)	Other Professional	1.91%	-5.68%	-20.71%	-25.21%	(\$29.53)	84.22%
(\$8.41)	Proc-Eye	1.41%	-16.50%	14.11%	-4.71%	(\$0.23)	0.65%
(\$21.69)	DME	0.38%	10.90%	-23.05%	-14.66%	(\$5.31)	15.14%
\$0.25	Proc-Dialysis	0.01%	18.35%	26.39%	49.59%	\$0.08	-0.24%

- Part B Rx Savings has historically been partially offset by Dissavings in Professional Claims but 2022 Savings hit the bottom line
- Other Professional results reflect very small \$ in that bucket in the US
- Dissavings service categories are generally due to Unit Cost increases in MD vs US

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 (CY)

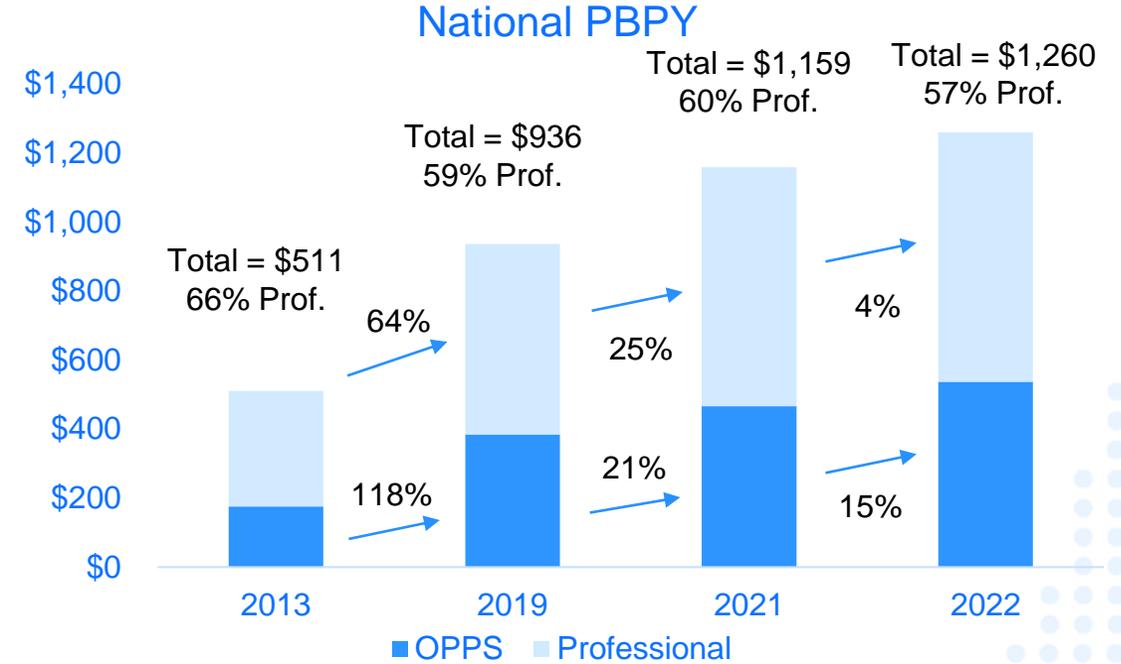
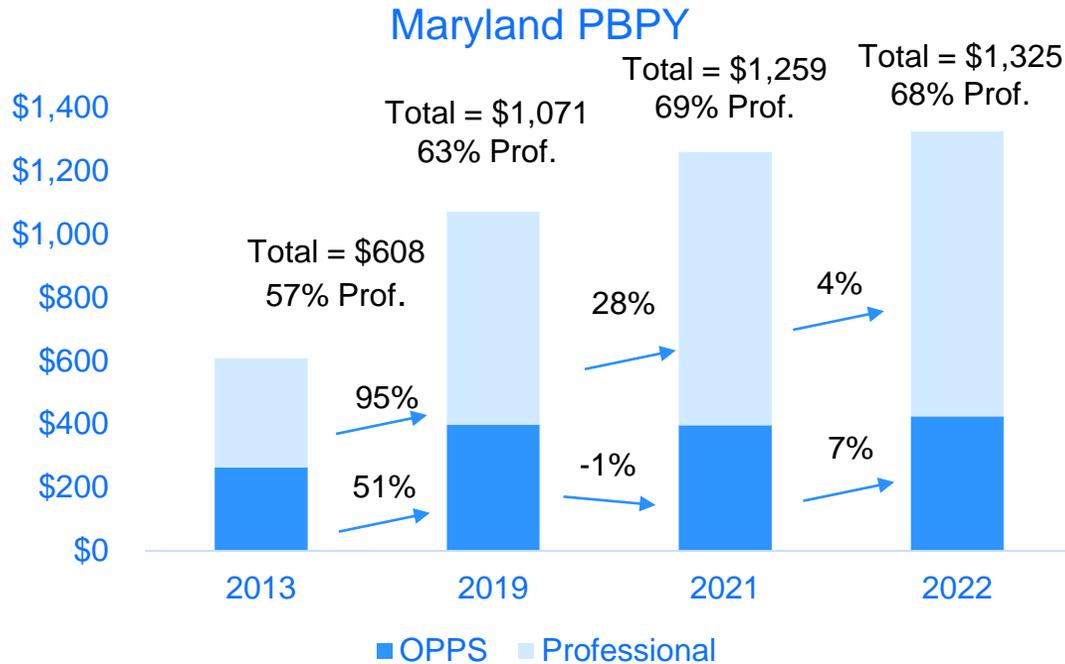
Cumulative (Savings) Costs \$M	2021 to 2022		MD Above (Below) National CAGR			Run Rate (Savings) Cost, \$M % of Savings	
		% of US Spend	Utilization	Unit Cost	Total		
\$16.05	E&M - Specialist	18.71%	11.32%	-10.60%	-0.48%	(\$3.15)	-1279.07%
\$116.26	Part B Rx	18.70%	6.35%	-5.99%	-0.02%	(\$0.13)	-53.80%
\$163.35	E&M - PCP	11.73%	9.39%	-3.28%	5.80%	\$29.54	11984.31%
\$15.80	Lab	9.12%	-1.08%	-4.26%	-5.29%	(\$17.70)	-7181.00%
\$31.81	Other Professional	6.84%	39.84%	-22.02%	9.05%	\$16.01	6495.84%
\$15.00	Imaging	6.53%	0.17%	-0.01%	0.15%	\$0.43	174.81%
(\$5.59)	DME	6.49%	-0.16%	0.09%	-0.07%	(\$0.12)	-46.77%
(\$1.87)	Proc-Minor	5.76%	-0.87%	-0.30%	-1.16%	(\$2.24)	-908.33%
(\$4.92)	ASC	4.18%	3.15%	-3.80%	-0.77%	(\$1.31)	-531.42%
(\$11.17)	Proc-Ambulatory	2.95%	-0.94%	-0.48%	-1.41%	(\$1.22)	-494.91%
\$0.64	Proc-Major Other	1.80%	-1.94%	-2.38%	-4.28%	(\$2.79)	-1130.23%
(\$3.22)	Proc-Eye	1.41%	-1.75%	0.88%	-0.89%	(\$0.36)	-147.30%
\$12.23	Proc-Major Cardiology	1.40%	0.89%	-2.95%	-2.09%	(\$1.46)	-590.49%
(\$2.80)	Proc-Major Orthopaedic	1.35%	-1.27%	-0.09%	-1.36%	(\$0.53)	-213.33%
(\$4.26)	Proc-Endocrinology	1.26%	0.99%	-0.14%	0.85%	\$0.28	115.20%
\$11.14	Proc-Oncology	1.19%	-0.32%	2.06%	1.74%	\$0.77	312.14%
\$1.93	Proc-Dialysis	0.58%	3.05%	1.32%	4.42%	\$0.93	375.36%

- PCP Visit Costs are the main driver of Professional Dissavings (includes MDPCP Program expenditures and their US equivalents)
- Specialist visits also substantially up relative to US offset by RVU mix reduction
- Considerable Savings in 2022 Lab Costs

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.

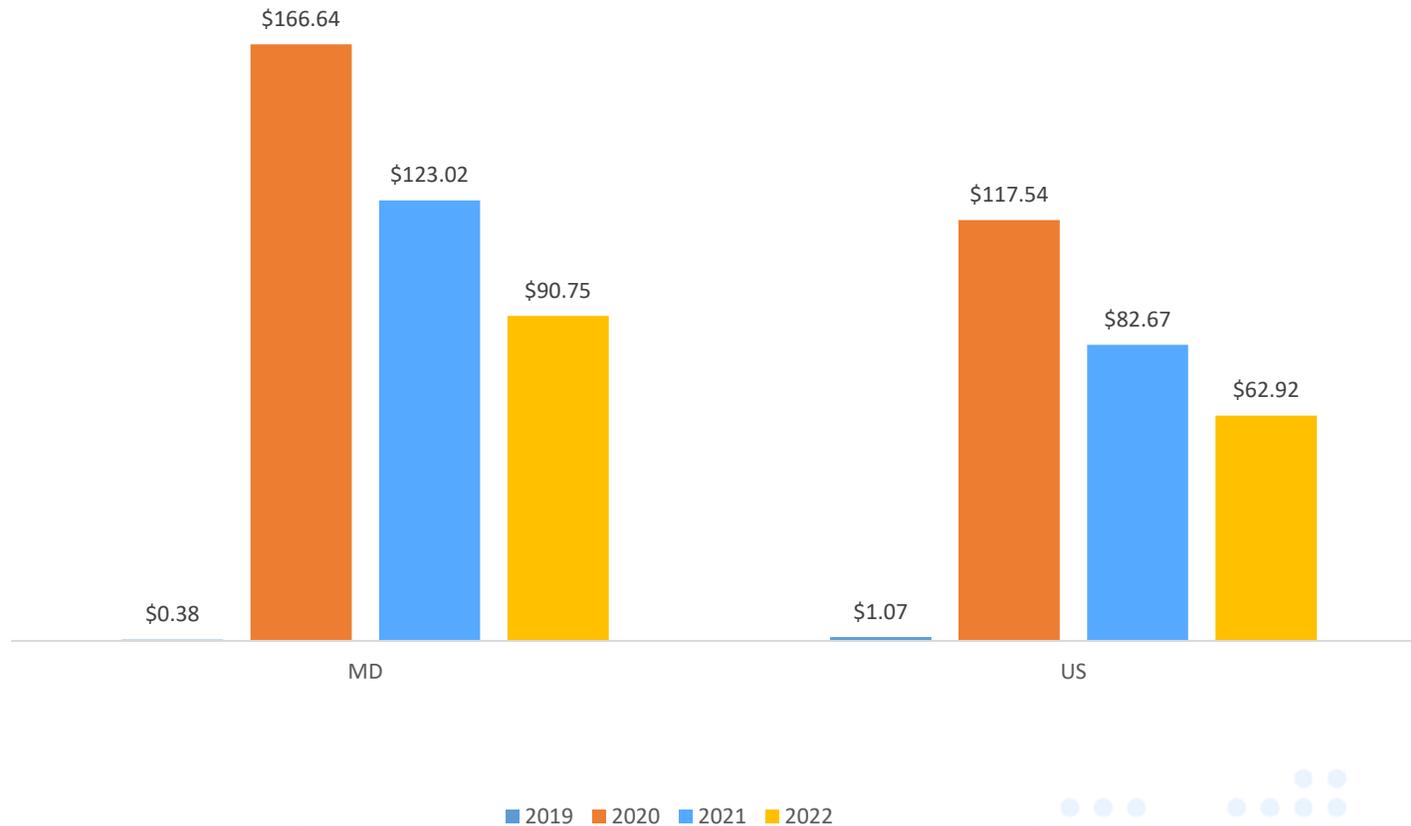
Mix of Part B Drug Spending

- ▶ 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%.
- ▶ 2021 continued the pattern, as MD went to 69% professional while national remained essentially flat.
- ▶ In 2022, MD dropped slightly to 68% while the Nation fell to 57% further widening the gap



2021 Telehealth Trend, MD vs US

TCOC per Capita Trend for Telehealth Services



- MD has consistently been around the 90th percentile of Telehealth Costs per Capita since Covid-19 behind states such as MA, NY, CA, CT & DC
- Telehealth was 5.7% of MD Professional E&M per Capita in 2022, 5.3% nationally

2022 Non-Claims Based Payments, except MDPCP, in \$M

Program	MD	Nation
Medicare Shared Savings Program (ACOs)	\$16.8	\$1,942.8
Oncology Care Model		159.0
Next Generation ACO model	0.0	262.6
Vermont Model	0.0	249.8
Direct Contracting	0.0	40.1
Comprehensive Joint Replacement		74.4
Comprehensive ESRD		136.4
Cardiovascular Risk Reduction Model		0.1
BPCI-A		77.6
ESRD Treatment Choices		0.1
Kidney Care Choices		46.6
Reach ACO Model	0.1	697.0
Total	\$17.0	\$3,686.6
% Trend Impact on 2013	0.2%	1.3%

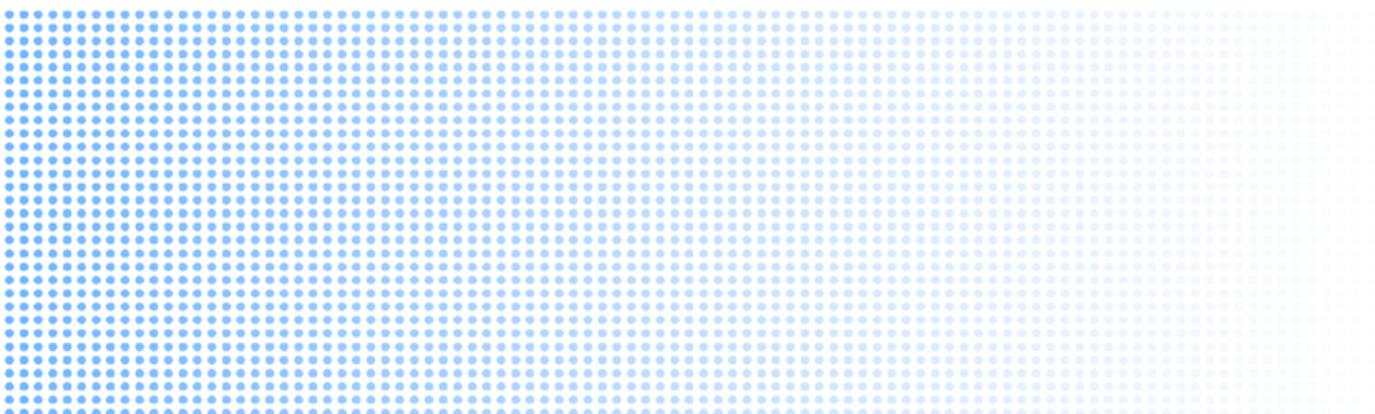
- Excludes MDPCP and equivalent national programs, amounts are still being finalized with CMMI.
- Currently 0.9% additional national trend which correlates to \$95 M in extra savings in MD
- For some programs there is an offset to these amounts in lower claims payments
- MSSP was credited in 2021, all other amounts will be credit for the first time this year, although they generally existed prior to CY2022.

High Level Summary of Savings Impact

- ▶ Since 2013 Maryland has generated approximately \$266 M of Savings compared to the national run rate. While there are varying ways to calculate and allocate Savings, Savings can generally be attributed to the following(\$ in M, savings are positive values):

IP: Reduced IP admits offset by higher acuity and LOS	(\$126)
OP Hospital (excl. ED & Part B Rx): Reductions in imaging, minor procedures, hospital clinics	\$256
PAC: Skilled Nursing, Home Health & Hospice	\$0
ED: Reduction in ED per Visit Costs	\$80
Part B Drugs: Shift to lower cost, office POS	\$165
Other Part B: Clinics, FQHCs, Dialysis Centers, etc...	\$22
MDPCP, CPC+, PCF Fees (net of lower claims based reimbursement)*	(\$141)
Other Professional: Some additional Primary Care plus Specialists and other professional categories	(\$86)
Other AAPM Dollars: MSSP, NGACO, OCM, CJR, CEC, Direct Contracting, VTACO, etc...	\$95
Net Savings	\$266

Reflects only MDPCP fees, other analysis shows that MDPCP has contributed to cost reductions in other areas. According to HSCRC analysis net impact of the program was a net cost \$84 mil.



CTI Analysis

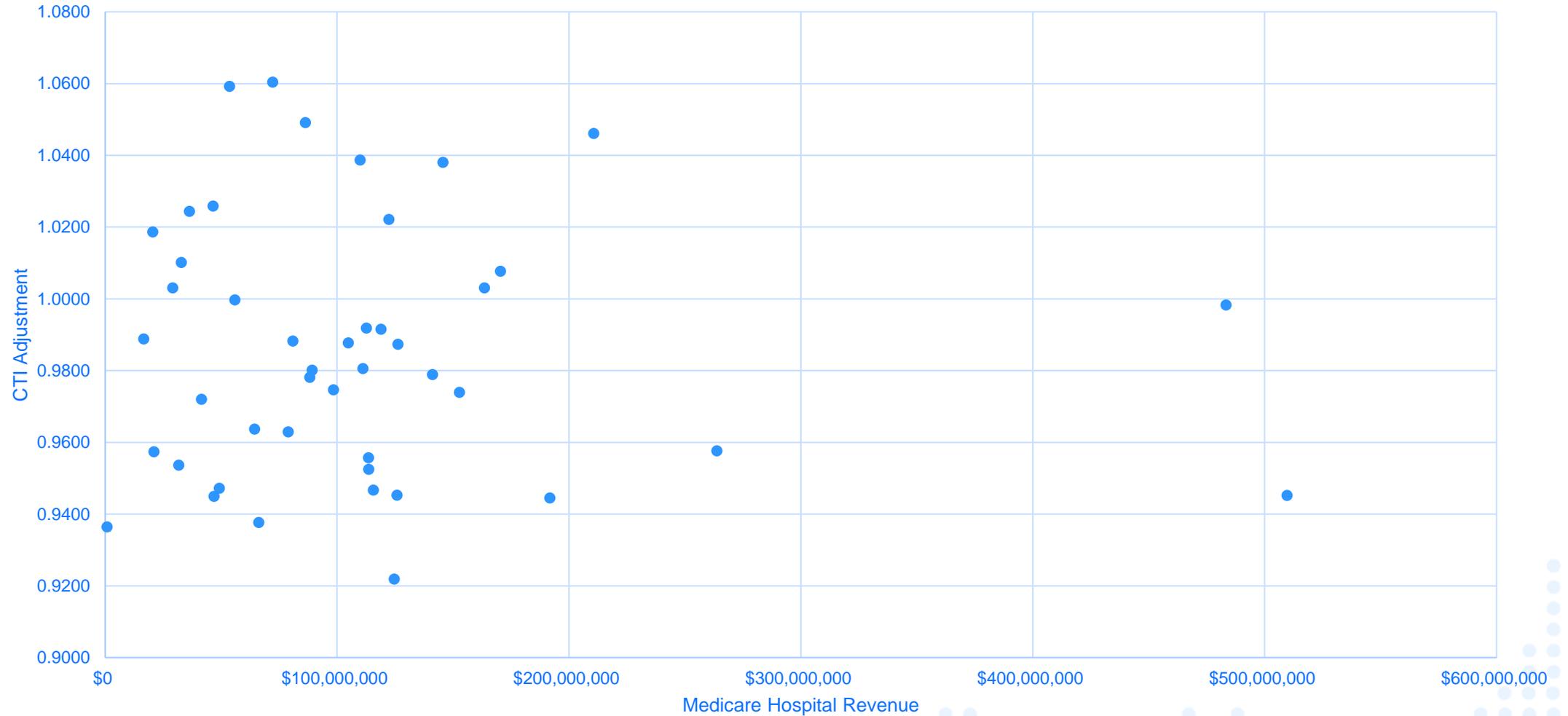
CTI Analysis

- Stakeholders asked staff to examine the CTI results and identify what was driving success in CTIs.
 - Size of the Hospital
 - Section of the Baseline Year
 - Specific CTI Criteria
- Overall, success in the CTI does not appear to be driven by the CTI definitions.
 - Some hospitals succeeded and other failed using very similar CTI definitions.
 - Success in the CTI is driven by operational not definitional factors.
 - The HSCRC is committed to developing a learning system so that hospitals can learn from one another's successes.
- However, there are some lessons learned...
 - Participation in primary care CTIs is important because it has leverage over more TCOC than hospital-based CTI.
 - Simpler definitions are better.
 - Hospitals that focused on high-utilizers at the hospital or chronic condition management were more likely to be successful.

Overview of CTI Results

Thematic Area	Number of CTI	Number Exceeding Target Price	Percent Exceeding Target Price	Number Exceeding MSR	Percent Exceeding MSR	Average Savings
Care Transitions	55	36	65%	28	51%	1.6%
Palliative Care	5	3	60%	3	60%	2.9%
Primary Care	23	14	61%	11	48%	2.2%
Geographic	10	5	50%	5	50%	3.2%
ED	14	8	57%	7	50%	1.0%
Total	107	66	62%	54	50%	1.9%

CTI reward / penalty vs size of hospital



Selection of Baseline Period

- The selection of the CTI baseline was not correlated with savings.
- All primary care CTI share the same baseline (2019) and therefore differences in primary care performance cannot be explained by the baseline.

Baseline	Number of CTI	CTI with Savings	Win Rate	Savings as a Percent of Target Price	Percent of MPA Revenue
July 2016 - June 2017	25	15	60%	7.5%	1.0%
July 2017 - June 2018	13	9	69%	7.3%	0.7%
July 2018 - June 2019	20	12	60%	7.1%	1.2%

Precision does not equal success

- The CTI allow hospitals to target their populations very precisely.
 - Each criteria restricts the CTI more narrowly. For example, hospital discharges with 1+ chronic conditions & 2 or more prior hospitalizations.
 - This is an 'intent to treat' estimate of the impact that a clinical intervention has on TCOC.
- More precision did not lead to a higher win rate. But the magnitude of savings decreased.
 - More criteria means fewer episodes, not a higher probably of success.
 - Hospitals did simple things well were most successful.

Number of Criteria	Number of CTI	Number with Savings	Winning Percentage	Savings as a Percent of MPA Dollars
0	2	1	50%	1.46%
1	26	11	42%	1.27%
2	15	9	60%	1.10%
3	9	5	56%	0.43%
4	5	4	80%	0.16%
5	1	0	0%	0.08%

Some criteria were associated with more success

- Hospitals that used geographic, chronic conditions, or prior utilization criteria were more successful.
- The role of geography is interesting. We are not sure what clinical processes are driving this result.
- Hospitals focusing on which DRGs patients had or discharge setting were less successful.

Criteria	Number of CTI	Number with Criteria	Number with Savings	Ratio
Geographic Service Area	58	19	15	79%
Diagnosis Codes	58	19	11	58%
# Chronic Conditions	58	31	21	68%
Prior Hosp or ED Use / Look Back	58	25	18	72%
Look Forward	58	14	8	57%

What types of CTI are Working?

- CTIs targeting heart failure, COPD, diabetes, and cancers were more successful than average.
- We are not sure what is driving those clinically, but suspect that for cancer and heart failure specifically, medication management is likely a key driver.

Chronic Conditions	Number of CTI	Number with Savings	Ratio
Heart Failure	22	16	73%
Chronic Obstructive Pulmonary Disease	24	17	71%
Diabetes	20	13	65%
Cancer	11	9	82%

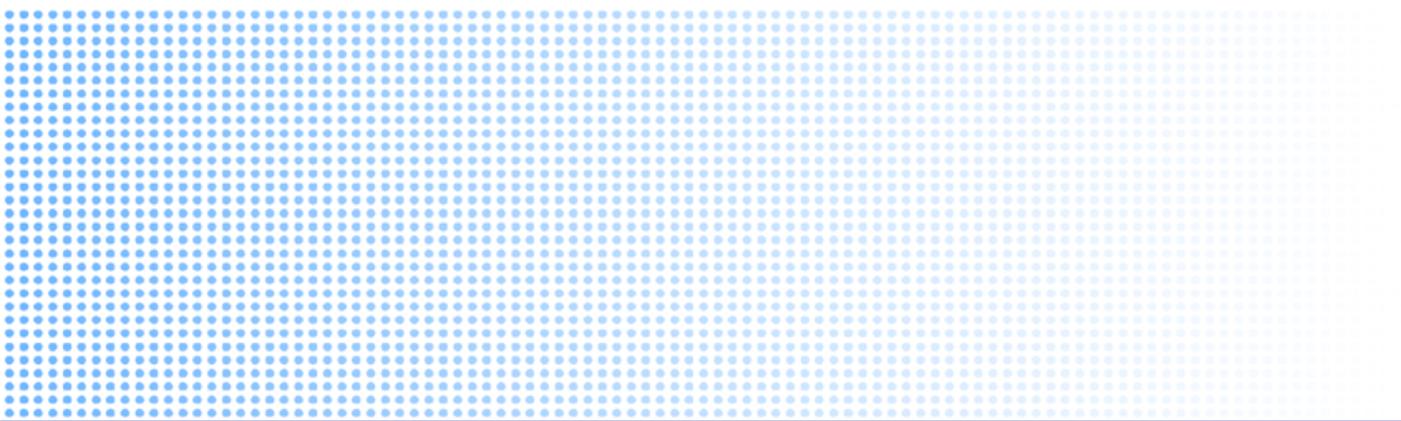
No Clear Pattern in Primary Care CTI

- Most hospitals chose primary care CTI that were based on their MDPCP populations, with no restrictions.
- Some hospitals chose to limit their MDPCP populations to those living in certain areas.
- These hospitals were more successful, although we are not sure what is driving that difference.

Baseline	Number of CTI	CTI with Savings	Win Rate	Savings	Percent of Revenue
All CTI	19	10	53%	6.7%	4.2%
CTI with Geographic Restriction	5	4	80%	9%	6%
CTI with Geographic & Chronic Conditions	4	3	75%	9%	5%

What's next?

- We will continue analyzing the CTI to try and identify what is driving success.
 - Most of the drivers of success are likely to be operational drivers, that we cannot identify through claims analysis.
 - We plan to work with CRISP and MHA to try and create some lessons learned that could be exported to other hospitals.
 - We will continue to analyze the CTI definitions, including NPI composition, and report out to the CT Steering Committee.
- Next Steps...
 - We are planning a report to the Commission on the CTI policy in September or early fall. This will include some suggestions on refining the CTI policy.
 - CTI Year 2 ends on July 1. We will report out on the savings the from the CTI program in the TCOC workgroup this time next year.
 - CTI Year 3 submissions are due this Friday!



Next TCOC Workgroups

Upcoming TCOC Agenda

- We are cancelling the July and August TCOC Meetings.
- We will reconvene in September to discuss the MPA policy for CY 24.
- Have a good summer!