maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

May 2023

Agenda

1. Progression Plan Update
2. Care Transformation Initiative Update
3. Population Health Analytics Tool
4. Benchmarking

Progression Plan

Progression Plan Comments

- Staff received three comments on the progression plan from the Maryland Hospital Association, the Johns Hopkins Health System, and CareFirst.
- Staff have updated our component of the Progression Plan. Our will be integrated with other workgroups and presented to the Commission.
  - The timing of that process is uncertain.
  - We will update this workgroup on the process for the joint progression plan shortly.

Comments on GBR 2.0

- Both the MHA and JHHS were supportive of the GBR 2.0 concept.
  - MHA supports voluntary hospital and care partner risk-sharing arrangements. As mentioned by staff, the GBR 2.0 model in its current form is best suited for rural hospital participation. GBR 2.0 would likely need refinement before applying to other geographic regions.
  - JHHS is supportive of the development of variations of GBR for different types of hospitals or different geographies of hospitals. GBR 2.0 is an example of this type of variation of GBR; JHHS is supportive of this recommendation if participation is purely voluntary and if participation is a fit for the hospital providing these services
- Staff reiterate that GBR 2.0 will be voluntary.

MHA Suggested Language

MHA suggested a revision to the progression plan:

> The workgroup recommends that, in developing any future demonstration designs under the Maryland Model, the State should prioritize and preserve the voluntary nature of Global Budget Revenue 2.0 (GBR 2.0). The State is strongly encouraged to proactively seek out the necessary flexibilities and accommodations, ensuring that participation in GBR 2.0 or similar initiatives remains entirely voluntary for all eligible entities. GBR 2.0 should not lead HSCRC or the State to determine physician payment levels, or otherwise determine maximum physician payments. This principle of voluntariness must be a cornerstone of the State's approach to promoting and facilitating innovative solutions through the Maryland Model.

Staff will add this language to the Progression Plan.

Supplemental Benefits

- JHHS indicated that providing supplemental benefits would overlap with the role of the Medicare Advantage plans.
  - JHHS believes that while using a portion of Medicare savings to provide supplemental benefits to Medicare beneficiaries is a worthy aspiration, this recommendation would use rate setting dollars to create an infrastructure that already exists through Medicare Advantage. If the goal is to create greater access to vision and dental benefits for Medicare beneficiaries, the state would be better served using these funds to supplement Medicare Advantage in Maryland.
- CareFirst noted that hiring a benefit manager to provide supplemental services would potentially add administrative costs to the system.
- Staff believe that it would benefit the public to offer supplemental benefits in FFS Medicare.
  - The infrastructure does not exist in Fee-For-Service and Staff believes that it would benefit the public if consumers did not have to trade off between additional benefits and narrow MA networks.
  - We will add a sentence to the progression plan indicating that participants questioned whether the State should provide supplemental benefits to consumers, given that some benefits may be available in MA.

Supplemental Benefits

- MHA supports the concept of retaining a portion of Medicare savings to reinvest in population health initiatives.
  - However, the hospital field is concerned about how it would affect hospital payment policy and identify a mechanism for holding the hospitals accountable for if there is a risk of not meeting the savings target.
  - MHA also indicated that it is important to consider the timing of this proposal given the financial condition of hospitals at present.
- MHA suggested that the report by revised to allow the pool to fund other population needs such as housing, transportation, or food security.
  - MHA suggest modifying the language in the report from “expanded” or “additional supplemental benefits” to “addressing identified statewide population needs.”
  - Staff will change the language to read “supplemental benefits or addressing identified statewide population health needs.”
- Staff agree with this point but believe that it is clear from the Progression Plan that it could include population health investments. The current language reads:
  - The workgroup recommended that the State propose to CMS that half of the Medicare savings rate be retained for population health investments, including additional benefits provided to Medicare beneficiaries.

Cost Sharing

- MHA opposes standardizing cost sharing for the following reasons:
  - The potential impact is minimal because it would primarily affect cost shares for Medicare outpatient services
  - The proposal may put Maryland at risk of failing its Medicare savings test by reconciling price differences through Medicare payments
  - Administrative costs will rise if billing and collection practices must adjust to new requirements
- JHHS is not supportive of reducing cost sharing for Medicare beneficiaries.
  - JHHS believes the HSCRC should address retained revenue and excess capacity issues to address consumer cost sharing.

Revised Language

- Staff revised the Progression Plan to remove the recommendation that the State does not pursue cost-sharing reform.
  - Staff believe that this captures the discussion at the previous TCOC workgroup.
  - The Progression Plan now summarizes the discussion, including the low economic incidence and the high administrative costs.
- The language now reads “The workgroup believes that it would be desirable to limit consumer cost sharing but noted that the economic incidence of the problem was small and the administrative costs would be substantial.”

Update on CTI Year 1

Year 1 CTI Results

- Staff have finalized the Year 1 (2020-2021) CTI results. In total, hospitals saved $127 million across all CTI.
  - Savings are measured relative to a 2016/2017 baseline, so the results are analogous to the annual run rate, and not an incremental year-over-year change in savings.
  - The CTI results tie roughly one third of the annual savings rate (in CY 21) to some sort of car transformation activity.
- CTI adjustments are made in a net neutral manner. That means that hospitals which failed to achieve savings will ‘pay for’ the savings of the successful hospitals.
  - 15 hospitals earned a positive reconciliation.
  - 11 hospitals earned savings but not enough to offset their share of the satewide savings.
  - 17 hospitals did not earn any savings.
- The magnitude of the adjustment ranges from +7% to -3% of Medicare revenue.

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%

Analysis of CTI Results

- We intend to spend the next couple meetings of the CT Steering Committee examining features of the CTI that may have driven success. Such as:
  - Were CTI which focuses on certain characteristics more successful than CTI which focused on different characteristics? (e.g. was it more successful to focus on chronic conditions or prior hospitalizations).
  - Were CTI that were “narrow” (e.g. targeted a narrowly defined population) more successful that CTI that were broader?
- If you have suggestions for interesting analytics, please let us know and we will add them to the agenda.
- Some questions will require more operational insights.
  - For example, the top four CTI in terms of savings were panel based primary care. But some of the least successful CTI were also panel-based primary care.
  - Staff will work with CRISP and MHA to try and facilitate the learning collaborative, but we welcome suggestions from the industry on how to enhance that collaboration.

Next Steps of CTI

- The CTI Adjustment will be added to the MPA as of July 1, 2023.
- Year 2 of the CTI is underway now and Year 3 starts on July 1, 2023.
  - CTI enrollment is required by our SIHISS targets. We are required to have 37% of our Medicare TCOC or 22% of our Medicare beneficiaries under a CTI by the end of 2023.
  - We expect a significant number of new CTI to begin on July 1 and so we are optimistic that we will meet that target.
- We plan on a report to the Commission on the CTI results in this summer.
  - This will include an analysis of which types of CTI / which targeted populations proved most successful.
  - We will also include, recommendations on changes to the methodology, including stop-losses on the risk under the CTI.

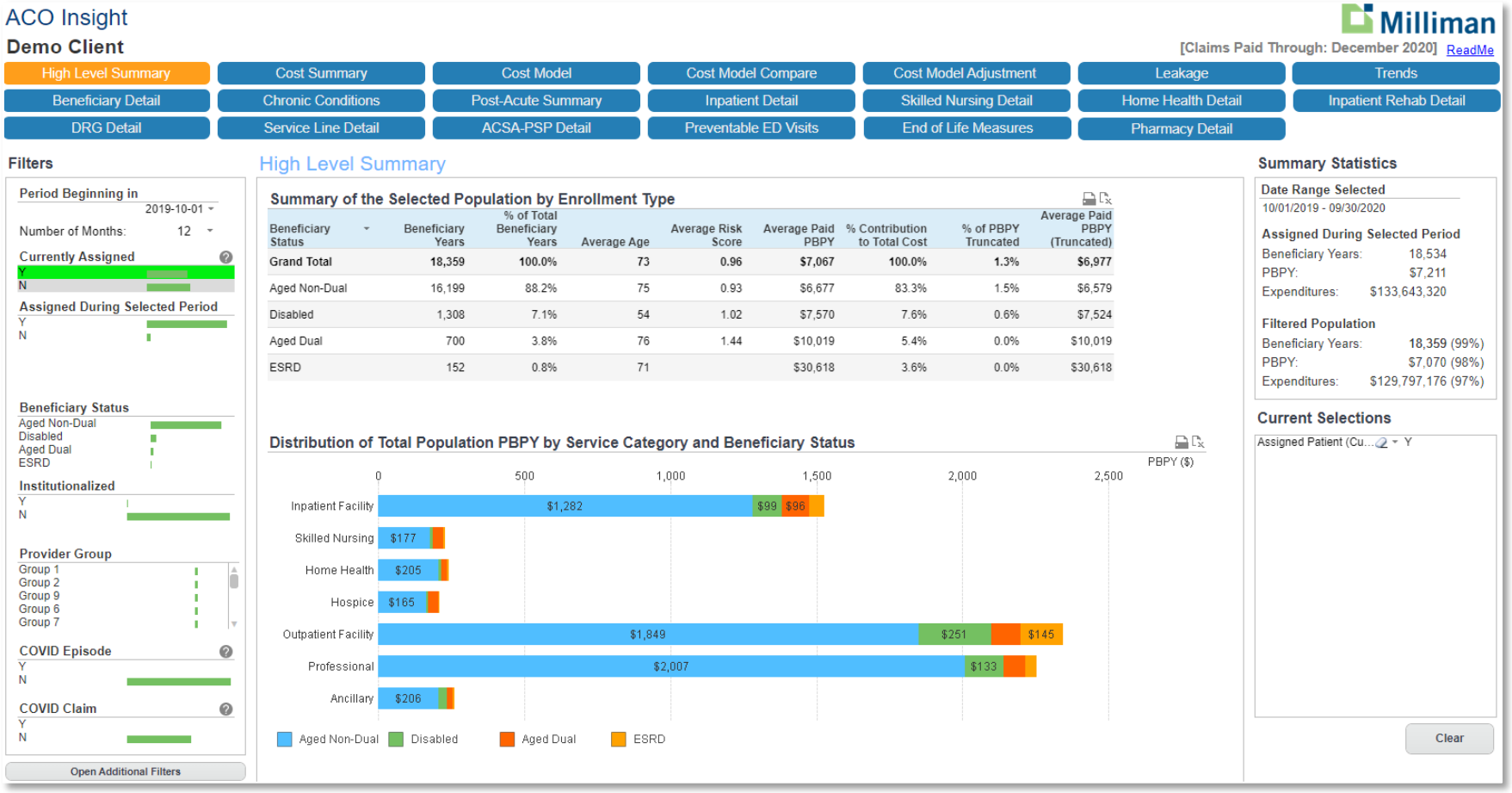
Population Health Diagnostic Analytical Tool

Population Health Diagnostic Tool

- Existing CRS tools in support of Medicare Population Health management tend to be:
  - Program focused (e.g. CTP, SIHIS) or
  - Focused on specific elements of care (MADE)
  - Relies on hospital analysis of the problem (DEX, MPA Sandbox, benchmarking)

- Is there a need/demand for a diagnostic tool that starts at a high level and allows hospitals to identify areas of spending to address
  - Include benchmarks to identify outliers
  - Allow drill down from high level to specific across the total spend
  - See Milliman “ACO Insight” example

ACO Insight is a dynamic reporting interface that provides claims data insight to organizations accountable for total cost of care in Medicare



ACO Insight provides meaningful and comprehensive performance benchmarks

Cost Model
(Select a Service Category to Show Service Detail)

		Utilization Type	DoHM %	Experience: Annual Utilization per 1,000	Experience: Paid PBPY	Experience: % of Paid PBPY	Benchmarks: Loosely Managed: Annual Utilization per 1,000	Benchmarks: Loosely Managed: Paid PBPY	Benchmarks: Well Managed: Annual Utilization per 1,000	Benchmarks: Well Managed: Paid PBPY
Inpatient Facility		**Admits**	**78%**	**225.7**	**$3,089**	**27.1%**	**310.7**	**$4,252**	**202.3**	**$2,768**
	Medical	Admits	89%	133.0	$1,143	10.0%	206.5	$1,776	123.9	$1,066
	+ Rehabilitation	Admits	-151%	23.4	$492	4.3%	13.9	$293	7.7	$161
	Surgical	Admits	107%	67.5	$1,432	12.6%	85.9	$1,823	68.7	$1,458
	+ Psychiatric	Admits	103%	1.9	$22	0.2%	4.4	$50	2.0	$22
Skilled Nursing		**Days**	**89%**	**998.1**	**$486**	**4.3%**	**1,952.4**	**$951**	**878.6**	**$428**
	Skilled Nursing	Days	89%	998.1	$486	4.3%	1,952.4	$951	878.6	$428
Home Health		**Visits**	**67%**	**2,107.5**	**$491**	**4.3%**	**3,951.8**	**$920**	**1,185.5**	**$276**
	Home Health	Visits	67%	2,107.5	$491	4.3%	3,951.8	$920	1,185.5	$276
Hospice		**Visits**		**1,197.4**	**$447**	**3.9%**				
	Hospice	Visits		1,197.4	$447	3.9%				
Outpatient Facility		**Visits**	**123%**	**5,051.4**	**$2,717**	**23.9%**	**8,841.9**	**$4,756**	**5,767.0**	**$3,102**
	Observation	Visits	169%	29.0	$51	0.4%	70.7	$123	45.9	$80
	Emergency Room	Visits	90%	331.2	$145	1.3%	403.6	$176	322.9	$141
	+ Surgery	Visits	-24%	532.6	$1,047	9.2%	492.0	$967	319.8	$629
	Radiology General - Therapeutic	Visits	-248%	248.8	$120	1.1%	166.4	$80	133.1	$64
	Radiology General - Diagnostic	Visits	134%	302.2	$65	0.6%	506.3	$109	354.4	$76
	+ Radiology - CT/MRI/PET	Visits	-38%	321.0	$84	0.7%	278.7	$73	167.2	$44
	Pathology/Lab	Visits	143%	608.9	$52	0.5%	2,131.1	$183	1,065.6	$92
	+ Drugs	Visits	96%	364.7	$755	6.6%	592.7	$1,226	355.6	$736
	Cardiovascular	Visits	130%	259.4	$148	1.3%	424.7	$243	297.3	$170
	PT/OT/ST	Visits	44%	975.2	$73	0.6%	1,287.2	$96	579.2	$43
	+ Psychiatric/Substance Abuse	Visits	153%	6.5	$1	0.0%	40.8	$5	18.4	$2
	+ Other	Visits	265%	684.0	$110	1.0%	2,029.6	$327	1,522.2	$245
	+ Preventive	Visits	-18%	387.9	$67	0.6%	418.1	$72	585.4	$101
Professional				**48,558.0**	**$3,438**	**30.2%**				
	Inpatient Surgery	Proced	111%	265.5	$84	0.7%	398.0	$126	278.6	$88
	Inpatient Anesthesia	Proced	125%	94.1	$18	0.2%	150.4	$29	105.3	$21
	Outpatient Surgery	Proced	11%	766.0	$168	1.5%	795.8	$174	517.3	$113
	Office Surgery	Proced	32%	2,311.5	$223	2.0%	2,602.8	$251	1,691.9	$163
	Outpatient Anesthesia	Proced	-94%	508.5	$61	0.5%	382.2	$46	248.5	$30
	+ Inpatient Visits	Visits	89%	2,276.6	$178	1.6%	3,532.1	$276	2,119.3	$166
	Office/Home Visits - PCP	Visits	74%	4,198.1	$275	2.4%	4,047.9	$266	4,250.3	$279
	Office/Home Visits - Specialist	Visits	367%	4,245.5	$340	3.0%	5,200.4	$416	4,940.4	$395
	Urgent Care Visits	Visits	124%	138.2	$11	0.1%	100.7	$8	130.9	$10
	+ Drugs	Proced	-2%	2,538.1	$999	8.8%	2,520.0	$992	1,512.0	$595
	Allergy Testing	Proced	-302%	34.9	$3	0.0%	14.8	$1	8.1	$1

A few key savings opportunities ACO Insight users focus on include…

1

Inpatient medical & surgical admissions

2

Post acute care services (30-day episodes)

- IP readmissions
- SNF
- acute IP rehab
- HH

3

ED visits

4

End of life / palliative care services

- In hospital deaths
- Hospice use

5

Part B drugs

- Biosimilars and other alternatives

6

Site of service

- IP to OP surgery for a few surgeries (i.e., hip and knee replacement, spinal fusion)
- Hospital OP surgeries to ASC
- Hospital OP High-tech imaging to office
- Hospital OP infused / injectable drugs to office
- Urgent care instead of ED
- Observation instead of IP

Benchmarking Update

Benchmarking

- Responses to additional questions received have been posted to the website (at the bottom of TCOC workgroup page)
- Preliminary 2021 Commercial and Medicare results will be used in Integrated Efficient policies
- Final 2021 Benchmarking data will be released over the summer

Next Steps

Next Steps on the TCOC Workgroup

- The next TCOC Workgroup meeting will be on June 28. Our agenda will cover:
  - Initial observations of which CTIs were effective and why.
  - An analysis of what is driving our Medicare savings.
- We do not intend to hold the July or August TCOC Workgroup meetings and we will likely reconvene in September.
  - We will cancel the TCOC Workgroup Meetings after the June meeting, pending any follow-up to the analysis.
  - When we reconvene, we anticipate discussing the Medicare Performance Adjustment and potential changes to the CTI revenue at risk.