



maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

January 2024

Agenda

1. Review of TCOC results through June 2023 (Consistent with Prior Reviews)
2. Review of analysis on site of service shifts from 2018 to 2022
3. Updates on care redesign activities
4. Update on AHEAD
5. Reconstitution of the Workgroup

TCOC Results, through June 2023

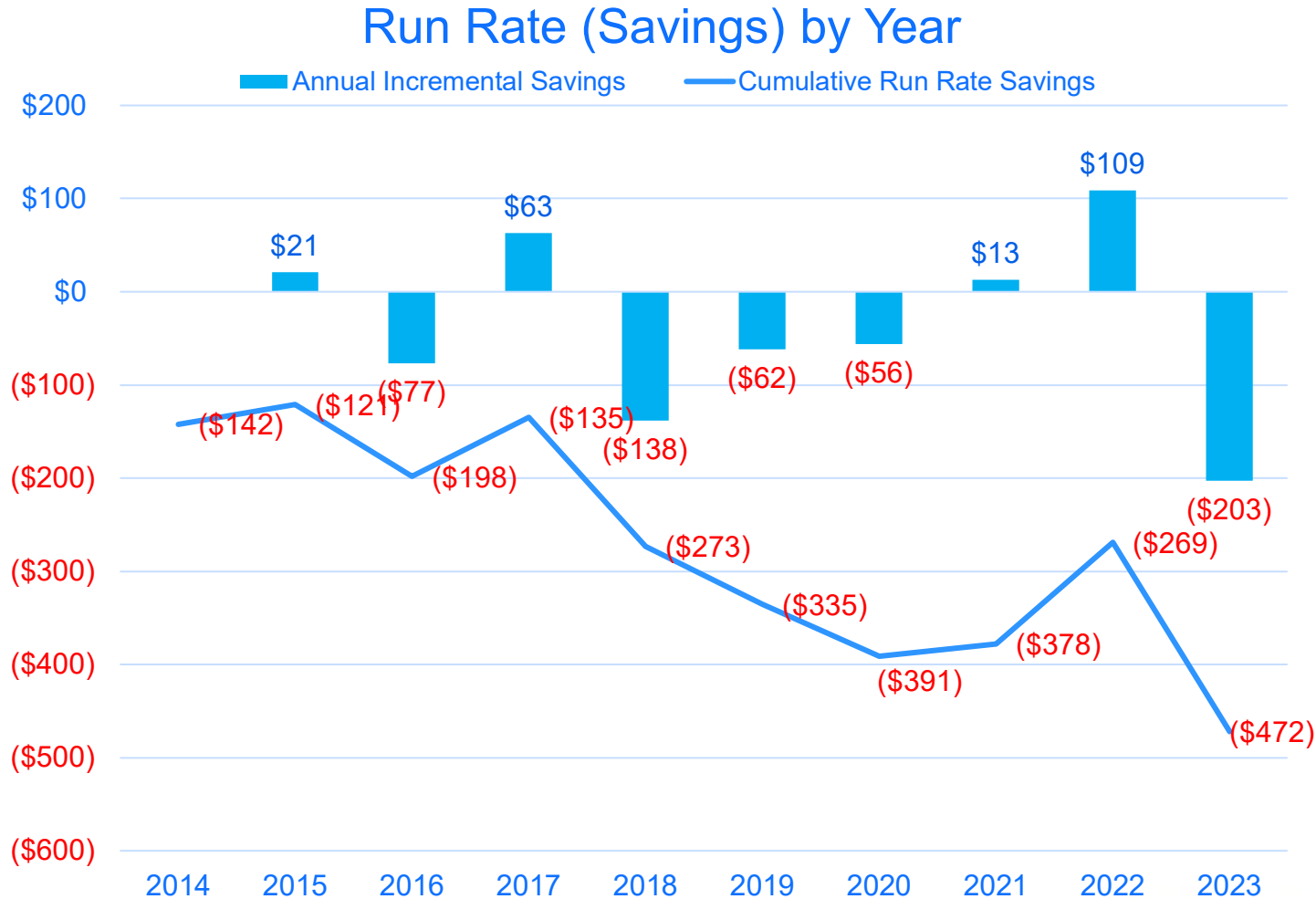
Presentation Context

- Presentation attached is a brief overview of changes in Maryland Medicare Total Cost of Care in the first half of CY2023.
 - Considerable volatility in TCOC in 2020, 2021, and 2022 makes 2023 analysis over any period complex.
 - 2022 Base Year 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
 - 2023 Performance Year MD Hospital costs had several one-time reductions to the GBR as well as a 1% increase to the Public Payer Differential in April
- HSCRC still will provide an update on the full year 2023 in comparison to prior years in mid 2024
 - Presentation focuses on three periods 2013 to 2019, 2019 to 2022 and 2022 to 2023
- Presentation assumes there are no changes in the net impact of Non-Claims Based Payments (NCBP) from CY2022 other than in MDPCP and equivalent national programs.

Background

- Analysis reflects through 1st Half CY 2023 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 \$440 M savings 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-PCP Non-Claims Based Payments are not included in 5% sample analyses
- 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
- Savings are reported as negative numbers – i.e. MD spending below the nation.

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
- Several adjustments were made to Hospital GBR in both the first six months of 2022 (increases) and the first six months of 2023 (decreases) adding significant savings that we do not expect to continue for the second half of 2023
- We expect to exceed our run rate requirement from CMS in 2023 of \$300M; additionally expect YOY guard-rail under 1% of National Growth
- 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 2022 vs 2022 to 2023 (1st Half CY)

	2013 to 2019, Average		2019 to 2022 Average		2022 to 2023 1 st Half	
	Average Run Rate (Savings)		Run Rate (Savings)		Run Rate (Savings)	
	Cost \$ M	% of Savings	Cost \$ M	% of Savings	Cost \$ M	% of Savings
Inpatient Hospital	(\$37)	59.0%	\$114	132%	(\$126)	60%
SNF	(\$6)	9.5%	\$2	3%	(\$1)	0%
Home Health	\$8	-12.3%	\$1	1%	(\$5)	2%
Hospice	\$3	-5.5%	(\$11)	-13%	(\$5)	2%
Total Part A	(\$31)	50.7%	\$106	122%	(\$138)	65%
Outpatient Hospital	(\$59)	94.9%	(\$65)	-76%	(\$98)	46%
ESRD	(\$2)	3.5%	\$6	7%	\$4	-2%
Outpatient Other	(\$4)	5.9%	(\$2)	-3%	(\$1)	0%
Clinic	(\$0)	0.1%	(\$1)	-2%	(\$1)	0%
Professional Claims	\$34	-55.1%	\$43	50%	\$23	-11%
Total Part B	(\$31)	49.3%	(\$19)	-22%	(\$73)	35%
Total	(\$62)		\$86		(\$211)	

- Hospital Claims are driving Total Savings in 2023
- Other AAPM Payments totaling ~ \$95M are excluded (e.g. MSSP, NGACO, AIPBP, etc...)

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 2023 1st half savings of \$203 million.

IP Savings, 2013 to 2019 vs 2019 to 2022 vs 2022 to 2023 (1st Half CY)

	2013 to 2019, Average		2019 to 2022, Average		2022 to 2023	
	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	(\$66)	-2.0%	\$17	0.5%	(\$16)	-0.8%
Avg Case Mix Index	\$44	0.2%	\$34	0.2%	\$30	1.3%
Cost per Day	(\$26)	-0.7%	\$47	1.2%	(\$135)	-5.0%
ALOS (CMI Adj)	\$11	1.6%	\$10	0.9%	(\$4)	-0.1%
Mix Impact	\$1		\$6		\$1	
Total Inpatient	(\$37)		\$113		(\$123)	

- Cost per Day is driving savings fluctuations since 2019
- Admits per K reductions has come back to contribute to Savings in 2023
- 2023 Case-Mix Adjusted Average Length of Stay is no longer a head-wind in 2023

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.

OP Savings, 2022 to 2023 (1st Half CY)

Cumulative (Savings) Costs \$M	2022 to 2023		MD Above (Below) National CAGR			Run Rate (Savings) Cost, \$M	
	% of US Spend	Utilization	Unit Cost	Total	% of Savings		
(\$131.71)	Part B Rx 24.01%	-0.39%	-13.07%	-13.41%	(\$24.28)	24.73%	
(\$22.66)	Imaging 11.11%	-3.15%	-0.68%	-3.81%	(\$3.31)	3.38%	
(\$7.31)	Proc-Major Cardiology 9.45%	1.59%	-1.09%	0.48%	\$0.18	-0.19%	
(\$6.86)	Proc-Major Orthopaedic 8.18%	-4.73%	-3.84%	-8.39%	(\$2.90)	2.95%	
(\$27.53)	Proc-Minor 7.60%	-4.77%	-3.70%	-8.29%	(\$4.37)	4.45%	
(\$39.29)	E&M - ER 7.20%	-0.73%	-7.43%	-8.11%	(\$4.81)	4.90%	
(\$4.95)	Proc-Major Other 5.72%	-4.98%	-0.39%	-5.35%	(\$1.72)	1.75%	
(\$8.34)	Proc-Endocrinology 4.91%	-0.77%	-3.76%	-4.50%	(\$1.28)	1.31%	
(\$33.13)	E&M - Other 4.82%	-3.34%	-11.66%	-14.61%	(\$12.58)	12.82%	
\$17.45	Lab 4.48%	-2.08%	-10.53%	-12.39%	(\$10.96)	11.17%	
(\$11.54)	Proc-Ambulatory 4.25%	-3.37%	-5.67%	-8.85%	(\$2.83)	2.88%	
(\$18.01)	Proc-Oncology 3.45%	0.80%	-7.76%	-7.02%	(\$3.51)	3.57%	
(\$125.13)	Other Professional 3.07%	-5.74%	-48.70%	-51.64%	(\$132.68)	135.13%	
(\$4.54)	Proc-Eye 1.33%	-3.56%	-0.59%	-4.13%	(\$0.26)	0.26%	
(\$2.95)	DME 0.40%	4.49%	-7.31%	-3.16%	(\$1.42)	1.44%	
\$0.22	Proc-Dialysis 0.00%	41.25%	56.58%	121.17%	\$0.21	-0.22%	

- Year-over-year savings in most categories and generally due to unit cost and utilization decreases
- Part B Rx Savings in Outpatient Hospital and Professional, for current year professional does not offset hospital

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, 2022 to 2023 (1st Half CY)

Cumulative (Savings) Costs \$M	2022 to 2023	MD Above (Below) National CAGR			Run Rate (Savings) Cost, \$M		
		% of US Spend	Utilization	Unit Cost	Total	% of Savings	
\$13.21	E&M - Specialist	17.56%	1.61%	-2.50%	-0.94%	(\$2.84)	-12.23%
\$111.45	Part B Rx	17.41%	-5.00%	3.65%	-1.53%	(\$4.81)	-20.76%
\$182.33	E&M - PCP	11.13%	6.53%	6.30%	13.24%	\$18.98	81.86%
\$55.19	Other Professional	10.55%	0.01%	16.33%	16.34%	\$23.38	100.81%
\$16.53	Lab	8.78%	0.84%	-0.36%	0.48%	\$0.73	3.16%
\$15.61	Imaging	6.40%	0.13%	0.32%	0.45%	\$0.61	2.61%
\$6.02	DME	6.36%	-0.14%	15.49%	15.33%	\$11.61	50.04%
(\$1.65)	Proc-Minor	5.80%	1.97%	-1.71%	0.23%	\$0.22	0.93%
(\$9.30)	ASC	4.36%	-1.07%	-3.85%	-4.87%	(\$4.38)	-18.88%
(\$13.17)	Proc-Ambulatory	3.01%	-2.06%	-2.57%	-4.58%	(\$2.00)	-8.63%
\$1.14	Proc-Major Other	1.75%	-3.37%	5.19%	1.65%	\$0.50	2.14%
(\$3.27)	Proc-Eye	1.39%	1.85%	-2.07%	-0.26%	(\$0.05)	-0.23%
(\$2.51)	Proc-Major Orthopaedic	1.39%	0.52%	0.92%	1.45%	\$0.29	1.25%
\$12.48	Proc-Major Cardiology	1.36%	-4.17%	5.16%	0.78%	\$0.25	1.10%
\$10.98	Proc-Oncology	1.20%	0.57%	-1.28%	-0.71%	(\$0.16)	-0.69%
(\$3.66)	Proc-Endocrinology	1.05%	-0.32%	4.71%	4.37%	\$0.60	2.61%
\$2.28	Proc-Dialysis	0.51%	5.13%	-1.35%	3.72%	\$0.35	1.52%

- PCP Visits, MDPCP included, are the main driver of Professional dissavings followed by DME
- Part B Rx Savings relative to US

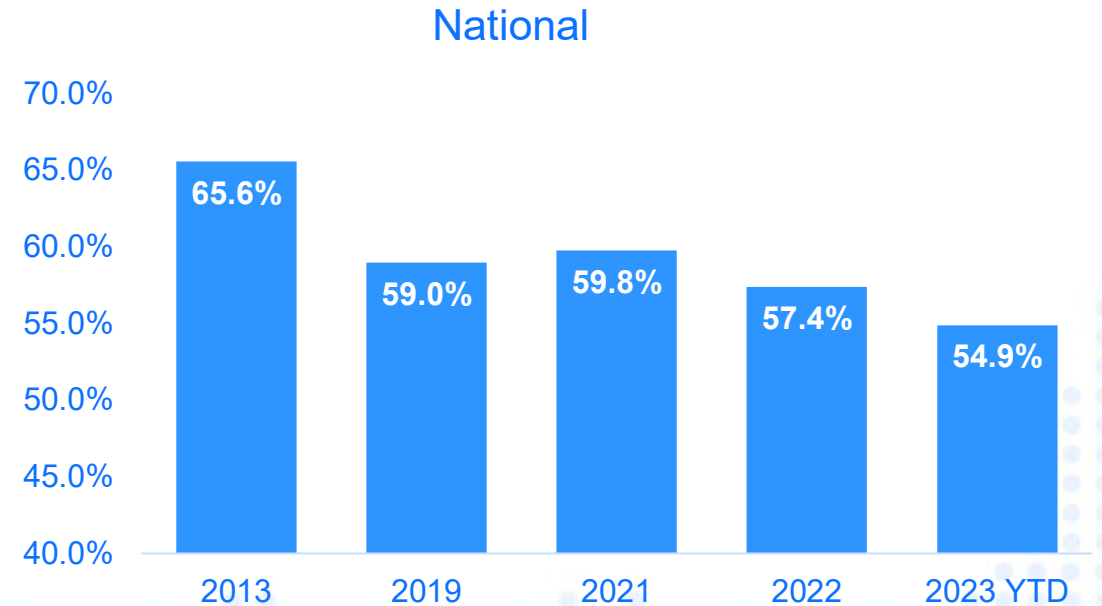
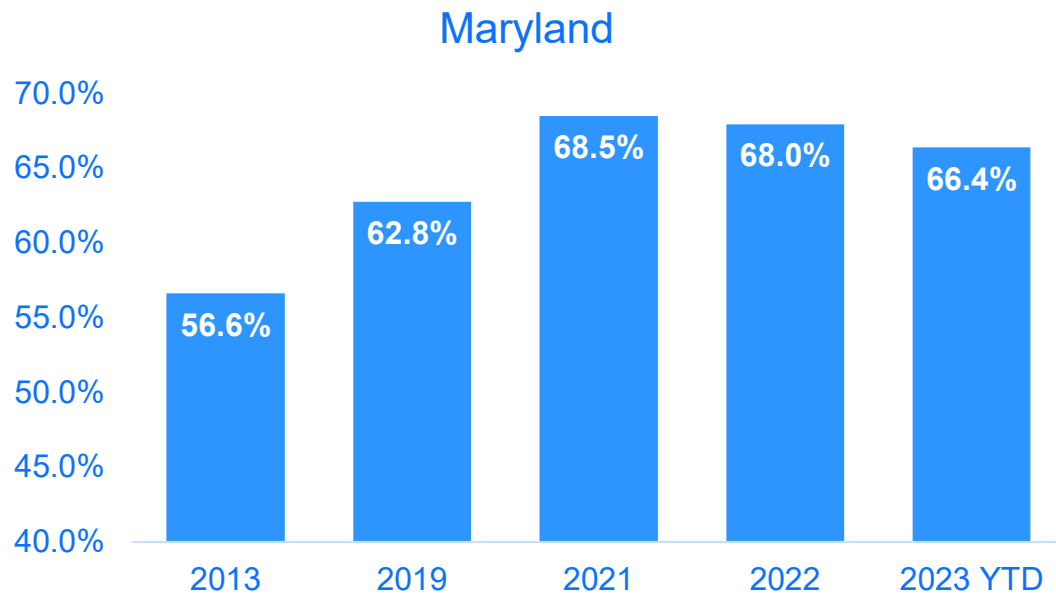
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% of Part B Spending in a Professional Setting

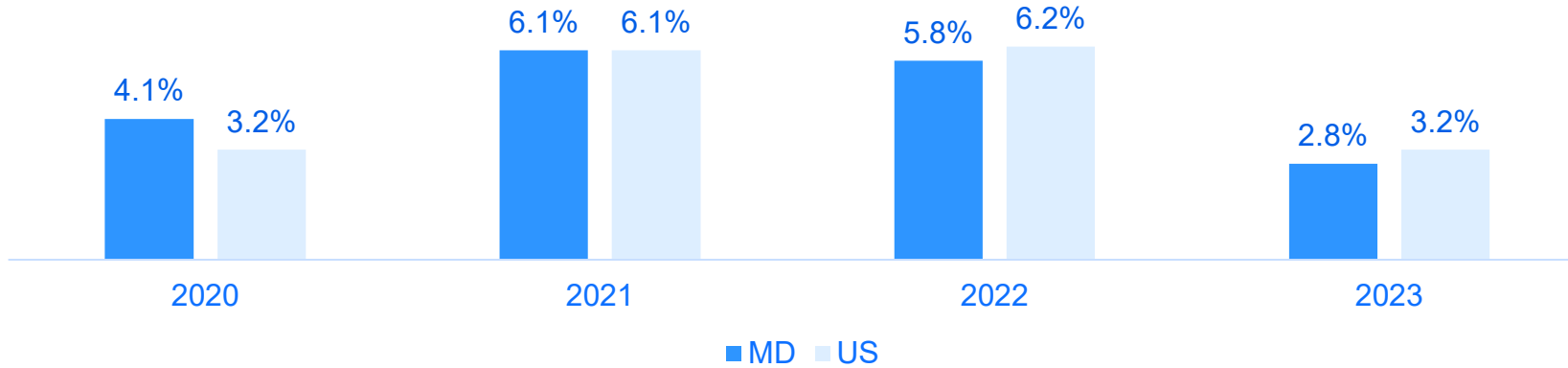
- ▶ Maryland's use of the professional setting has increased by 10% points while the nation's decreased by about the same amount. After a brief slow down during the pandemic the nation has gone back to the secular trend.
- ▶ Part B spending has generated ~\$200 M of savings, primarily driven by site of service, without administrative burdens on providers or patients.
- ▶ On a PMPY basis Maryland has gone down from an 18% over the nation to 5% over*. This is the promise from the model, higher hospital Medicare rates are maintained and covered by more efficient resource utilization.



*See Appendix for detail

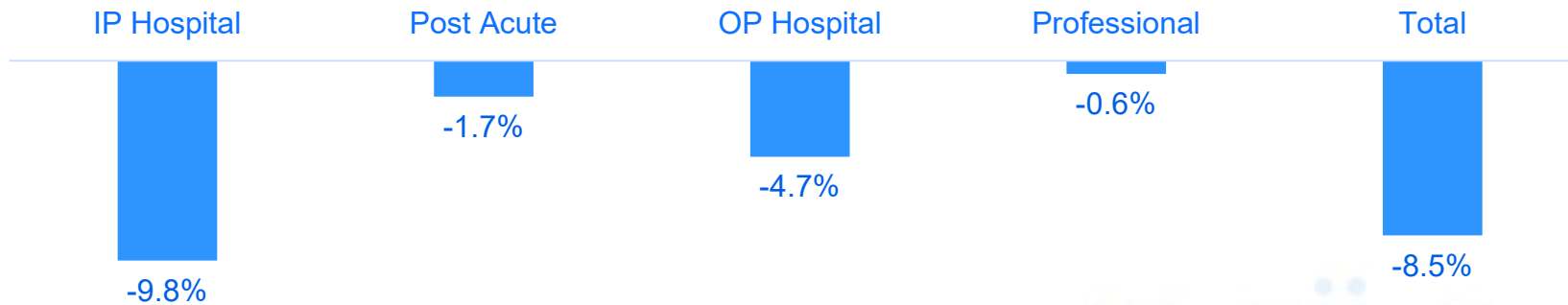
2023 COVID-19 Medicare Spending

FFS COVID Patients* as at % of Total



- In 2023 H1, 2.8% of MD TCOC per Capita was from Claims with Covid-19 diagnosis (0.4% below US).

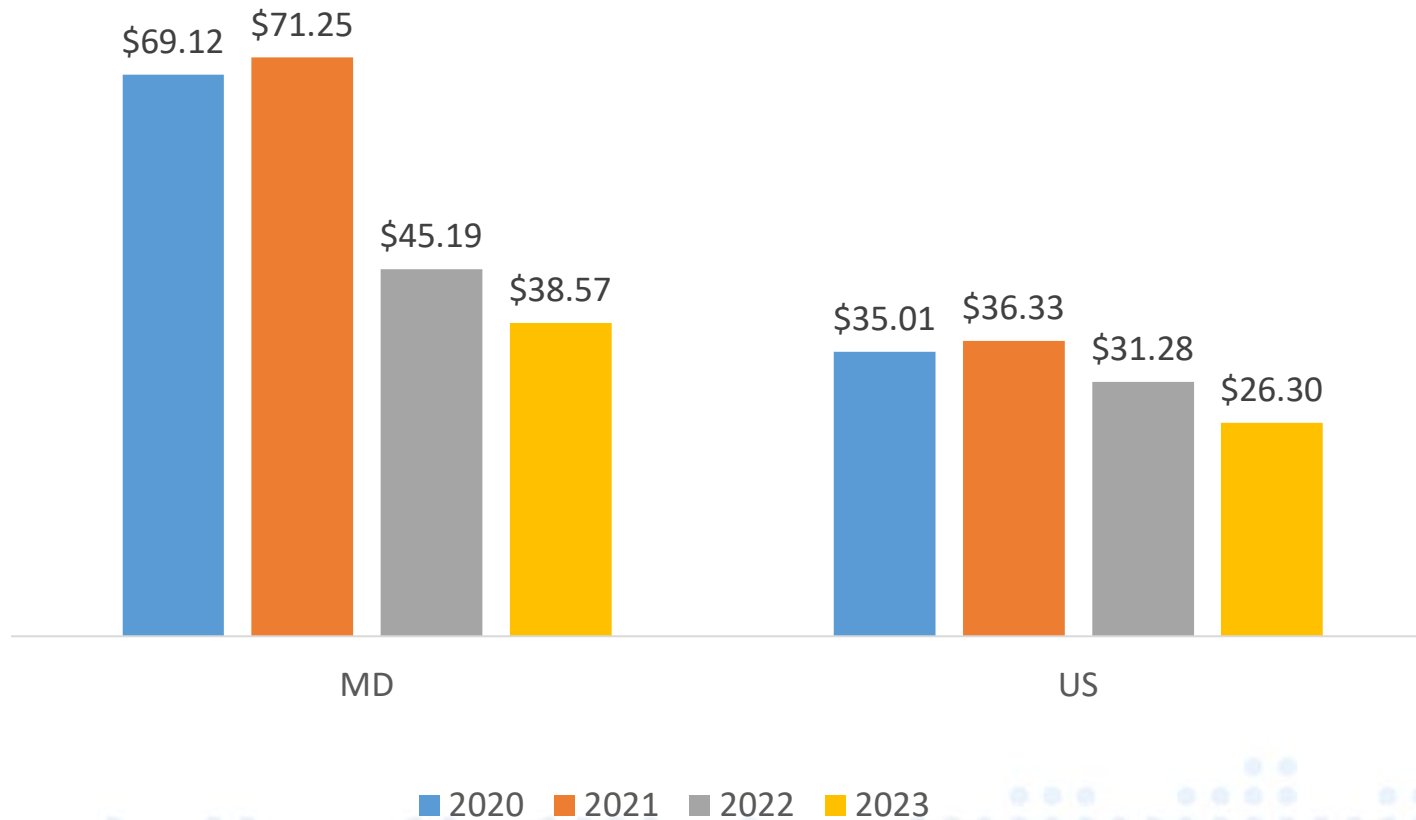
Per Capita COVID Growth Comparison, 2022 to 2023
MD % Over (Under) US



* 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.

2023 Telehealth Trend, MD vs US

TCOC per Capita Trend for Telehealth Services



- MD ranked 7th in Telehealth Cost per Capita for 2022H1 and 2023H1
- Telehealth was 0.57% of MD TCOC per Capita in 2021, 0.45% nationally

Trends in Healthcare Site of Service Shifts - Medicare Fee-for-Service, 2018-2022

Background

- The purpose of this analysis is to evaluate how medical procedures shift across places of service. We sought to understand the financial implication of these shifts on the healthcare landscape within Medicare Fee-for-service.
 - To provide a nuanced view, we examined the site of service shift patterns at the county level. This allows us to identify regional variations and understand the local dynamics influencing healthcare service delivery.
 - We are also interested in evaluating quarterly trends to identify any evidence of procedures returning to hospitals. This analysis aids in understanding the evolving preferences and practices and medical service utilization.
 - This data set was also used in the HSCRC's analysis of deregulation but the focus here is on overall shifts in total cost of care.

Background continued...

- Analysis reflects data from CY 2018 through CY 2022.
- Analysis utilizes Chronic Conditions Warehouse (CCW) data, national data is 5% sample, although focus of this presentation is on Maryland.
- Individual surgeries are identified based on coding on the professional claims and a mapping developed specific to this analysis.
- Site of service is categorized by CMS professional place of service codes:
 - 21 for Hospital Inpatient (IP), 22 for Hospital Outpatient (OP), and 24 for Ambulatory Surgery Center (ASC).
- Measuring Total System Savings:
 - Setting the Baseline and Comparing Mixes:
 - To measure the shift in volume between 2018 and 2022, we held the average unit costs for CY22 constant within each site of service bucket (inpatient, outpatient, ASC) and assessed the change in procedure distribution.
 - Addressing the Volume vs. Shift Dilemma:
 - Acknowledging the challenge of differentiating volume decline from actual shift impact, we calculated pure volume decline savings. This involved comparing the total units across all places of service in CY22 to CY18 and applying CY22 prices.
 - Isolating Net Impact:
 - Subtracting the pure volume decline from the aggregate net impact, we isolated the net impact of the mix shift, revealing approximately \$90 Million in spending decline between all places of service during this time period.

Summary

1. Examine shifts in place of service by procedures between 2018 vs 2022.
 - a) Data reflects a shift in healthcare service delivery from Inpatient to Outpatient and Ambulatory Service Centers from 2018 to 2022.
 - b) This trend is particularly pronounced in elective surgeries such as Hip and Knee Arthroplasties.
2. Evaluate quarterly patterns.
 - a) Several procedures, such as Elective Hip and Knee Arthroplasty, saw no evidence of a 'bounce back' to pre-pandemic levels.
 - b) In contrast, other procedures such as Colonoscopy - Diagnostic/Therapeutic and Endoscopy - Screening/Diagnostic remained relatively stable between these periods.
3. Analyze patterns by county.
 - a) General uniformity is observed in service shifts across all regions.
 - b) Lumbar Fusion and Lumbar Spine Decompression saw consistent reductions in IP settings across all counties.
 - c) Colonoscopy - Diagnostic/Therapeutic and Endoscopy - Screening/Diagnostic experienced a smaller shift in comparison to other high-impact procedures.
4. Measure the overall site of service shift by high impact procedures and the cost impact.
 - a) Results reflect roughly a \$90M decrease in spending caused by the mix change between 2018 to 2022.
 - i. Notably, Elective Hip Arthroplasty (non-fracture), Elective Knee Arthroplasty, Colonoscopy - Diagnostic/Therapeutic, Endoscopy - Screening/Diagnostic, and Lumbar Spine Decompression or Discectomy procedures experienced the largest decrease in spending during this period.
 - b) While the Endoscopy - Screening/Diagnostic and Colonoscopy - Diagnostic/Therapeutic procedures experienced only a slight transition in service locations, their high volume and high-to-low cost nature between IP, OP, and ASC led to a significant decline in healthcare spending.
 - c) Pure volume decline accounted for \$175M decrease in spending. This presentation focuses on the shift because we believe that reflects a change in healthcare delivery where the volume changes could still be a function of the pandemic. HSCRC intends to update the data to reflect CY 2023 results.

Navigating Shifts and Impacts – CY 2018 vs. CY 2022

- The Medical Claims Analytics data identified 32 types of services / procedures. The proportion of these procedures are measured by place of service (IP, OP, and ASC), and evaluated between 2018 to 2022 to examine the movement between places of service within a fixed period of time.

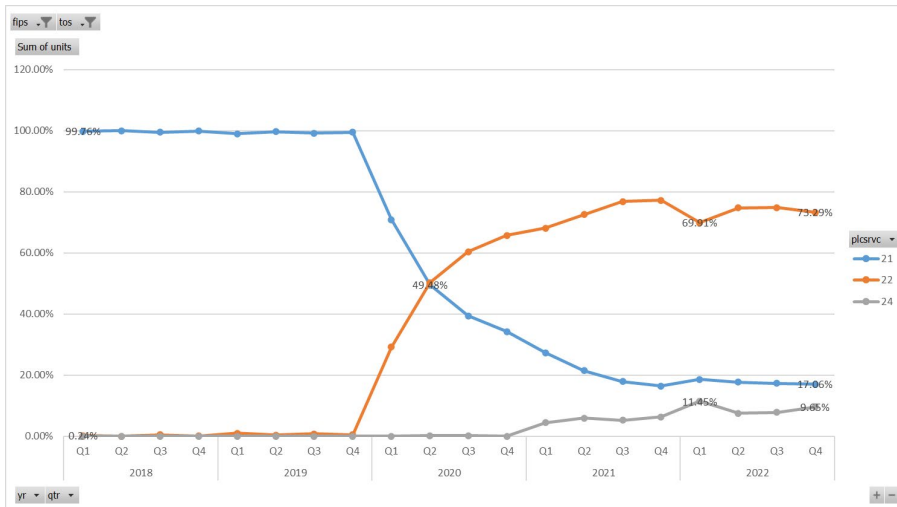
Row Labels	Total Sum of units	Inpatient Shift in Units (%)			Outpatient Shift in Units (%)			Ambulatory Service Center Shift in Units (%)		
		CY18 IP Share (%)	CY22 IP Share (%)	CY22-CY18 Variance	CY18 OP Share (%)	CY22 OP Share (%)	CY22-CY18 Variance	CY18 ASC Share (%)	CY22 ASC Share (%)	CY22-CY18 Variance
Aortic/Mitral Value Replacement - Open	2,596	100%	100%	0%	0%	0%	0%	0%	0%	0%
CABG(coronary artery bypass graft)	6,844	100%	100%	0%	0%	0%	0%	0%	0%	0%
Cardiac Cathertization	76,310	43%	43%	0%	57%	57%	0%	0%	0%	0%
Carotid Endarterectomy	3,320	99%	99%	0%	1%	1%	0%	0%	0%	0%
Cervical Spine Fusion (ACDF)	3,674	72%	59%	-13%	26%	39%	12%	2%	3%	1%
Cholecystectomy (Gall Bladder) - Laproscopic	9,945	47%	42%	-5%	51%	51%	1%	3%	7%	4%
Cholecystectomy (Gall Bladder) - Open	1,331	99%	99%	0%	1%	1%	0%	0%	0%	0%
Colonoscopy - Diagnostic/Therapeutic	202,790	5%	3%	-1%	24%	22%	-2%	71%	74%	3%
Colonoscopy - Screening	95,253	8%	6%	-1%	24%	23%	-1%	68%	70%	2%
Elective Hip Arthroplasty (non-fracture) - Revision	2,702	100%	87%	-12%	0%	12%	12%	0%	0%	0%
Elective Hip Arthroplasty (non-fracture) - Total	16,045	100%	18%	-82%	0%	73%	73%	0%	9%	9%
Elective Knee Arthroplasty - Partial	1,588	19%	4%	-15%	67%	66%	-1%	14%	29%	15%
Elective Knee Arthroplasty - Revision	3,536	98%	81%	-17%	2%	18%	17%	0%	0%	0%
Elective Knee Arthroplasty - Total	25,632	65%	9%	-57%	35%	73%	39%	0%	18%	18%
Endoscopy- Foreign body removal	1,182	65%	78%	13%	35%	22%	-13%	0%	0%	0%
Endoscopy- Hemostasis and Varices Tx (Bleeding)	7,121	81%	79%	-1%	19%	20%	1%	0%	0%	0%
Endoscopy- Removal of tumor, polyp, or other lesion	5,170	14%	14%	0%	41%	34%	-7%	45%	52%	8%
Endoscopy- Screening BILIARY AND PANCREATIC	632	87%	76%	-11%	12%	24%	12%	1%	0%	-1%
Endoscopy -Screening/Diagnostic	190,575	17%	15%	-2%	26%	26%	0%	57%	59%	2%
Endoscopy-Diagnostic/Therapeutic/Stenting BILIARY AND PANCREATIC	8,423	53%	53%	0%	47%	47%	0%	0%	0%	0%
Endoscopy-Dilation or Stenting	15,494	11%	12%	1%	36%	33%	-2%	53%	55%	2%
Endovascular repair of Abdominal Aortic Aneurysm	2,406	99%	99%	0%	1%	1%	0%	0%	0%	0%
Knee Arthroscopy ? lavage/debridement	922	16%	29%	13%	28%	28%	0%	56%	43%	-13%
Knee Arthroscopy ? meniscal tear repair	6,510	2%	7%	5%	35%	28%	-7%	63%	65%	2%
Lumbar Fusion	13,614	98%	87%	-11%	2%	12%	11%	0%	1%	1%
Lumbar Spine Decompression or Discectomy	14,140	74%	64%	-10%	24%	28%	4%	2%	8%	7%
Minimally Invasive Direct Coronary Artery Bypass (MIDCAB)	342	100%	98%	-2%	0%	2%	2%	0%	0%	0%
PCI- percutaneous coronary intervention	20,831	58%	59%	1%	42%	41%	-1%	0%	0%	0%
Renal Artery Angioplasty or Stenting	3,944	29%	49%	21%	64%	48%	-16%	7%	3%	-5%
Shoulder Arthroscopy ? Frozen Shoulder	331	0%	11%	11%	49%	64%	15%	51%	24%	-27%
Shoulder Rotator Cuff Repair	6,435	2%	1%	-1%	52%	48%	-5%	46%	51%	5%
Transcatheter Aortic/Mitral Valve replacement	5,963	100%	99%	-1%	0%	1%	1%	0%	0%	0%
Grand Total	755,600	27%	21%	-6%	29%	31%	2%	45%	48%	4%

- Inpatient Services (IP) Shifts:**
 - There was a 6% overall decrease in IP services from 2018 to 2022.
 - Elective Hip Arthroplasty (non-fracture) - Total showed a drastic 82% decrease in IP.
 - Elective Knee Arthroplasty - Total also had a significant 57% decrease in IP services.
- Outpatient Services (OP) Shifts:**
 - OP services experienced an overall increase of 2% during the same period.
 - A notable increase in OP for Elective Hip Arthroplasty (non-fracture) - Total (73%) and Elective Knee Arthroplasty - Total (39%).
 - Cardiac Catheterization and PCI-percutaneous coronary intervention remained stable in OP services.
- Ambulatory Service Center (ASC) Trends:**
 - ASC services saw an overall increase of 4% from 2018 to 2022.
 - Significant increases for Elective Knee Arthroplasty - Total (18%) and Elective Knee Arthroplasty - Partial (15%).
 - In contrast, Shoulder Arthroscopy – Frozen Shoulder witnessed a notable shift out ASC services (27% decrease).

Quarterly Trends for Elective Hip and Knee Arthroplasty

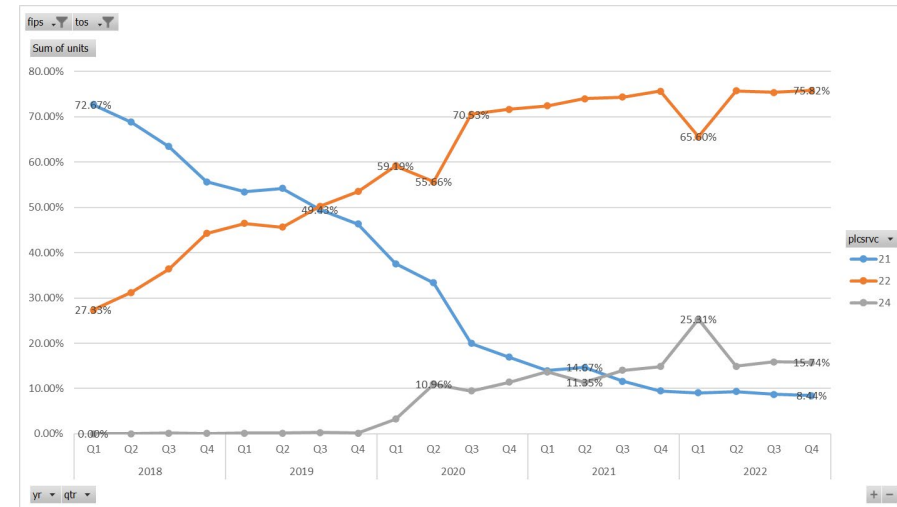
- Analyzing the quarterly shifts in service locations from 2018 to 2022 provides insights into how the COVID-19 pandemic influenced the distribution of medical procedures across different care settings. It helps us assess whether surgical practices are reverting to their pre-pandemic norms.

Elective Hip Arthroplasty (Non-Fracture)



- Dramatic shift from IP (21, Blue) to OP (22, Orange) with a modest increase in ASC (24, Grey) admissions post-COVID-19.
- In 2018, the majority of these surgeries were performed in IP settings, reflecting traditional surgical practices.
- By 2022, a significant proportion of these procedures had transitioned to OP, indicating a paradigm shift in surgical care.

Elective Hip Arthroplasty

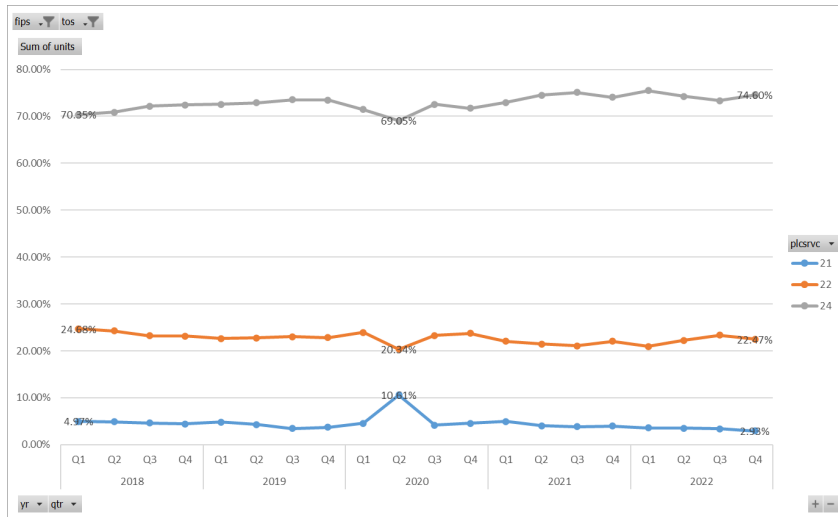


- Consistent decline in IP (21, Blue) admissions, accompanied by a significant rise in both OP(22, Orange) and ASC (24, Grey) admissions post-COVID-19.
- These results follow a similar trend as those for Elective Hip surgeries. However, Elective Knee experienced a higher shift towards ASC.

Quarterly Trends for Colonoscopy and Endoscopy Procedures

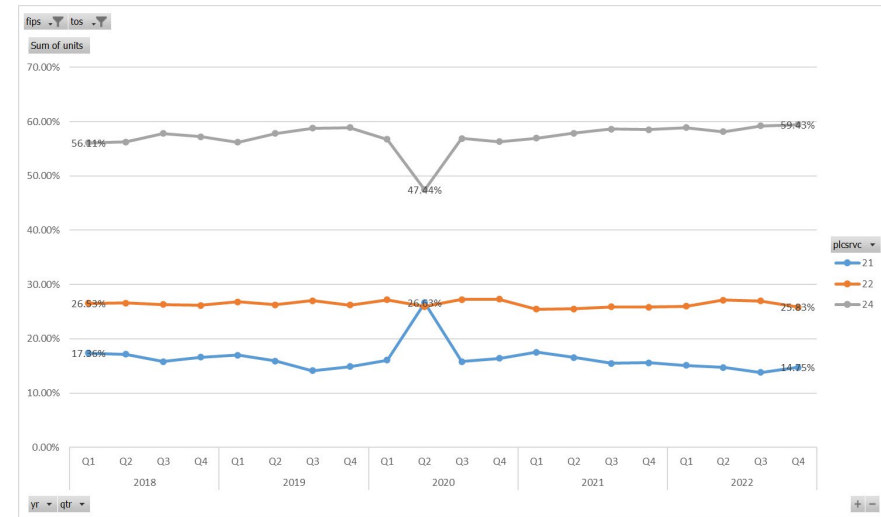
- Conversely, certain surgeries remained largely unaffected by the COVID-19 pandemic, maintaining their pre-pandemic levels.

Colonoscopy - Diagnostic/Therapeutic



- Consistent and notable increase in services performed in ASC (24, Gray) settings, along with a corresponding decline in IP (21, Blue) services.

Endoscopy - Screening/Diagnostic



- Gradual decrease in IP (21, Blue) services, while OP (22, Orange) services remained relatively stable throughout this period. There is also a notable increase in services performed in ASC.

Consistency across geographies

- The Medical Claims Analytics data identified 32 types of services / procedures. The proportion of these procedures are measured by place of service (IP, OP, and ASC), and evaluated between 2018 to 2022 to examine the movement between places of service within a fixed period of time.

Row Labels	Inpatient Shift in Units (%)			Outpatient Shift in Units (%)			Ambulatory Service Center Shift in Units (%)		
	CY18 IP Share (%)	CY22 IP Share (%)	CY22-CY18 Variance	CY18 OP Share (%)	CY22 OP Share (%)	CY22-CY18 Variance	CY18 ASC Share (%)	CY22 ASC Share (%)	CY22-CY18 Variance
Colonoscopy - Diagnostic/Therapeutic	5%	3%	-1%	24%	22%	-2%	71%	74%	3%
Anne Arundel	5%	3%	-1%	16%	11%	-6%	79%	86%	7%
Baltimore	5%	5%	0%	30%	34%	4%	65%	62%	-4%
Baltimore City	9%	7%	-2%	53%	56%	3%	37%	37%	-1%
Montgomery	3%	2%	-1%	13%	12%	-2%	84%	86%	3%
Prince Georges	6%	3%	-2%	26%	21%	-5%	69%	76%	7%
Rural	4%	3%	-1%	27%	28%	1%	69%	69%	0%
Suburban	4%	3%	-1%	18%	15%	-2%	78%	81%	4%
Elective Hip Arthroplasty (non-fracture) - Total	100%	18%	-82%	0%	73%	73%	0%	9%	9%
Anne Arundel	100%	10%	-90%	0%	76%	76%	0%	15%	15%
Baltimore	100%	10%	-90%	0%	88%	88%	0%	1%	1%
Baltimore City	100%	20%	-80%	0%	79%	79%	0%	1%	1%
Montgomery	100%	15%	-85%	0%	61%	61%	0%	24%	24%
Prince Georges	100%	15%	-84%	0%	79%	79%	0%	5%	5%
Rural	100%	26%	-74%	0%	66%	65%	0%	9%	9%
Suburban	100%	22%	-77%	0%	72%	71%	0%	6%	6%
Elective Knee Arthroplasty - Total	65%	9%	-57%	35%	73%	39%	0%	18%	18%
Anne Arundel	42%	3%	-39%	58%	78%	20%	0%	19%	19%
Baltimore	49%	4%	-45%	51%	87%	36%	0%	9%	9%
Baltimore City	63%	12%	-51%	37%	85%	48%	0%	4%	4%
Montgomery	81%	7%	-74%	19%	66%	47%	0%	26%	26%
Prince Georges	75%	14%	-61%	25%	69%	44%	0%	17%	17%
Rural	77%	14%	-63%	23%	62%	39%	0%	24%	24%
Suburban	67%	10%	-57%	33%	72%	39%	0%	18%	18%
Endoscopy - Screening/Diagnostic	17%	15%	-2%	26%	26%	0%	57%	59%	2%
Anne Arundel	17%	15%	-2%	21%	20%	-1%	62%	65%	4%
Baltimore	16%	16%	0%	31%	34%	4%	54%	50%	-3%
Baltimore City	29%	29%	0%	45%	44%	-1%	26%	27%	2%
Montgomery	13%	11%	-2%	18%	19%	1%	69%	70%	1%
Prince Georges	22%	18%	-4%	25%	25%	-1%	52%	57%	5%
Rural	14%	12%	-1%	30%	33%	3%	56%	54%	-2%
Suburban	15%	13%	-3%	22%	20%	-2%	63%	67%	4%
Lumbar Fusion	98%	87%	-11%	2%	12%	11%	0%	1%	1%
Anne Arundel	99%	78%	-21%	1%	21%	20%	0%	1%	1%
Baltimore	98%	87%	-11%	2%	13%	11%	0%	0%	0%
Baltimore City	99%	87%	-11%	1%	13%	11%	0%	0%	0%
Montgomery	100%	89%	-11%	0%	11%	10%	0%	1%	1%
Prince Georges	99%	94%	-5%	1%	4%	3%	0%	2%	2%
Rural	100%	86%	-14%	0%	14%	13%	0%	0%	0%
Suburban	97%	88%	-10%	3%	11%	8%	0%	1%	1%
Lumbar Spine Decompression or Discectomy	74%	64%	-10%	24%	28%	4%	2%	8%	7%
Anne Arundel	67%	45%	-23%	32%	42%	9%	1%	14%	13%
Baltimore	72%	66%	-6%	28%	34%	6%	0%	0%	0%
Baltimore City	84%	82%	-2%	16%	18%	2%	0%	0%	0%
Montgomery	59%	49%	-10%	35%	35%	0%	6%	16%	10%
Prince Georges	87%	65%	-22%	13%	14%	1%	0%	21%	21%
Rural	84%	78%	-6%	13%	21%	8%	4%	1%	-3%
Suburban	76%	69%	-7%	23%	23%	0%	1%	8%	7%
All Other Procedures	35%	34%	-1%	36%	35%	-1%	29%	31%	2%
Grand Total	27%	21%	-6%	29%	31%	2%	45%	48%	4%

- Measurement:**
 - Several counties were grouped by rural and suburban categories as their results individually were too small to evaluate. Called out individually are Anne Arundel, Baltimore, Baltimore City, Montgomery, and Prince George's county.
 - The analysis focused on examining a select set of procedures across various geographies, prioritizing those with significant volume and cost implications.
- Observations:**
 - A notable shift was observed from Inpatient (IP) to Outpatient (OP) services for Elective Hip and Knee surgeries across all evaluated counties.
 - Lumbar Fusion and Lumbar Spine Decompression saw consistent reductions in IP settings across all counties.
 - General uniformity is observed in service shifts across all regions.

Distribution by Total System Impact

As we pivot from analyzing the shifts in units between different places of service from 2018 to 2022, we now turn our focus to the culmination of this analysis: the total net impact in system savings.

Row Labels	Increase (Decrease) in Spending Caused by Mix Change	% Impact
Aortic/Mitral Value Replacement - Open	\$ 2,560	0.01%
CABG(coronary artery bypass graft)	\$ -	0.00%
Cardiac Cathertization	\$ 989,583	0.42%
Carotid Endarterectomy	\$ 3,760	0.04%
Cervical Spine Fusion (ACDF)	\$ (1,344,752)	-6.59%
Cholecystectomy (Gall Bladder) - Laproscopic	\$ (1,846,157)	-7.89%
Cholecystectomy (Gall Bladder) - Open	\$ (1,439)	-0.01%
Colonoscopy - Diagnostic/Therapeutic	\$ (15,887,542)	-21.48%
Colonoscopy - Screening	\$ (8,085,617)	-18.09%
Elective Hip Arthroplasty (non-fracture) - Revision	\$ (475,839)	-2.78%
Elective Hip Arthroplasty (non-fracture) - Total	\$ (15,721,250)	-28.43%
Elective Knee Arthroplasty - Partial	\$ (681,201)	-18.06%
Elective Knee Arthroplasty - Revision	\$ (1,001,732)	-4.46%
Elective Knee Arthroplasty - Total	\$ (14,520,597)	-18.87%
Endoscopy- Foreign body removal	\$ 564,855	11.43%
Endoscopy- Hemostasis and Varices Tx (Bleeding)	\$ (555,960)	-1.62%
Endoscopy- Removal of tumor, polyp, or other lesion	\$ (437,540)	-10.29%
Endoscopy- Screening BILIARY AND PANCREATIC	\$ 14,304	0.65%
Endoscopy -Screening/Diagnostic	\$ (26,052,718)	-14.13%
Endoscopy-Diagnostic/Therapeutic/Stenting BILIARY AND PANCREATIC	\$ (64,557)	-0.24%
Endoscopy-Dilation or Stenting	\$ 271,973	1.91%
Endovascular repair of Abdominal Aortic Aneurysm	\$ (32,150)	-0.15%
Knee Arthroscopy ? lavage/debridement	\$ 502,513	21.81%
Knee Arthroscopy ? meniscal tear repair	\$ 677,965	16.04%
Lumbar Fusion	\$ (6,682,009)	-5.37%
Lumbar Spine Decompression or Discectomy	\$ (12,280,525)	-13.57%
Minimally Invasive Direct Coronary Artery Bypass (MIDCAB)	\$ (336)	-0.01%
PCI- percutaneous coronary intervention	\$ 1,266,185	1.53%
Renal Artery Angioplasty or Stenting	\$ 9,233,629	54.28%
Shoulder Arthroscopy ? Frozen Shoulder	\$ (48)	-0.02%
Shoulder Rotator Cuff Repair	\$ (345,403)	-3.75%
Transcatheter Aortic/Mitral Valve replacement	\$ (63,463)	-0.10%
Grand Total	\$ (92,553,510)	-6.61%

- Overall Decline: Total system declines across all procedures and counties amount to roughly \$90M, a 6.6% decrease in spending due to mix change.
- Later slides compare Maryland's change to the nation.

Row Labels	Increase (Decrease) in Spending Caused by Mix Change (\$\$)	Increase (Decrease) in Spending Caused by Mix Change (%)
Colonoscopy - Diagnostic/Therapeutic	\$ (15,887,542)	-21.48%
Elective Hip Arthroplasty (non-fracture) - Total	\$ (15,721,250)	-28.43%
Elective Knee Arthroplasty - Total	\$ (14,520,597)	-18.87%
Endoscopy -Screening/Diagnostic	\$ (26,052,718)	-14.13%
Lumbar Fusion	\$ (6,682,009)	-5.37%
Lumbar Spine Decompression or Discectomy	\$ (12,280,525)	-13.57%
All Other Procedures	\$ (1,408,868)	-0.18%
Grand Total	\$ (92,553,510)	-6.61%

- Results for a county-level analysis are evaluated by High Impact Procedures (Next Slide).

Percent Distribution by Total Spending Decline: Heat Map

- This heatmap underscores the varied impact of healthcare efficiencies across counties by high-impact procedures as a proportion to the total spending decline.
- Key Observations:
 - **Hip/Knee Arthroplasty Impact:** Elective Hip and Knee Arthroplasty display notable regional differences, with Baltimore County (8% for Hip Arthroplasty and 5% for Knee Arthroplasty) and Montgomery County (4% for Hip Arthroplasty and 5% for Knee Arthroplasty) seeing the highest impacts, possibly reflecting regional preferences or needs for these surgeries.
 - **Lower Impact in Spine Surgeries:** Both Lumbar Fusion and Lumbar Spine Decompression or Discectomy show relatively lower impact percentages compared to other procedures.
 - **Endoscopy has the Highest \$ Impact as a % of the Total:** Endoscopy has the highest individual impact, with a particularly notable increase in Prince Georges (6%) and other Suburban counties (8%). While this procedure leads in the total spending decline, it's important to note this can largely be attributed to their high volume and high-to-low cost nature between places of service, as it only experienced a slight shift between service locations.
 - **Baltimore City: Lower Procedure Impacts:** Baltimore City demonstrates consistently lower impacts (5% of total for all high impact procedures).

	Anne Arundel	Baltimore County	Baltimore City	Montgomery County	Prince Georges	Rural	Suburban	Total High Impact
Colonoscopy	2%	0%	2%	2%	3%	2%	4%	15%
Elective Hip Arthroplasty	3%	8%	2%	4%	2%	1%	2%	22%
Elective Knee Arthroplasty	2%	5%	0%	5%	3%	2%	2%	18%
Endoscopy	3%	0%	0%	3%	6%	2%	8%	23%
Lumbar Fusion	2%	2%	1%	1%	0%	0%	1%	7%
Lumbar Spine Decompression or Discectomy	3%	2%	0%	2%	3%	0%	2%	13%
Total High Impact	16%	16%	5%	17%	17%	8%	19%	98%

Maryland vs the Nation

- Let's now compare Maryland's healthcare service shifts with the national averages to understand how our state's strategies under the Total Cost of Care model measure up against broader trends across the country.

Maryland

Sum of units	2018	2019	2020	2021	2022
21	26.74%	25.51%	26.55%	22.15%	20.64%
22	28.68%	28.79%	30.49%	30.78%	31.10%
24	44.58%	45.70%	42.96%	47.06%	48.26%
	100.00%	100.00%	100.00%	100.00%	100.00%

Shift (2022 - 2018) (%)
-6.1%
2.4%
3.7%

The Nation

Sum of units	2018	2019	2020	2021	2022
21	28.68%	28.19%	27.56%	23.18%	22.10%
22	41.34%	41.68%	42.23%	44.15%	44.86%
24	29.98%	30.13%	30.21%	32.67%	33.03%
	100.00%	100.00%	100.00%	100.00%	100.00%

Shift (2022 - 2018) (%)
-6.6%
3.5%
3.1%

- Maryland experienced a -6.1% shift in IP services, decreasing from 26.74% to 20.64%, slightly less than the national average shift of -6.6%.
- In OP services, Maryland showed a modest increase of 2.4%, from 28.68% to 31.10%, compared to the nation's increase of 3.5%.
- ASC services in Maryland rose from 44.58% to 48.26%, a 3.7% increase, indicating a significant shift towards non-hospital settings. The nation, with a 3.1% increase, follows a similar trend, though Maryland's shift is more pronounced.

Summary

- Pre-pandemic Maryland used less IP and more ASC for the included services.
 - The nation moved out of IP at a slightly higher rate during the pandemic closing that gap to a small degree, although Maryland remains slightly less reliant on IP (20.6% vs 22.1%).
 - Despite starting with a much higher use of ASC's pre-pandemic Maryland increased its advantage over the nation during the pandemic.
- Net the impact of the changes in Maryland spending on model savings were relatively small. However, if going forward Maryland retains some of these patterns and the nation does not, significant savings could accrue.
- The HSCRC intends to update this analysis for CY23 data later this year.

Update on Care Redesign Activities

Updates

- Discussing potential new CTI focused on Outpatient Surgery
 - Working with Mercy
 - Expect to finalize decision to include or not by next month's meeting
- EQIP Grouper
 - Evaluating change from Prometheus Grouper to PACES Grouper for CY2025
 - Final decision by end of February, basis for decision:
 - Continuity of results
 - Coverage of key clinical areas
 - Acceptability to critical specialty constituents (meetings in February)
- EQIP Primary Care RFI – responses due January 26th
 - Dedicated working group for this project, announcement forthcoming

Prometheus Contract Ends Dec 2024 – What Next?

PROMETHEUS Considerations



Development since 2006, currently acquired by Change Healthcare (part of Optum)



Promotes coordination and collaboration across the continuum of care at the specialist level



97 episodes grouped into clinically relevant areas: Procedural, Acute, Chronic and Other



Alignment with CareFirst's episode program



Detailed grouper methodology is a 'black box'



Prometheus episode development has stalled. HSCRC must create custom episodes outside of the 97 available.



Limited to quarterly data runs for performance data



CareFirst's considering future strategy

Patient-Centered Episodes of Care System (PACES)

- Independent, 501(c)(3) organization operating in a community model on the following principals:
- Governance: PACES is led by a dedicated leadership team and governed by a non-profit board of directors comprised of healthcare industry experts.
- **Transparency:** All episode definitions are open-source, and all the details of the grouping logic are available. There is no "black box."
- The sole focus of the PACES Center is on developing a clinically sound episode grouper in collaboration with the clinical community and market stakeholders and keeping it up to date over time
- PACES is NOT a software as a service offering, nor will we be developing business intelligence/analytic applications, beyond the episode definitions and the associated grouper business rules



AHEAD Update

AHEAD Update

- Currently preparing response to NOFO due March 18
- Advisory committees will advise on NOFO response
 - Population Health Transformation Advisory Committee (P-TAC)
 - Primary Care Transformation Advisory Committee (PCP-TAC)
 - Healthcare Transformation Advisory Committee (H-TAC)
- Award announcement in May 2024 and pre-implementation period begins
- Implementation begins January 1, 2026

Reconstitution of TCOC Workgroup

Reconstitution

- **Purpose**

- The success of the Total Cost of Care Model and the Care Redesign programs will be measured, in part, by reductions in potentially avoidable utilization, readmissions, and ultimately reduced costs due to higher quality healthcare and improvements in patient health. Understanding and managing the drivers of total cost of care and establishing sound approaches to incenting and measuring care transformation activities across the State is essential to ensuring overall success.
- The charge of the TCOC workgroup is to provide technical feedback to HSCRC on the methodologies and calculations that underpin care transformation and total cost of care management activities.

- **Workgroup Membership**

- HSCRC will reach out to historic members to confirm continued involvement
- Individuals who would like to be official members should let HSCRC know



Next Steps

Next Steps

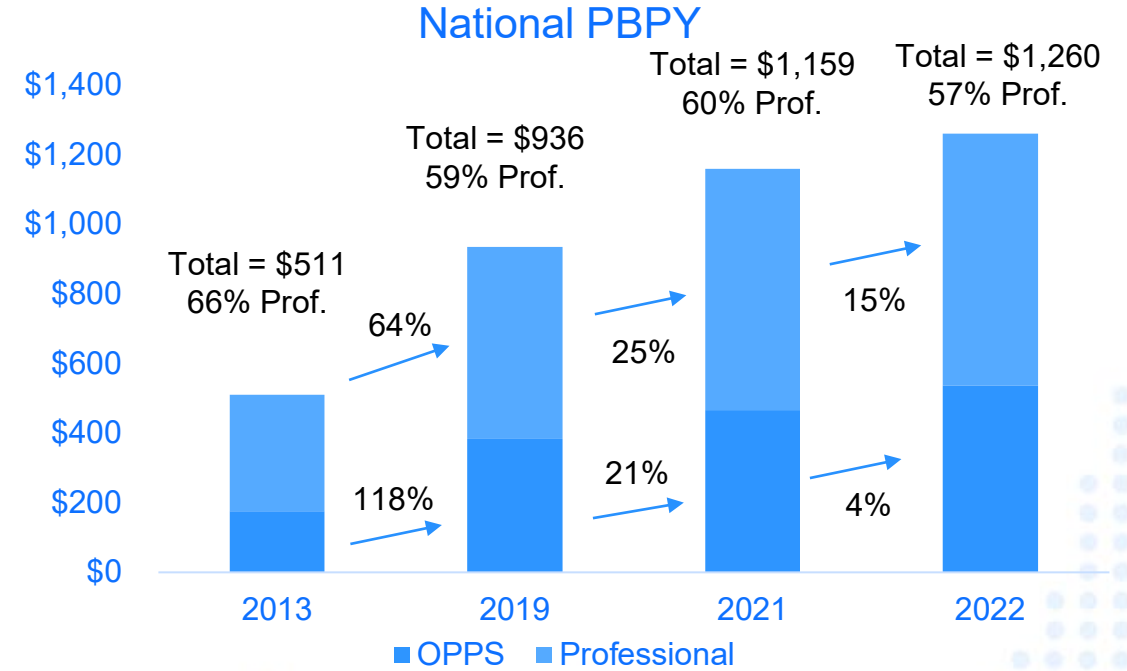
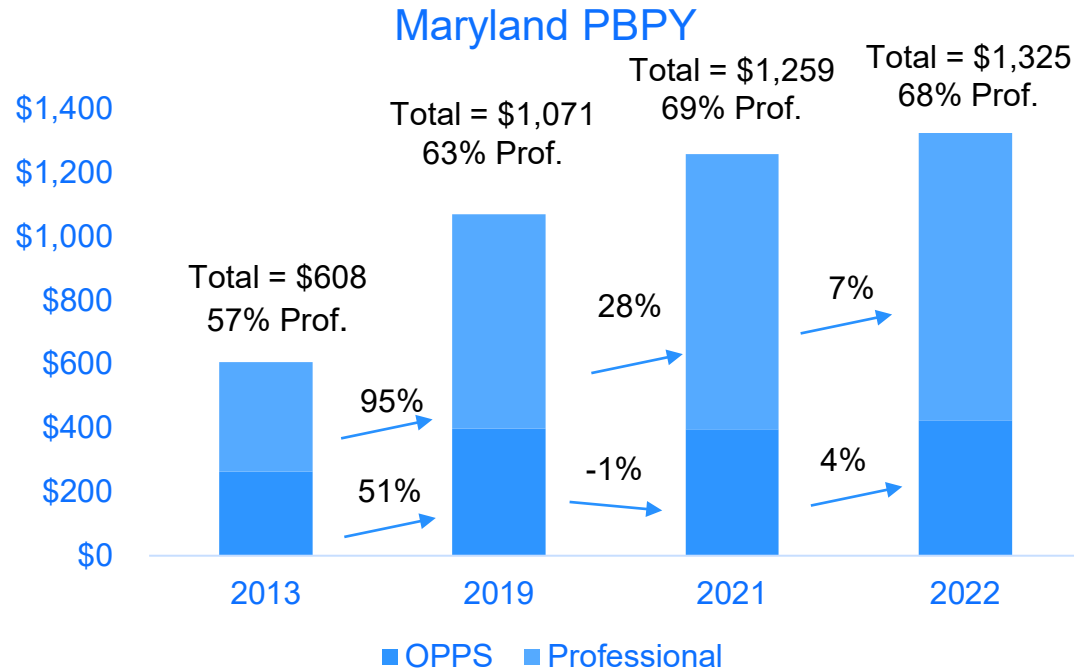
- MPA timing, Staff expects:
 - No further comments received.
 - MPA proposal sent to CMS with a response in January.
 - Final recommendation to go to Commission in March.
- February 28th workgroup agenda:
 - Review CMS feedback on MPA
 - Update on Care Redesign Activity
 - Overview of periodic review of benchmarking
 - Update on population health measure for inclusion in MPA
- Expecting minimal changes to MPA for CY25, will likely cancel meetings through the spring
 - Update the benchmarking starting the in the summer

Thank You
Next Meeting: February 28th, 8-10 am

Appendix

Part B Drug Drill Down

- ▶ 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
- ▶ In 2023 thru 6 months, MD % Professional is 66.4% versus the Nation at 54.9% (maintaining gap from 2022)



PACES – Episodes of Care

- There currently are 1,090 PACES procedural, chronic condition, and acute condition episodes in various stages of refinement
 - 90 are considered finalized and fully deployable
 - 100 are in queue to be finalized withing the next 12 months
- All the episodes are grouped into 15 Clinical Chapters based on their clinical domain
- The 33 PY3 Prometheus clinical episodes align with finalized deployable PACES episodes
- PACES convenes expert clinical panels in all relevant specialties to review the detailed codes for every episode
 - Clinical experts who are willing to spend 2-3 hrs can assist with finalizing episodes that are not currently deployable
- HSCRC/CRISP can run monthly performance reporting using PACES definitions

Current Fully Vetted Episode Inventory

PROCEDURES = 41

Cardiology/CV

- Cardiac Catheterization
- CABG
- Percutaneous Cardiac Intervention
- Open Heart Valve Surgery
- Pacemaker Insertion

General Surgery

- Mastectomy
- Ventral Hernia Repair
- Inguinal Hernia Repair
- Breast Reconstruction

GI

- Cholecystectomy
- Colonoscopy
- Colectomy
- EGD Endoscopy
- Bariatric Surgery
- ERCP
- GE Reflux Surgery

GU

- TURP
- Prostatectomy
- Urinary Endoscopy

OB/GYN

- Colpopexy
- Colporrhaphy
- C-section
- Vaginal Delivery

Ophthalmology

- Cataract Surgery IOL
- Cataract Surgery Secondary Membranous
- Glaucoma Surgery
- Retina and Vitreous Procedures
- Retina/Choroid Destructive Therapy

Ortho Surgery

- Hip Replacement
- Knee Replacement
- Shoulder Arthroscopy/Rotator Cuff Repair
- Shoulder Replacement
- Lumbar and Sacral Spine Surgery
- Fracture/Dislocation Treatment Pelvis/Hip/Femur
- Repair Fracture/Dislocation of Arm, Wrist, Hand
- Repair Fracture/Dislocation of Lower Leg, Ankle, Foot

Thoracic Surgery

- Lung Resection

Vascular Surgery

- Leg Vein Ablation
- Leg Revascularization
- Leg Vein Angioplasty
- AV Fistula Creation and Revision



CONDITIONS = 48

Cardiology

- Acute MI
- HF Acute
- HF Chronic
- IHD
- Atrial Fibrillation/Flutter Acute
- Atrial Fibrillation/Flutter Chronic
- Chronic HTN, Essential
- Chronic HTN, Secondary

Endocrine

- Diabetes
- Osteoporosis

ENT

- Sleep Apnea
- Acute Sinusitis
- Chronic Sinusitis

GI

- Chronic Cholecystitis
- Diverticulitis of Colon
- C-Difficile Colitis
- Acute Cholecystitis
- Acute Intestine Perforation
- Chronic Esophagitis
- Acute Peptic Ulcer
- Chronic Peptic Ulcer
- Acute UGI Bleed/Hemorrhage
- Chronic UGI Bleeding Other

Hematology

- Acute DVT Extremity
- Chronic Anemia

ID

- Cellulitis

Musculoskeletal

- Osteoarthritis
- Spine Stenosis/Spondylosis, Cervical
- Low Back Pain
- Spine Stenosis/Spondylosis Thoracic

Neuro

- Acute Ischemic Stroke
- Parkinsons DX

OB/GYN

- Pregnancy

Oncology

- Colon Ca
- Lung Ca
- Breast Ca

Ophthalmology

- Macular Degeneration

Primary Care

- UTI
- Diabetes

Pulmonary

- Acute URI
- Acute PE
- Pneumonia
- Asthma
- COPD

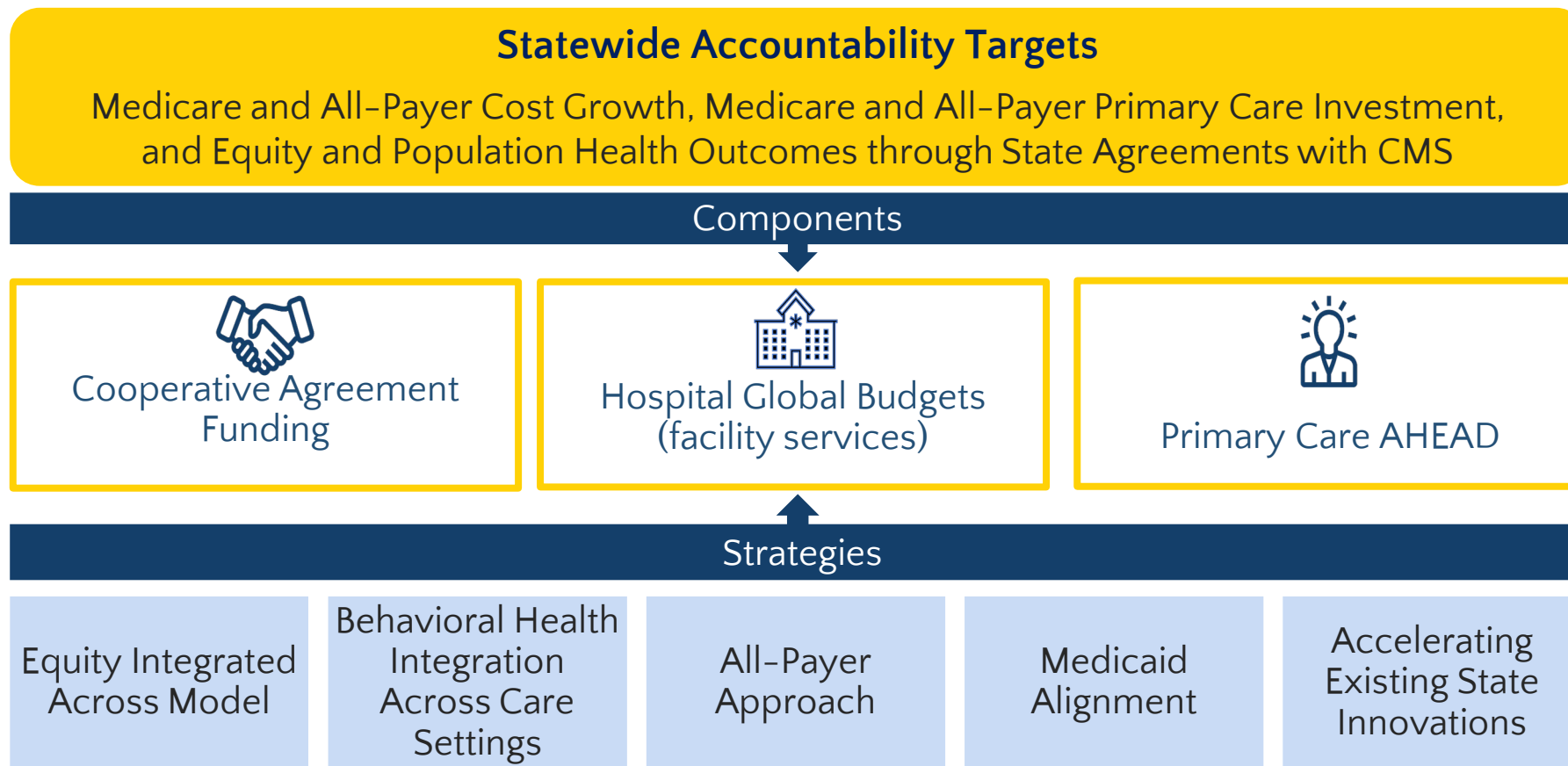
Rheumatology

- Rheumatoid Arthritis
- Osteoarthritis

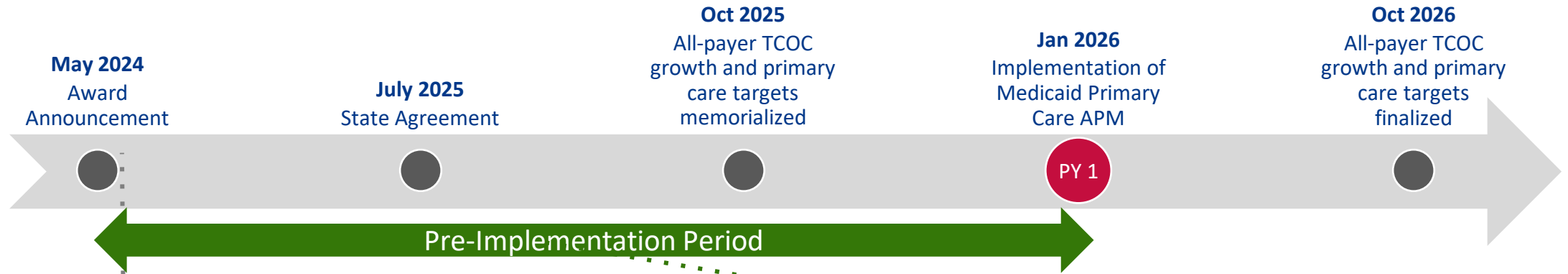
Vascular

- Abd Aneurysm
- Thoracic Aortic Aneurysm
- Peripheral ASVD
- Varicose Veins (Venous Insufficiency Varicosities)

States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model



Looking AHEAD



- Maryland's NOFO response will seek to **leverage new federal resources** to plan for the future of the Maryland Health Model.
- Applying in Cohort 1 will secure **Maryland's role as a leader** in competing for federal funding while providing it **time to negotiate** new model terms prior to 2026 implementation.

- The State envisions that **policy development and decision-making** will begin in July 2024 (the beginning of the Pre-Implementation Period) and continue through the July 2025 execution of the State Agreement. There will be **opportunity for community input** throughout this time frame.

What Maryland Brings to the Table

The AHEAD Model reflects decades-long lessons from Maryland and other states. Thus, Maryland brings many unique strengths to its AHEAD application, including:

Maryland has a long history of **successfully financing healthcare on an all-payer basis**.

Maryland has the opportunity to **harness existing momentum and align** different **health equity promotion activities** at the local and state levels.

Maryland's Medicaid program has partnered for decades with the HSCRC to implement innovative payment models.

The **robust Maryland Model governance structure** provides a solid foundation for evolution of AHEAD Model governance.

Maryland's experience **operating the Maryland Primary Care Program** will help advance the goals of Primary Care AHEAD.

Maryland's **technical expertise in establishing and improving global budgets** is unparalleled.

Maryland's **decades of investment in a robust data infrastructure** support AHEAD Model success.

TCOC Model and AHEAD

Feature	MD TCOC Model	AHEAD
Hospital Global Budgets	Maryland has a well developed all payer hospital global budget model.	Maryland can use the same methodology under AHEAD, subject to CMS approval.
Cost Targets	Medicare savings target.	Medicare savings target, primary care investment targets, and all payer savings targets (including Medicaid, MA, and commercial insurance)
Primary Care Program	Maryland has a well-developed Medicare primary care program.	A primary care program that is aligned between Medicare and Medicaid is required.
Quality	Maryland has a robust hospital quality program, including a measure on disparities. The MDPCP Program also has a quality program.	Similar hospital quality targets. For other providers/programs, Maryland will select quality measures from a list of measures provided by CMS.
Population Health & Equity	Maryland set population health targets related to diabetes, opioids, maternal morbidity, and childhood asthma.	States will select a set of population health measures from a menu of options provided by CMS. State must develop a health equity plan and equity targets.