maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

July 24, 2024

Agenda

- Tentative Positions on AHEAD Terms Discussion
- Savings Discussion Analysis
- Benchmarking Update
- Next Steps and Future Meetings

Update on AHEAD

- On July 2, Governor Wes Moore announced that MDH and HSCRC received grant funding from the Centers for Medicare and Medicaid Services to support Maryland's implementation of the federal States AHEAD Model.
- Expecting additional feedback on contractual terms and savings target in late July or August.
- Today's meeting will focus on known terms for discussion, other items to be discussed in future forums.

AHEAD Terms Discussion –Tentative Positions

Areas of Focus

- Finalize Savings Setting Approach Position
- Share of Spending Under GBRs
- MPA-Related Terms

Savings Calculation, Proposed Position

- Select Option 2 – No administratively set growth rate (See appendix)
- Pursue extension of first year true up to a 2- or 3-year phase

Share of Spending Under GBR – Recap of Discussion

Area	Approximate Spend	Discussion	Direction
High-Cost Drugs	2.1%	• HSCRC is revisiting approach later this year but don't expect a material revision in exempted amount	Continue As Is
High-Cost Supplies	1.6% (approximation, likely a high estimate, would need a strategy to define this category)	• Has not been a significant driver of outlier costs to date, may be somewhat covered by Quaternary/Complex care.	Lower Priority, allow sufficient exemption to consider expansion into this area in the future.
Quaternary/ Complex Care	2.7% based on current definition Depending on exact approach Staff estimates tertiary definition would add ~5%	• Current policy does not count towards the exemption but using the exemption would simplify the policy • Exempting all Tertiary care would likely include categories that are subject to management (e.g. spinal fusion). • Care that is exempted from GBR becomes unpredictable revenue for the hospital, particularly smaller hospitals.	Expand exemption to allow for a Quaternary exemption and possibly an expansion to other complex care within the Tertiary category.
Obstetrics	6.4%	• Argument for exemption is limited to pure volume risk, which is addressed via demographic adjustment. • Other costs risks in OB should remain within the GBR or similar construct.	Do not consider for exemption, address volume risk through other policies if needed.
Behavioral	3.2%+	• Hospital-based BH care is a last-resort, excluding BH from the GBR would remove incentives for creating better community-based care.	Do not consider for exemption, support access growth through other polices where needed.
Trauma	?	• Overlaps with Quaternary/Complex Care • Primary funding challenges relate to costs outside the GBR	Consider for exemption as part of any expansion of the Quaternary/Complex definition.

Considerations:

- Exemptions are likely high-cost growth areas therefore exemption % needs to exceed current spending levels.
- Exemptions are from the GBR not from the savings target.

MPA Contractual Revisions

- Staff proposed to pursue 3 revisions:
  - Lower or change 95% beneficiary attribution threshold
  - Pursue greater patient-level data sharing
  - Explicitly allow CTI-like attribution methodologies within MPA

- There is general constituent support for pursuing these alternatives, particularly the third item.

CY2023 Savings Analysis

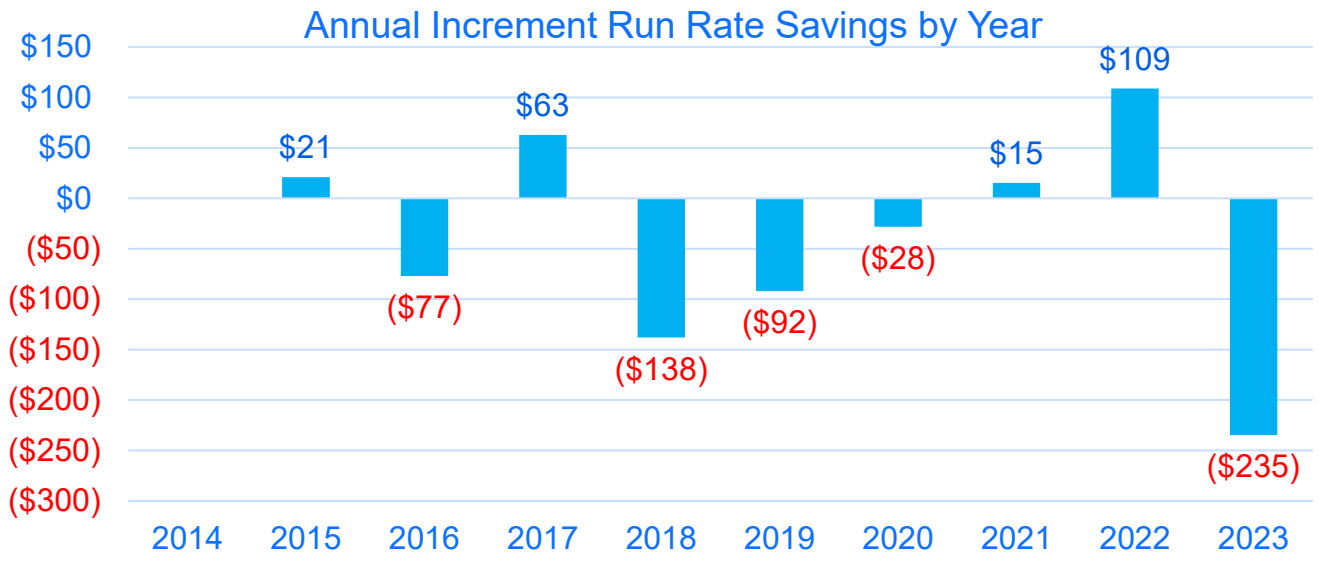
Presentation Context

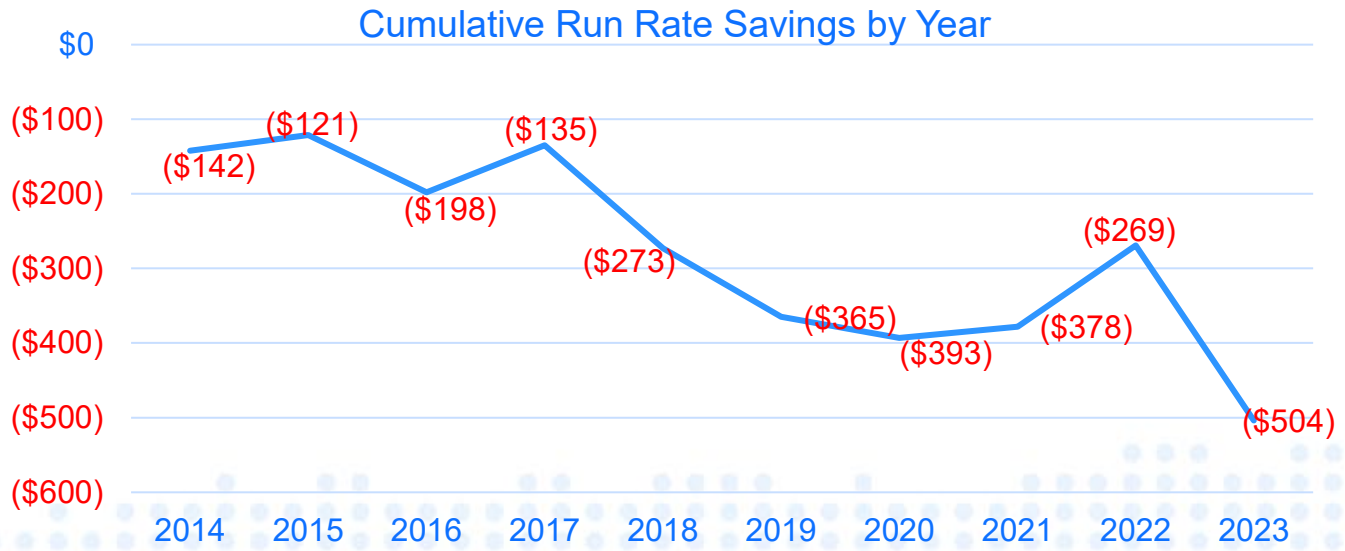
- Presentation displays update comparing previous years to the full year 2023 Maryland Medicare Total Cost of Care.
- Presentation focuses on three periods 2013 to 2019, 2019 to 2022 and 2022 through 2023
  - TCOC in 2020, 2021, and 2022 showed considerable volatility, complicating 2023 comparison.
    - In addition to the unusual conditions of the COVID public health emergency in 2020-2021, 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.

Background

- Analysis reflects CY 2023 with 3 months run out.
- Analysis compares Maryland trend to US trend using the 5% national Medicare sample in each cost bucket and thus differs from the savings disclosed in Commission reporting.
  - Effects of differences in relative shares of cost buckets between MD and National data is not shown.
  - 5% sample differs from 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, Official Scorekeeping





- 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
- We significantly exceeded our run rate requirement from CMS in 2023 of $300M. CMS has not signed off on 2023 savings, so amounts are not final.
- The source for the graphs are the CMMI national reporting data and will not tie to other slides in this presentation that use the 5% sample.

maryland health services cost review commission

TCOC Savings, 2013 to 2019 vs 2019 to 2022 vs 2022 to 2023

	2013 to 2019, Average		2020 to 2022 Average		2023	
	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	($37)	59%	$114	132%	($83)	41%
SNF	($6)	10%	$2	3%	$0	0%
Home Health	$8	-12%	$1	1%	($11)	5%
Hospice	$3	-6%	($11)	-13%	($5)	2%
Total Part A	($31)	51%	$106	122%	($98)	48%
Outpatient Hospital	($59)	95%	($65)	-76%	($119)	58%
ESRD	($2)	4%	$6	7%	$6	-3%
Outpatient Other	($4)	6%	($2)	-3%	($3)	2%
Clinic	($0)	0%	($1)	-2%	($2)	1%
Professional Claims	$34	-55%	$43	50%	$13	-6%
Total Part B	($31)	49%	($19)	-22%	($105)	52%
Total	($62)		$86		($204)	

- Hospital Claims are driving Total Savings in 2023, but savings has shifted back toward parity between Parts A and B since the end of the COVID-19 pandemic.
- Other AAPM Payments totaling ~ $77M are excluded (e.g., MSSP, NGACO, AIPBP,etc.)

Note: amounts above reflect change in each individual bucket. Change in shares of total of each bucket would also impact overall savings. Amounts based on 5% sample data. CMMI total expenditure data show 2023 savings of $235 million.

Amounts may not add up due to rounding.

IP Savings, 2013 to 2019 vs 2020 to 2022 vs 2023

	2013 to 2019, Average		2020 to 2022, Average		2023	
	Run Rate (Savings) Cost $ M	Growth Rate, MD vs US	Run Rate (Savings) Cost $ M	Growth Rate, MD vs US	Run Rate (Savings) Cost $ M	Growth Rate, MD vs US
Admits per K	($66)	-2.0%	$17	0.5%	($11)	-0.8%
Avg Case Mix Index	$44	0.2%	$34	0.2%	$20	1.3%
Cost per Day	($26)	-0.7%	$47	1.2%	($91)	-5.0%
ALOS (CMI Adj)	$11	1.6%	$10	0.9%	($3)	-0.1%
Mix Impact	$1		$6		$1	
Total Inpatient	($37)		$114		($83)	

- Cost per Day is driving savings fluctuations since 2022.
- Admits per 1,000 reductions has come back to contribute to savings in 2023.
- 2023 Case-Mix Adjusted Average Length of Stay no longer limits savings in 2023.

Note: amounts above reflect change in each individual bucket. Change in shares of total of each bucket would also impact overall savings. Amounts based on 5% sample data.

Amounts may not add up due to rounding.

Outpatient Facility Savings, CY 2023

Cumulative (Savings) Costs $M		MD Above (Below) National Compound Annual Growth Rate: Utilization	Unit Cost	Total	CY 2023 (Savings) Cost, $M
($280)	Part B Rx	0.9%	-8.3%	-7.4%	($26)
($41)	Imaging	-2.4%	-4.8%	-7.1%	($13)
($7)	Proc-Major Cardiology	2.6%	-1.9%	0.6%	$0
($44)	Proc-Minor	-3.4%	-2.1%	-5.4%	($6)
($80)	E&M - ER	0.9%	-2.3%	-1.5%	($2)
($13)	Proc-Major Orthopedic	1.0%	-5.3%	-4.4%	($3)
($0)	Proc-Major Other	-0.4%	0.3%	-0.1%	($0)
($13)	Proc-Endocrinology	1.9%	-1.6%	0.3%	$0
$53	Lab	-0.7%	-8.6%	-9.3%	($16)
($48)	E&M - Other	-0.7%	-14.6%	-15.1%	($26)
($12)	Proc-Ambulatory	-5.2%	-2.3%	-7.4%	($5)
($30)	Proc-Oncology	1.8%	-5.0%	-3.3%	($3)
($68)	Other Professional	-5.1%	44.0%	36.7%	$61
($8)	Proc-Eye	-3.4%	-0.1%	-3.5%	($0)
($21)	DME	3.7%	-16.7%	-13.6%	($14)
$0	Proc-Dialysis	25.0%	23.9%	54.8%	$0

- Year-over-year savings in most categories are 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.

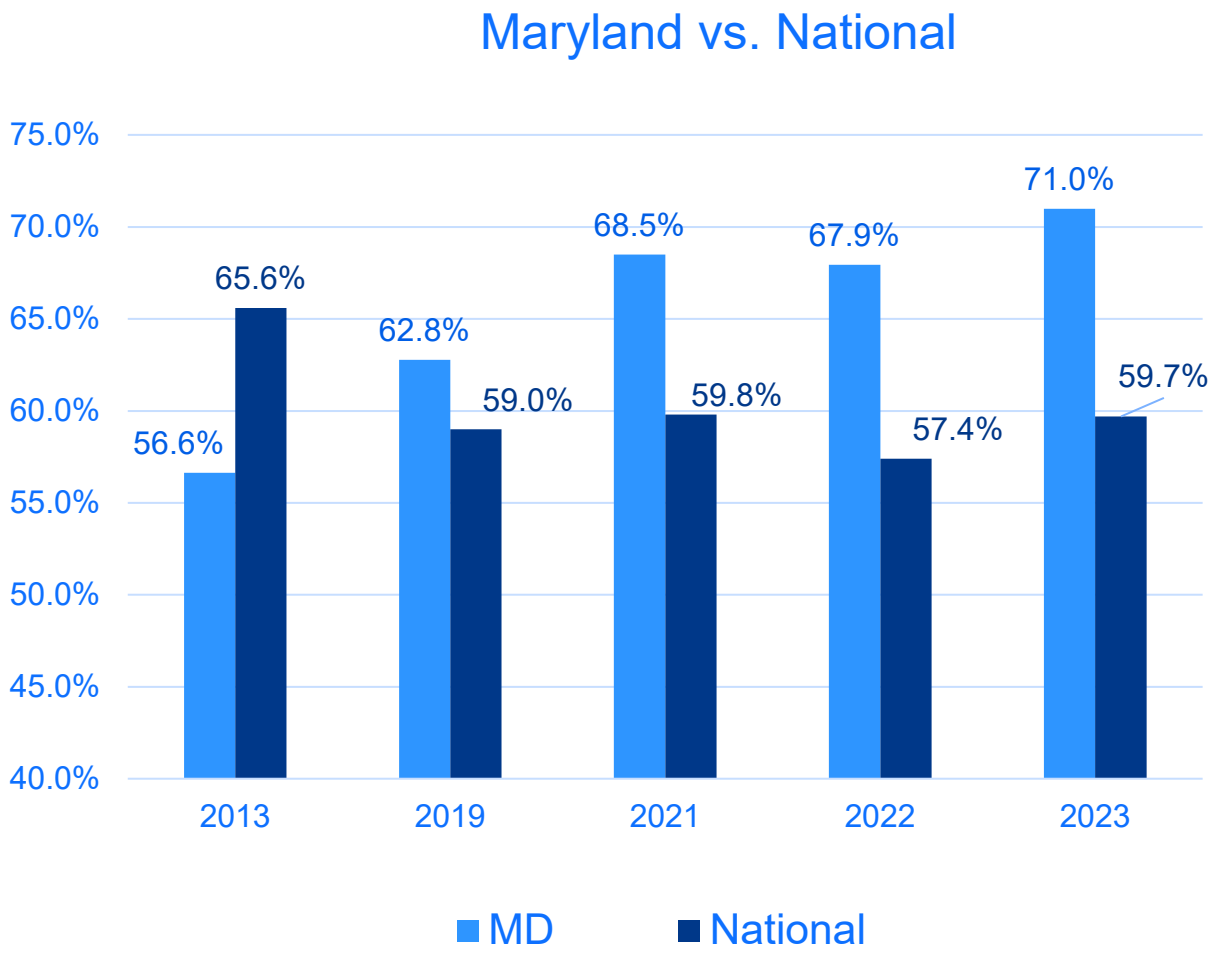
Professional Savings, CY 2023

Cumulative (Savings) Costs $M		MD Above (Below) National CAGR			CY 2023(Savings) Cost, $M
		Utilization	Unit Cost	Total	
$117	Part B Rx	1.1%	-3.4%	-2.4%	($19)
$16	E&M - Specialist	0.8%	-1.7%	-1.0%	($6)
($2)	E&M - PCP	0.7%	6.3%	7.0%	$35
$16	Lab	0.5%	-1.1%	-0.6%	($2)
$15	Imaging	0.0%	-0.1%	-0.1%	($0)
($6)	DME	2.5%	23.9%	27.0%	$63
$32	Other Professional	-2.1%	5.7%	3.5%	$7
($2)	Proc-Minor	1.0%	-1.2%	-0.2%	($0)
($5)	ASC	-2.1%	-2.9%	-4.9%	($9)
($11)	Proc-Ambulatory	-0.8%	-3.4%	-4.2%	($4)
$1	Proc-Major Other	-2.2%	5.0%	2.6%	$2
$12	Proc-Major Cardiology	-2.3%	2.4%	0.1%	$0
($3)	Proc-Eye	0.8%	-1.4%	-0.6%	($0)
($3)	Proc-Major Orthopedic	-1.0%	3.1%	2.2%	$1
($4)	Proc-Endocrinology	-1.2%	4.3%	3.1%	$1
$11	Proc-Oncology	-0.1%	-0.3%	-0.4%	($0)
$2	Proc-Dialysis	2.5%	1.1%	3.6%	$1

- DME is the main driver of Professional dissaving followed by PCP visits, MDPCP included.
- Part B Rx Savings relative to 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. Amounts may not add up due to rounding.

% of Part B Spending in a Professional Setting



- During the past decade, Maryland's use of the professional setting has increased by almost 15% while the nation's decreased by about 6%.
- On a PMPY basis Maryland has gone down from 19% greater than the nation to 2%*. This is the intent of the model, higher hospital Medicare rates are maintained and covered by more efficient resource utilization.

*See Appendix for detail

High Level Summary of Savings Impact

- Since 2013 Maryland has generated approximately $504 M of savings compared to the national run rate. While there are varying ways to calculate and allocate savings, savings can generally be attributed to the following ($ in M):

IP: Reduced IP admits and cost per day somewhat offset by higher LOS	($78)
OP Hospital (excl. ED & Part B Rx): Reductions in imaging, minor procedures, hospital clinics	($282)
PAC	($4)
ED: Reduction in ED per Visit Costs	($90)
Part B Drugs: Shift to lower cost, office POS	($184)
Other Part B	($24)
MDPCP, CPC+, PCF Fees (net of lower claims-based reimbursement) but not offsetting TCOC savings**	$149
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.*	($77)
Net Savings	($504)

Reflects only MDPCP fees, other analysis shows that MDPCP has contributed to cost reductions in other areas.
**According to HSCRC analysis net cost of the program was ~$31 M.

Benchmarking Update

Topics for Discussion

- County vs PUMA
- Metrics for Analysis
  - Goal for today is to narrow the list of potential metrics for preliminary analysis
  - Metrics selected for inclusion will be analyzed, no decisions have been made on whether they will ultimately be added to the model
  - Areas for discussion were selected based on prior feedback, Federal model and discussion last month
  - Metrics identified today are in addition to the metrics used or tested in the prior model (listed in appendix)

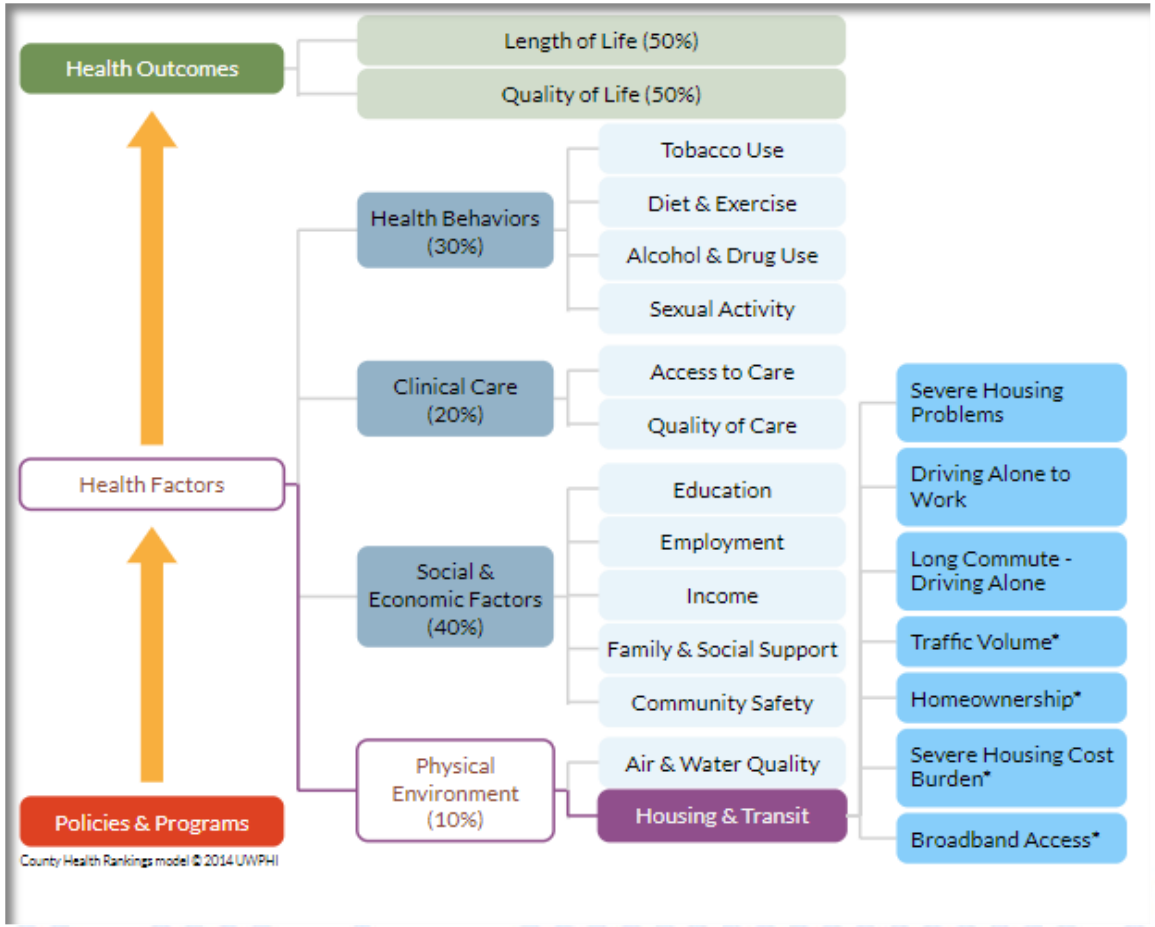
State methodology will continue to use the county

Component	County	Public Use Micro Areas (PUMAs)
Geographic Unit	Each Maryland county is matched to 20 (for five large urban counties) or 50 (for all other counties) peer comparison counties outside Maryland. Subsequently, county results are mapped to hospital PSAP using a crosswalk.	Uses Public Use Micro Areas (PUMAs) as the matching unit. PUMAs are non-overlapping, statistical geographic areas that partition states into areas with at least 100,000 people. Each Maryland PUMA was matched to eight to 20 benchmark PUMAs (on average, 13).
Pros	• Counties are easier to understand and use for hospitals. • Provides granular information for primary service area (PSAP) distributions • Boundaries do not change over time. • Most data is available at the county level.	• Statistically more reliable. • Aligns with federal evaluation approach.
Cons	• Some counties are very small, resulting in large variations in estimates.	• Not easy to understand the boundaries. • PSAPs will be same for some hospitals due to overlaps. • Only measures from American Community Survey (Population, income, poverty) are available at PUMA level.

Health Factors

Potential new measures: Health Factors

Benchmarking metrics are chosen to control for social and economic factors. For health factors, state methodology tested percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted).



https://www.countyhealthrankings.org/health-data/county-health-rankings-measures

Composite Measures

Health Outcomes

Length of Life	Premature Death
Quality of Life	Poor or Fair Health
	Poor Physical Health Days
	Poor Mental Health Days
	Low Birthweight

Health Factors

Health Behaviors

Tobacco Use	Adult Smoking
Diet and Exercise	Adult Obesity
	Food Environment Index
	Physical Inactivity
	Access to Exercise Opportunities
Alcohol and Drug Use	Excessive Drinking
	Alcohol-Impaired Driving Deaths
Sexual Activity	Sexually Transmitted Infections
	Teen Births

Social & Economic Factors

Education	High School Completion
	Some College
Employment	Unemployment
Income	Children in Poverty
	Income Inequality
Family and Social Support	Children in Single-Parent Households
	Social Associations
Community Safety	Injury Deaths

Clinical Care

Access to Care	Uninsured
	Primary Care Physicians
	Dentists
	Mental Health Providers
Quality of Care	Preventable Hospital Stays
	Mammography Screening
	Flu Vaccinations

Physical Environment

Air and Water Quality	Air Pollution - Particulate Matter
	Drinking Water Violations
Housing and Transit	Severe Housing Problems
	Driving Alone to Work
	Long Commute - Driving Alone

These factors may be considered as outcomes of the health care system

Health Factors and Outcome Rankings, 2024 report

Highest scores represent worse factors or outcomes compared to national average (Z-scores)*

County	Health Factors	Rank for Health Factors
Baltimore City	0.29	1
Somerset	0.25	2
Caroline	0.04	3
Allegany	-0.01	4
Dorchester	-0.05	5
Washington	-0.13	6
Cecil	-0.18	7
Wicomico	-0.21	8
Garrett	-0.21	9
Worcester	-0.30	10
Prince George's	-0.38	11
Kent	-0.42	12
St. Mary's	-0.42	13
Charles	-0.47	14
Baltimore	-0.50	15
Talbot	-0.58	16
Queen Anne's	-0.60	17
Calvert	-0.72	18
Harford	-0.73	19
Anne Arundel	-0.74	20
Carroll	-0.80	21
Frederick	-0.81	22
Montgomery	-1.20	23
Howard	-1.34	24

*A positive Zscore indicates a value for that county higher than the average of counties in the U.S.; a negative Z-score indicates a value for that county lower than the average of counties in the U.S. For example, if a county has a Z-score on a measure of 1.2 that means the county is 1.2 standard deviations above the national average of counties for that measure.

Source: https://www.countyhealthrankings.org/health-data/county-health-rankings-measures

Maryland vs. Benchmark Scores Comparison, 2024 report

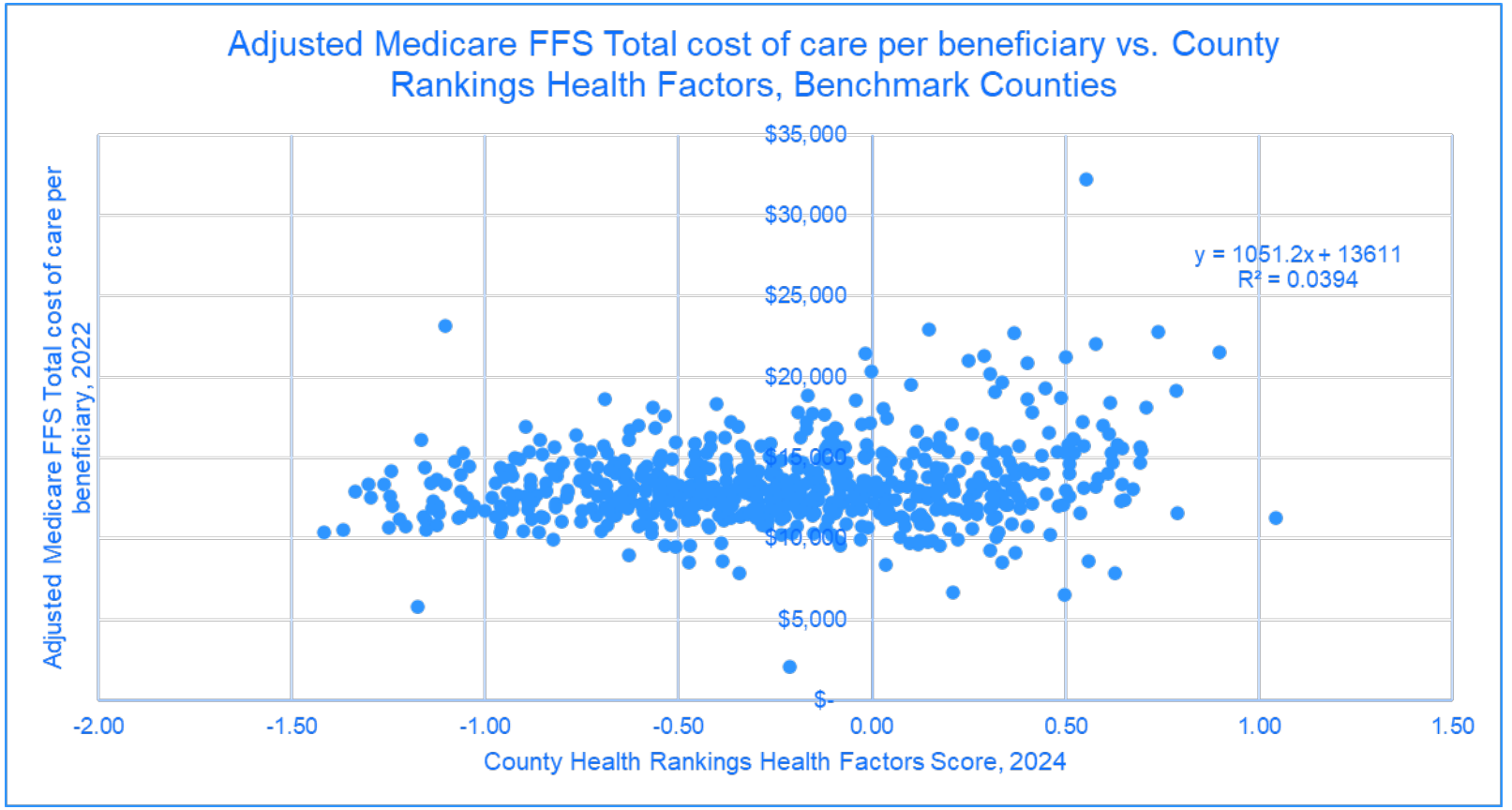
	Health Factors Score	
County	MD	Benchmark Average
Baltimore City	0.29	-0.04
Somerset	0.25	-0.51
Caroline	0.04	0.30
Allegany	-0.01	0.18
Dorchester	-0.05	0.34
Washington	-0.13	-0.37
Cecil	-0.18	-0.38
Wicomico	-0.21	-0.03
Garrett	-0.21	-0.20
Worcester	-0.30	-0.35
Prince George's	-0.38	-0.70
Kent	-0.42	0.15
St. Mary's	-0.42	0.37
Charles	-0.47	-0.49
Baltimore	-0.50	-0.60
Talbot	-0.58	-0.36
Queen Anne's	-0.60	-0.55
Calvert	-0.72	-0.79
Harford	-0.73	-0.76
Anne Arundel	-0.74	-0.83
Carroll	-0.80	-0.81
Frederick	-0.81	-0.74
Montgomery	-1.20	-0.94
Howard	-1.34	-0.91

- Benchmark counties have similar health factor scores (high correlation factor of 0.69).
- Eastern Shore counties seem to have different scores compared to their benchmarks.

Source: https://www.countyhealthrankings.org/health-data/county-health-rankings-measures

County Health Rankings and Medicare TCOC per beneficiary

Correlation between health factors and Medicare TCOC is low: 0.04

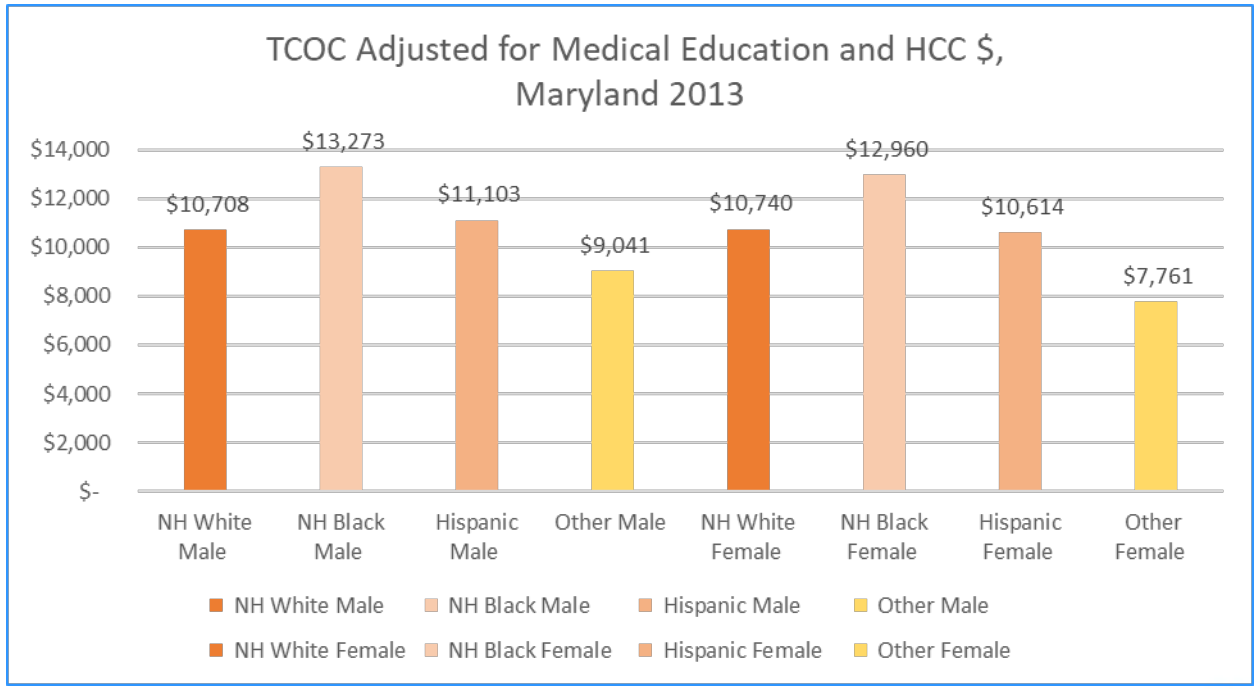


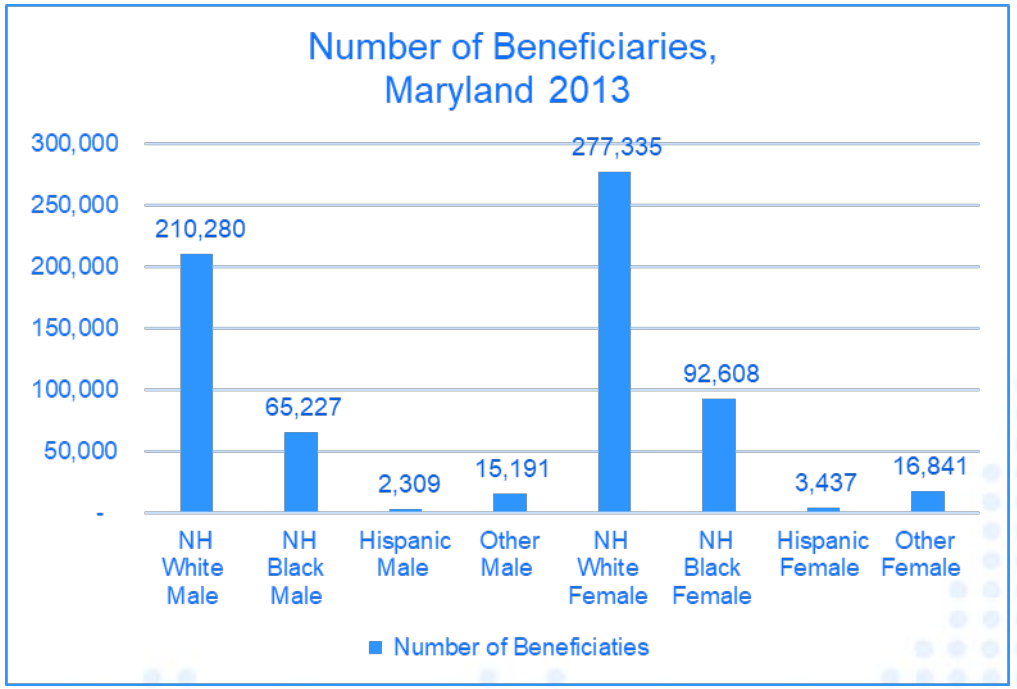
Medicare Beneficiary Characteristics

Race and Ethnicity

Race and ethnicity

Non-Hispanic Blacks have the highest TCOC (adjusted for Medical education and HCC only) for both males and females. Other race category has the lowest TCOC.





Source: Mathematica's analysis of 2013 Medicare FFS claims.

Beneficiary Distribution Comparison by Race and Ethnicity

Since matching variables did not consider race and ethnicity, benchmark counties have different composition for counties with smaller Non-Hispanic (NH) White populations.

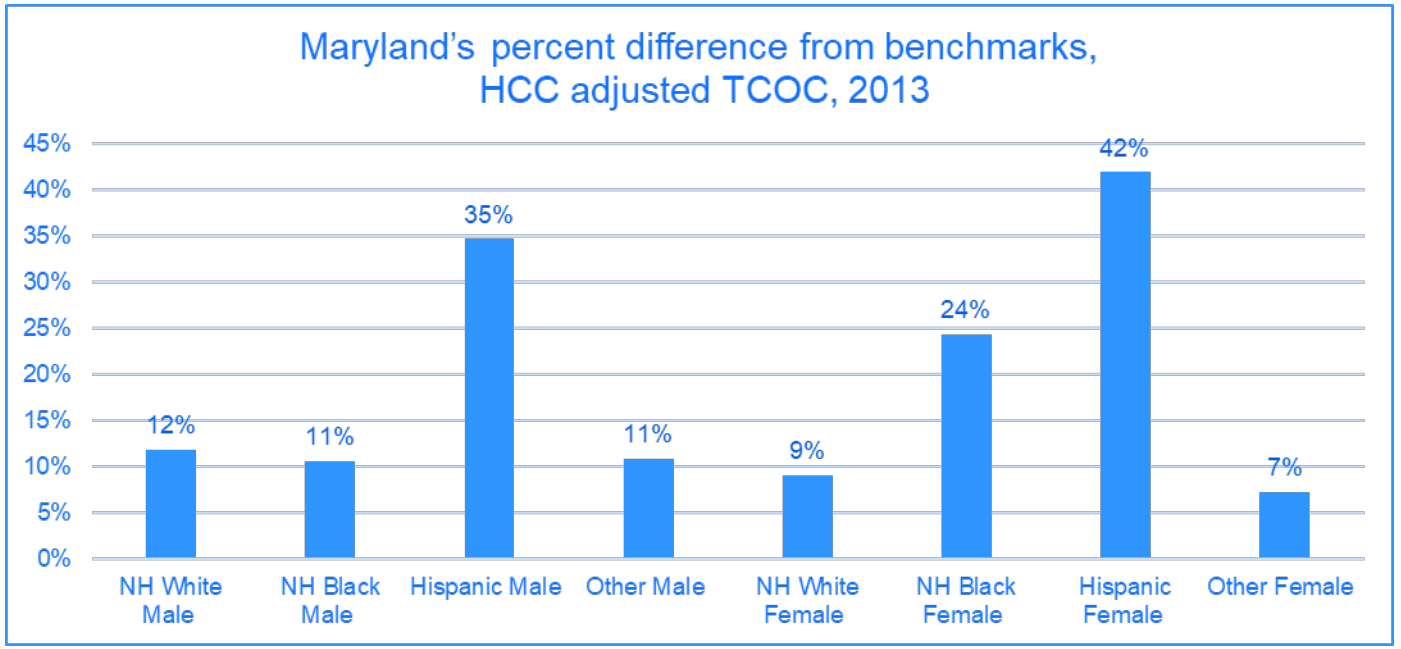
Percent Medicare Beneficiaries by Race and Ethnicity

County Name	NH White Male			NH Black Male			NH Black Female			Hispanic Male		
	MD	Benchmark	Difference	MD	Benchmark	Difference	MD	Benchmark	Difference	MD	Benchmark	Difference
PRINCE GEORGES	14%	30%	-16%	25%	5%	21%	35%	6%	28%	0.8%	2.6%	-2%
BALTIMORE CITY	18%	28%	-10%	23%	8%	15%	33%	11%	23%	0.1%	3.0%	-3%
CHARLES	30%	39%	-9%	12%	3%	9%	17%	4%	14%	0.1%	1.8%	-2%
HOWARD	31%	39%	-7%	6%	2%	4%	10%	3%	7%	0.2%	0.6%	0%
DORCHESTER	34%	40%	-7%	10%	3%	7%	14%	4%	10%	n.c.	0.9%	n.c.
MONTGOMERY	29%	34%	-5%	5%	3%	2%	8%	4%	4%	1.2%	1.2%	0%
CAROLINE	37%	42%	-5%	6%	2%	4%	8%	2%	6%	*n.c.*	1.0%	n.c.
KENT	38%	42%	-4%	6%	2%	4%	8%	2%	6%	n.c.	0.8%	n.c.
TALBOT	39%	42%	-3%	5%	1%	4%	6%	1%	5%	*n.c.*	0.3%	n.c.
ST. MARYS	38%	41%	-3%	6%	2%	5%	8%	2%	6%	*n.c.*	0.5%	n.c.
BALTIMORE	32%	34%	-2%	8%	5%	3%	12%	7%	5%	0.1%	1.3%	-1%
WICOMICO & SOMERSET	33%	35%	-2%	9%	7%	2%	12%	8%	4%	0.2%	1.1%	-1%
CALVERT	37%	38%	-1%	6%	3%	4%	8%	3%	5%	n.c.	0.9%	n.c.
WORCESTER	40%	41%	-1%	4%	2%	2%	6%	3%	4%	n.c.	0.2%	n.c.
ANNE ARUNDEL	36%	37%	0%	6%	3%	3%	8%	4%	4%	0.1%	0.8%	-1%
HARFORD	38%	38%	0%	4%	3%	1%	5%	3%	2%	0.1%	0.6%	-1%
FREDERICK	38%	38%	0%	3%	3%	0%	4%	3%	1%	0.3%	1.0%	-1%
QUEEN ANNES	42%	41%	1%	3%	2%	1%	5%	3%	2%	n.c.	0.6%	n.c.
WASHINGTON	41%	39%	2%	2%	3%	-1%	2%	3%	-1%	*0.1%*	1.0%	-1%
CARROLL	41%	39%	2%	1%	3%	-1%	2%	3%	-2%	0.1%	0.6%	-1%
ALLEGANY & GARRETT	43%	41%	3%	1%	4%	-3%	1%	5%	-4%	*n.c.*	0.2%	n.c.
CECIL	43%	40%	3%	2%	3%	-1%	2%	4%	-1%	0.1%	1.4%	-1%

Source: Mathematica's analysis of 2013 Medicare FFS claims.

Statewide Difference by Race and Ethnicity

TCOC spending adjusted for HCC indicates Maryland has much higher TCOC per beneficiary for Hispanics and NH Black Females; however, this comparison may not be accurate due to small sample sizes in the benchmarks.



Source: Mathematica's analysis of 2013 Medicare FFS claims.

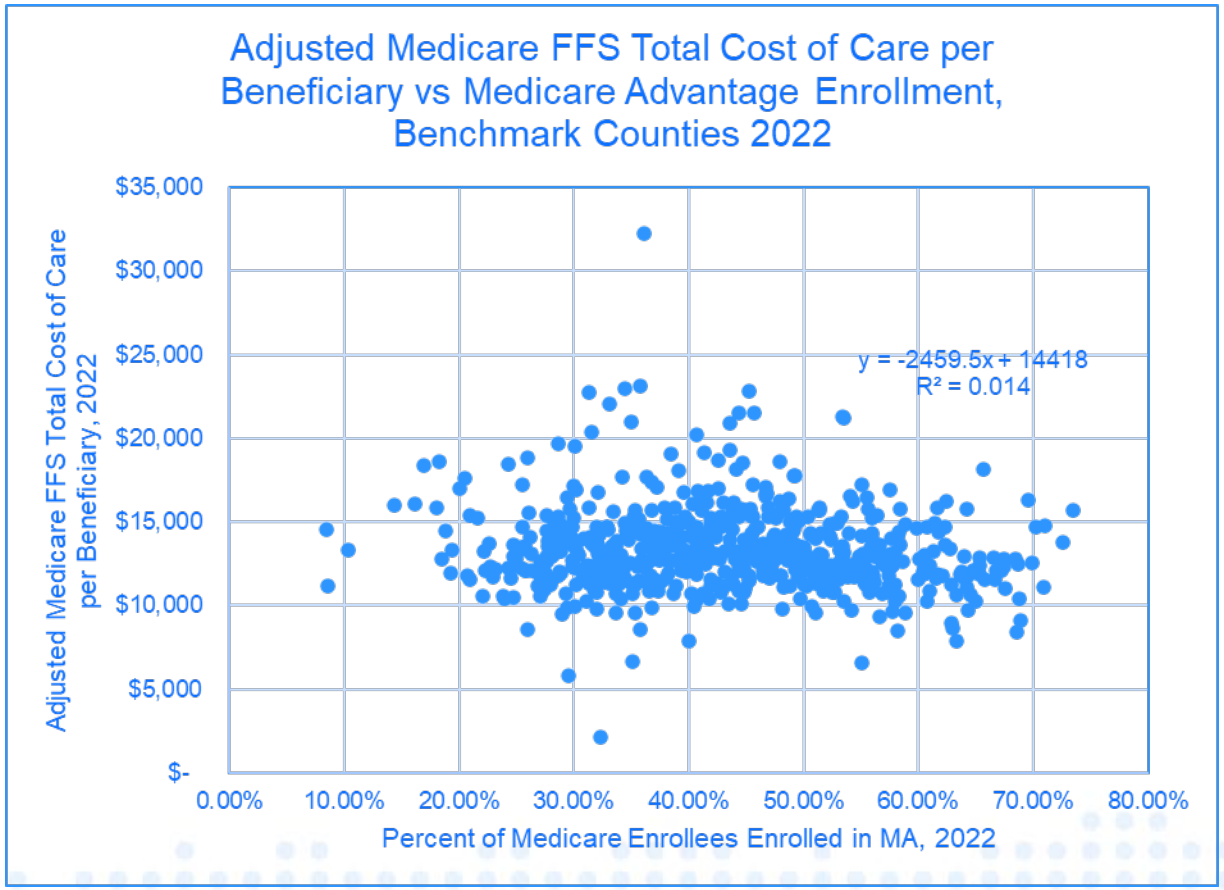
County Level Difference for NH Black Male and Female

Difference in benchmark comparison for NH Black Females are differential results in Baltimore and Prince George's county comparisons .

County Name	NH Black Male			NH Black Female			Beneficiary Counts		$ Difference	
	MD	Benchmark	Difference	MD	Benchmark	Difference	NH Black Male	NH Black Female	NH Black Male	NH Black Female
TALBOT	$ 12,065	$ 2,670	352%	$ 10,788	$ 2,202	390%	407	552	$ 3,827,603	$ 4,741,677
ALLEGANY & GARRETT	$ 13,489	$ 5,522	144%	$ 15,735	$ 6,016	162%	158	153	$ 1,256,740	$ 1,483,703
ST. MARYS	$ 13,028	$ 5,792	125%	$ 12,857	$ 5,376	139%	766	981	$ 5,542,925	$ 7,335,513
WORCESTER	$ 11,250	$ 6,459	74%	$ 11,319	$ 6,423	76%	515	751	$ 2,467,377	$ 3,675,333
DORCHESTER	$ 12,239	$ 7,085	73%	$ 12,366	$ 6,185	100%	704	922	$ 3,626,250	$ 5,697,268
WASHINGTON	$ 14,398	$ 9,284	55%	$ 12,710	$ 8,763	45%	400	442	$ 2,046,281	$ 1,745,275
CARROLL	$ 13,824	$ 10,337	34%	$ 10,603	$ 10,729	-1%	351	418	$ 1,223,225	$ (52,550)
WICOMICO & SOMERSET	$ 13,194	$ 10,394	27%	$ 11,616	$ 10,195	14%	1,768	2,376	$ 4,950,826	$ 3,375,358
BALTIMORE	**$ 14,453**	**$ 12,471**	**16%**	**$ 14,496**	**$ 10,848**	**34%**	**8,561**	**13,177**	**$ 16,972,535**	**$ 48,072,462**
CALVERT	$ 12,145	$ 10,829	12%	$ 11,409	$ 10,735	6%	654	863	$ 860,305	$ 581,643
HARFORD	$ 12,953	$ 11,628	11%	$ 13,915	$ 10,977	27%	1,181	1,491	$ 1,564,384	$ 4,378,089
CECIL	$ 12,098	$ 10,935	11%	$ 12,335	$ 8,445	46%	303	329	$ 352,963	$ 1,280,094
BALTIMORE CITY	$ 15,750	$ 14,242	11%	$ 14,995	$ 13,407	12%	17,510	24,877	$ 26,408,366	$ 39,485,158
FREDERICK	$ 12,464	$ 11,273	11%	$ 12,690	$ 11,030	15%	712	934	$ 848,680	$ 1,551,146
KENT	$ 13,950	$ 12,987	7%	$ 12,774	$ 4,334	195%	299	440	$ 287,737	$ 3,716,468
HOWARD	$ 11,097	$ 10,532	5%	$ 12,140	$ 10,507	16%	1,505	2,283	$ 849,566	$ 3,728,315
ANNE ARUNDEL	$ 13,282	$ 13,056	2%	$ 12,529	$ 10,856	15%	3,595	5,014	$ 812,349	$ 8,389,062
CHARLES	$ 11,824	$ 12,259	-4%	$ 12,194	$ 7,293	67%	1,714	2,391	$ (746,395)	$ 11,715,488
CAROLINE	$ 14,209	$ 15,031	-5%	$ 10,815	$ 7,005	54%	305	424	$ (250,376)	$ 1,614,032
MONTGOMERY	$ 11,988	$ 13,243	-9%	$ 11,715	$ 11,071	6%	4,593	7,399	$ (5,761,831)	$ 4,764,795
PRINCE GEORGES	**$ 12,814**	**$ 14,445**	**-11%**	**$ 12,620**	**$ 11,487**	**10%**	**18,997**	**26,077**	**$ (30,991,361)**	**$ 29,563,116**
QUEEN ANNES	$ 9,115	$ 12,637	-28%	$ 10,485	$ 6,794	54%	228	316	$ (804,191)	$ 1,167,889

Medicare Advantage Participation Rates and TCOC

Medicare Advantage enrolment rate has a very low correlation with Medicare FFS spending per beneficiary, adjusted for socio-economic factors (correlation 0.01).



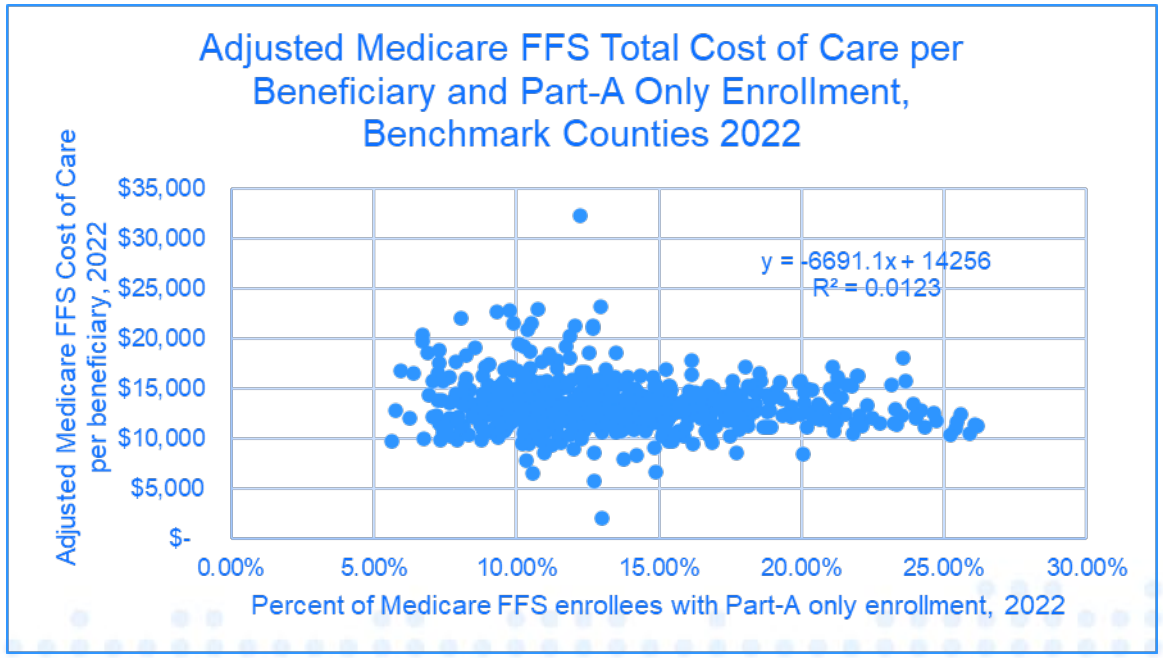
County	Percent Medicare Advantage Enrollment	
	MD	Benchmark Average
Baltimore City	30%	44%
Prince George'S County	25%	40%
Baltimore County	22%	54%
Harford County	21%	43%
Montgomery County	18%	37%
Washington County	17%	45%
Worcester County	16%	44%
Carroll County	16%	42%
Howard County	16%	39%
Garrett County	16%	41%
Anne Arundel County	16%	37%
Cecil County	15%	48%
Frederick County	14%	40%
Somerset County	14%	51%
Charles County	14%	43%
Dorchester County	12%	42%
Wicomico County	12%	48%
Caroline County	10%	41%
Kent County	10%	41%
Allegany County	10%	45%
Queen Anne'S County	9%	43%
Talbot County	8%	37%
Calvert County	7%	40%
St. Mary'S County	5%	36%

Enrollment data source: https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data

Part-A Only Enrollment

Both state methodology and federal evaluation restrict the analysis to beneficiaries with both Part-A and Part B enrollment.

Part-A only enrolment rate has a very low correlation with Medicare FFS spending per beneficiary, adjusted for socio-economic factors (correlation 0.01)

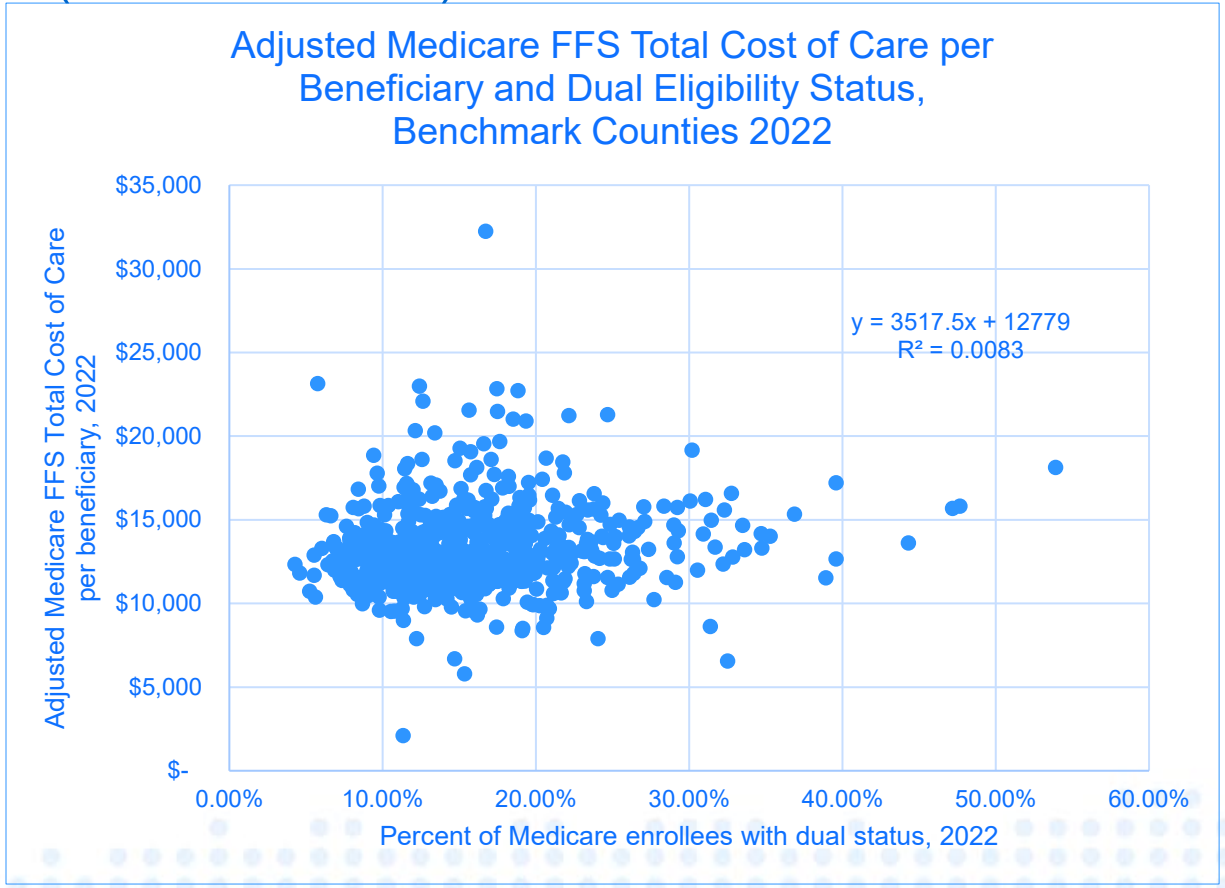


County	Percent Part-A only MD	Benchmark Average
Prince George's County	24%	18%
Montgomery County	23%	18%
Howard County	20%	17%
Charles County	16%	15%
Baltimore City	16%	18%
Frederick County	16%	18%
Anne Arundel County	16%	16%
Baltimore County	15%	19%
Harford County	14%	17%
Carroll County	14%	17%
Calvert County	13%	18%
Cecil County	12%	15%
St. Mary'S County	12%	12%
Queen Anne'S County	11%	14%
Washington County	11%	15%
Wicomico County	11%	14%
Caroline County	10%	11%
Dorchester County	10%	11%
Worcester County	9%	12%
Talbot County	9%	11%
Somerset County	9%	14%
Kent County	8%	11%
Garrett County	7%	10%
Allegany County	6%	11%

Enrollment data source: https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data

Dual Eligible Status

Percent of Medicare enrollees with dual enrollment has a very low correlation with Medicare FFS spending per beneficiary, adjusted for socio-economic factors (correlation 0.01).



County	Percent Total Beneficiaries with Full Dual Medicaid and Medicare enrollment: MD	Benchmark
Baltimore City	34%	18%
Somerset County	26%	25%
Dorchester County	23%	18%
Allegany County	21%	20%
Caroline County	21%	18%
Wicomico County	20%	18%
Washington County	18%	16%
Garrett County	18%	15%
Prince George'S County	16%	23%
Cecil County	15%	12%
Baltimore County	15%	29%
St. Mary'S County	15%	13%
Montgomery County	14%	19%
Charles County	14%	11%
Kent County	13%	16%
Howard County	12%	10%
Worcester County	11%	13%
Harford County	11%	11%
Frederick County	11%	13%
Talbot County	10%	13%
Calvert County	10%	12%
Anne Arundel County	10%	15%
Carroll County	9%	10%
Queen Anne'S County	9%	10%

Enrollment data source: https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data

Area-level Socio Economic Factors

Deprivation index

Potential new measures

- A composite measure of social and economic drivers of health in addition or to replace median income and deep poverty
  - Area deprivation index
    - CMMI uses this measure for payment adjustments
  - Social vulnerability index
    - Federal evaluation used this measure
  - Social deprivation index
  - Child opportunity index
  - Structural racism effect index

Exhibit 4 Explanatory power of the Structural Racism Effect Index (SREI) and other indices for predicting census tract–level variation in disease prevalence, 2020

		R^2				
	Prevalence, %	SREI	ADI	SVI	SDI	COI
Poor mental health	14	0.73	0.53	0.51	0.58	0.67
Poor physical health	13	0.71	0.53	0.55	0.48	0.65
Diabetes	11	0.57	0.42	0.44	0.35	0.54
High blood pressure	31	0.35	0.39	0.15	0.09	0.27
Asthma	10	0.48	0.37	0.34	0.37	0.54

SOURCES All health outcomes are from the Centers for Disease Control and Prevention's (CDC's) PLACES Project (see note 29 in text), data for 2020. Self-reported disease prevalence data are from the CDC Behavioral Risk Factor Surveillance System, and small-area estimates are from the CDC's PLACES Project. The SREI was calculated by the authors, using data from the sources listed in the exhibit 1 notes, which correspond to a full list of sources in supplement 2 in the appendix (see note 23 in text). The Area Deprivation Index (ADI) was calculated at the census tract level by the authors using Census Bureau American Community Survey 2015–19 5-year estimates. The Social Vulnerability Index (SVI) is from Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry. CDC/ATSDR Social Vulnerability Index [Internet]. Atlanta (GA): CDC; [last reviewed 2023 Jul 12; cited 2023 Aug 26]. Available from: https://www.atsdr.cdc.gov/placeandhealth/svi/. The Social Deprivation Index (SDI) is from Robert Graham Center. Social Deprivation Index (see note 16 in text), data for 2019. The Child Opportunity Index (COI) is from diversitydatakids.org. Child Opportunity Index (COI) [Internet]. Waltham (MA): Brandeis University; c 2023 [cited 2023 Aug 25]. Available from: https://www.diversitydatakids.org/child-opportunity-index. NOTE The unit of analysis is the census tract.

Source: https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00659

Social Risk Composite Measures

SDOH DOMAIN(S)	Dimension(s)	Area Deprivation Index	Social Vulnerability Index (SVI)
ECONOMIC WELLBEING	Income & poverty levels	✓	✓
ECONOMIC WELLBEING	Educational attainment	✓	✓
ECONOMIC WELLBEING	Employment & occupation	✓	✓
ECONOMIC WELLBEING	Family & household composition	✓	✓
ECONOMIC WELLBEING	Housing availability & affordability	✓	✓
ECONOMIC WELLBEING	Cost of living & other	✓	✓
ECONOMIC WELLBEING	Geographic or social mobility		
ECONOMIC WELLBEING	Public assistance rate		
EDUCATION ACCESS & QUALITY	Education access		
EDUCATION ACCESS & QUALITY	Teacher Workforce		
EDUCATION ACCESS & QUALITY	Academic achievement		
BUILT ENVIRONMENT	Housing type/safety/quality	✓	✓
BUILT ENVIRONMENT	Transportation	✓	✓
BUILT ENVIRONMENT	Food access & quality		
BUILT ENVIRONMENT	Physical activity access		
BUILT ENVIRONMENT	Community resources & services		
PHYSICAL & CHEMICAL ENVIRONMENT	Water pollution, air pollution		
PHYSICAL & CHEMICAL ENVIRONMENT	Toxic waste sites		
PHYSICAL & CHEMICAL ENVIRONMENT	Heat, climate change		
SOCIAL & COMMUNITY CONTEXT	Social capital, cohesion & support		
SOCIAL & COMMUNITY CONTEXT	Community empowerment		
SOCIAL & COMMUNITY CONTEXT	Attitudes & social norms		
SOCIAL & COMMUNITY CONTEXT	Safety		
SOCIAL & COMMUNITY CONTEXT	Other social & community context		
HEALTHCARE ACCESS & QUALITY	Health insurance		✓
HEALTHCARE ACCESS & QUALITY	Healthcare utilization		
HEALTHCARE ACCESS & QUALITY	Availability of healthcare centers		
HEALTHCARE ACCESS & QUALITY	Availability of providers		
SOCIAL DEMOGRAPHICS	Racial & ethnic composition		✓
SOCIAL DEMOGRAPHICS	Language		✓
SOCIAL DEMOGRAPHICS	Age distribution		✓
SOCIAL DEMOGRAPHICS	Sex distribution		
SOCIAL DEMOGRAPHICS	Disability status		✓
OPPRESSION & MARGINALIZATION	Racial residential segregation		
OPPRESSION & MARGINALIZATION	Place-based inequities		
OPPRESSION & MARGINALIZATION	Discriminatory policies & practices		
OPPRESSION & MARGINALIZATION	Cultural attitudes, stigma		

Area based measures: Place of patient's residence

Area Deprivation Index (ADI): The index was originally developed using data from the 1990 census, updated with 2020 data.

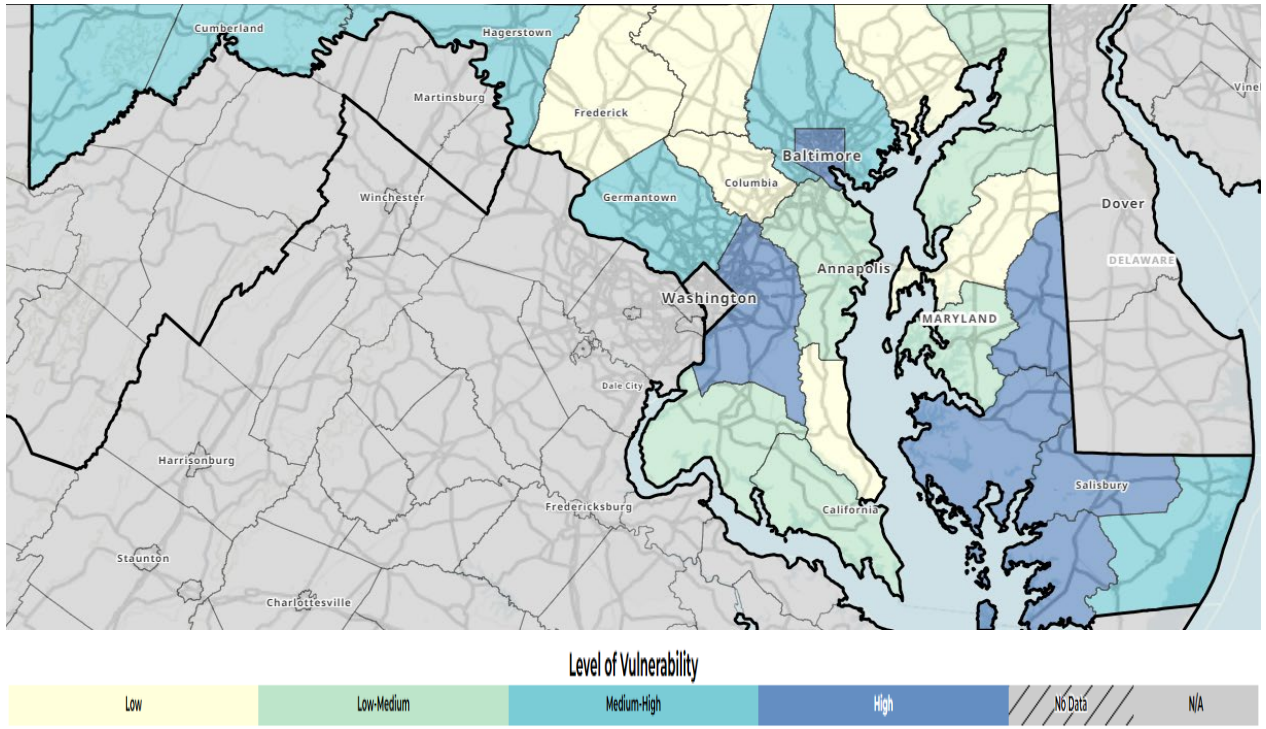
Example use: CMMI payment adjustments.

Social Vulnerability Index (SVI): The index is largely intended to assess needs before, during, and after an emergency event such as severe weather, floods, disease outbreaks, or chemical exposure.

Example use is for the CDC to distribute emergency funds.

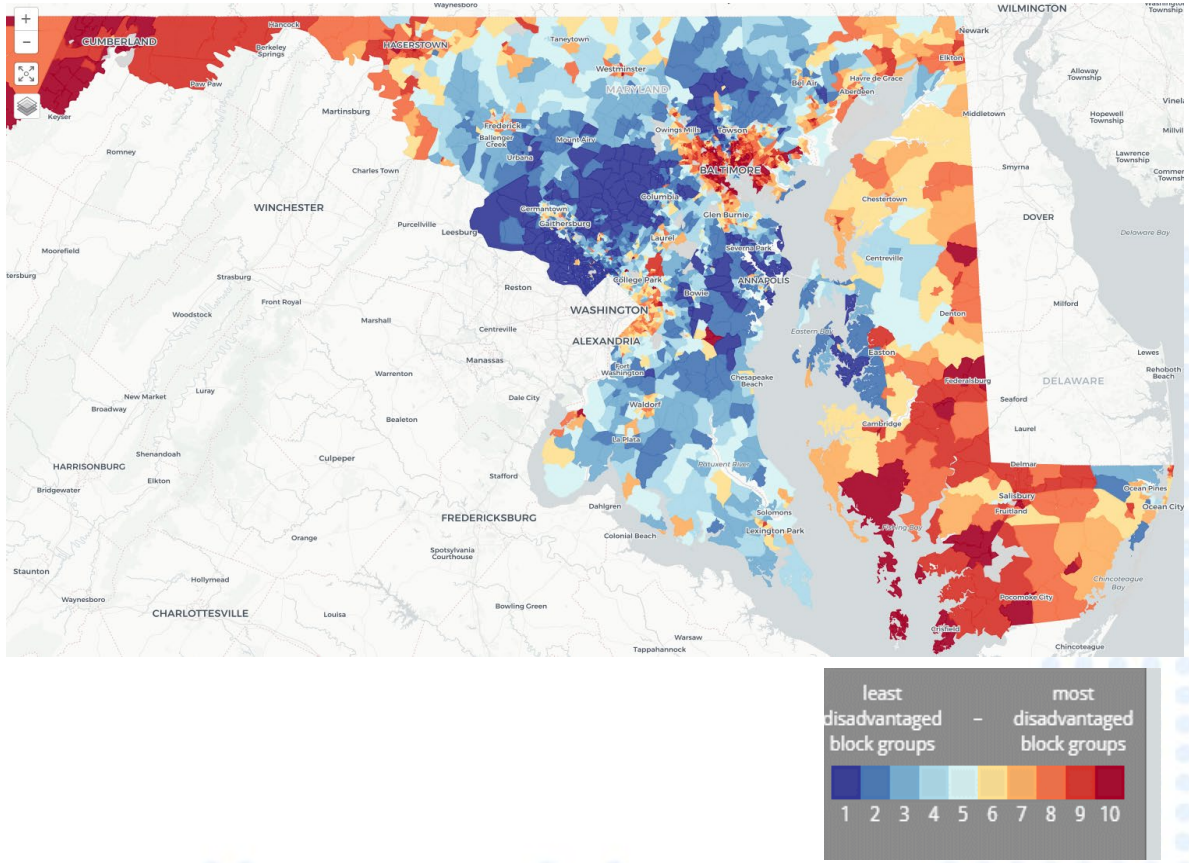
Comparison of Area Deprivation Index

Social Vulnerability Index (SVI)



Source: https://svi.cdc.gov/map/

Area Deprivation Index (SVI)



Source: https://www.neighborhoodatlas.medicine.wisc.edu/mapping

Next steps

- Comments on the selection of geography were due July 12th.
  - Keep county level analysis
- Recap on high-level approach
  - Not to consider:
    - Health outcomes
    - MA penetration
    - Part-A only
    - Dual status
    - % Hispanic
  - Continue to evaluate:
    - Health factors- health behaviors
    - Non-Hispanic Black
    - Social and economic factors (index vs. individual measure)
- Review preliminary results from baseline model on August 28th (this meeting may need to be rescheduled)

Next Steps

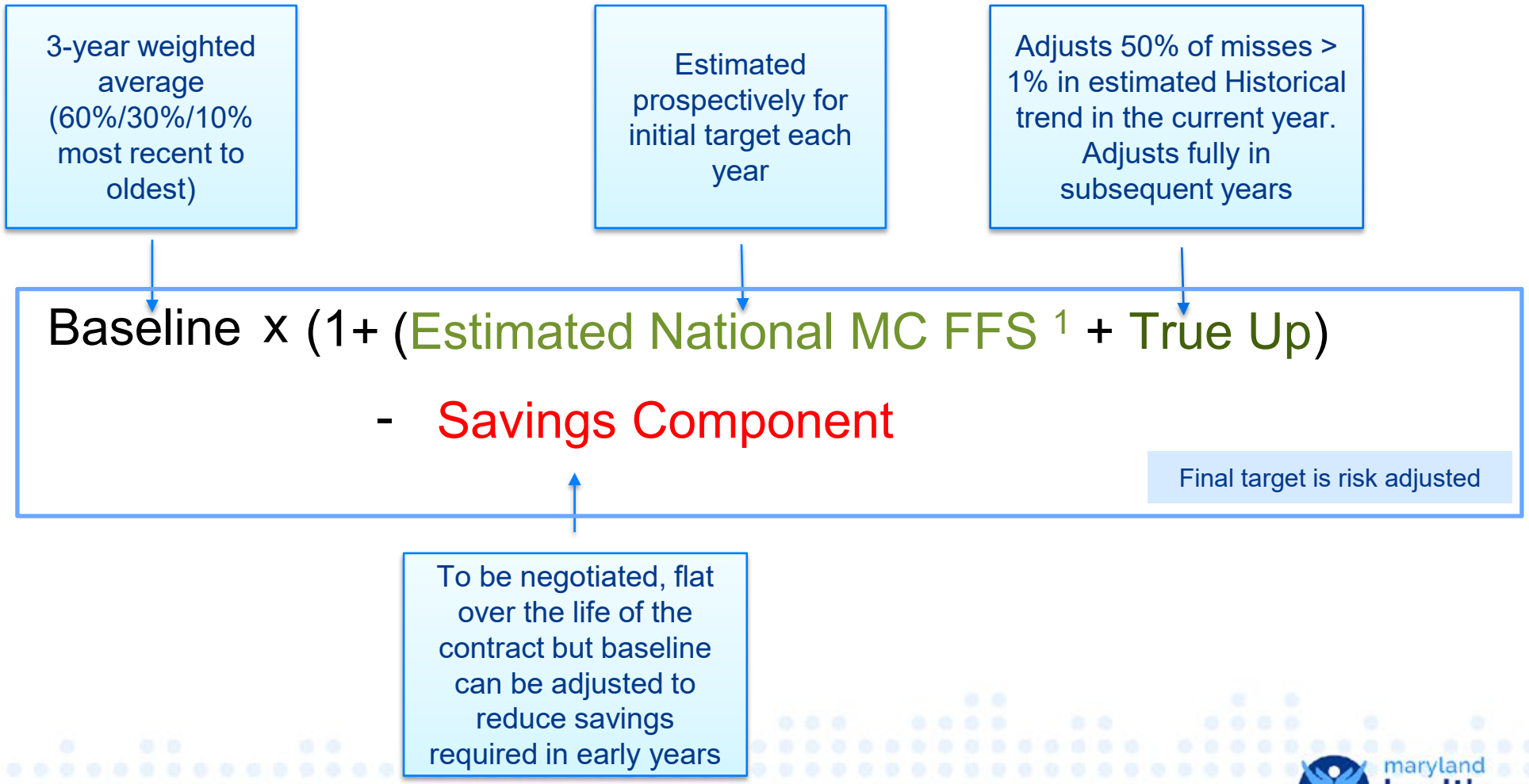
TCOC Workplan for Upcoming Months

- Next combined HSCRC TCOC Workgroup/H-TAC Meeting is August 28th
- TCOC Workgroup Priorities – Approximate timeline (will vary with AHEAD-related needs)
  - September to October – Finalize benchmarking, discuss changes to the MPA policy
  - November – draft MPA recommendation to commission for CY2025
- Other TCOC Related dates:
  - CTI – Reviewing FY24 and FY25 programs for overlap, will reach out soon
  - EQIP Enrollment – Now open
  - EQIP-PC RFA Released July 18th, responses due August 30th

Thank You
Next Meeting August 28, 8-10 am (Tentative)

Appendix

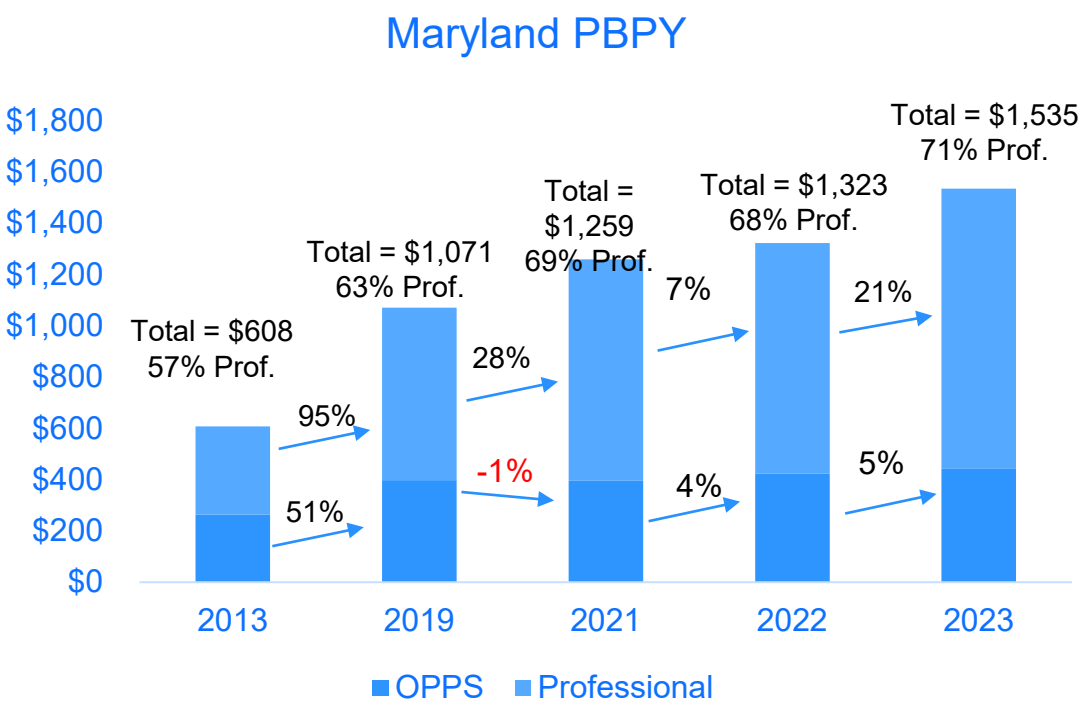
Current Understanding of Proposed AHEAD Expenditure Target (without Administratively Set Growth Rate) (option 2)

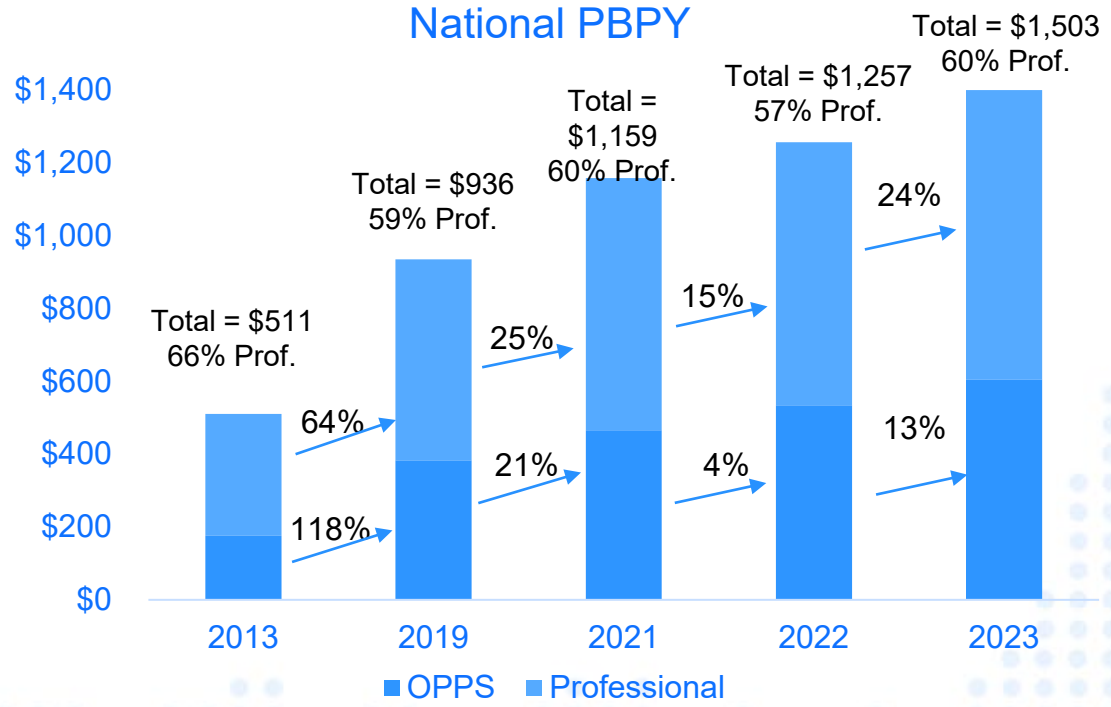


1. 33% of both trends are calculated against national $ and added to MD $ instead of applying trend to MD Base $.

Part B Drug Drill Down

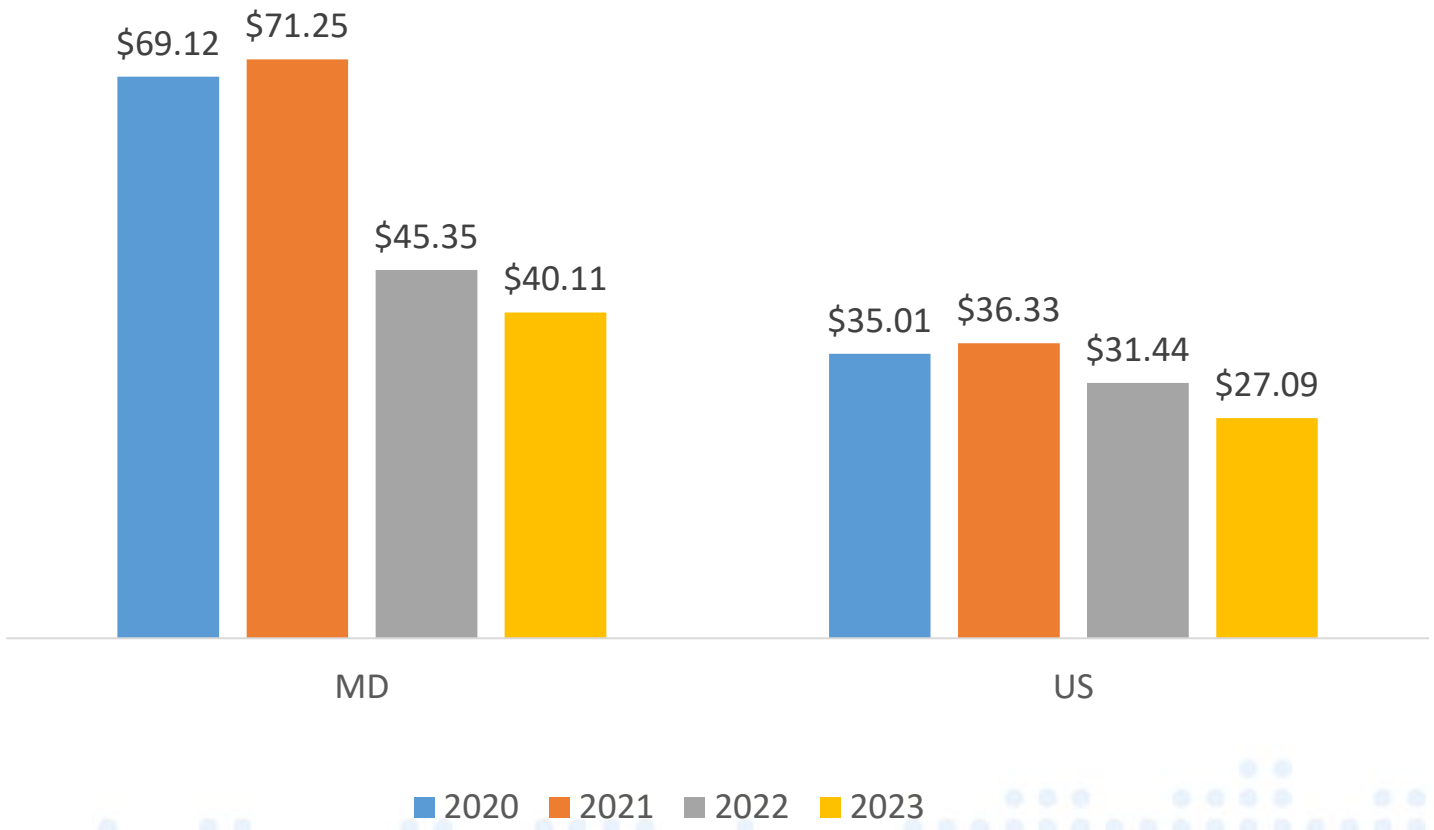
- Through 2019 Maryland was successful in shifting Part B Rx to the professional setting going up from 57% professional to 63% professional while the nation dropped from 66% to 59%.
- 2021 continued the pattern, as MD went to 69% professional while national remained essentially flat.
- In 2022, MD dropped slightly to 68% while the Nation fell to 57% further widening the gap.
- In 2023, MD % Professional was 71% versus the Nation at 59.7% (maintaining gap from 2022).





2023 Telehealth Trend, MD vs US

TCOC Per Capita Trend for Telehealth Services



- MD ranked 7th in Telehealth Cost per Capita for CY 2022 and 5th for CY 2023
- Telehealth was 0.59% of MD TCOC per Capita in CY 2023, 0.43% nationally

Matching and Adjustment Variables

Area level population characteristics

	State implementation methodology	Federal methodology
Area-level population characteristics	• Population density - population per square mile • Total population estimate • Rural/urban continuum code • Median household income • % population in deep poverty • Regional purchasing parities • % uninsured adults in 2015 (test-only) • % 65 and older (test-only) • % all adults with diabetes (test-only) • % non-Hispanic Black (test-only) • Bureau of Labor Statistics (BLS) wage all industry, all ownership type (test-only) • BLS wage for all industries, private ownership (test-only) • BLS wage for ambulatory healthcare service, private ownership (test-only)	• Regional purchasing parities • Median household income categories • % below federal poverty level, adjusted for cost of living • Log population density • % Hispanic

Matching variables

	State implementation methodology	Federal methodology
Characteristics of Medicare Beneficiaries	• % Medicare beneficiaries eligible for Medicaid (test-only) • Average Hierarchical Condition Category (HCC) Score	• Average age • % Black, 4-category distribution • % non-Hispanic White • % female • Average % of the population living in a rural area in the PUMA, calculated based on Medicare beneficiaries' zip code and census urban and rural classification by ZCTA. • % original reason for Medicare entitlement: disability, ESRD • Average HCC risk score
Characteristics of the healthcare system and insurance market		• Number of primary care providers (PCPs) per 1,000 Medicare beneficiaries