maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

June 25, 2025

Agenda

- AHEAD Update
- MPA and Benchmarking Update
- Semi-Annual TCOC Update
  - CY 2024 Savings Analysis
  - Part B Drug Savings
- High Value Care Plans & New Paradigms in Care Delivery Update
- Next Steps & Upcoming Meetings

AHEAD Update

MPA and Benchmarking

MPA Update

- July 1 Adjustments will be applied as captured in the worksheet distributed last month
  - No edits from CMS or hospitals
  - Two comments received from hospitals
- Mercy argued that HSCRC should implement the stop gain provisions adopted for Year 5 in Year 4 as with this change the potential upside is still significant but losses to the rest of the industry are more limited
  - Staff do not believe they should change the rules for an active year except in extreme circumstances and this situation does not meet that criteria
- UMMS is concerned that applying the MPA quality adjustments to CTI has a larger impact than intended and that the measures themselves aren't relevant.
  - Staff note CMMI specifically required this element of the program.
  - Staff are open to addressing this situation in the 2026 MPA policy.

Benchmarking Update

- Medicare
  - Introducing RPP into the regression did not have a significant impact even at the PSAP ranking level therefore Staff plan to retain the approach used previously while updating all the relevant data.
  - Data should be available shortly and will include new Primary Service Area Definitions
  - Industry had enquired about adjusting benchmarking for catheter fraud issue. HSCRC calculated the impact on the adjusted results of removing the relevant spending from Maryland and the benchmark.
    - Impact on most counties was <+/-1% point versus benchmark
    - In ranking terms 6 counties were impacted with 3 pairs switching places
    - Staff do not think the impact merits the added complexity of adding this adjustment
- Commercial
  - Continue to work with the APCD to addressing remaining data issues
  - Expect results soon.

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Drivers of Maryland FFS Medicare Savings

CY 2024 and Recap of Savings Since 2013

June 2025

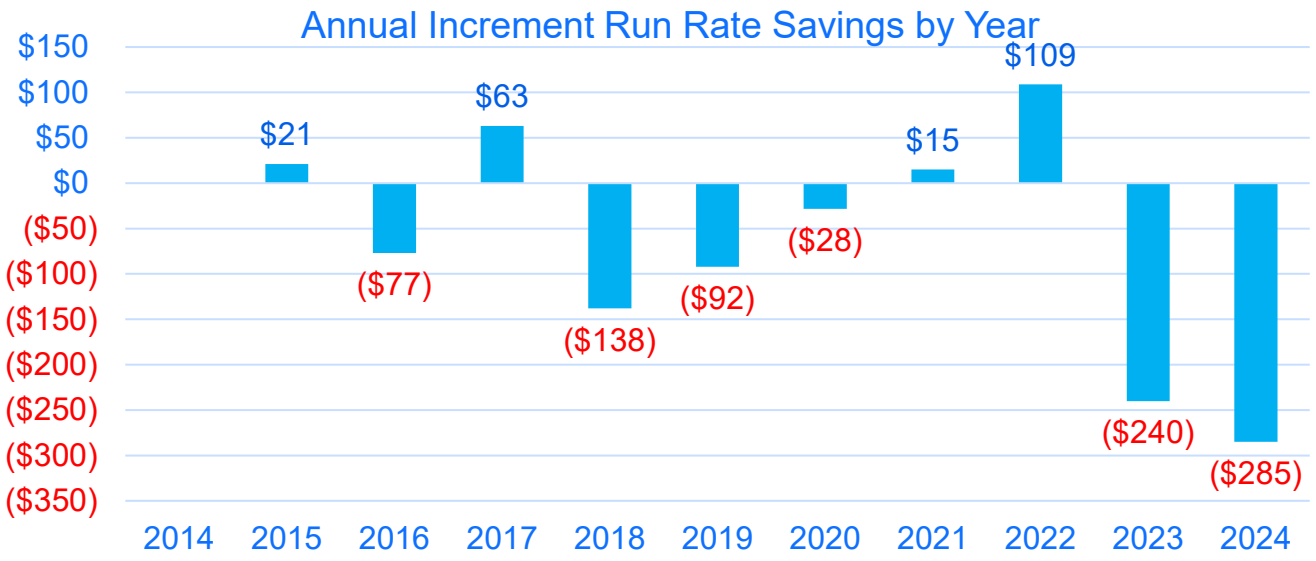
Presentation Context

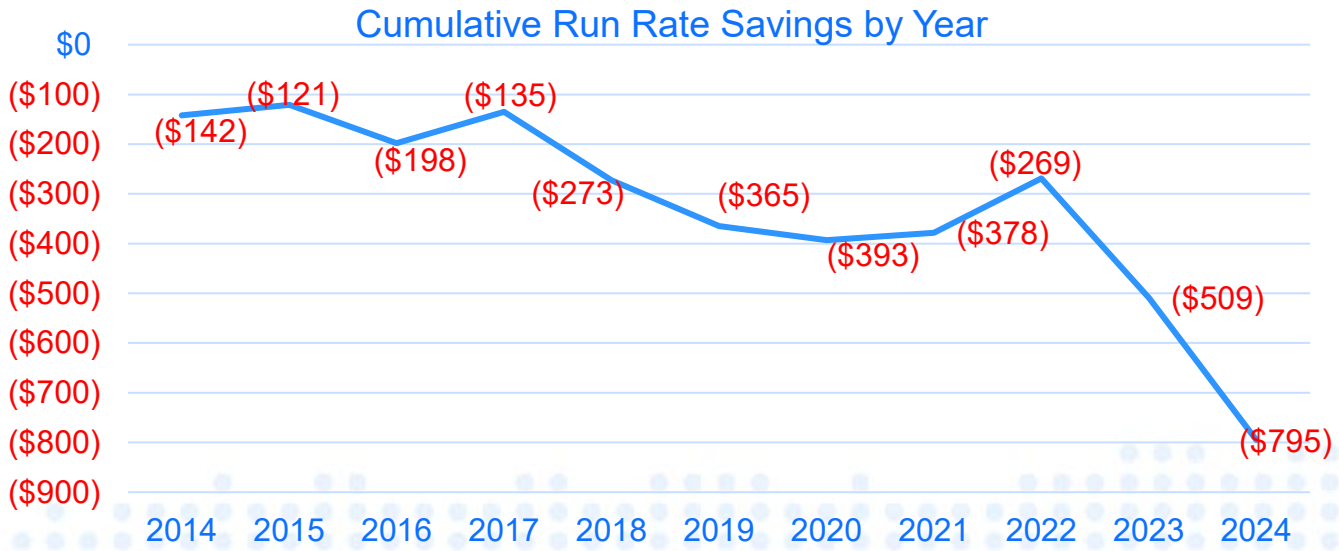
- Presentation displays update comparing previous years to the full year 2024 Maryland Medicare Total Cost of Care.
- Presentation focuses on four periods 2013 to 2019, 2019 to 2022, 2023 and 2024
  - TCOC in 2020, 2021, and 2022 showed considerable volatility, complicating 2023 comparison.
    - In 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 2024 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-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 under TCOC model
- 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 both 2023 and 2024.
- 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.
- Part C savings and Outcome Based Credits are included on this slide but excluded from subsequent slides.

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TCOC Savings, 2013 to 2019 vs 2019 to 2022 vs 2022 to 2023 vs 2023 to 2024

	2013 to 2019, Average		2020 to 2022, Average		2023		2024	
	Average Run Rate (Savings) Cost $ M	% of Savings	Average Run Rate (Savings) Cost $ M	% of Savings	Run Rate (Savings) Cost $ M	% of Savings	Run Rate (Savings) Cost $ M	% of Savings
Inpatient Hospital	($37)	59%	$114	132%	($83)	41%	($32)	13%
SNF	($6)	10%	$2	3%	$0	0%	($2)	1%
Home Health	$8	-12%	$1	1%	($11)	5%	($1)	0%
Hospice	$3	-6%	($11)	-13%	($5)	2%	$5	-2%
Total Part A	($31)	51%	$106	122%	($98)	48%	($30)	12%
Outpatient Hospital	($59)	95%	($65)	-76%	($119)	58%	($126)	52%
ESRD	($2)	4%	$6	7%	$6	-3%	($0)	0%
Outpatient Other	($4)	6%	($2)	-3%	($3)	2%	($11)	5%
Clinic	$0	0%	($1)	-2%	($2)	1%	($2)	1%
Professional Claims	$34	-55%	$43	50%	$13	-6%	($74)	30%
Total Part B	($31)	49%	($19)	-22%	($105)	52%	($214)	87%
Total	($62)		$86		($204)		($244)	

- Hospital claims are still driving the majority of total savings in 2024, but savings has shifted predominantly to Part B and Professional is a significant source of savings for the first time.
- Historically growth in MDPCP fees has offset Professional savings but MDPCP fees were flat from FY23 to FY24.

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		2024	
	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	Run Rate (Savings) Cost $ M	Growth Rate, MD vs US
Admits per K	($66)	-2.0%	$17	0.5%	($11)	-0.8%	$3	0.5%
Avg Case Mix Index	$44	0.2%	$34	0.2%	$20	1.3%	$12	0.3%
Cost per Day	($26)	-0.7%	$47	1.2%	($91)	-5.0%	($44)	-1.3%
ALOS (CMI Adj)	$11	1.6%	$10	0.9%	($3)	-0.1%	($4)	-0.1%
Mix Impact	$1		$6		$1		$1	
Total Inpatient	($37)		$114		($83)		($32)	

- Cost per Day is driving savings fluctuations since 2022
- Admits per 1,000 reductions again swung back to contribute to dissavings in 2024
- Case-Mix Adjusted Average Length of Stay no longer limits savings in 2024

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 2024

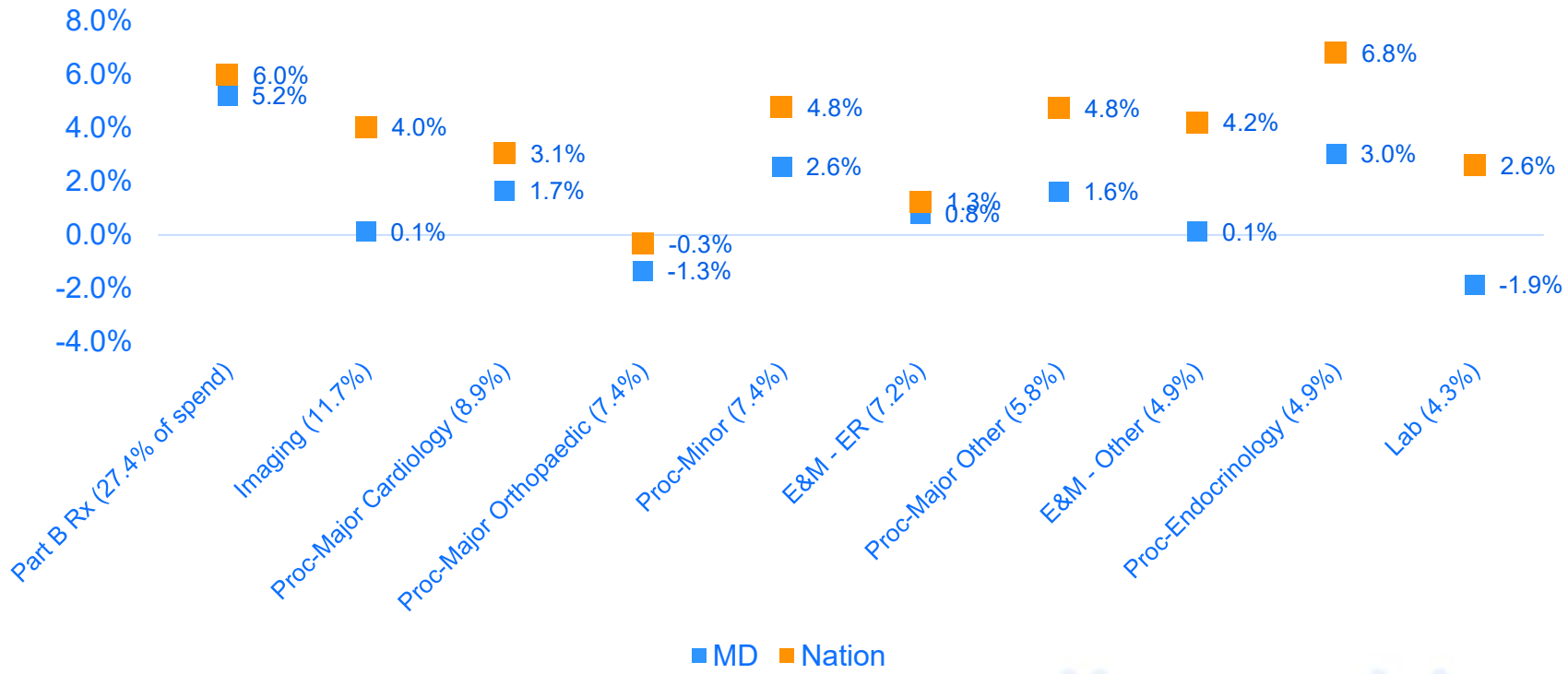
2023 to 2024 Cumulative (Savings) Costs $M		% of US Spend	MD Above (Below) National Compound Annual Growth Rate: Utilization	Unit Cost	Total	CY 2024 (Savings) Cost, $M	% of Savings
($280.2)	Part B Rx	27.4%	-0.7%	-7.8%	-8.5%	($31.7)	25.1%
($41.0)	Imaging	11.7%	-3.8%	-3.7%	-7.3%	($13.3)	10.6%
($7.1)	Proc-Major Cardiology	8.9%	-1.4%	-0.8%	-2.1%	($1.7)	1.3%
($44.1)	Proc-Minor	7.4%	-2.1%	-4.0%	-6.0%	($6.1)	4.9%
($80.0)	E&M - ER	7.2%	-0.5%	-4.5%	-4.9%	($6.1)	4.8%
($12.8)	Proc-Major Orthopaedic	7.4%	-1.0%	0.3%	-0.7%	($0.4)	0.4%
($0.3)	Proc-Major Other	5.8%	-3.0%	-1.1%	-4.1%	($2.8)	2.3%
($12.7)	Proc-Endocrinology	4.9%	-3.6%	-0.7%	-4.3%	($2.6)	2.1%
$53.1	Lab	4.3%	-4.4%	1.6%	-2.8%	($4.5)	3.6%
($47.9)	E&M - Other	5.0%	-3.9%	-10.5%	-14.0%	($21.7)	17.2%
($12.2)	Proc-Ambulatory	3.9%	-2.2%	7.9%	5.5%	$3.3	-2.6%
($29.9)	Proc-Oncology	3.3%	-5.6%	3.9%	-1.9%	($1.8)	1.4%
($68.0)	Other Professional	1.2%	1.4%	-11.6%	-10.3%	($22.5)	17.8%
($8.4)	Proc-Eye	1.2%	-6.7%	1.6%	-5.2%	($0.6)	0.5%
($21.3)	DME	0.4%	6.3%	13.0%	20.1%	$18.4	-14.6%
$0.2	Proc-Dialysis	0.0%	-15.8%	-42.0%	-51.2%	($0.6)	0.4%

- Part B Rx Savings in Outpatient hospital setting has remained consistent, even with professional no longer offsetting and seeing savings itself
- Maryland utilization growth was lower in nearly every category and in all the large categories.

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.

Hospital OP Utilization Trends

- Maryland versus National utilization trend (24 over 23) in 10 highest cost OP hospital areas (reflects trend values behind differences shown on prior slide.



Professional Savings, CY 2024

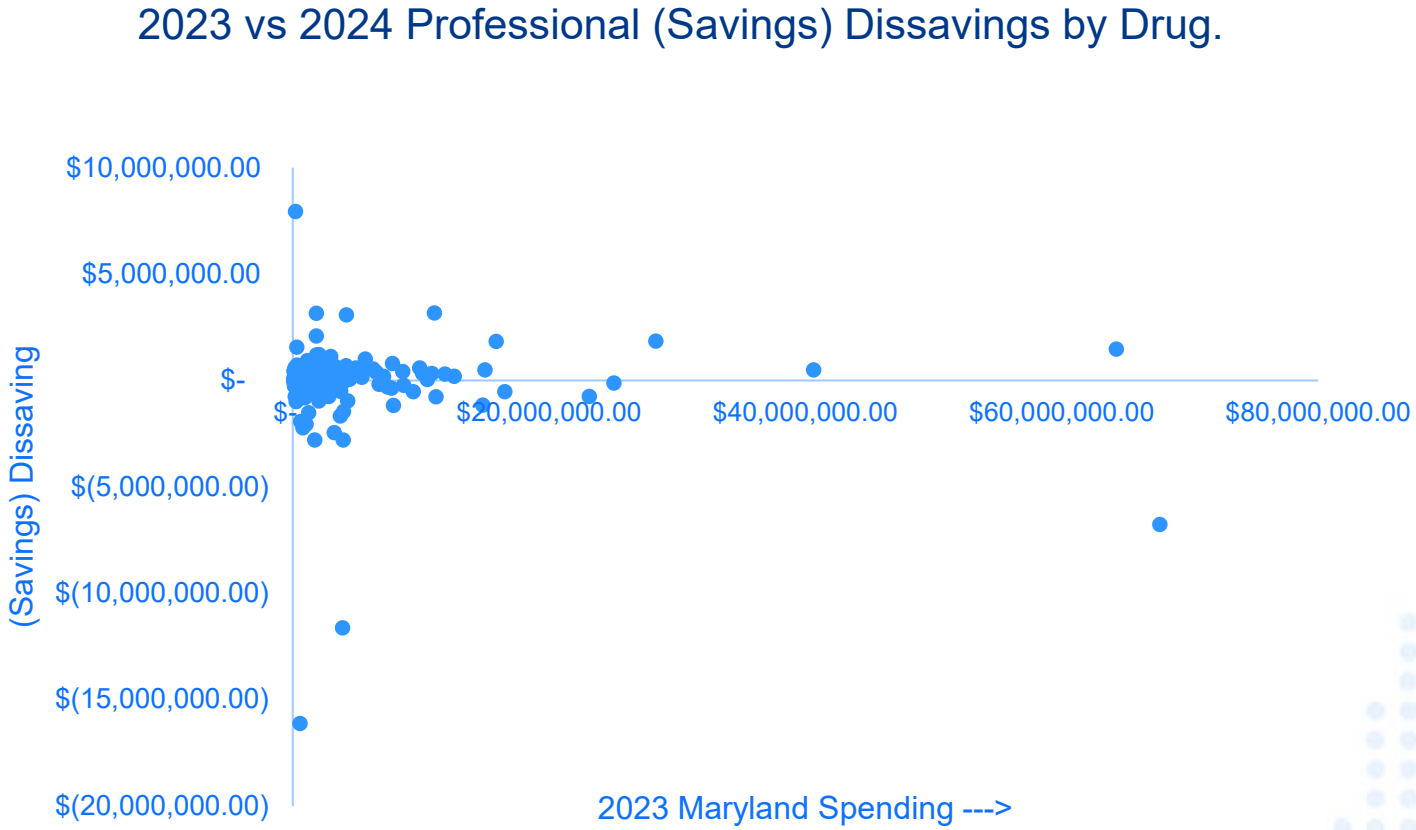
Cumulative (Savings) Costs $M		2023 to 2024 % of US Spend	MD Above (Below) National CAGR Utilization	Unit Cost	Total	Run Rate (Savings) Cost, $M	% of Savings
$116.5	Part B Rx	24.8%	2.8%	-8.1%	-5.6%	($54.7)	73.5%
$16.1	E&M - Specialist	16.6%	-0.7%	-0.8%	-1.5%	($10.0)	13.4%
$6.8	E&M - PCP	10.1%	0.2%	2.5%	2.7%	$10.3	-13.8%
$15.9	Lab	8.9%	0.4%	-1.2%	-0.8%	($3.0)	4.0%
$14.8	Imaging	6.1%	0.0%	-2.4%	-2.4%	($7.2)	9.7%
($5.5)	DME	7.4%	2.2%	-3.4%	-1.3%	($3.4)	4.6%
$31.9	Other Professional	5.5%	2.4%	-9.8%	-7.6%	($13.9)	18.6%
($1.8)	Proc-Minor	5.4%	-0.9%	-0.7%	-1.6%	($3.2)	4.4%
($4.9)	ASC	4.5%	-5.0%	5.4%	0.1%	$0.2	-0.3%
($11.1)	Proc-Ambulatory	3.0%	0.8%	1.9%	2.7%	$2.6	-3.5%
$0.6	Proc-Major Other	1.6%	-1.5%	0.6%	-0.9%	($0.6)	0.8%
$11.8	Proc-Major Cardiology	1.1%	0.5%	-3.3%	-2.8%	($1.6)	2.2%
($3.3)	Proc-Eye	1.3%	-0.9%	-0.8%	-1.6%	($0.7)	0.9%
($2.7)	Proc-Major Orthopaedic	1.2%	-0.9%	0.5%	-0.4%	($0.1)	0.2%
($4.3)	Proc-Endocrinology	0.9%	-0.9%	-3.0%	-3.9%	($1.1)	1.5%
$11.2	Proc-Oncology	1.1%	-2.0%	-1.4%	-3.4%	($1.6)	2.1%
$1.9	Proc-Dialysis	0.4%	2.1%	-2.0%	0.1%	$0.0	-0.0%

- Part B Rx Savings relative to US has continued to accelerate
- Generally, unit cost savings reflect differing mix growth as MD fee schedules are the same as national.
- PCP visits are the only significant source of dissavings in 2024.

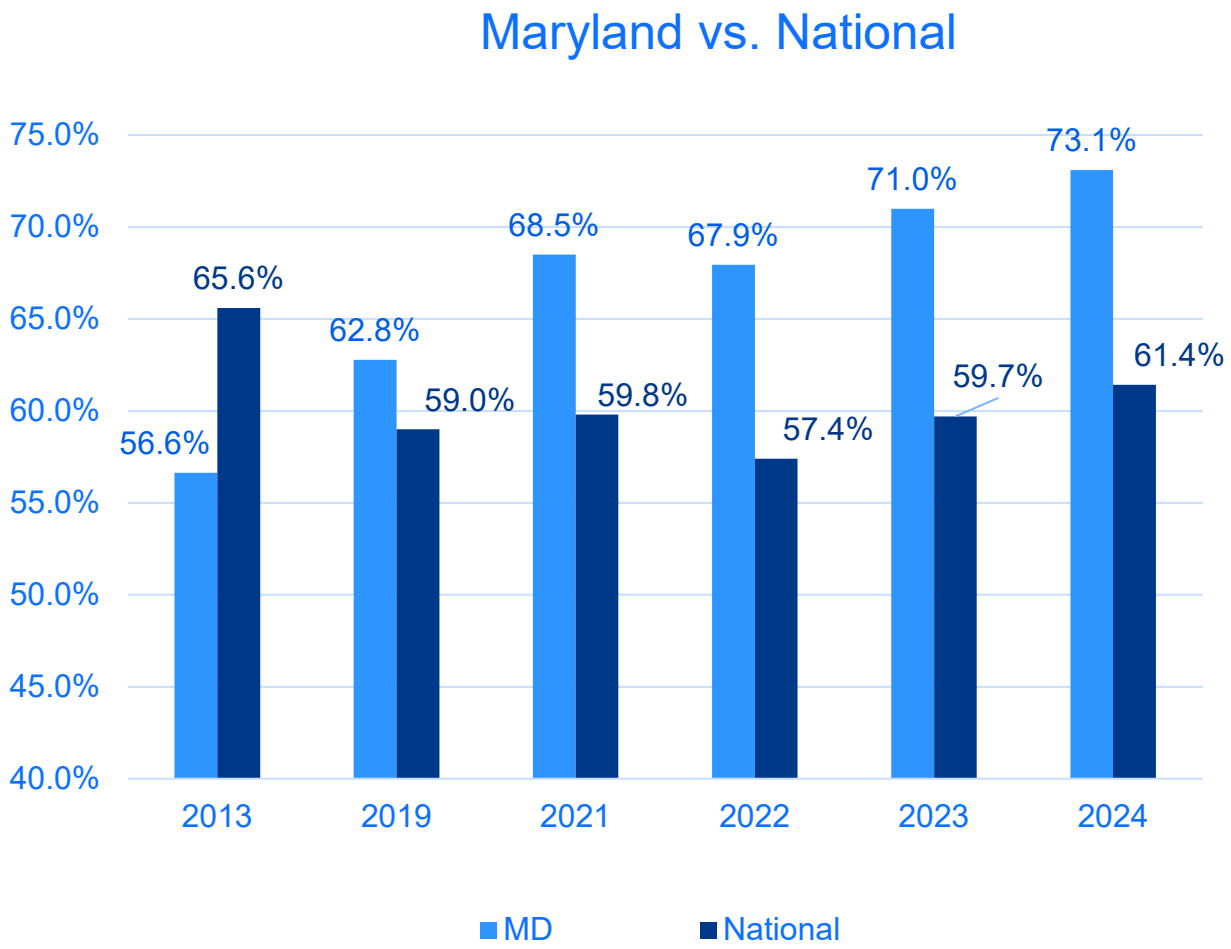
Note: amounts above reflect change in each individual bucket, mix impact of different shares of each bucket would also impact overall savings, also amounts represent 5% sample data. Amounts may not add up due to rounding.

Professional Part B Rx

- There was no strong pattern driving Maryland savings.
- Higher spend drugs were more likely to drive dissavings
- There are only a couple of individual drugs where Maryland is deriving significant savings, and they do not account for the bulk of the savings.
- Most of the savings is generated by a small advantage in relatively low-spend drugs.
- Savings may reflect ongoing volatility of broader shifts in drug delivery patterns and could stabilize at a more consistent level in coming years.



% of Part B Spending in a Professional Setting



- Since 2013, Maryland's use of the professional setting has increased by greater than 15% while the nation's decreased by about 4%. After a brief slow down during the pandemic the nation has gone back to the secular trend.
- On a PMPY basis Maryland has gone down from 19% greater than the nation to 3% less than the nation*. 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 $795 M of savings compared to the national run rate. While there are varying ways to calculate and allocate savings, savings can generally be attributed to the following ($ in M):

IP: Reduced IP admits and cost per day somewhat offset by higher LOS	($128)
OP Hospital (excl. ED & Part B Rx): Reductions in imaging, minor procedures, hospital clinics	($428)
PAC: Skilled Nursing, Home Health & Hospice	($2)
ED: Reduction in ED per Visit Costs	($80)
Part B Drugs: Shift to lower cost, office POS	($154)
Other Part B: Clinics, FQHCs, Dialysis Centers, etc.	($93)
MDPCP, CPC+, PCF Fees (net of lower claims-based reimbursement)	$189
Other Professional: Some additional Primary Care plus Specialists and other professional categories	$12
Other AAPM Dollars: MSSP, NGACO, OCM, CJR, CEC, Direct Contracting, VTACO, etc.*	($111)
Net Savings	($795)

*Reflects only MDPCP fees, other analysis shows that MDPCP has contributed to cost reductions in other areas. According to HSCRC analysis net impact of the program was ~$21 M.

Part B Drug Savings

MD Part B Drug Benchmark Analysis

Methods and Results

Jonathan Gellar, Sule Gerovich, and Lauren Forrow

June 17, 2025

Additional methodological details are available in an accompanying memorandum.

Goals

- Understand the changes in Part B drug utilization and spending in Maryland compared to the nation, since the advent of the All-Payer Model
- Inform HSCRC's payment policy for high-cost drugs

Data Sources

- All data comes from CCW Medicare claims (hMetrix)
  - Three years:
    - 2013: Baseline (before global budgeting)
    - 2019: Before the 2020 public health emergency
    - 2023: After the public health emergency (most recent full year)

Definitions

- Primary outcome: Medicare spending on covered Part B drugs and associated costs
  - Drug payments: includes direct drug payments and other drug payments
  - Ancillary payments: includes facility, professional, and infusion payments
- Measure definitions
  - Visits: unique dates of service for a given beneficiary
  - Units: total units of each drug
  - Users: number of unique patients with a drug claim
  - Beneficiaries: total number of Medicare FFS beneficiaries
- Resource use:
  - EAPG 3M weights based on year of service
  - 2023 CDSA status

Inclusion criteria

- Identify claims with two conditions:
  - 3M EAPG type="drugs" and category 18 (radiation therapy) or 24 (chemotherapy and other drugs).
    - Note: excludes category 32 (hematology)
  - APC status G or K (identifies drugs for which CMS makes a separate payment)

Exclusions

- hMetrix employed a density clustering method to detect unit outliers
  - 2% of records identified as outliers and excluded
- J0887 (epoetin beta) and J0879 (difelikefalin)
  - In 2023, J0887 and J0879 constitute 36.5% of all MD drug units
    - Neither was used in 2013 or 2019
    - Both used to treat complications associated with ESRD
  - High intensity (units/user), low drug cost, high facility cost
  - The drugs skew results, so we remove them from all analyses

Site of service

- Two sites of service:
  - HOPD: all facility claims with claim type 40 (Hospital outpatient) and payments from physician claims on the same day of the visit
  - PO: all claims where the place of service is office, home, or ASC, excluding claims that are pulled to HOPD

Analytic Methods

Accounting cost deconstruction

- Based on Fronstin et. al. (2020)

$$Spending = Units \times Price/Unit$$

- Key insights:
  - Separate HOPD and PO spending to investigate setting shifts
  - Run “counterfactual simulations” on the percentage of units that occur in a PO setting (and the associated spending consequences)

Fronstin, P., Roebuck, M. C., & Stuart, B. C. (2020). Cost Differences for Oncology Medicines Based on Site of Treatment. *EBRI Issue Brief*.

Counterfactual simulation

- What would Maryland have looked like, had it followed national trends?
  - Compare data during “post-period” to “pre-period” (baseline)
  - “Parallel trends” assumption:

$$MD_{post,CF} = MD_{pre} + \left(National_{post} - National_{pre}\right)$$

- Compare to what was observed in Maryland post-period
  - We call the difference the “impact” of Maryland policies, under the given counterfactual assumption

Example: Pre-pandemic impacts (2019 vs. 2013) on spending due to shifts in setting (HOPD to PO): JCode J0897 (Denosumab)

	National		Maryland		Counterfactual	Impact
	2013	2019	2013	2019	2019	
HOPD Units	2,213,463	5,445,395	324,180	432,019		
PO Units	3,884,340	8,793,177	793,943	2,223,844		
Total Units	6,097,803	14,238,572	1,118,123	2,655,863	2,655,863	
%PO	64%	62%	71%	84%	69%	15%
PO Price				$19.89	$19.89	
PO Spending				$44,241,479	$36,489,767	$7,751,712
HOPD Price				$29.41	$29.41	
HOPD Spending				$12,707,226	$24,168,166	-$11,460,940
Total				$56,948,705	$60,657,933	-$3,709,228

71% + (62%-64%)

Complication: data suppression

- CMS limits all our data to values of 11 or higher
  - Any value below 11 is suppressed (considered missing)
  - Includes units, visits, users, and payment values
- Our approach
  - Any counts of utilization (units, visits, or users) that are suppressed are treated as 0
  - For drugs that did not exist in an earlier year, we use the national number from the existing year as the counterfactual
  - When Maryland prices (per-unit or per-visit) are missing, we impute when feasible using a combination of the prior year and the national price
    - If imputation is not feasible, we exclude the drug

Overview

Analysis Overview

- Two impacts:
  - Pre-pandemic impact in 2019 (using 2013 as the baseline)
  - Post-pandemic impact in 2023 (using 2019 as the baseline)
- Separate drug spending vs. ancillary spending
  - Ancillary spending includes facility, professional, and infusion costs
- Two analyses
  - Setting shift (PO vs. HOPD)
  - Drug intensity (units/user)

Results overview

Outcome	Pre-pandemic impact (2019)	Post-pandemic impact (2023)
Setting Shift (%PO)	-$67,434,516 (-5%)	-$77,652,245 (-5%)
Drug Intensity (units/user)	-$45,981,989 (-4%)	$19,208,832 (2%)

- Negative impact values indicate savings
- Impacts are not mutually exclusive across analyses
  - Each analysis has its own assumptions, which conflict with the assumptions of the other analysis – for example, setting shift analysis does not control for changes in drug intensity
  - Therefore, they cannot be added to get a total impact

Impacts on setting shift (and associated savings)

Impacts on setting shift

- Counterfactual assumption:
  - For each drug, the **proportion of units and visits** that occur in a physician office (%PO) would have changed according to the national trend, if Maryland did not implement its policies

  - In addition, we assume that the model does not affect:
    - Total number of **units** and **visits** for the drug
    - **Drug price per unit** and **ancillary spending per visit** associated with the drug

Descriptive statistics: Part B drug spending

	Drug Spending			Ancillary Spending		
	2013	2019	2023	2013	2019	2023
Maryland HOPD Spending	$261,841,365	$412,223,433	$422,482,958	$97,512,658	$142,727,705	$148,824,868
Maryland PO Spending	$258,467,519	$692,655,476	$872,611,234	$52,165,673	$71,085,941	$64,902,028
Maryland Total Spending	$520,308,885	$1,104,878,908	$1,295,094,192	$149,678,331	$213,813,646	$213,726,896
%PO (Maryland)	50%	63%	67%	35%	33%	30%
%PO (Nation)	59%	56%	47%	35%	30%	28%

Descriptive statistics: Part-B drug units and visits

	2013		2019		2023	
	Maryland	Nation	Maryland	Nation	Maryland	Nation
Drug Units (drug spending)						
Total Units	20,383,446	128,751,227	52,849,383	371,385,627	75,337,889	386,404,382
%PO	54%	46%	57%	49%	46%	41%
PO Price/Unit[a]	$23.57	$24.38	$22.81	$17.33	$25.31	$19.90
HOPD Price/Unit[a]	$27.72	$14.98	$18.31	$13.17	$10.33	$15.14
Drug Visits (ancillary spending)						
Total Visits	290,819	1,574,098	498,600	2,833,998	636,370	2,802,379
%PO	69%	64%	57%	45%	48%	44%
PO Price/Visit	$260.52	$215.64	$249.81	$207.52	$214.19	$175.90
HOPD Price/Visit	$1,064.85	$707.16	$664.40	$399.76	$444.20	$352.85

[a] The drug mix will differ in an HOPD vs. PO setting, which is responsible for some of the differences in price/unit.

Descriptive statistics: Part-B drug units and visits, controlling for drug mix

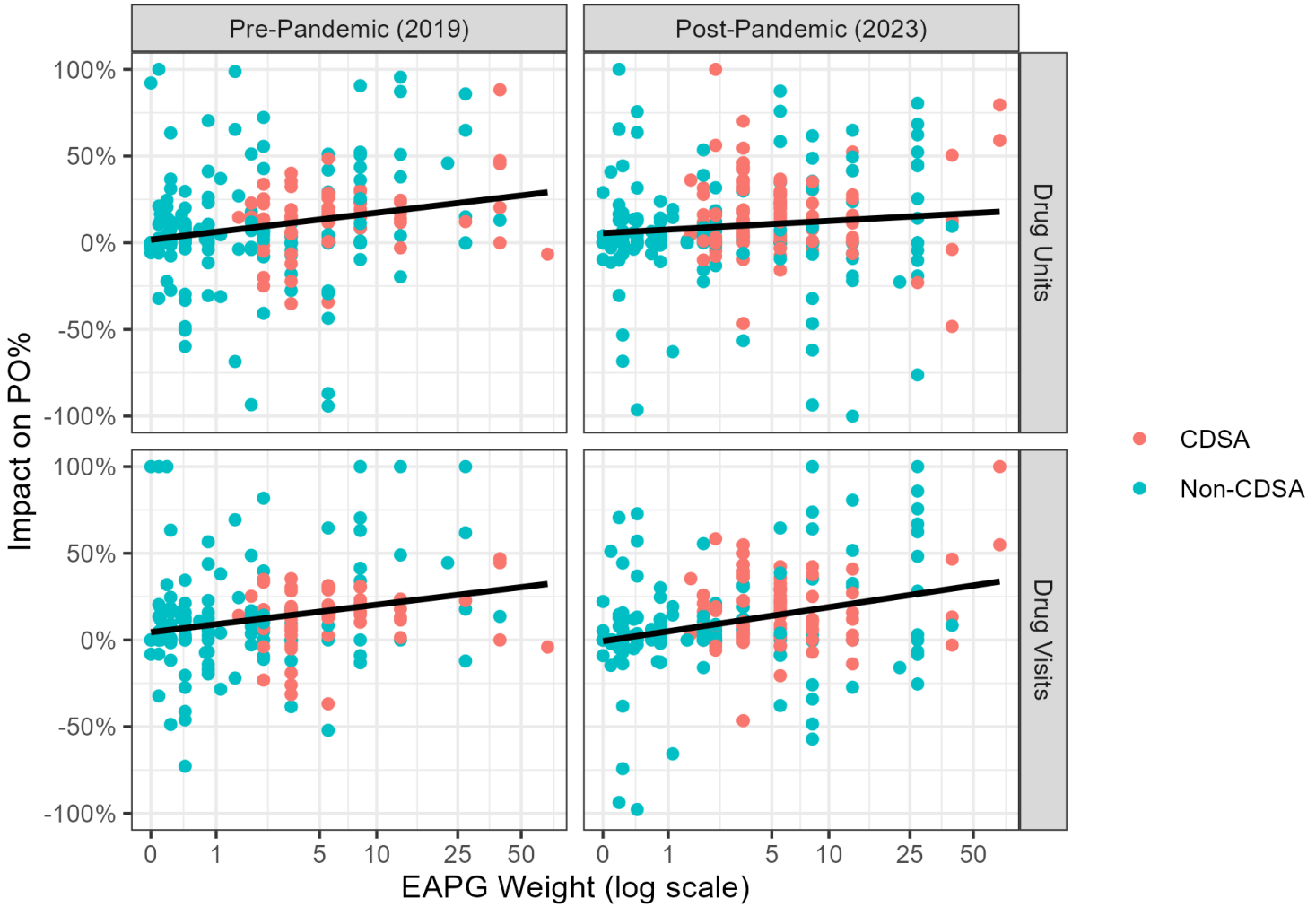
	2013		2019		2023	
	Maryland	Nation[b]	Maryland	Nation[b]	Maryland	Nation[b]
Drug Units (drug spending)						
Total Units	20,383,446	20,383,446	52,849,383	52,849,383	75,337,889	75,337,889
%PO	54%	54%	57%	44%	46%	32%
PO Price/Unit[a]	$23.57	$23.53	$22.81	$22.51	$25.31	$25.84
HOPD Price/Unit[a]	$27.72	$18.26	$18.31	$11.97	$10.33	$7.74
Drug Visits (ancillary spending)						
Total Visits	290,819	290,819	498,600	498,600	636,370	636,370
%PO	69%	66%	57%	48%	48%	37%
PO Price/Visit	$260.52	$215.51	$249.81	$211.71	$214.19	$180.30
HOPD Price/Visit	$1,064.85	$535.61	$664.40	$411.54	$444.20	$331.23

[a] The drug mix will differ in an HOPD vs. PO setting, which is responsible for some of the differences in price/unit.
[b] National drug mix is reweighted to match the Maryland drug use in the corresponding year.

Counterfactual Simulation: Main Results

	Pre-pandemic (2019)			Post-pandemic (2023)		
	Maryland	Counterfactual	Impact	Maryland	Counterfactual	Impact
Drug Spending						
HOPD	$390,583,365	$577,210,837	($186,627,472)	$419,803,474	$623,049,986	($203,246,512)
PO	$658,643,289	$519,950,035	$138,693,254	$867,443,660	$726,313,931	$141,129,729
Total	$1,049,226,654	$1,097,160,871	**($47,934,217)**	$1,287,247,134	$1,349,363,917	**($62,116,783)**
% Savings			**-5%**			**-5%**
Savings/Beneficiary			**($62)**			**($86)**
Ancillary Spending						
HOPD	$140,752,732	$169,526,919	($28,774,187)	$80,226,124	$100,805,864	($20,579,739)
PO	$70,923,751	$61,649,863	$9,273,888	$64,150,612	$59,106,335	$5,044,278
Total	$211,676,483	$231,176,782	**($19,500,299)**	$144,376,737	$159,912,198	**($15,535,462)**
% Savings			**-9%**			**-11%**
Savings/Beneficiary			**($25)**			**($21)**

Impacts on setting shift, by drug



"Impact on PO%" is the percentage of drug units (top) or visits (bottom) shifted from HOPD to PO, due to each policy in the corresponding year.

Impacts on setting shift, by drug

Maryland shifted higher-resource drugs to the PO setting more than lower-resource drugs in both periods, both in terms of drug units and drug visits.

	Pre-pandemic (2019)	Post-pandemic (2023)
Drug Units		
Spearman correlation between %PO and EAPG Weight	0.357	0.22
Average increase in %PO for every 1-unit increase in EAPG weight	0.6% (p=0.005)	0.3% (p=0.014)
Average difference in %PO for CDSA (vs. non-CDSA) drugs	3.3% (p=0.152)	6.4% (p<0.001)
Drug Visits		
Spearman correlation between %PO and EAPG Weight	0.387	0.321
Average increase in %PO for every 1-unit increase in EAPG weight	1.1% (p<0.001)	0.8% (p<0.001)
Average difference in %PO for CDSA (vs. non-CDSA) drugs	5.8% (p=0.001)	8.7% (p<0.001)

NOTE: All statistics are weighted by the count of units (drug spending) or visits (ancillary spending) corresponding to each drug

Summary of impacts on setting shift

- Pre-pandemic, Maryland shifted both drug units and drug visits towards the PO setting
  - The shift was larger for high-resource drugs
  - This resulted in a net savings of $48M in drug spending and $20M in ancillary spending
- These trends continued post-pandemic
  - The shift was larger for high-resource drugs
  - This resulted in a net savings of $62M in drug spending and $16M in ancillary spending

Impacts on drug intensity (and associated savings)

Impacts on drug intensity

- Counterfactual assumption:
  - For each drug, the **drug intensity (units/user)** would have changed according to the national trend, if Maryland did not implement its policies

- Key limitation:
  - We do not control for underlying patient health status and diagnosis.
    - In other words, changes in drug intensity could be due to changes in the health needs of the underlying patients, not necessarily Maryland's policies.

Aggregate utilization statistics

	2013	2019	2023
Total units (Maryland)	20,383,720	52,849,575	75,338,108
Total users (Maryland)	77,351	117,289	128,627
Average units/user (Maryland)	264	451	586
Average units/user (Nation)	306	597	576
Absolute Difference (MD – Nation)	-42	-146	10
% Difference (MD/Nation)	-14%	-24%	+2%

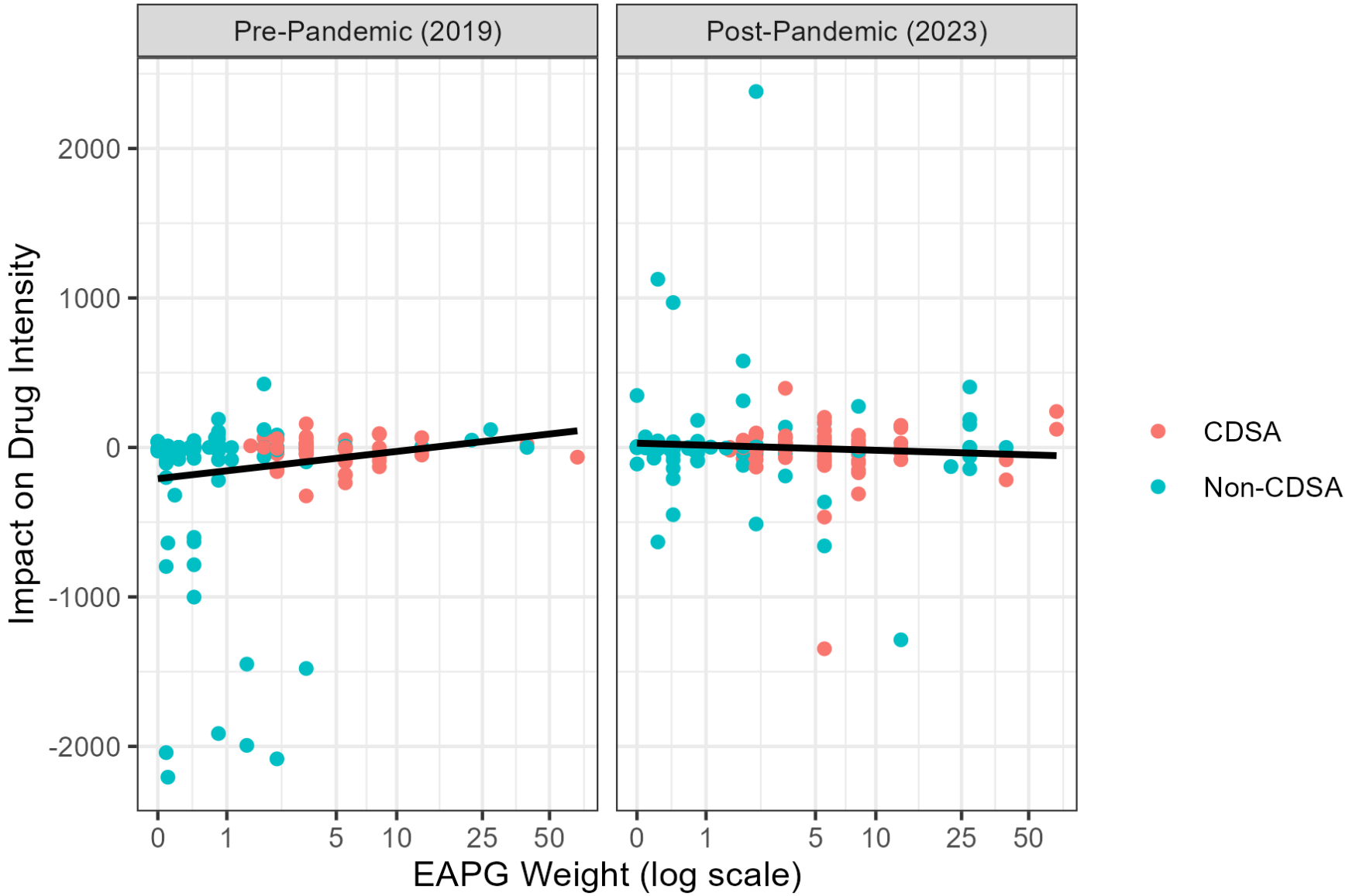
Note: average units/user reflects both drug intensity and drug mix changes

Counterfactual Simulation: Main Results

	Pre-pandemic (2019)	Post-pandemic (2023)
Maryland Average Intensity	380	317
Counterfactual Average Intensity	408	320
Intensity Impact (%)	**-28 (-7.4%)**	**-3 (-1.0%)**
Savings Per User	**($345)**	**$138**
Total Savings	**($45,981,989)**	**$19,208,832**
Total Drug Payments	$1,060,753,350	$1,247,885,063
% Savings	**-4%**	**2%**
Savings/Beneficiary	**($60)**	**$27**

NOTE: Despite the reduction in intensity in MD 2023, savings estimate show a higher cost in Maryland due to changes in drug intensity. Please see slides 31-32 for additional detail.

Impacts on drug intensity, by drug



Impacts on drug intensity: vutrisiran impact

- The impact on 2023 spending due to intensity shifts is driven in large part by J0225 (vutrisiran injection)
  - Accounts for $13M of the $19M in increased spending
  - One of the more expensive drugs, at $2,055/unit. Approved in 2023.
  - High intensity:
    - MD: 214 units/user for 43 users
    - Nation: 60 units/user for 116,620 users

* Note: All utilization for this drug is at physician offices in Maryland, vs. 50% at POs elsewhere in the nation. Location does not have a significant impact on units per user.

Drugs with the 10 largest impacts (+/-) on 2023 net spending due to intensity shifts

										% Savings	% Impact units
Statewide totals								19,208,832.31	(420,742.03)	2%	-1%
JCode	users	intensity_MD	intensity_CF	intensity_impact	intensity_ratio	unit_price	CDSA2023	savings	Total Impact_uni	Drugs Impact on Savings	Drugs Impact on Utilization
J0225	42	213.7	60.08	153.59	0.72	$ 2,055.22	Non-CDSA	$ 13,257,661	6,450.73	69%	2%
J0178	17673	7.3	6.82	0.52	0.07	$ 853.61	Non-CDSA	$ 7,853,063	9,199.86	41%	2%
A9607	96	738.6	498.20	240.45	0.33	$ 205.23	CDSA	$ 4,737,260	23,082.77	25%	5%
J2777	4502	239.7	220.91	18.79	0.08	$ 36.97	Non-CDSA	$ 3,127,581	84,587.60	16%	20%
J9145	180	945.4	743.97	201.45	0.21	$ 69.67	CDSA	$ 2,526,088	36,260.28	13%	9%
J9271	2538	1,036.5	1,049.96	(13.44)	(0.01)	$ 57.20	CDSA	$ (1,951,460)	(34,113.67)	-10%	-8%
J9306	189	2,245.0	2,711.09	(466.09)	(0.21)	$ 23.39	CDSA	$ (2,060,544)	(88,091.48)	-11%	-21%
J9228	261	291.5	327.58	(36.07)	(0.12)	$ 232.43	CDSA	$ (2,188,293)	(9,414.78)	-11%	-2%
J3380	605	1,054.7	1,224.15	(169.44)	(0.16)	$ 23.05	CDSA	$ (2,362,365)	(102,509.39)	-12%	-24%
J9299	945	1,773.8	1,863.11	(89.28)	(0.05)	$ 31.76	CDSA	$ (2,679,803)	(84,372.83)	-14%	-20%

Impacts on drug intensity, by drug

	Pre-pandemic (2019)	Post-pandemic (2023)
Spearman correlation between intensity shift and EAPG weight	0.204	0.084
Average increase in intensity shift for every 1-unit increase in EAPG weight	2.9 (p=0.435)	-0.7 (p=0.697)
Average difference in intensity shift for CDSA (vs. non-CDSA) drugs	39.6 (p=0.095)	-7.0 (p=0.647)

Summary of impacts on drug intensity

- Pre-pandemic trends show that average drug intensity in Maryland decreased between 2013 and 2019
  - The decrease in drug intensity was larger for low-resource drugs than high-resource drugs. Still, decreasing drug intensity saved Maryland an estimated $46M in 2019.
- Post-pandemic, we estimate that average drug intensity in Maryland slightly decreased between 2019 and 2023
  - However, because certain high-cost drugs saw large increases in intensity, there was a net increase of $19M in spending due to these intensity shifts.
  - $13M of that increase was due to a single drug: J0225 (vutrisiran).
  - Overall, the relationship between the intensity shift and resource use is weak.

Overall Summary

Outcome	Pre-pandemic (2019)	Post-pandemic (2023)
Setting Shift (%PO)	-$67,434,516 (-5%)	-$77,652,245 (-5%)
Drug Intensity (units/user)	-$45,981,989 (-4%)	$19,208,832 (2%)

Larger shift for high-resource drugs

Resulted in savings pre-pandemic but increases in spending post-pandemic, due to the precise mix of drugs that increased vs. decreased in intensity

Questions?

High Value Care Plans & New Paradigms in Care Delivery

High Value Care Plans (HVCP)

RY26 Update Factor Final Recommendation

- Requires hospitals to report on their improvement targets and outcomes as part of their high value care plans aimed at reducing statewide potentially avoidable utilization.
- Failure to report on targets and outcomes will result in a take back of 0.27 percent of inflation removed in the RY 2026 rate orders.
- **All hospitals reported and completed necessary revisions for this year.**

Primary Clinical Focus Areas

Sepsis Management

- Frequently paired with **CHF (heart failure)**
- Related to both readmission reduction and transitional care

Congestive Heart Failure (CHF)

- Regularly tracked alongside **sepsis**, **COPD**, **diabetes**, and **palliative consults**

Diabetes, CHF, and Obesity

- Repeated emphasis, often linked with **avoidable ED utilization**
- Suggests a population health management approach

Chronic Conditions & Readmissions

- COPD, psychiatric conditions, opioid use, acute kidney injury (AKI)
- Special attention to **Medicaid**, **high-risk**, **psych**, and **socially deprived** populations

End of Life (EOL) Care/Hospice/ Palliative Care

- Highlighted alongside **OPAT** and **MVP**

Transitional Care

- Focus on reducing SNF readmissions, especially with infections (e.g., **UTI**, **CDI**)

Health Disparities Focus

- African American (AA) Medicare members, maternal care, deprived areas

Primary Performance Metrics

Readmission Rate (esp. 30-day all-cause)	• Most frequently mentioned metric • Includes behavioral health and medical readmissions
Total Cost of Care (TCOC)	• Often paired with reductions in ED visits and readmissions • Includes post-acute utilization (PAU)
Emergency Department (ED) Visit Rate	• Focus on reduction in ED use
Length of Stay (LOS)	• Including SNF (Skilled Nursing Facility) days
Mortality Rates	• Especially for sepsis and end-of-life (EOL) care
Referral and Follow-Up Metrics	• Timely follow-up after discharge • Increased referrals and consult completions
Social Determinants of Health (SDOH)	• Interventions tracked for impact on outcomes
Patient Engagement	• E.g., diabetes education participation, long-term treatment opt-in

VBCI Tool Update

- The Value Based Care Insights (VBCI) tool has been refreshed with CCLF data through January 2025 data, and the Post-Acute Care Dashboard has been added.
- For VBCI feedback or questions, please email vbci-support@crisphealth.org or visit the website.

Next Steps

- Hospitals are required to report on an interim and annual basis. Reporting templates will be sent out at a later date
  - Interim Report Due Date: December 31, 2025
  - Annual Report Due Date: Summer 2026
- For additional questions please reach out to hscrc.tcoc@maryland.gov

New Paradigms in Care Delivery Update

New Paradigms in Care Delivery

Purpose

Provides matching funding to hospitals to **accelerate innovative solutions that avert the need for traditional hospitalization** through targeted investment in **transformative solutions.**

Funding

- Commissioners approved a $30 million Transformation Fund in the RY 2026 Update Factor to match hospital investments in innovative initiatives.
- Funding supports initiatives that may be too expensive or speculative to fund in the normal course of business.
- This funding is intended as a one-time adjustment to approved hospital rates.
- Hospitals that receive funding will implement programs in FY 2026.

Initiatives

- Received sixteen proposals ranging from palliative care, sepsis, heart failure networks, social determinants of health, to forensic nursing and maternal health.

Heart Failure Proposal Examples

- Alternatives to hospitalization that provide specialized clinic-based settings for the treatment of heart failure exacerbations.
  - Clinic innovates heart failure management through three key approaches: clinic-based IV diuresis; extensive case management and leveraging technology.
  - Partnership with community cardiologists is critical in this model.
- Fully integrated heart failure network that connects every care setting—home, community, ambulatory, hospital, and post-acute—into a seamless system of support.
  - Network will unify multidisciplinary teams using standardized communication tools and NCQA-aligned workflows, ensuring smooth transitions, and reducing fragmentation throughout the patient's journey.
  - Remote Patient Monitoring (RPM) and centralized telehealth services, will scale system-wide and allow for early detection and rapid intervention, reducing preventable hospitalizations.

Next Steps

- HSCRC is discussing proposals with hospitals.
- Finalize funding and MOU in coming weeks.
- Provision of funding in July rate orders.
- Kick-off calls with awardees in late July.

Next Steps

TCOC Workplan for Upcoming Months

- Upcoming TCOC Workgroup Dates
  - July 23
  - August 27
  - 2025 Meeting Dates (Tentative) posted on TCOC Workgroup Webpage
- Future Meetings Topics
  - July
    - TBD (Will cancel if small agenda)

Upcoming Important CTI and EQIP Dates

- CTI
  - CRISP Reports Migration – June 30th (EQIP & CTI users migrating to CRISP HIE Portal)
  - 2027 Program Change Discussion – August 2025
- EQIP
  - EQIP Enrollment
    - Enrollment Webinar: June 18th at 12pm – Registration Link
    - Open Enrollment Begins: July 1st
    - Enrollment Close Date: August 29th
  - EQIP Subgroup Meetings
    - Jul 18th, Sep 19th, Nov 21st

Thank You
Next Meeting July 23, 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 and 2023, MD Professional increased to 71% while the Nation stayed steady, further widening the gap
- In 2024, MD % Professional was 73% versus the Nation at 61% (slightly increasing gap from 2023)