maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

September 2023

Agenda

1. Administrative issues and timelines
2. Update on EQIP results
3. Revisions to MPA for CY24
4. Revisions to CTIs for Y2 and beyond

Administrative Issues and Timelines

Changes to Meeting/Management Structure

- Cancelled the CTI Steering Committee and added membership to this meeting
  - Will kick off additional ad hoc series if needed
  - CRISP Learning Collaborative will continue to facilitate information sharing on CTIs
- HSCRC will be looking to fill Deputy Director role to focus on managing MPA, EQIP and CTIs
- Welcome to Lynne Diven

Value-Based Program Timelines

- MPA
  - Draft Y6 (CY24) policy will be submitted to the Commission in December
  - Request to CMS due by 12/31/23
  - Final approval in early 2024
- EQIP
  - Y1 (CY22) payments expected in late October
  - Y3 (CY24) enrollment complete, vetting process ongoing
  - Groups wishing to develop new episodes for Y4 should be contacting HSCRC now
- CTIs
  - Y1 (FY22) settlement in MPA adjustment effective 7/1/23
  - Y2 (FY23) completed 6/30, episode and claims run out to 3/31/24, settlement in Q2 of 2024
  - Y3 (FY24) Enrollment was extended to June 30.
  - Y3 Initial Data available October 27, 2023, covering claims from July to September
  - Hospitals wishing to suggest changes to or addition of thematic areas for Y4 should contact the HSCRC soon

Population Health Spending Diagnostic Tool – Progress Update

Discussed in TCOC May Meeting

- Existing CRS tools in support of Medicare Population Health management tend to be:
  - Program focused (e.g. CTP, SIHIS) or
  - Focused on specific elements of care (MADE)
  - Relies on hospital analysis of the problem (DEX, MPA Sandbox, benchmarking)
- Is there a need/demand for a diagnostic tool that starts at a high level and allows hospitals to identify areas of spending to address
  - Include benchmarks to identify outliers
  - Allow drill down from high level to specific across the total spend
  - See Milliman “ACO Insight” example

Current Status/Next Steps

- Held demos for small industry audiences on two alternative tools in August
- Received positive feedback on the concept
- CRISP will be releasing an RFP soon
  - Will work with CRISP RAC to include hospital representation in the evaluation process
  - Goal will be to award by 12/31 and if acceptable tool is identified, implement by 7/1/24

EQIP Results

Episodes for PY1, Episode Type, Length

Cardiology	Gastroenterology and General Surgery	Orthopedics and Neurosurgery
Pacemaker / Defibrillator – Procedure, 30	Colonoscopy – Procedure, 14	Hip Replacement & Hip Revision – Procedure, 90
Acute Myocardial Infarction – Acute, 30	Colorectal Resection – Procedure, 90	Hip/Pelvic Fracture – Acute, 30
CABG &/or Valve Procedures – Procedure, 90	Gall Bladder Surgery – Procedure, 90	Knee Arthroscopy – Procedure, 90
Coronary Angioplasty – Procedure, 90	Upper GI Endoscopy – Procedure, 14	Knee Replacement & Knee Revision – Procedure, 90
		Lumbar Laminectomy – Procedure, 90
		Lumbar Spine Fusion – Procedure, 180
		Shoulder Replacement – Procedure, 90

Enrollment Summary

EQIP entities enrolled:	50
Total Care Partners:	1,979
Specialties represented:	32
Smallest Entity:	1 CP
Largest Entity:	994 CPs
Entities participating in more than 2 episodes:	19

Clinical Episode Categories	Number of EQIP Entities	Number of Care Partners
Cardiology	20	1,317
Gastroenterology	17	1,245
Orthopedics	25	1,745

EQIP Year 1 Results

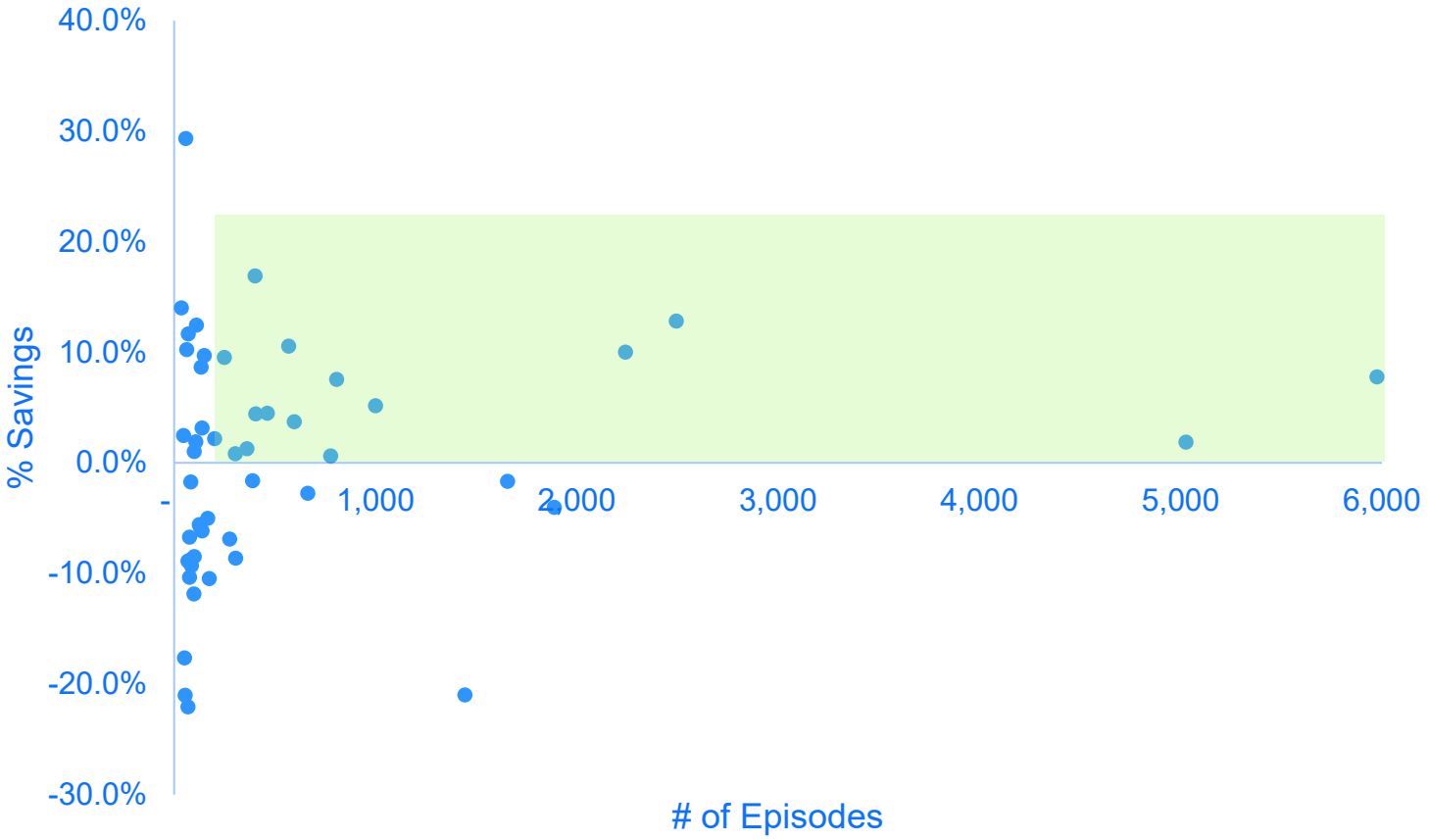
- EQIP saved $20 million in total cost of care in 2022. Overall, EQIP episodes accounted for ~$400 million in costs so the savings rate was approximately 5%.
  - Savings were only counted if the entity exceeded a 3% minimum savings rate, which was created to ensure that savings and payouts from EQIP would be statistically significant.
  - 19 EQIP entities earned savings out of a total of 50. However, the majority of the smaller practices had difficulty earning savings.
- Based on the savings, we expect to pay out $13 million in incentive payments to physicians (i.e., 60% of the total earned savings).

Size Matters!

- The amount of savings earned by the practices was partially determined by the number of episodes the practice had.
  - On average the top quintile in terms of volume saved about $1 mil. The lower quintiles had very little impact.
  - Similarly, the average percent savings per episode was correlated with the number of episodes.
  - Note because there is substantial variation within the lower quartiles. For instance, Q5 varies from +29% to -22% episode savings.
- This could be because larger practices had more resources to use in the program.
- It could also be because the statistical noise from the small sample size has washed out the signal from the program.

Quintile based on number of Episodes	Average $ Savings by Quintile	Average Savings % by Quintile
1 (>687 Episodes)	$992,459	2%
2 (127-287 Episodes)	$309,631	3%
3 (76-127 Episodes)	$(3,136)	0%
4 (35-76 Episodes)	$ (116,642)	-3%
5 (<35 Episodes)	$ (16,068)	-2%

Distribution of Savings by EQIP Entity



- If EQIP had no effect, we would expect to see a random distribution, with equal numbers of episodes above and below $0.
- Instead, we see a skewed distribution towards savings among larger practices (green shaded area)
- This makes intuitive sense as there is little reason to expect costs to increase because of EQIP.
- Most smaller practices did not see significant savings, whereas large practice with significant economies of small earn most of the savings.

Note: EQIP Entity shown at approximately 6,000 episodes actually had over 12,000 episodes but is shown at this lower number to allow for a narrower axis.

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Analysis by Episode Type

Episode	% of Total Baseline Spend	% Savings
Acute Myocardial Infarction	3.7%	-1.7%
CABG &/or Valve Procedures	10.8%	-4.6%
Pacemaker / Defibrillator	9.8%	3.9%
Coronary Angioplasty	8.0%	1.0%
Total Cardiology	32.3%	-0.3%
Colonoscopy	4.5%	1.8%
Colorectal Resection	2.4%	-13.2%
Gall Bladder Surgery	1.8%	-6.3%
Upper GI Endoscopy	3.5%	3.6%
Total Gastroenterology	12.2%	-1.8%
Hip Replacement & Hip Revision	12.2%	7.9%
Hip/Pelvic Fracture	5.8%	-8.6%
Knee Arthroscopy	0.7%	8.5%
Knee Replacement & Knee Revision	21.6%	9.4%
Lumbar Laminectomy	1.7%	0.6%
Lumbar Spine Fusion	10.4%	8.9%
Shoulder Replacement	3.2%	-6.9%
Total Orthopedics	55.5%	5.9%

- Savings do not reflect exclusion of episodes below MSR, as that is applied at an entity level, so % savings is lower.
- Orthopedics represents both the largest share of episodes and the best savings.

Overall Assessment & Next Steps

- CRISP Learning Collaborative has commissioned a formal evaluation study, expect to release it in the next 3-6 months.
- CRISP/MedChi to host Learning Collaborative highlighting practices earning incentive payments.
- The Year 1 results are favorable and exceeded our expectations.
  - The program savings exceeds that from CMMI's bundled payment programs and other programs nationally.
  - While the dollar value of the savings is small in the context of MD TCOC, EQIP could have a substantial impact on the savings test if the savings rate can be maintained as the program grows.
- Years 2 and 3 will substantially expand the program.
  - We are adding new episodes. 25 new episodes in Year 2 and 5 new episodes in Year 3.
  - The number of participants is also increasing substantially. We expect to have around 4 thousand participants in Year 3, about 2 times the size of the program in Year 1.
- Support for smaller practices
  - In Year 3 MedChi assisted smaller practices in grouping together into single entities
  - In Year 4+, we are considering providing practices with some practice transformation supports.
    - Currently, EQIP has been very low touch with practices, meaning limited engagement between HSCRC / CRISP staff and the practices.
    - This has ensured that the administrative burden on the program on participants remains small. However, it is clear small practices may not have the resources to identify and deploy interventions that will lead to their success.
    - Practice transformation support could help raise the smaller practices to the level of success of the best performing practices.

Revision to MPA and CTIs

MPA Revenue At Risk

- In its 2023 MPA Approval Letter, CMS indicated that it expected the State to increase the Revenue at Risk under the MPA in 2024.
  - Staff believe that CMS expects an increasing the revenue at risk to at least 2% of Medicare revenue in 2024 and potentially further increases in the future.
  - Increasing the revenue at risk to 2% would double the revenue at risk under the traditional portion of the MPA.
- The MPA has a 33% marginal savings rate. This means that in order to realize the maximum revenue at risk, a hospital would have to exceed the national growth rate by 6 percentage points.
- Staff believe that increasing the revenue at risk is reasonable but will propose to re-institute the CTI buy out at the same time.

Update on Population Health Measure

- Performance Measurement Workgroup has developed and is implementing a measure on diabetes screening in the hospital as the population health measure.
- Measure currently in testing, expect measure to be finalized this year and implemented for CY24 and incorporated into MPA quality measurement.
- Assuming adoption of the 2% at risk and the changes as outlined in last year's MPA proposal the adjustment will be as shown at right.

Proposed MPA Quality Adjustment

- Step 1: MPA TCOC x 1/3 result subject to +/- 2% cap.
- Step 2: Step 1 x (1+ 2 x (RRIP + MHAC + Pop Health Reward/Penalty))
- Where:
  - MPA result is expressed as percentage points above or below target
  - RRIP and MH are each up to +/- 2%
  - Population health is worth +/- 4%
  - Calculation is reversed if MPA TCOC result is a penalty
  - Total adjustment can not exceed +/- 2.16% of Medicare payments
- % of MPA reward at risk for quality = 16%

MPA Policy Changes for Future Years

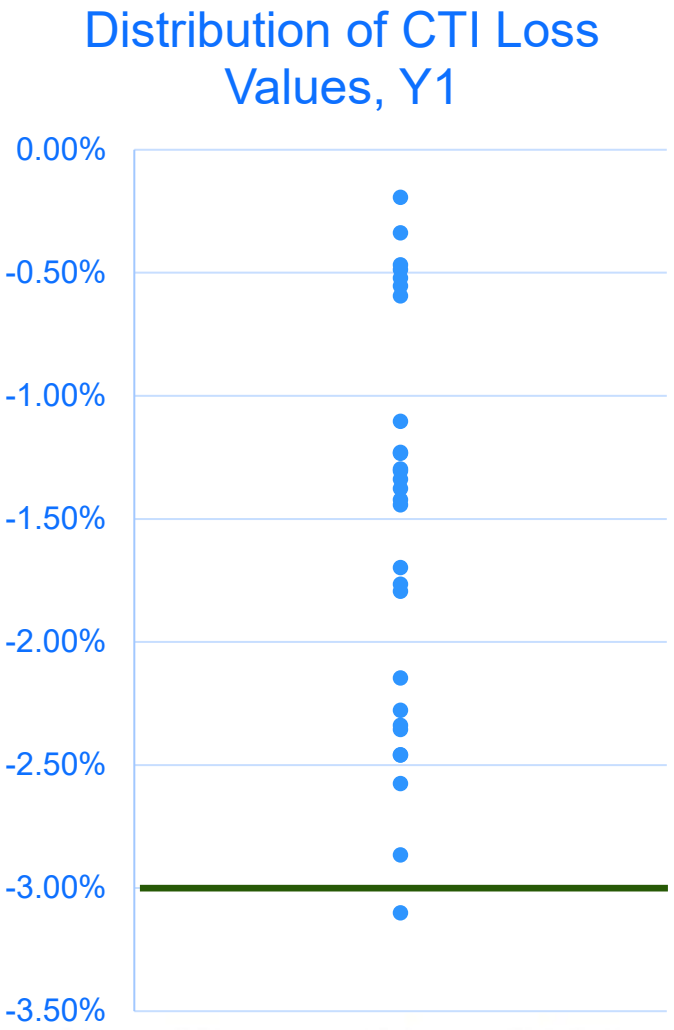
- Staff do not intend to make substantive change to the MPA other than those referenced in the prior slides.
- However, we will gather comments on Y6 MPA policy at the same time as CTI comments, as discussed in next section.

Proposed Revisions to CTI Program

- Cap downside risk at 3%
  - Consistent with MPA the quality adjustment would be applied after the cap.
  - Spread impact across all hospitals in order to maintain revenue neutrality
  - Effective impact would be max risk before quality at slightly over 3% (as hospital at max loss of 3% would receive allocation of the offset)
  - Reduce total risk with MPA by re-introducing CTI Buy Out

- Reintroduce CTI Buy Out
  - Under prior buy out a hospitals MPA risk was reduced based on the ratio of CTI impacted beneficiaries to total MPA attributed beneficiaries
    - Recognizes hospital's greater ability to impact CTI populations
    - Combined with higher MPA at risk it focus relief on hospitals pursuing Care Transformation through CTI while leaving inactive hospitals fully exposed.
  - CMS previously did not sign off on the CTI buy out
    - Combination of high MPA exposure and data on actual CTI risk may help reverse that decision.
    - If CMS does not change their position, HSCRC would eliminate the provision of the MPA policy, no other changes would be made.

Derivation of 3% Loss Cap



- Under Staff of 3% cap proposal, Y1 realized risk effectively becomes benchmark for future max risk
- Maintains maximum exposure from Y1 even as/if $ under CTI and/or effectiveness of top programs increases.
- For Y1 reallocation to implement max would have been < $50k

Request for Comment

- Staff will plan to dedicate the October meeting to a further discussion of CTI program and MPA policy revisions
  - Comments/suggestions should be submitted to william.henderson@maryland.gov
  - Formal or informal communications are welcome
  - To guarantee inclusion in the October 25th discussion comments should be submitted by **October 11th**
  - Comments on MPA changes are welcome but Staff has a strong bias towards limiting changes to MPA to those identified in this presentation

Thank You
Next Meeting: October 25th, 8-10 am