maryland
health services
cost review commission

March 3, 2022

The Honorable Shane E. Pendergrass
Chair, House Health and Government Operations Committee
Room 241, House Office Building
Annapolis, MD 21401

RE: HB 1148 – Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization

Dear Chair Pendergrass and Committee Members:

The Health Services Cost Review Commission (HSCRC) submits this letter of information for House Bill 1148 (HB 1148), "Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization." HB 1148 is an important step forward, allowing insurers and certain non-hospital providers to enter into value-based payment arrangements. These arrangements have the potential to support the State in meeting the Maryland Health Model's goals of reducing healthcare costs and improving health outcomes.

The HSCRC is an independent state agency responsible for regulating the quality and cost of hospital services to ensure all Marylanders have access to high value healthcare. The HSCRC establishes rates for hospital services and helps direct the State's innovative efforts to transform the health care delivery system and achieve goals under the Maryland Health Model. One of the main components of the Maryland Health Model is the Total Cost of Care (TCOC) Model Agreement (2019 to 2028) between the State of Maryland and the Federal Centers for Medicare and Medicaid Services (CMS).

Prior to the TCOC Model, Maryland and CMS participated in the All-Payer Model Agreement (2014-2018). Under the All-Payer Model, hospitals in Maryland transitioned to global budget revenues (GBRs). GBRs are considered the highest category of value-based care.[1] HSCRC sets an annual revenue target (GBR) for each hospital by taking into account inflation, changes in population, the hospital's performance on quality and efficiency metrics, and other factors. The hospital must meet, but not exceed this target. Maryland was highly successful under the All-Payer Model, generating significant Medicare savings while also improving quality of care in hospitals and reducing unnecessary hospitalizations. Under this model, hospitals gained significant experience operating under a value-based care payment system. As this model drew to a close, it was clear that the next model would need to foster greater collaboration and innovation across the health care system, not just in hospitals, to further improve population health, manage chronic conditions outside of hospitals, and generate additional savings across the whole health care system.

The TCOC Model, which began in 2019, contains annual targets that Maryland must meet to satisfy the terms of the agreement. Achieving these goals requires hospital and non-hospital providers to work together to improve outcomes across the care spectrum and advance population health. The State, in collaboration with CMS, has developed new, innovative programs such as the Maryland Primary Care Program (MDPCP) and the Episode Quality Improvement Program (EQIP). These programs use value-based payments to align incentives for primary care doctors and specialists, respectively, with the goals of the TCOC Model.

[1] https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

The MDPCP and EQIP programs are particularly important because physicians in Maryland have generally been excluded from the value-based payment programs that CMS has made available in other States due to the existence of the state-wide model agreements in Maryland. Thus, while Maryland is ahead of other states in adopting value-based payment in hospitals, the opportunity for these programs for physicians arose in Maryland later than it did in other states. In addition, these programs are limited to Medicare payments. Maryland law restricts the sorts of value-based programs that commercial insurers can enter into, limiting opportunities for all-payer alignment. CMS has been encouraging Maryland to seek opportunities to align Medicaid and commercial payers with the incentives under the Total Cost of Care Model.

By allowing for certain voluntary capitated payment arrangements and two–sided incentive arrangements between commercial payers and healthcare practitioners, HB 1148 helps to further align hospital and non-hospital providers in alignment with the Maryland Health Model and creates an opportunity for greater all-payer alignment outside of hospitals. HSCRC believes that HB 1148 is an important step forward towards value-based payment in the commercial market. HSCRC urges insurers to consider the needs of small practices when implementing this bill, to ensure that these practices understand the benefits and risks inherent in these new value-based contracts. In the coming years, HSCRC hopes that providers and insurers continue to discuss opportunities to take additional steps forward on the value-based payment journey.

We encourage, as part of the reports required by section 2 of HB 1148, inclusion of information on the implications and impact of the payment arrangements allowed by HB 1148 on the Total Cost of Care Model, including any interaction between the arrangements and hospital GBR payments. This will help the State to better understand how to design and implement incentives that align hospital and non-hospital services.

Hospital and non-hospital provider alignment is critical to the success of the Maryland Health Model, as is Medicare, Medicaid, and commercial payer alignment. HSCRC believes that HB 1148 supports this aim by increasing value-based opportunities in the State. If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at 410-382-3855 or megan.renfrew1@maryland.gov.

Sincerely,

Megan Renfrew
Associate Director of External Affairs