Senate Finance Committee

Senator Melony G. Griffith, Chair
Senator Katherine Klausmeier, Vice-Chair

Tuesday, January 24, 2023

Agenda

1:00 p.m.

Briefing from the Maryland Health Care Commission

- Ben Steffen, Executive Director
- David Sharp, Director, Center for Health Information and Innovative Care Delivery
- Paul Parker, Center for Health Care Facilities Planning and Development

1:45 p.m.

Briefing from the Health Services Cost Review Commission

- Katie Wunderlich, Executive Director
- Megan Renfrew, Associate Director of External Affairs

Introduction to the Health Services Cost Review Commission and the Total Cost of Care Model

Senate Finance Committee

January 24, 2022

Katie Wunderlich, Executive Director

Megan Renfrew, Associate Director of External Affairs

Overview

- HSCRC and Maryland Health Model Overview
- Total Cost of Care (TCOC) Model and Hospital All-Payer Rate Setting
- Health Equity and Population Health
- TCOC Model Performance
- Appendix:
  - Glossary of Acronyms
  - Total Cost of Care Model Performance
  - Rural and Safety Net Hospitals

HSCRC - Who We Are

The Maryland Health Services Cost Review Commission (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.

HSCRC's vision is to enhance the quality of health care and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders.

The HSCRC establishes rates for all hospital services and helps develop the State's innovative efforts to transform the delivery system and achieve goals under the Maryland Health Model.

Maryland’s Unique Healthcare System: Overview

Maryland Health Model

All-Payer Hospital Rate Setting System

- The HSCRC has set hospital rates, on an all-payer basis, since the 1970s
- The system can be adjusted to achieve CMS agreement targets and other statewide priorities

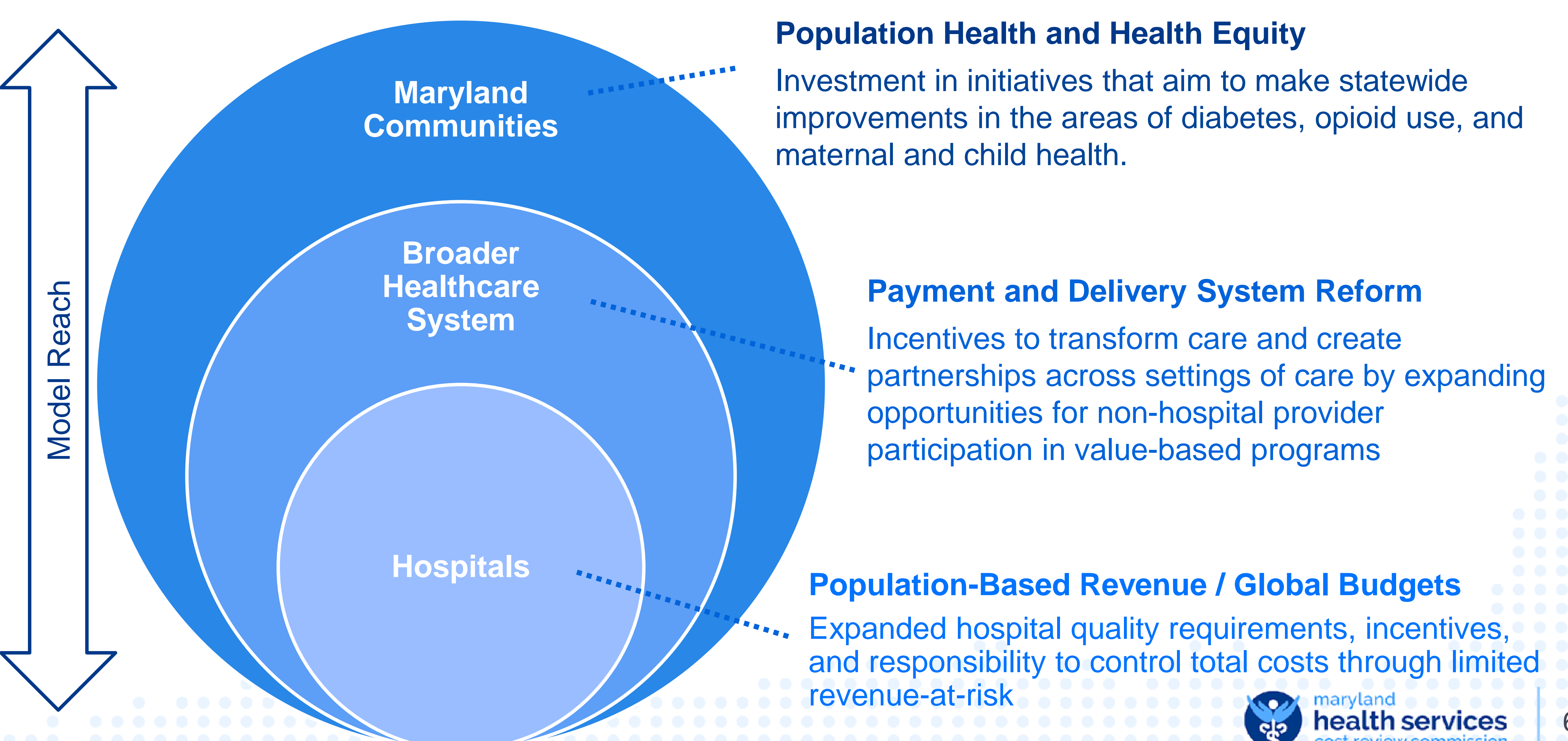
Commission Policies

CMS-MD Agreement

- A commitment between the State and Federal Government to use global budgets for hospitals, reform the health care and delivery system, and improve population health.
    - All-Payer Model (2014-2018)
    - Total Cost of Care Model (2019-2028)

Total Cost of Care Model

TCOC Model Components



Population Health and Health Equity

Investment in initiatives that aim to make statewide improvements in the areas of diabetes, opioid use, and maternal and child health.

Payment and Delivery System Reform

Incentives to transform care and create partnerships across settings of care by expanding opportunities for non-hospital provider participation in value-based programs

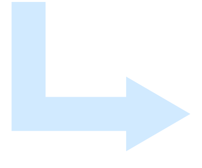
Population-Based Revenue / Global Budgets

Expanded hospital quality requirements, incentives, and responsibility to control total costs through limited revenue-at-risk

The Maryland Health Model is important to our State

The Maryland Health Model improves the quality of life of Marylanders by:

- Controlling hospital cost growth while improving quality and patient outcomes
- Guaranteeing equitable funding of uncompensated care
- Stabilizing hospital revenue in order to ensure access to care in all parts of the state (ex. COVID-19)
- Equalizing hospital charges for all payers (including the uninsured), benefiting consumers, and employers
- Supporting population health and health equity initiatives



Losing the Model would deprive **Maryland communities of these benefits**.

HSCRC Quality Program Overview

- The purpose of the HSCRC Quality Program is to create all-payer incentives for Maryland hospitals to provide efficient high-quality patient care and to support delivery system improvements across the State.
- The overarching goals of the Program are to:

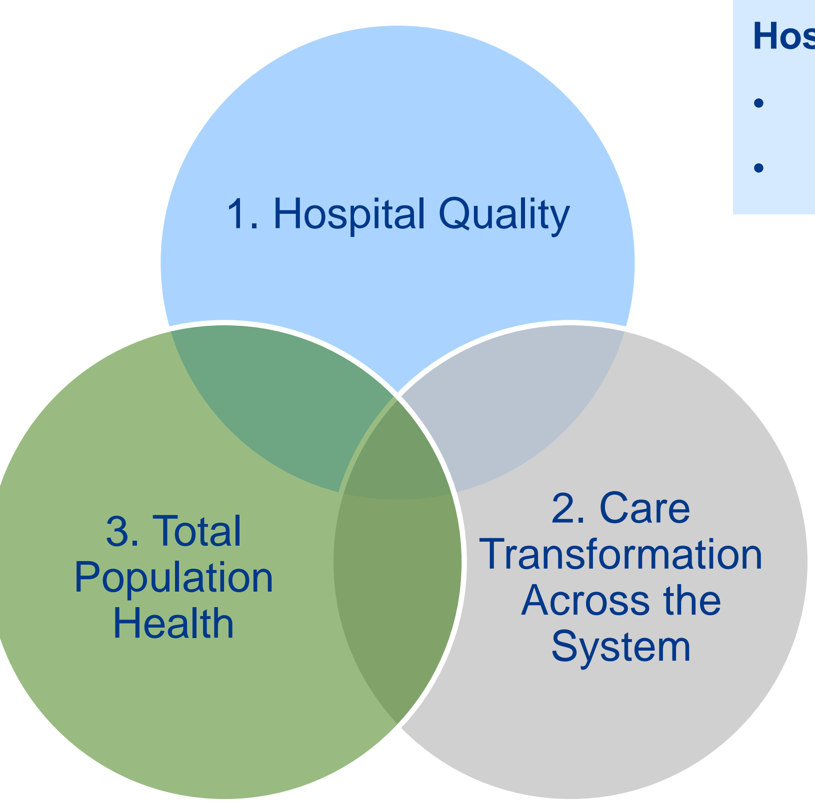
Implement standardized pay-for-performance programs that reward or penalize hospitals based on patient outcomes;

Utilize **a broad set of quality measures** that appropriately reflects the delivery of quality health care services provided at Maryland hospitals;

Provide timely and accurate year-to-date reports on quality initiatives using hospital case-mix data;

Align the incentives for enhancing health care quality in the hospital setting with **broader State health initiatives**.

Statewide Integrated Health Improvement Strategy



Hospital Quality

- Reduce avoidable admissions
- Improve Readmission Rates by Reducing Within-Hospital Disparities

Care Transformation Proposed Goals

- Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models*
- Improve care coordination for patients with chronic conditions

Total Population Health Proposed Goals

- Priority Area 1 (Diabetes): Reduce the mean BMI for adult Maryland residents
- Priority Area 2 (Opioids): Improve overdose mortality
- Priority Area 3 (Maternal and Child Health):
  - Reduce severe maternal morbidity rate
  - Decrease asthma-related emergency department visit rates for ages 2-17

*Value-based models including the Care Redesign Program, Care Transformation Initiatives, and qualifying successor models.

Care Transformation & New Model Programs

Voluntary programs that focus on improving quality and value in healthcare by shifting away from fee-for-service payments

Episode Care Improvement Program (ECIP)

Allows a hospital to link payments across their providers during an episode of care

Episode Quality Improvement Program (EQIP)

Engages specialist physicians in a Medicare episode-based payment program

Care Transformation Initiatives (CTIs)

Initiatives undertaken by a hospital to reduce the TCOC of a defined population

Care Redesign Programs

Programs that align hospitals and non-hospital providers by providing Medicare waivers that allow hospitals to share resources with non-hospital providers. HSCRC can develop new tracks.

The Model Invests in Primary Care

The Maryland Primary Care Program (MDPCP) supports Maryland primary care providers as they **deliver advanced primary care**.

53%

of eligible Maryland Medicare FFS beneficiaries are attributed to an MDPCP practice.*

The goal of MDPCP is to build a **strong, effective primary care delivery system**, inclusive of **medical, behavioral and social needs**.

In conjunction with value-based opportunities for other providers under the Total Cost of Care Model, MDPCP seeks to **transform care delivery through primary care**.

MDPCP **targets upstream interventions** through chronic disease management and preventative care, helping to **improve population health and care outcomes.**

**Beneficiaries with both Part A + B coverage*

Emergency Department Wait Times

A long-standing issue with multiple underlying causes

Actions Taken:

- MIEMSS/HSCRC Study on ED Overcrowding (2017, 2019).
- ED performance measures added to the hospital quality reimbursement program.
- Seed Funding for Mobile Integrated Health and EMS treat-in-place to reduce avoidable ED visits.
- Funded Regional Partnerships to help reduce behavioral health burden on the ED.
    - $79.1 over 5-years (CY 2021 - 2025) to expand crisis services in the Lower Eastern Shore, Prince George's County, and the Greater Baltimore Metropolitan region.
    - Development and expansion of crisis call centers, mobile crisis teams, and residential crisis centers are expected to reduce repeat BH visits in EDs and boarding times in participating hospitals by 2025.

Health Equity and Population Health

HSCRC Health Equity and Population Health Initiatives

The HSCRC is committed to working to ensure Maryland eliminates longstanding health disparities and achieves more equitable health outcomes on a population-wide basis. HSCRC addresses health equity and population health through the following initiatives:

- Statewide Integrated Health Improvement Strategy
- Hospital Quality Program
- Special Funding Programs
- Data and Hospital Reporting
- Financial Assistance & Uncompensated Care Fund
- State Agency Collaboration

Programs Directed to Population Health Improvement

The Commission provides additional funding through the all-payer rate setting system to support SIHIS activities across the state.

Regional Partnership Catalyst Program

Supports hospital-led community partnerships that address statewide population health goals

Maternal and Child Health Initiative

Directs funding to the Maryland Department of Health to address statewide maternal and child health goals

HSCRC Regional Partnership "Catalyst Program"

Purpose

Invests in hospital partnerships with community organizations to build **sustainable programs that support the population health goals** of the Total Cost of Care (TCOC) Model.

How it Works

- Hospitals must develop and maintain meaningful community partnerships related to program funding, resource sharing, and/or in-kind support.
- Funding streams are based on the Statewide Integrated Health Improvement Strategy (SIHIS) population health priority areas.

Funding Stream I: Diabetes Prevention & Management Programs	Funding Stream II: Behavioral Health Crisis Services
• Support implementation of CDC approved diabetes prevention programs and diabetes management programs	• Support behavioral health models that improve access to crisis services

- **Program timeline:** January 1, 2021, to December 31, 2025

HSCRC Regional Partnership “Catalyst Program” (cont.)

Funding and Collaboration

- The HSCRC is providing $165.4 million in five-year (2021-2025) cumulative funding to nine proposals.
  - $86.3 million to six diabetes proposals
  - $79.1 Million to three behavioral health proposals
- Over 30 hospitals participating in at least one Regional Partnership funding stream.
- Robust statewide community collaboration with 250+ community-partners, including local health departments, non-profits, local businesses, faith-based organizations, community healthcare providers, academic institutions, and others.

Diabetes Prevention & Management Programs Regional Partnerships	Behavioral Health Crisis Services Regional Partnerships
• Saint Agnes and Lifebridge Diabetes Health Collaborative • Baltimore Metropolitan Diabetes Regional Partnership • Nexus Montgomery (ended in 2022) • Totally Linking Care • Western Regional Partnership • Full Circle Wellness for Diabetes in Charles County	• Greater Baltimore Integrated Crisis System • Totally Linking Care • Tri-County Behavioral Health Engagement

Maternal and Child Health Funding Initiative

Purpose

To fund programs and initiatives led by the Maryland Department of Health (MDH) to **address the maternal and child health goals under the Statewide Integrated Health Improvement Strategy** (SIHIS).

Funding and Initiatives

- The HSCRC is directing $40 million in cumulative funding for four years (FY22 – FY25) to support maternal and child health interventions led by Medicaid, Managed Care Organizations (MCOs), and the Prevention and Health Promotion Administration (PHPA) under MDH.
- This funding will support new services not previously offered to Medicaid beneficiaries and continued efforts to reduce healthcare disparities.

Medicaid and MCO Programs and Initiatives

- Home Visiting Services Pilot
- Reimbursement for Doula Services
- Centering Pregnancy
- Healthy Steps
- Maternal Opioid Misuse (MOM) Model Expansion

PHPA Programs and Initiatives

- Asthma Home Visiting Program
- Eliminating Disparities in Maternal Health Initiative

Maryland Model Provides Additional Funding for Hospitals in Rural and High Poverty Areas

The Total Cost of Care Model provides a significant advantage to hospitals in rural and low-income areas compared to peer hospitals in other states.

- In Maryland, all-payers pay the same hospital rates. Hospital rates for public payers (Medicare and Medicaid) are higher than rates at peer hospitals.
- Hospitals in rural and low-income areas have the highest share of public payers, resulting in strong funding for these hospitals compared to peer hospitals.
- Maryland hospitals in disadvantaged areas receive higher total public payer reimbursement per person than peer hospitals in other states.
  - In rural counties[1], hospitals receive **$311 million** more annually in reimbursement for hospital services delivered to Medicare and Medicaid enrollees when compared to national hospitals in similar rural areas ($848 per enrollee).
  - In counties with higher levels of deep poverty[2], hospitals receive **$1.0 billion** more annually in reimbursement for hospital services delivered to Medicare and Medicaid enrollees when compared to national hospitals with areas with similar levels of deep poverty ($1,770 per enrollee).

1. Rural counties include Allegany, Caroline, Dorchester, Garrett, Kent, Somerset, St. Mary’s, Talbot, Washington, Wicomico and Worcester
2. Counties with higher levels of deep poverty include Allegany, Kent, Wicomico, Baltimore City, Caroline, Dorchester, Somerset

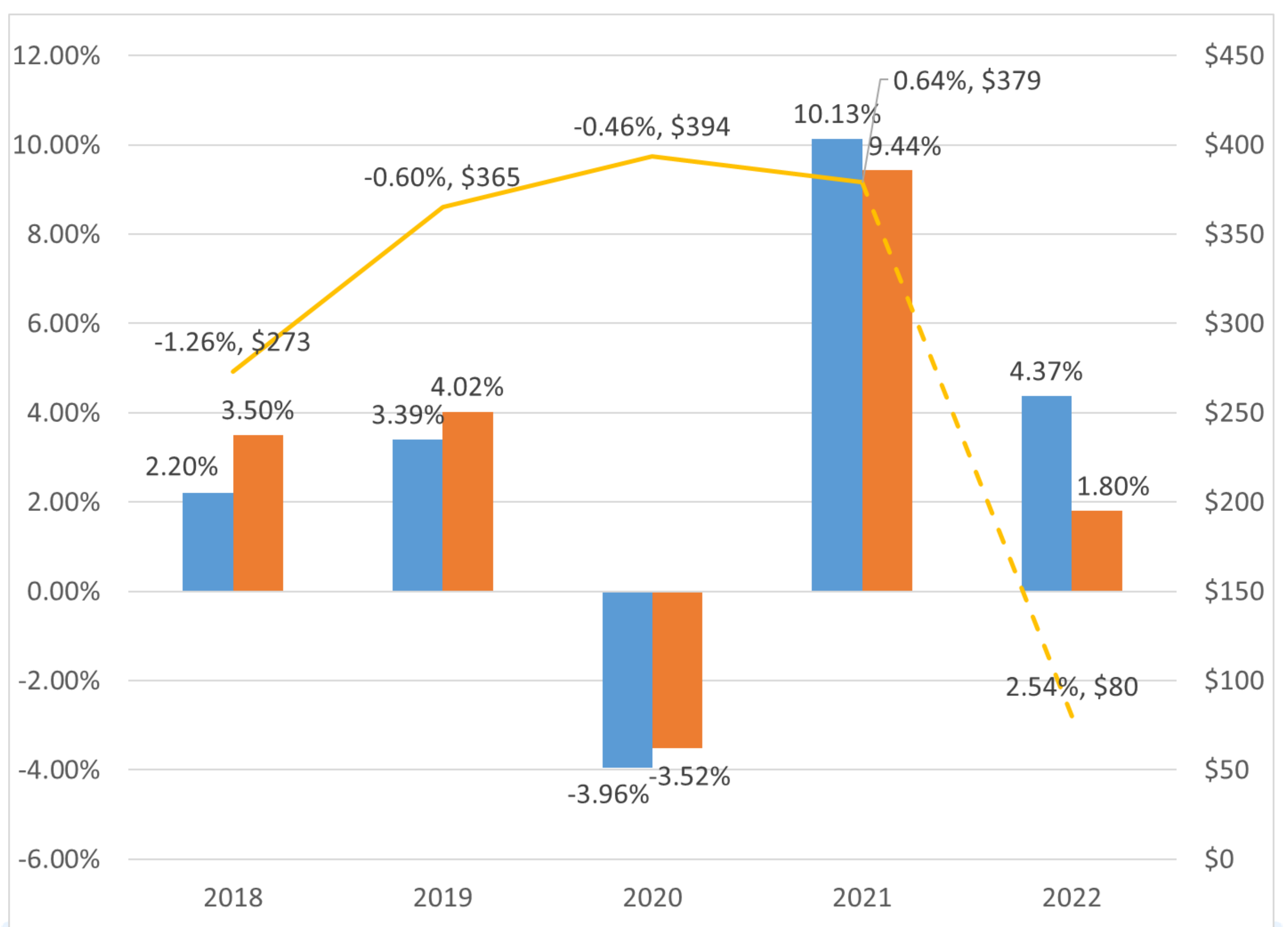
TCOC Model Performance

Total Cost of Care (TCOC) Model Targets

The TCOC Model requires the State of Maryland to meet the following targets:

Annual Medicare TCOC Savings	TCOC Guardrail Test	All-Payer Hospital Revenue Growth Per Capita	Readmissions Reductions for Medicare	All-Payer Reductions in Hospital-Acquired Conditions	Hospital Revenue under Population-Based Payment Methodology
Must build up to $300 million in annual savings to Medicare by 2023	Must not exceed growth in national Medicare spending per beneficiary by more than 1% in any year and/or exceed national spending growth for two years	≤ 3.58% per capita annually	Must match or exceed National and previous Maryland Medicare Readmission rates	Must match or exceed previous Maryland all-payer potentially preventable condition (PPC) rates	≥ 95% over the course of the Model

CY 2022 Medicare Total Cost of Care Projection



Projection based on data through May 2022.

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Actions Taken to Generate Additional Medicare Savings

All-Payer Rate reduction

- Reduces all-payer hospital rates by $40M
- Implemented by HSCRC through rate orders in January 2023

Medicare-only payment reductions

- Discount on Medicare payments
- Reduces hospital revenues by $64M; No cost shifting to other payers
- Requires CMMI approval, possible implementation March 2023

Public Payer Differential

- 1% increase to differential
- Reduces Medicare & Medicaid Rates; Increases Commercial Payer Rates by $50M; No impact on hospitals
- Time limited: duration of FY 2023 and 2024
- Requires CMMI approval, possible implementation March 2023

Reduction in **Medicaid Deficit Assessment**

- $50M reduction in special funding from hospitals to Medicaid
- Requires State/Legislative Approval through State Budget; July 1, 2023, effective date if approved
- Offsets reductions to hospital revenues from other policies

TCOC Model: Moving Forward

The Maryland Total Cost of Care Model State Agreement states:

> "Under this Model, CMS and the State will test whether statewide healthcare delivery transformation, in conjunction with Population-Based Payments, improves population health and care outcomes for individuals, while controlling the growth of Medicare Total Cost of Care."

The agreement includes:

An 8-year performance period

A 2-year transition period

Model Year 1 (2019)

Model Year 2 (2020)

Model Year 3 (2021): **CMS releases first evaluation report**

Model Year 4 (2022): **State begins stakeholder engagement process for expansion**

Model Year 5 (2023): **CMS releases second evaluation report**

Model Year 6 (2024):
- **State submits proposal for next Model iteration**
- **CMS assesses SIHIS**
- **CMS decides whether to expand the Model**

Model Year 7 (2025)

Model Year 8 (2026)

Model Year 9 (2027)

Model Year 10 (2028)

Review

- HSCRC is an independent, special funded, commission that sets private hospital rates and manages and coordinates other aspects of the Maryland Health Model.
- The Total Cost of Care Model includes hospital, non-hospital providers, and population health efforts, with the goal of reducing total healthcare spending and improve health outcomes in Maryland. The model benefits the State as a whole, including clear benefits for rural and safety net hospitals.
- The Statewide Integrated Health Improvement Strategy seeks to address disparities in hospital quality outcomes and includes three population health focus areas: diabetes, opioid use, and maternal and child health
- HSCRC is working to improve health equity and population health through many projects, including funding focused on diabetes, behavioral health crisis services, and maternal and child health.
- Maryland has historically met required targets in the agreement with CMMI; however, 2022 performance will not meet three targets. HSCRC has taken action to improve performance.

Thank you!

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Appendix: Glossary of Acronyms

Acronyms

BH – Behavioral Health

CDC – Centers for Disease Control and Prevention

CMMI - Center for Medicare & Medicaid Innovation

CMS – Centers for Medicare & Medicaid Services

CTIs – Care Transformation Initiatives

CY – Calendar Year

ECIP – Episode Care Improvement Program

ED – Emergency Department

EMS – Emergency Medical Services

EQIP – Episode Quality Improvement Program

FFS – Fee-for-Service

HSCRC – Health Services Cost Review Commission

MCOs – Managed Care Organizations

MDH – Maryland Department of Health

MDPCP – Maryland Primary Care Program

MHAC – Maryland's Hospital Acquired Condition program

MOM – Maternal Opioid Misuse Program

MY – Model Year

PHPA – Prevention and Health Promotion Administration

PPC – Potentially Preventable Conditions

RUCC – Rural Urban Continuum Code

SIHIS - Statewide Integrated Health Improvement Strategy

TCOC – Total Cost of Care

YOY – Year Over Year

Appendix: TCOC Performance

TCOC Model Year 1 Performance – Exceeded Targets

Performance Measures	2019 Targets	2019 Results	Met
Annual Medicare TCOC Savings	$120M in annual Maryland Medicare TCOC per Beneficiary of savings for MY1 (2019)	$364.85 million	✓
TCOC Guardrail Test	Cannot exceed growth in National Medicare TCOC per beneficiary by more than 1% per year and cannot exceed the National Medicare TCOC per beneficiary by any amount for 2+ consecutive years	0.6 percentage points below the National growth rate	✓
All-Payer Revenue Limit	All-payer growth ≤ 3.58% per capita	2.5% per capita	✓
Improvement in All-Payer Potentially Preventable Conditions	Exceed the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition program (MHAC)	.13 percentage point reduction	✓
Readmissions Reductions for Medicare	Maryland's aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate at regulated hospitals ≤ the National Readmission Rate for Medicare FFS beneficiaries	14.94% (below the national rate of 15.52%)	✓
Hospital Population Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	98% of Regulated Revenues are under Maryland's 'Rate Setting System'	✓

TCOC Model Year 2 Performance – Exceeded Targets

Performance Measures	2020 Targets	2020 Results	Met
Annual Medicare TCOC Savings	$156M in annual Maryland Medicare TCOC per Beneficiary of savings for MY2 (2020)	$390.6million	✓
TCOC Guardrail Test	Cannot exceed growth in National Medicare TCOC per beneficiary by more than 1% per year and cannot exceed the National Medicare TCOC per beneficiary by any amount for 2+ consecutive years	0.5 percentage points below the National growth rate	✓
All-Payer Revenue Limit	All-payer growth ≤ 3.58% per capita	.21% per capita	✓
Improvement in All-Payer Potentially Preventable Conditions	Exceed the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition program (MHAC)	.06 percentage point reduction	✓
Readmissions Reductions for Medicare	Maryland's aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate at regulated hospitals ≤ the National Readmission Rate for Medicare FFS beneficiaries	15.18% (below the national rate of 15.55%)	✓
Hospital Population Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	98% of Regulated Revenues are under Maryland's 'Rate Setting System'	✓

TCOC Model Year 3 Performance – Exceeded Most Targets

Performance Measures	2021 Targets	2021 Results	Met
Annual Medicare TCOC Savings	$222M in annual Maryland Medicare TCOC per Beneficiary of savings for MY3 (2021)	$378.1million	✓
TCOC Guardrail Test	Cannot exceed growth in National Medicare TCOC per beneficiary by more than 1% per year and cannot exceed the National Medicare TCOC per beneficiary by any amount for 2+ consecutive years	0.6 percentage points above the National growth rate	✓
All-Payer Revenue Limit	All-payer growth ≤ 3.58% per capita	2.37% per capita ($1.71 billion below the maximum revenue amount)	✓
Improvement in All-Payer Potentially Preventable Conditions	Exceed the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition program (MHAC)	.013 percentage point reduction	✓
Readmissions Reductions for Medicare	Maryland's aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate at regulated hospitals ≤ the National Readmission Rate for Medicare FFS beneficiaries	15.64% (above the national rate of 15.41%)	
Hospital Population Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	98% of Regulated Revenues are under Maryland's 'Rate Setting System'	✓

Medicare FFS Readmissions from CMMI

Readmissions - Rolling 12M through May 2022

	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY2021	Rolling 12 month CY 22
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.11%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.46%

TCOC Model Savings Targets

2019

2026

Potential for Model Expansion / Permanence

	Annual Medicare TCOC Savings (in millions)							
	2019	2020	2021	2022	**2023**	2024	2025	2026
Target	$120	$156	$222	$267	**$300**	$336	$372	$408
Actual	$365	$391	$378	≈$80 (TBD)	TBD	TBD	TBD	TBD

TCOC Savings Targets include Medicare Parts A and B, relative to a 2013 base.

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Appendix: Rural and Safety Net Hospitals

Groupings of Maryland Counties

To illustrate the additional payments made by public payers (Medicare and Medicaid) to hospitals in Maryland, the HSCRC compared hospital payments per enrollee in each Maryland county to the average of all counties in the rest of the country with (1) the same level of population density and (2) the same range of deep poverty. The population density groups and poverty ranges are shown below.

Counties Summarized By Density		
Density Category based on RUCC Code[1]	Maryland Counties Included	# of Maryland Public Payer Enrollees (CY2021)
1	Anne Arundel, Baltimore, Calvert, Carroll, Cecil, Charles, Frederick, Harford, Howard, Montgomery, Prince George's, Queen Anne's, Baltimore City	2,287,477
2	Somerset, Washington, Wicomico, Worcester	189,690
3	Allegany, St. Mary's	85,092
6	Caroline, Dorchester, Garrett, Kent, Talbot	92,343

Counties Summarized By % Deep Poverty		
% Deep Poverty[2]	Maryland Counties Included	# of Maryland Public Payer Enrollees (CY2021)
0.0 – 4.0%	Anne Arundel; Calvert; Carroll; Howard; Queen Anne’s; Charles; Frederick; Garrett; Harford; Montgomery; Talbot	1,085,613
4.0 – 6.0%	Baltimore County; Cecil; Prince George's; St. Mary’s; Washington, Worcester	1,007,475
6.0 – 8.0%	Allegany; Kent; Wicomico	115,093
> 8.0%	Baltimore City; Caroline; Dorchester; Somerset	446,421

1. RUCC is the Rural Urban Continuum code a value assigned to every county by the US Department of Agriculture, The values range from 1 (most urban) to 9 (most rural)
2. As reported in the American Community Survey for 2017 to 2021. Deep Poverty is defined by the U.S. Census Bureau as households with incomes below 50% of the poverty level.
3. For this analysis, the HSCRC compared these broad groups to all counties in the nation with the same categorization. No further adjustments have been made which to improve comparability.

Estimate of Additional Hospital Payments by County

Maryland hospitals receive higher payments per public insurance program enrollee (Medicaid and Medicare) compared to hospitals in other States and the benefit is greater in counties that are more rural or have higher poverty levels.

Counties Summarized By Density		
Density Category based on RUCC Code	% of Payments from Government Payers	Extra Hospital Payments Per Public Payer Enrollee versus National Peers[1]
1	63%	$444
2	70%	$779
3	66%	$1,104
6	71%	$756

~367k enrollees, at an average extra payment of $848 = $311 M extra funding

Counties Summarized By % Deep Poverty		
% Deep Poverty	% of Payments from Government Payers	Extra Hospital Payments Per Public Enrollee versus National Peers[1]
0.0 – 4.0%	57%	$70
4.0 – 6.0%	64%	$842
6.0 – 8.0%	72%	$872
> 8.0%	75%	$2,001

~560k enrollees, at an average extra payment of $1,770 = $1.0 B extra funding

1. HSCRC compared hospital payments per beneficiary in each Maryland county to the average of all counties in the rest of the country with (1) the same level of population density and (2) the same range of deep poverty. The dollar amount is derived by calculating the difference in CY2021 Medicare Fee-For-Service payments per beneficiary between Maryland counties and the counties in the same grouping nationally and then assuming the difference, on a per Maryland dollar basis, is the same for Medicare Advantage and Medicaid. This is likely conservative as typically Medicaid pays less than Medicare. Amounts includes disproportionate share payments but excludes medical education.