maryland
health services
cost review commission

Population Health Innovations Subgroup

August 20, 2024

Agenda

- Welcome & Member Introduction (10 minutes)
- Revenue for Reform (60 minutes)
  - Overview of Policy Intent
  - FY 2025 Updates (Tracks & Measurement Approach)
  - Discussion of FY 2026 Revisions
- High Value Care Plans (35 minutes)
  - Overview of Goals and Basic Requirements
  - Discussion
  - MedInsight Value-Based Care Insights (VBCI) Demonstration
- New Paradigms (5 minutes)
- Advancing Innovation in Maryland (5 minutes)
- Next Steps & Announcements (5 minutes)

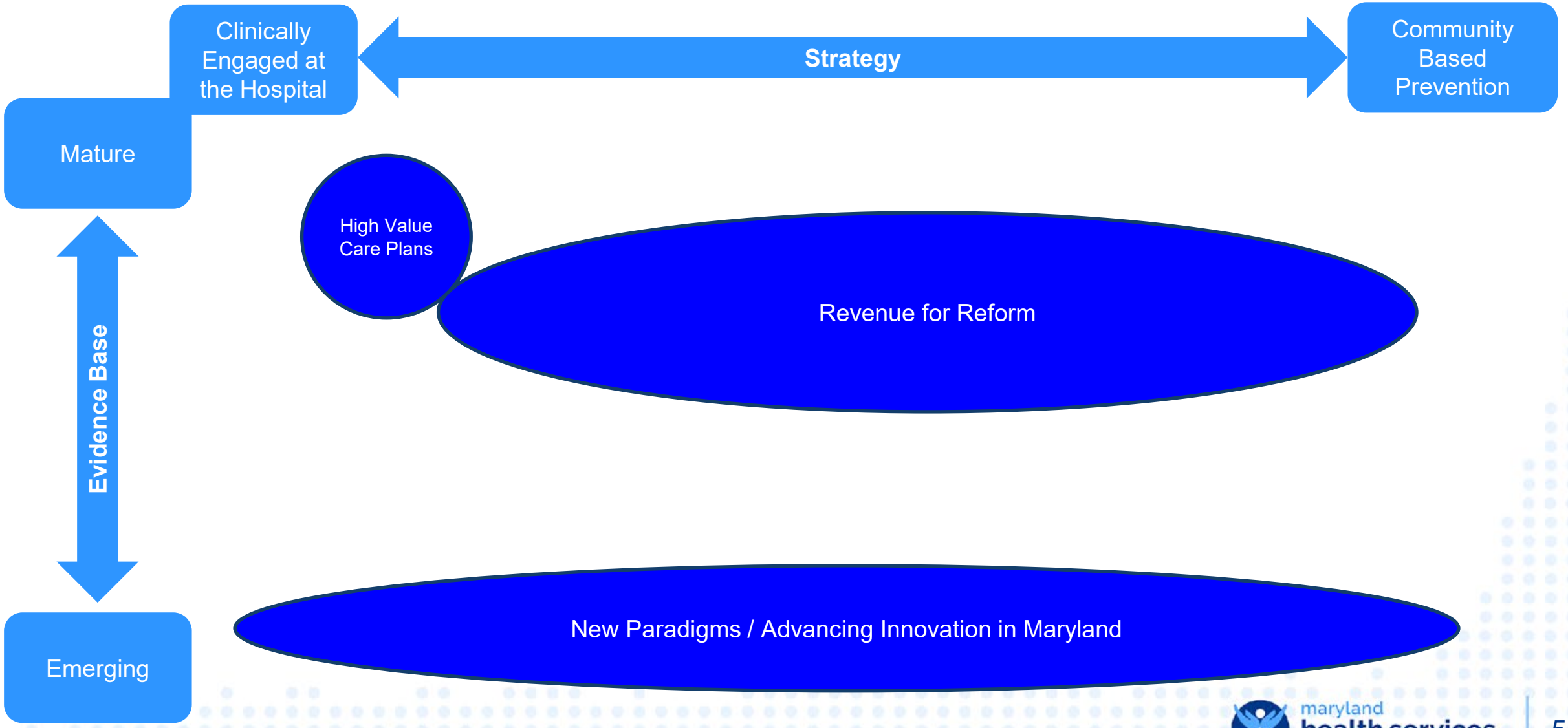
Members

- **Andrea Limpuangthip,** Mercy Medical Center
- **Andrew Anderson**, Johns Hopkins Bloomberg School of Public Health
- **Annice Cody**, Holy Cross Health
- **Darci Smith**, Gordon Feinblatt Law
- **David Granger**, CareFirst
- **David White**, MedStar Health
- **Ed Beranek**, Johns Hopkins Health System
- **Heather Kirby**, Frederick Health
- **Jamar Slocum**, United Medical Center & Social Mission Alliance
- **John Chessare**, Greater Baltimore Medical Center
- **Josh Repac**, Meritus Health
- **Kai Shea**, Johns Hopkins Bayview
- **Kara Harrer**, Calvert Health
- **Kate Stradar**, Adventist HealthCare
- **Kathryn Fiddler**, Tidal Health
- **Katie Rouse**, On Our Own of Maryland
- **Kim Moeller**, Johns Hopkins Bayview
- **Laura Russell**, LifeBridge Health
- **Madeline Jackson-Fowl**, University of Maryland Medical System
- **Marcella Bailey**, Mercy Medical Center
- **Mary Kim**, Adventist HealthCare
- **Peter Hill**, Johns Hopkins Health System
- **Rachel Johnson**, Nemours Children's Health
- **Raquel Samson**, University of Maryland Medical System
- **Richard Birkner**, Calvert Health
- **Ryan Anderson**, MedStar Health
- **Sharon McClernan**, LifeBridge Health
- **Tequila Terry**, Maryland Hospital Association

Purpose

- The Population Health Innovations Subgroup will advise HSCRC on the development and evolution of the following HSCRC population health programs and initiatives, offering input on overall strategy and practical considerations impacting design and implementation.
- These programs are all enabled under other HSCRC policies and seek to focus hospital efforts on strategies that maximize the effectiveness of Maryland's investments in the care delivery system:
  - Revenue for Reform - FY 2026 Revisions
  - High-Value Care / Population Health Management Plans
  - New Paradigms in Care Delivery
- Note: This subgroup is **not** considering revisions to the policies enabling these programs (i.e. Integrated Efficiency and Update Factor).

Programs Map



Revenue for Reform

Policy Intent

- Revenue for Reform is a component of the Integrated Efficiency policy, which Commissioners approved in July 2023.
- The primary goals of the Revenue for Reform policy are to:
  - Direct hospital retained revenue to community-based population health investments and drive population health improvement.
  - Support projects that advance the goals of the Total Cost of Care Model to improve health equity, population health, and reduce total cost of care.
  - Create a virtuous cycle between less need for hospital services and growing hospital investments in the community.
- Under this policy, hospitals are required to invest in approved community health activities or return funds to payers.
- Hospitals that are permitted to make population health investments **will continue to spend those dollars annually**. As a result, this funding can be utilized for sustainable health investments.

Updates to FY 2025 Tracks

- Track 1: Community Health Spending
  - **(Track 1A) Multidisciplinary Care Transitions and Care Management Programs:** Direct spending to address top conditions driving hospital avoidable utilization, readmissions, and/or cost through tailored, multidisciplinary care transitions and/or care management programs.
  - **(Track 1B) Evidence-Based Community Health Improvement Programs:** Invest in existing or implement new evidence-based community health improvement programs within primary service area.
- Track 2: Physician Spending
  - Allows spending on primary care, mental health providers, and dental providers in a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA).
  - Allows limited loan repayment assistance for new provider recruitment.
- Track 3: State Pre-Approved Projects
  - These projects are cleared by MDH and HSCRC to provide a high value for community health and the Model.

Updates to Track 3

- HSCRC and MDH have approved two approaches
  - **Local Health Investment Fund** – with specific purposes to be determined through a community-engaged process.
  - Community-based Interventions
    - "Street Medicine" – Mobile Addiction Treatment and Primary Care Services
    - Primary Care Services for Undocumented and Uninsured People
    - Supportive Housing Expansion for Medically-Vulnerable People Experiencing Homelessness
    - Note: Health Care for the Homeless is ready to implement these programs in Baltimore, or hospitals can choose alternative providers with the same level of deliverables for new services in these areas.
- Applications to participate in Track 3 will be considered automatically approved by MDH and HSCRC.
- If there are insufficient Track 1 and 2 investments, hospitals will be directed to invest in Track 3.

Review Approach – Community Health

- A committee formed by the MDH and HSCRC will review the applications and either approve or deny the application.
- In order to be approved, an application will be evaluated on the following:
  - **Meets Community Need:** Intervention addresses a top condition driving avoidable utilization/readmissions/cost **or** or it fulfills a need identified in the Community Health Needs Assessment (CHNA).
  - **Impact on Root Causes and Disparities:** The intervention targets the root causes of the identified condition or community need and addresses disparities within the patient population.
  - **Community Partnership:** The application shows strong collaboration with a trusted community partner to support the implementation of community-based programs.
  - **Impact Measurement Approach:** The application provides a comprehensive impact measurement strategy with relevant metrics, including baseline and performance targets, also disaggregated by race and ethnicity.
  - **Implementation Plan:** The application demonstrates how the intervention is integrated into the hospital's overall population health strategy.
- HSCRC and MDH staff may schedule meetings with the hospital to review applications. During this process, the review committee may recommend modifications to the application's scope.
- If the committee rejects an application and the hospital is unable to offer an alternative investment, hospitals will be directed to support projects under Track 3.

Performance Measurement Approach: Track 1

- As part of the FY 2025 application, HSCRC developed a standardized impact measurement approach.
- Hospitals will be required to identify measures available through CRISP reporting tools.
  - Public Health Dashboard
  - Medicare Analytics & Data Engine (MADE)
  - Multi-Payer Reporting Suite
  - Pre-Post Reports
  - Care Transformation Initiative-like option
- These reporting tools can provide both aggregate and patient-level data on cost savings, utilization, quality, and equity measures.
- Hospitals must provide a relevant impact measure leveraging any of these tools, as well as a baseline and performance target(s).
- If no CRISP tool is appropriate for a given intervention, hospitals may provide a custom measure with a baseline and performance target with justification for not using CRISP reporting tools.
- Hospitals must include baseline and performance targets specific to race and ethnicity as part of their impact measurement approach.

Review Approach – Physician Spending

- A committee formed by MDH and HSCRC will review the applications and either approve or deny the application.
- In order to be approved, an application will be evaluated on the following:
  - **Population Served:** Serves a population in an HPSA or MUA and describes health needs of beneficiaries in served community, including any disparities present
  - **Innovation to Expand Access**: Application offers innovative approach to expand access to care (e.g. use of telehealth, training pipelines, placement incentives)
  - **Implementation Plan:** Application outlines a recruitment timeframe and a plan to improve access and care coordination while waiting on new providers
  - **Staffing Model & Training:** Application proposes innovative staffing models and training plans that address patient engagement, trauma informed care, and cultural competency
  - **Reasonableness of Funding:** The spending per provider and per beneficiary is reasonable for the scale of services provided
- HSCRC and MDH staff may schedule meetings with the hospital to review applications. During this process, the review committee may recommend modifications to the application's scope.
- If the committee rejects an application and the hospital is unable to offer an alternative investment, hospitals will be directed to support projects under Track 3.

Performance Measurement Approach: Track 2

- Practices that are currently participating in MDPCP will report measure performance to the hospital. The hospital will provide this data to HSCRC in an annual progress report.
- Practices that are participating are expected to report on the following MDPCP measures:
  - CMS 165 - Controlling high blood pressure,
  - CMS 122 - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
  - CMS 2 - Depression Screening & Follow-up
- If these measures are not appropriate for a supported provider type (e.g. pediatrician, OBGYN), the hospital should propose another measure in their application that aligns with the CMS national quality strategy.

Discussion Topics

- FY 2025 Application – August Discussion
  - **Review Approach:** What other criteria should the review committee consider while evaluating R4R applications?
  - **Impact Measurement:** Does the Track 1 impact measurement approach (described on prior slides) provide sufficient guidance and flexibility to measure intervention impact?
  - **Physician Spending:** What is a reasonable range of spending on a by-provider basis? On a per beneficiary basis?
- FY 2026 – August/September Discussion
  - **Multi-Year Planning:** To support the strategic use of R4R dollars and new investments, HSCRC proposes transitioning to multi-year plans with annual reporting requirements, rather than requiring annual applications. What is the appropriate duration for a multi-year R4R investment plan? What are some other considerations?
  - **Track 3 Projects:** HSCRC aims to expand the list of pre-approved projects under Track 3. Are there specific interventions that hospitals believe would support their goals and should be considered for Track 3 in FY 2026?
  - **Impact Measurement:** Balancing the need to ensure interventions are effective with the reality that some may take years to show return on investment (ROI) or demonstrate impact can be challenging. How should a future R4R impact measurement approach address this challenge?

Timeline

- FY 2025 Application
  - September 6 - HSCRC releases FY 2025 R4R application. HSCRC will include a memo for hospitals impacted outlining total amounts eligible for safe harbor under R4R policy.
  - November 4 – Hospital applications due to HSCRC.
  - November/December – State Review
  - December – Hospitals notified if applications are approved/rejected
- FY 2026 Policy & Application
  - November 2024 - Draft Recommendation
  - November / December 2024 - Public Comment
  - January 2025 - Final Recommendation and Commissioner Vote
  - March 2026 - FY 2026 Application Released

High Value Care Plans

High Value Care Plans

- The FY 2025 Update Factor recommendation included a requirement for hospitals to submit population health management plans as part of an efforts to reduce statewide potentially avoidable (PAU).
- Hospital plans must include, at a minimum,
  - identify at least 3 conditions driving avoidable utilization, readmissions, and/or cost within their hospital,
  - describe programs, initiatives, and interventions intended to address the conditions identified, as well as the resources committed to these efforts;
  - specify participation in statewide efforts to address core population health goals, such as reducing maternal mortality and overdose;
  - provide performance improvement indicators and outcomes for the identified conditions and programs, including, as appropriate, measures related to equity.
- Hospitals that do not submit plans or submit plans that do not meet passing criteria will be subject to a 0.19% clawback in their January rate orders.

Base Requirements for Plans

- Description of the hospital's population health organizational structure.
- Overview of the hospital's population health strategy.
- Strategy to reduce low value care (priority area of focus), citing an opportunity analysis conducted using Milliman's MedInsight Value-Based Care Insights (VBCI) tool to identify clinically defined subpopulations with improvement opportunity.
- Performance improvement targets leveraging a CTI-like framework.
- Define a minimum amount of specific population health management investments.
- Include specifying partnerships with outpatient providers, community-based organizations and public health departments to achieve population health goals.
- Include the potential for investments in social contributors to health.

MedInsight Value-Based Care Insights (VBCI) Demonstration

Advancing VBC with industry leading methodologies

Milliman IP and publicly available resources

Continuous Innovation:

MedInsight is constantly introducing new features, metrics, and benchmarks

- Milliman HCG Grouper
- Milliman Medicare FFS Benchmarks
- Milliman DRG Benchmarks
- Post-Acute Care Benchmarks (NY developed using Medicare 100% data)
- Potentially Preventable Preference Sensitive Admissions (NY developed)
- NYU Potentially Preventable ED Visits Algorithm
- CMS-HCC Risk Adjustment Model
- Chronic Condition Grouping
- AHRQ Prevention Quality Indicators (PQI) Software (for ACSAs)

Comprehensive VBC data metrics

VBC Insights

VBC Analytics

VBC Contracts

Cost models and trends

- High-level summary
- Cost summary
- Cost model
- Cost model compare
- Cost model adjustment
- Leakage trends

Beneficiary level and post-acute care

- Beneficiary detail
- Chronic conditions
- Post-acute summary
- Inpatient detail
- Skilled nursing facility detail
- Home health detail
- Inpatient rehab detail

DRG and service line

- DRG detail
- Service line detail
- ACSA-PSP detail
- Preventable ED visits
- End-of-life measures
- Pharmacy detail

Streamline healthcare reporting and analytics with VBC-ready reports

Dashboard categories	Included reports
High-level summary and beneficiary detail	• Demographic information by enrollment type or status • Costs and trends by high-level service categories (IP, SNF, professional, etc.) • Beneficiary detail (risk score, annual costs, attributed provider) • Chronic condition cost summary
Utilization and cost by service category	• Cost and utilization by detailed service categories with benchmarks • Service line detail (by procedure and revenue codes) • Utilization adjustment model • Leakage reports (requires additional data from client to identify OON providers) • Pharmacy detail (by chronic conditions, USP Class, Non-proprietary drug name)
Potentially avoidable Services	• Utilization and cost for ED visits, preventable vs. non-preventable • Utilization and cost for preference sensitive and ambulatory cares sensitive admissions • End of life metrics
Post-acute care (PAC)	• Inpatient discharge by site of service (SNF, IP rehab, HH, readmissions) • SNF & home health volume and costs by facility • PAC utilization and cost by DRG compared to benchmarks • PAC readmission rates and costs by DRG

Key use cases to maximize your impact?

1

Inpatient medical & surgical admissions

2

Post acute care services (30-day episodes)

- IP readmissions
- SNF
- acute IP rehab
- HH

3

ED visits

4

End of life/palliative care services

- In hospital deaths
- Hospice use

5

Part B drugs

- Biosimilars and other alternatives

6

Site of service

- IP to OP surgery for a few surgeries, i.e., hip and knee replacement, spinal fusion
- Hospital OP surgeries to ASC
- Hospital OP High-tech imaging to office
- Hospital OP infused/injectable drugs to office
- Urgent care instead of ED
- Observation instead of IP

Discussion

- HSCRC will require an overview of hospital population health strategies in their HVC plans. Responses would include descriptions of the population health team's workplan and programs they oversee. How should HSCRC define this plan requirement to ensure hospitals capture the relevant areas of work?
- What other tools, other than VBCI, can be used to perform the required analysis to identify the priority area of focus?
- What other tools, other than a CTI-like framework, are appropriate to measure performance? What tools are appropriate for non-Medicare populations?

Timeline

- October 15 - HSCRC releases High Value Care Plan template
- October 22 - Milliman VBCI Tool Goes Live
- December 15 - High Value Care Plans Due to HSCRC
- December/January - State Review & Hospital Follow-Ups, if necessary
- January 15 - Hospitals Notified if Plans Approved/Rejected
- Any clawbacks reflected in January Rate Orders

New Paradigms in Care Delivery

Background and Criteria

- In the FY25 Update Factor the Commission approved up to $20 M for investment in innovative clinical solutions.
  - $20M will match investments committed by hospitals or other entities to pursue transformative ideas.
  - The funding shall be awarded based on a competitive process to be administered by HSCRC
- Up to three proposals will be selected based on documented criteria that will include but are not limited to:
  - degree of innovation and risk involved (i.e. why the approach is hard to implement in the absence of this funding),
  - speed of implementation,
  - the share of funding provided by the applicant versus requested from the State,
  - likelihood of scalability and
  - estimated long-term impact on lowering total cost of care and/or increasing quality.

Timeline

- HSCRC is currently researching programs/structures to ensure the application process aligns with potential uses of the money.
- Staff are beginning the work to put together a process for awarding this money.
- Staff expect award process to start later in the fall with funding likely to be implemented mid-2025.

Advancing Innovation in Maryland (AIM)

AIM Overview

- **Advancing Innovation in Maryland (AIM)** contest is a public-private partnership involving the Maryland Department of Health (MDH), the HSCRC, and local foundations.
- Goal is to surface ideas to support Maryland's unique health care model, which incentivizes better health, prevention of complications, and more efficient care.
- Contest will award cash prizes to individuals and organizations with ideas to promote improved population health and reduce overall health care costs for the state.
- Seeking ideas in three categories, all with the dual goal of improving health outcomes and promoting affordability:
  - **Innovative Interventions**: Ideas for interventions that a hospital can implement, by itself or in coordination with community partners.
  - **Innovative Collective Action:** Ideas for programs or platforms that require collective implementation by all hospitals within a region or statewide, by themselves, or in coordination with community partners.
  - **Innovative Payment Approaches**: Ideas for payment innovations that the Health Services Cost Review Commission can implement.
- In addition to the cash prizes, winning ideas will be presented to the Health Secretary and the Health Services Cost Review Commission for consideration.
- More information about the AIM contest, including a call for ideas, will be released in the coming weeks.

Next Steps

- Next Subgroup Meeting - September 24th (9-11AM)
  - Revenue for Reform - Discussion
  - High Value Care Plans
    - Discussion
    - VBCI Tool Demo
- Send any written feedback on FY 2025 R4R discussion by Monday, August 26, 2024 to hscrc.grants@maryland.gov
- Send any new discussion topics or written feedback on R4R FY26 and High Value Care Plans by Friday, September 13, 2024 to hscrc.grants@maryland.gov

Appendix

New Paradigms Recommendation Language

- *Transformation Funding: One of the paths to success under global budgets is to find innovative solutions that avert the need for traditional hospitalization. While significant progress has been made in averting these admissions Staff believe there is an opportunity to accelerate these efforts through targeted investment in transformative solutions that may be too expensive or speculative to be funded in the normal course of business. For example, hospital-at-home approaches in rural areas could reduce cost, while also eliminating the travel burden on patients, but can't be tested at scale and therefore require extra investment to develop a proof of concept.*
- *The Transformation Fund will provide approximately $20 M to match investments committed by hospitals or other entities to pursue these transformative ideas. The funding shall be awarded based on a competitive process to be administered by HSCRC staff as an extension of the Care Transformation Initiative program; both Maryland hospitals and other entities, in partnership with a Maryland hospital, will be eligible. Staff shall select at most 3 proposals based on documented criteria that will include but not be limited to (1) degree of innovation and risk involved (i.e. why the approach is hard to implement in the absence of this funding), (2) speed of implementation, (3) the share of funding provided by the applicant versus requested from the State, (4) likelihood of scalability and (5) estimated long-term impact on lowering total cost of care and/or increasing quality.*