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NOTICE OF WRITTEN COMMENT PERIOD

Notice is hereby given that the public and interested parties are invited to submit written comments to the Commission on the staff draft recommendations and updates that will be presented at the March 10, 2020 Public Meeting:

1. Draft Recommendation on the Payer Differential for Medicare Advantage

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATIONS ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE MARCH 24, 2020, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.

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582nd Meeting of the Health Services Cost Review Commission
March 10, 2020

(The Commission will begin public session at 11:30 am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

EXECUTIVE SESSION
11:30 am

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104

2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on January 13, 2020

2. Docket Status – Cases Closed

   2549A – University of Maryland Medical Center

3. Docket Status – Cases Open

   2550A – Johns Hopkins Health System 25510A – Johns Hopkins Health System

   2552A – Johns Hopkins Health System

4. Presentation on Regional Partnership Catalyst Grant Program Activities
   a. Greater Baltimore Regional Integrated Crisis System (GBRICS)
   b. Nexus Montgomery

5. Draft Recommendation on Medicare Advantage Payer Differential

6. Workgroup Updates
   a. Efficiency Workgroup
   b. Payment Models Workgroup
   c. Performance Measurement Workgroup

7. Policy Update and Discussion
    a. COVID-19 Surge Policy
    b. Model Monitoring
    c. Legislative Update

8. Legal Report
9. Hearing and Meeting Schedule

Cases Closed

The closed cases from last month are listed in the agenda

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF March 2, 2021

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2550A	Johns Hopkins Health System	2/22/2021	N/A	N/A	ARM	DNP	OPEN
2551A	Johns Hopkins Health System	2/24/2021	N/A	N/A	ARM	DNP	OPEN
2552A	Johns Hopkins Health System	2/26/2021	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2021**
SYSTEM	*	**FOLIO:**	**2360**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2550A**

Staff Recommendation

March 10, 2021I

INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on February 22, 2021 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to add outpatient joint replacement services to the global rate arrangement approved for bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, thyroid surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services, eating disorder, gender affirming surgery, and gall bladder surgery with Assured Partners. The Hospitals request that the approval be for the period from March 1, 2021 to September 30, 2021.

II. OVERVIEW OF APPLICATION

The contract will be continue to be held and administered by JHHC, which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar procedures at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians continues to hold the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

The experience under the current arrangement for the last year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination to add outpatient joint replacement services to bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, thyroid surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services, eating disorder, gender affirming surgery, and gall bladder surgery approved effective October 1, 2020, for the period from March 1, 2021 to September 30, 2021. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2021**
SYSTEM	*	**FOLIO:**	**2361**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2551A**

Staff Recommendation

March 10, 2021

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on February 24, 2021 on behalf of its member Hospitals (the "Hospitals") for a new alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a global rate arrangement for Cardiovascular services, Bariatric Surgery, Orthopedic Services (shoulder, hip, knee, and spine), Gallbladder, Thyroid/Parathyroid, Oncology Diagnosis, and Prostate services with Employer Direct Healthcare. The System requests that the approval be for a period of one year beginning April 1, 2021.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar joint replacement services at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff believes that this arrangement is similar to several other successful arrangements approved by the Commission.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Cardiovascular services, Bariatric Surgery, Orthopedic Services (shoulder, hip, knee, and spine), Gallbladder, Thyroid/Parathyroid, Oncology Diagnosis, and Prostate services with Employer Direct for a one-year period commencing April 1, 2021. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2021**
SYSTEM	*	**FOLIO:**	**2362**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2552A**

Staff Recommendation

March 10, 2021

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on February 26, 2021 on behalf of its member Hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for joint replacement and joint replacement consult services with Carrum Health, Inc. Carrum also seeks approval to add Cardiovascular, and Spine surgery to the arrangement. The System requests that the approval be for a period of one year beginning April 1, 2021.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar joint replacement services at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that the little activity under this arrangement has been positive and believes that the modified arrangement is similar to several other successful arrangements approved by the Commission.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement, joint replacement consult services, bariatric, cardiovascular and spine surgery services for a one year period commencing April 1, 2021. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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Draft Recommendation on Payer Differential for Medicare Advantage

March 10, 2020

This document contains the draft recommendation to change the Medicare Advantage payer differential, pending federal approval. Comments may be submitted by email to latonya.hamilton@maryland.gov and are due by March 25, 2021.

P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

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Table of Contents

maryland
health services
cost review commission

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
This draft recommendation seeks ways to increase access and options for seniors and dual eligible individuals through Medicare Advantage. The State is committed to finding ways to improve access to care, enhance quality and care transformation, improve health outcomes and ultimately lower the cost of care for all Marylanders.	A payer differential specific to Medicare Advantage has the potential to better align the State's all-payer hospital rate setting system with the Medicare Advantage rate setting methodology. This change to the payer differential is subject to CMS approval.	This recommendation is revenue neutral to hospitals.	This recommendation would change the allocation of charges across payers and would result in lower charges for Medicare Advantage patients and higher charges for other payers (Medicaid, Medicare FFS, Commercial, self-pay).	By strengthening the Medicare Advantage market and increasing options for seniors and dual eligible individuals, this recommendation has the opportunity to increase access to care and support services for Marylanders.

Overview

Since 2014, Maryland has worked with the Center for Medicare and Medicaid Innovation (CMMI) to reduce cost of care in Maryland and improve quality and health outcomes. The partnership has been successful thus far in implementing payment and system delivery reforms, resulting in over $1.4 billion dollars of hospital savings and improved hospital quality. The initiatives benefit not only Medicare fee-for-service (FFS) beneficiaries living in Maryland, but also all other patients under our all-payer rate setting system. While the Total Cost of Care (TCOC) Model agreement focuses primarily on Medicare FFS targets, the HSCRC must also maintain its historic hospital all-payer rate setting system that seeks to provide access, equity, and contain costs across all payers. Under this unique system, Maryland is able to fulfill its obligations of the TCOC Agreement while at the same time continue its equally important obligation to regulate the remaining 60 percent of the market that includes consumers enrolled in payers other than Medicare FFS.

As an all-payer system, we work to align our State programs across all payers, including commercial insurers, Medicaid, Medicare FFS and Medicare Advantage, to improve access to care, enhance quality and care transformation, improve health outcomes and ultimately lower the cost of care for all Marylanders. The following draft recommendation seeks to align the goals and infrastructure of the Medicare Advantage market under the terms of the all-payer hospital rate setting authority consistent with the Maryland Total

Cost of Care Model. Specifically, the Maryland Health Services Cost Review Commission (HSCRC), proposes to temporarily adjust the public payer differential for Medicare Advantage (MA) plans under the TCOC Model in order to improve access to MA for seniors and dual eligibles in Maryland. The MA market is significantly underperforming due in part to interactions between the Maryland rate setting model and the MA rate setting methodology. The lack of performance leaves consumers with few or no options for MA plans, including plans for dual eligibles, in a significant portion of the State.

This recommendation would align MA with the TCOC Model by adjusting the public payer differential, pending approval by the Centers for Medicare & Medicaid Services (CMS). The proposal would effectively adjust MA rates to what they would be but for the impact of the hospital rate setting component of the TCOC Model, while ensuring the State would still meet all required savings targets under the terms of the agreement with CMS. The recommendation does not undermine any of the goals or expectations of the TCOC Contract, harm hospitals, other providers, or beneficiaries.

Since early in Maryland's All-Payer system, government payers have been afforded a differential from rates paid by private payers. Currently, government payers (Medicare and Medicaid) pay 92.3 percent of HSCRC-approved hospital charges. The differential is designed to reflect differences in the practices of classes of payers, which result in cost-of-care differences. Under the TCOC Model Agreement, the HSCRC has the ability to adjust the public payer differential with CMS approval. CMS most recently approved a public payer differential change that took effect in July 2019[1], which resulted in a 1.17 percent rate increase for commercial payers and a savings of $46 million to Medicare.

The enclosed draft recommendation proposes to increase the public payer differential for MA plans, which will result in a 0.5 percent rate increase for other payers and annual savings of $75 million to MA plans. The resulting differential for MA would be approximately 16.88 percent and would be in effect from January 1, 2022 to December 31, 2024. This proposal will only take effect with CMS approval, in accordance with our TCOC Model Agreement.

The aim of this proposal is to adjust MA hospital costs to where the rates would be absent the State's all-payer rate setting. We believe that this adjustment will attract more MA investment in the State and accomplish significant complementary goals, including strengthening infrastructure to coordinate care for Medicare beneficiaries, assuring Maryland beneficiaries the same choice of coverage and benefits as beneficiaries in other states, creating a competitive MA marketplace, and supporting Federal and State policy goals under the TCOC Model. In CY2024, HSCRC would evaluate the proposal's effects and determine a path forward to potentially include MA-enrolled beneficiaries in the TCOC Model and examine

[1] Differential Increase effective July 1, 2019. Memorandum to Hospital CFOs. Available at: https://hscrc.maryland.gov/Documents/pdr/PolicyClarification/2019/DifferentialMemo061019.pdf

other ways to expand the MA-like benefits to other Maryland beneficiaries. While this differential will increase charges for Medicare FFS, the TCOC Model sets stringent annual savings goals that the State will continue to meet. The State is committed to lowering costs for Medicare total cost of care and to transforming the care delivery system. This proposal will better align the Maryland TCOC Model and the Medicare Advantage market to provide expanded services and lower total costs while not diminishing the hospitals or any other component of the TCOC demonstration.

Past Funding

In February 2020, the Commission approved a grant program to support MA through Maryland hospitals. This was intended to be an interim step to increase support for Medicare Advantage access throughout the State. The Medicare Advantage Partnership Grant Program was designed to achieve the following:

- Encourage partnerships and strategies that result in long term health improvement of Medicare Advantage Partnership beneficiaries
- Improve Medicare Advantage penetration and/or improved services to high cost and high risk populations
- Preserve and/or expand access to the number of 4+ Star Rating Medicare Advantage plans in the State to promote competition and access for seniors
- Develop strategies that improve care coordination and quality of services offered in Medicare Advantage Plans
- Extend healthcare transformation efforts to the Medicare Advantage market.

The Medicare Advantage Partnership Grant was authorized as a temporary funding mechanism for Fiscal Years 2020 and 2021. Hospitals were able to apply to participate in the grant program by partnering with an MA organization to submit a proposed list of activities that would result in increased quality and expanded access.

Grant Program Impact Areas

The Medicare Advantage Partnership Grants were narrowly focused to foster increased stability for Medicare Advantage organizations, expand access and create more robust plan designs for beneficiaries, and/or improved quality ratings. Hospitals agreed to spend grant funds on activities to focus on driving impact in one or more of the following areas:

Star Rating Measure Improvement

Medicare Advantage contracts are rated on up to 45 unique quality and performance measures. Grant funds should be used to design and implement strategies that will result in improvement in the Part C/Part D measures established by CMS for the Medicare Advantage Program. The MAP Grant Program was

designed to leverage hospital expertise on quality in an effort to improve star rating measures of Medicare Advantage plans. By doing this, the Medicare Advantage Plans will be eligible for higher reimbursement from CMS. This additional funding can then be returned to enrollees in the form of enhanced benefits and reduced cost-sharing.

Increase in Annual Wellness Visits

The Annual Wellness Visit provides an annual opportunity for Medicare Advantage beneficiaries to work with their providers to create or update their personalized prevention plan. This visit can be particularly important for beneficiaries who are high cost or who have high healthcare needs. The Annual Wellness Visit creates an opportunity to proactively assess changes in beneficiary health by performing a health risk assessment at 12 month intervals. Grant funds are being used to design and implement strategies that result in an increase in the number of annual wellness visits per year.

Expansion of Coverage

Maryland's current Medicare Advantage Plan penetration and distribution of services do not provide adequate coverage and choice for all eligible Marylanders. Plans are concentrated in urban counties while rural counties have far fewer choices without the extra benefits Medicare Advantage plans can provide, such as vision or dental services. Grant funds are being used to design and implement strategies that result in the expansion of coverage and access to these services.

High Cost Beneficiary Penetration

It has been well documented that a small portion of Medicare patients account for more than half the program's spending in any given year. This is true of Medicare Advantage Plans as well. According to a 2019 study by the Commonwealth Fund, "37 percent of Medicare Advantage enrollees have chronic conditions and functional limitations requiring a range of medical and social services; many also contend with low income, low education, and isolation." Because of this, the grant program was designed to encourage hospitals to collaborate with Medicare Advantage Plans to identify and address the high cost/high need beneficiaries. Grant funds are being used to design and implement outreach, education, enrollment, prevention, and management strategies that identify and target these beneficiaries with appropriate coverage and services.

Across these four impact measurement areas, hospitals and their Medicare Advantage Plan partners were required to define areas they intend to address and then start working to make progress in these areas. While this grant program was intended to be an interim step to increase quality among MA plans, it is not a sustainable long-term solution. To address and mitigate payment inconsistencies, HSCRC believes that a

change to the underlying MA payment is necessary. Thus, this draft recommendation represents an additional adjustment that could be made to mitigate the disadvantage that MA plans face in Maryland.

Proposal to Change Payer Differential for Medicare Advantage

The HSCRC believes that care transformation and delivery system reform can be best achieved when all stakeholders, including hospitals, providers, post-acute providers, and payers are engaged. While the TCOC Model is a hospital-based model targeting Medicare FFS cost and quality improvements, staff believe that the proposed change to the differential for MA can benefit Marylanders by providing an additional support for care coordination, wrap around services, and non-hospital care alignment for high and rising risk Marylanders. All Marylanders should have access to choice, enhanced benefit offerings, and competition that could be offered through a robust MA market. **The draft recommendation would temporarily increase the public payer differential from 7.7 percent to 16.88 percent for MA from January 1, 2022 until December 31, 2024.** While this recommendation is revenue neutral to hospitals, it does change the allocation of charges across payers as the table below depicts.

			Payer Differential			Estimated Net Revenue			
	FY2019 Revenue (in000s)	Payer Mix	Current	Proposed	Projected Rate Increase	Current (in000s)	Proposed (in000s)	Change (in 000s)	% Change
Medicare Revenue	$6,516,300	37.20%	7.70%	7.70%	0.50%	$6,014,545	$6,044,469	$29,924	0.50%
Medicaid Revenue	788,244	4.50%	7.70%	7.70%	0.50%	727,549	731,169	3,620	0.50%
Blue Cross Revenue IP	1,087,915	6.21%	2.25%	2.25%	0.50%	1,063,437	1,068,728	5,291	0.50%
Blue Cross Revenue OP	1,195,576	6.83%	2.00%	2.00%	0.50%	1,171,664	1,177,494	5,829	0.50%
Medicare MCO	852,318	4.87%	7.70%	16.88%	0.50%	786,690	711,990	(74,700)	-9.50%
Medicaid MCO	2,715,718	15.50%	7.70%	7.70%	0.50%	2,506,607	2,519,078	12,471	0.50%
Medicare Deductibles paid by Medicaid	114,617	0.65%	2.00%	2.00%	0.50%	112,325	112,884	559	0.50%
Uncompensated Care	758,319	4.33%	100.00%	100.00%	0.50%	-	-	-	
Other Payors	3,488,009	19.91%	2.00%	2.00%	0.50%	3,418,249	3,435,255	17,007	0.50%
Total	$ 17,517,016	100.00%				$15,801,066	$15,801,066	($0)	0.00%

The HSCRC projects that, absent the effects of the TCOC waiver, the average MA benchmark in Maryland would be 100.8 percent of fee-for-service spending (4.9 percent above the current level). The proposed increase in the payer differential reflects the additional discount necessary to reduce MA costs by the amount of revenue lost due to the 4.9 percent gap.

The 100.8 percent benchmark was calculated by looking at the average benchmark among the national peer counties identified for each Maryland county and blending to a Maryland average based on MA enrollment. Given a national average of 103.6 percent, the HSCRC believes using the lower benchmark of 100.8 percent appropriately reflects that, even in the absence of the TCOC model, Maryland would be unlikely to fall into the quartiles for the lowest cost counties (107.5 or 115 percent of FFS).

At current enrollment levels the differential change would reduce hospital expenditures for MA plans by $75 million. This increased differential for MA would not apply to other public payers (Medicare FFS and Medicaid). To maintain revenue neutrality for hospitals, hospital rates would need to increase by 0.5 percent

for other payers resulting in cost increases of $30 million for Medicare FFS, $16 million for Medicaid and $29 million for other payers. The amount of rate increase required varies depending on the Medicare Advantage enrollment; therefore, should the State be successful in increasing enrollment, the rate offset would also increase proportionally. For example, doubling the enrollment would double the increase to 1.0 percent. The initial analysis in this draft recommendation was performed on FY 2019 revenue and enrollment. Should this recommendation be accepted by the Commission and CMS, a revised analysis would be performed with the most recent revenue and enrollment data.

This proposal is budget neutral and would not change the savings target for the TCOC Model and would not require any other Model changes. The current demonstration requires $300 million in savings by CY 2023 compared to the CY 2013. The HSCRC projects that the Model would still achieve annual savings that reach or exceed $300 million in CY 2023 under this proposal.

In CY 2024, Maryland is scheduled to begin working on the next iteration of the TCOC Model. Before that time, staff should complete an analysis of the Medicare Advantage market to determine the best path forward, including potentially incorporating MA enrolled beneficiaries into the TCOC Model.

Including MA in the TCOC Model has the potential to strengthen infrastructure to coordinate care for Medicare beneficiaries, assure Maryland beneficiaries the same choice of coverage and benefits as beneficiaries in other states, create a competitive MA marketplace, and support Federal and State policy goals under the TCOC Model.

Recommendation

Pending federal approval of the differential change, the draft recommendation would do the following:

1. Temporarily increase the public payer differential from 7.7 percent to 16.88 percent for MA from January 1, 2022 until December 31, 2024.
2. Prepare a report to be submitted to the Commission in July 2024 that compares penetration levels across the State, by county, to assess the effectiveness of the differential change on access and options to MA plans in Maryland.
3. Nothing in this recommendation shall change the State's commitment to achieve TCOC savings under the terms of the contract with CMS.

Policy Update Report and Discussion

Staff will present materials at the Commission Meeting.

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TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: March 10, 2020

RE: Hearing and Meeting Schedule

April 14, 2021 To be determined - GoTo Webinar

May 12, 2021 To be determined - GoTo Webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.