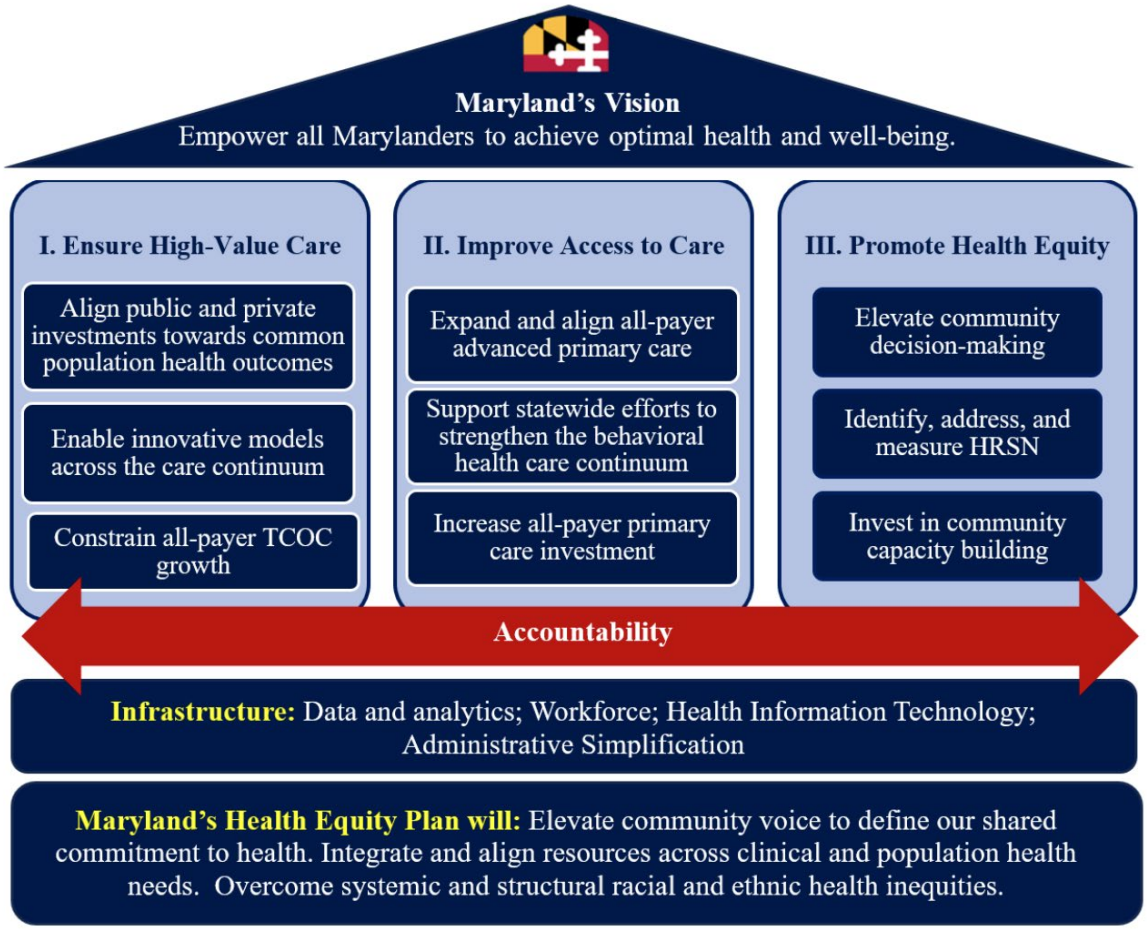
maryland
health services
cost review commission

HSCRC Opportunity for Comment

Written comments should be submitted to hscrc.care-transformation@maryland.gov by Monday, February 3, 2025. Stakeholders who submit written comments by this date will have the opportunity to provide verbal testimony at the HSCRC Public Meeting. on Wednesday, February 12, 2025

AHEAD envisions a health care system that empowers all Marylanders to achieve optimal health and well-being by ensuring high-value care, improving access to care, and promoting health equity (Figure). With the model due to start on January 1, 2026, this is an opportune moment for the Health Services Cost Review Commission to consider policy changes and investments to maximize Maryland's success.



In order to spur a productive conversation and prioritize our work, the Health Services Cost Review Commission is interested in comments on the following draft questions we developed internally, interested as well as health equity considerations and ideas for data analysis to inform the answers to our questions.

1. **Ensuring High Value Care**. A core goal under AHEAD is to bring innovative and affordable care models to the state that improve the health of Marylanders.

    a. Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. *To further drive this work, how can the payment system better recognize effective efforts?*

    b. Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. *How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?*

    c. Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average: https://lownhospitalsindex.org/unnecessary-back-surgery/. *How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?*

    d. The Health Services Cost Review Commission policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. *Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?*

    e. Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them?

2. **Improving Access to Care.** Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires many steps, including appropriate hospital budgeting, sufficient investment outside of hospitals and effective oversight in those other levels of care.

    a. Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. *How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?*

b. Reducing ER wait times is a state priority. *Should the HSCRC consider payment policy to slow the rate of volume declines in specific health systems for specific services related to ER wait times?*

c. As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. *What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning population-based payment and creating an excessive financial incentive for hospital-based treatment?*

d. Hospital global budgets are adjusted every year for statewide population growth. *How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?*

e. Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita and administrative costs?

3. **Other topics**. There are several cross-cutting policy areas that could also be addressed in 2025.

a. Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC. *With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?*

b. Facility conversions. *Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to free-standing medical facilities or other lower acuity providers?* Such a step could be designed to increase funding for hospitals seeing more patients as well as permit the restructuring of services at the conversion facilities to meet community needs. If so, what policies should guide this process?

c. Percentage of revenue under global budgets. Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. *What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home?*

4. *What other major changes to policies under the Maryland Model of population-based payment should be considered?* Please be as specific as possible.