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Annual Report

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Fiscal Year 2023 Activities and Calendar Year 2023 Total Cost of Care Model Performance

June 2024

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Executive Summary

This annual report is prepared in accordance with Section 19-207(b)(9) of the Health-General Article of the Annotated Code of Maryland (MSAR #12506). This report includes:

- An overview of the State's application to the AHEAD Model;
- An overview of the TCOC Model and implementation activities related to the Model;
- A summary of the State's performance under the TCOC Model; and
- An update on other HSCRC activities, including care transformation efforts, public and private partnerships, stakeholder engagement, quality initiatives, and rate-setting methodology development.

Highlights from the report are included below.

AHEAD Model

As the planned end date of the Total Cost of Care (TCOC) Model approaches, the HSCRC is planning its next iteration under the States Advancing Health Equity and Development (AHEAD) Model. As envisioned by the Center for Medicare and Medicaid Innovation (CMMI), AHEAD will place a greater emphasis on health equity, primary care, and curbing healthcare cost growth. Maryland's unique all-payer system will continue under AHEAD, and hospital global budgets will evolve with a greater population health focus.

The HSCRC applied to participate in AHEAD in March 2024. A decision is expected in Summer 2024. The State will officially begin policy development in July 2024 which will continue through December 2025, with implementation beginning in January 2026. HSCRC, in partnership with MDH, will continue to engage key partners and the public at large as it plans the state's implementation strategy.

Total Cost of Care Model Performance

Under the TCOC Model, Maryland is measured annually against six key metrics to determine if Maryland is driving Medicare cost savings and hospital quality improvement. Maryland met all TCOC Model targets in 2023. These results are preliminary and not considered final until verified by CMMI.

Performance Measures	Annual 2023 Targets	Target Met
Annual Medicare TCOC Savings	Achieve $300M in annual Maryland Medicare TCOC per Beneficiary of savings	✓
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	✓

All-Payer Revenue Limit	All-payer growth ≤ 3.58% 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)	✓
Readmissions Reductions for Medicare	Maryland's aggregate Medicare 30-day risk-adjusted all-cause, all-site readmission rate at regulated hospitals ≤ the National Readmission Rate for Medicare FFS beneficiaries	✓
Hospital Population-Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	✓

Hospital Quality Programs

The Maryland Model provides incentives and penalties for hospitals to achieve the best outcomes in treating patients. The HSCRC operates three quality programs: the Quality-Based Reimbursement (QBR) Program, the Maryland Hospital Acquired Conditions (MHAC) Program, and the Readmissions Reduction Incentive Program (RRIP).

Quality-Based Reimbursement Program

- Safety: Infections are a major problem in hospitals but can be controlled. For the healthcare-associated infection measures, Maryland is performing worse than the nation on CAUTI, SSI-Hysterectomy, and C.Diff. The State performs better than the nation on CLABSI and MRSA, and performs on par with the nation on SSI-Colon.
- Clinical Care: Two of 41 hospitals worsened slightly on the inpatient mortality measure, but Statewide performance has improved.
- Patient and Community Engagement: Maryland continues to lag the nation in performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience measures. This is an area of significant concern for the HSCRC.

Maryland Hospital Acquired Conditions: Potentially Preventable Conditions, or PPCs, are negative outcomes that may result from the process of care in hospitals. In CY23, there has been an improvement in the PPCs included in the payment program, with fewer PPCs overall compared to the 2018 base year.

Readmissions: Under the Maryland Model, lower acuity patients receive treatment outside of hospitals, and higher acuity patients are treated inside hospitals, which could increase readmissions. CMMI analyzed Maryland's readmissions on a risk-adjusted basis, and found them to be below national average 2023.

Population Health

Statewide Integrated Health Improvement Strategy: In 2021, CMMI approved Maryland's Statewide Integrated Health Improvement Strategy (SIHIS) which was designed to improve health outcomes, achieve health equity, and control the total cost of care for Marylanders. Maryland established improvement goals across three domains: Hospital Quality, Care Transformation, and Total Population Health, specifically diabetes, opioid use disorder, and maternal and child health. The State met all but one 2021 performance milestones and is awaiting final 2023 performance data.

Revenue for Reform: The primary goal of Revenue for Reform is to direct hospital retained revenue to community-based population health investments and to drive population health improvement. In FY 2024, $26.1 million was directed to community health and expanding and maintaining access to physicians in Baltimore City, Prince George's County, Montgomery County, and the Eastern Shore.

Care Transformation and Partnership Programs

Episode Care Improvement Program: Beginning Jan. 1, 2024, 16 hospitals are participating in the Episode Care Improvement Program, which allows hospitals to link payments among providers for an episode of care, aligning incentives among hospitals, physicians and post-acute care facilities to improve quality and generate savings.

Episode Quality Improvement Program: This program allows specialty providers to coordinate care through clinical episodes and increases accountability for patients. Providers can receive incentive payments by improving quality and reducing cost of care. As of Jan. 1, 2024, there were 119 EQIP entities and 3,217 care providers enrolled – representing 40 specialties.

Care Transformation Initiatives: Under this program, hospitals are assigned Medicare beneficiaries and are accountable for the total cost of care in six categories, including palliative care, primary care and outpatient services. In FY 2022, 43 hospitals participated, generating $127 million in Medicare savings. The total savings for FY23 is being calculated.

Maryland Primary Care Program: As of January 2024, there were 511 participating practices in this program, which allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization. In particular, these practices track diabetes, hypertension, body mass index (BMI) and depression – and integrate behavioral health services into the primary care setting. This program also focuses on advancing health equity and reducing disparities at the primary care level. In 2023, $30.5 million was invested in the Health Equity Advancement Resource and Transformation (HEART) Payment program to provide resources to practices to support the social needs of high-risk patients.

Regional Partnerships: The HSCRC developed the Regional Partnership Catalyst Program to build sustainable programs to advance the population health goals of the TCOC Model, specifically diabetes and behavioral health, over five years (CY 2021 – CY 2025). $X was directed to six Regional Partnerships to implement diabetes prevention and management programs. HSCRC decided to end funding for these programs due to concerns over long-term sustainability. Funding ends in June 2024, but all six have indicated they will seek to continue to provide services. $79.1 million is directed to three Regional Partnerships to build and expand access to behavioral health crisis services, including mobile response teams, crisis stabilization centers, and same-day access to behavioral health care.

Maternal and Child Health Funding Initiative: The HSCRC is directing $40 million cumulatively over five years (FY 2022 – FY 2025) to Medicaid and MDH to fund initiatives that address severe maternal mortality and childhood asthma. In FY 2023, Medicaid expanded access to doula care, home-visiting programs for young mothers and infants, group-based prenatal care programs, and asthma-home visiting programs for children with moderate to severe asthma. MDH has also funded asthma home-visiting programs and home visiting programs for eligible non-Medicaid beneficiaries.

Hospital Financial Performance

Update Factor: Each year, the HSCRC adjusts hospitals' Global Budget Revenue to account for inflation and demographic shifts, and to provide resources for care coordination and population health strategies. On July 1, 2023, the HSCRC approved a 3.75 percent per capita revenue increase for hospitals under global budgets.

Audited FY 2023 Data: The HSCRC monitors hospital financial performance and regulates inpatient and outpatient services located at hospitals – but not the rates of physicians. Maryland's regulated hospital industry remained profitable despite low total operating margins. Both the regulated operating and total profit margin increased over FY 2022.

- The total combined audited regulated and unregulated operating margin was 0.01 percent (0.80 percent in FY 2022).
- The total margin, i.e., the combined operating and non-operating margins, was 2.36 percent (-2.01 percent in FY 2022).
- The operating margin for services regulated by the HSCRC was 6.62 percent (6.48 percent in FY 2022).

Introduction

The 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-quality healthcare. The HSCRC achieves this by regulating revenues that hospitals raise through patient billing and

by designing and driving innovative healthcare delivery programs. Together, these efforts provide better care coordination and better health outcomes for Marylanders.

The HSCRC is at the forefront of Maryland's transformative effort to improve the quality of care for all by emphasizing population health and health equity, while lowering healthcare spending growth under the unique Maryland Health Model (or "Maryland Model"). The Maryland Model improves health care for people across the state by encouraging hospitals, physicians, and other healthcare professionals to work collaboratively to provide high-quality care to patients. The Maryland Model introduces new investments and incentives in the state to engage the wide range of providers in care transformation efforts.

The Maryland Model is the latest iteration of a first-of-its-kind state-level effort to coordinate hospital costs that dates back to the 1970s. Under the current version of the Maryland Model, which runs from 2018 through 2026,[1] our system:

- Rewards better health outcomes through pay-for-performance programs that drive higher quality;
- Guarantees that low-income individuals have access to care at all hospitals by providing equitable funding for uncompensated care;
- Creates a stable and predictable revenue system for hospitals, a benefit that was particularly important in the pandemic;
- Invests in population health and health equity by using savings from reduced hospital utilization; and
- Provides support for state healthcare infrastructure and subject matter expertise on healthcare financing and reform.

This report describes the achievements the Maryland Model has made since its implementation. The HSCRC, the State, hospitals, non-hospital providers, payers, and a broad spectrum of community partners work together to achieve the objectives of the Maryland Model, creating long-term health improvements and cost savings for Marylanders.

The Maryland Model has two major components:

- The Total Cost of Care (TCOC) Model Agreement with the federal government, which seeks to improve health outcomes and control healthcare costs by aligning hospitals and non-hospital providers (e.g. primary care and specialty physicians) to transform the healthcare delivery system.
- Maryland's long-standing all-payer hospital rate-setting system, which aligns hospitals payments from Medicare and Medicaid with those from insurance providers.

[1] Maryland anticipates transitioning to the AHEAD Model in January 2026, thereby ending the TCOC Model a year early.

The TCOC Model, which began in January 2019, aims to enhance the quality of healthcare and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders. The HSCRC helps direct the State's innovative efforts to transform the delivery system and achieve goals under the TCOC Model.

In 2023, the HSCRC focused on ensuring that the State met the 2023 Medicare total cost of care savings target under the TCOC agreement with the Center for Medicare and Medicaid Innovation (CMMI), while responding to hospital requests for funding support and balancing the interests of consumers, employers, and insurers to control hospital costs.

Also in 2023, the HSCRC began the planning process for the next iteration of the Maryland Model. In March 2024, HSCRC submitted an application to the Centers for Medicare and Medicaid Services (CMS) States Advancing Health Equity and Development (AHEAD) Model, which, if awarded, will continue Maryland's unique all-payer system and provide greater emphasis on health equity and community decision making in health care delivery systems.

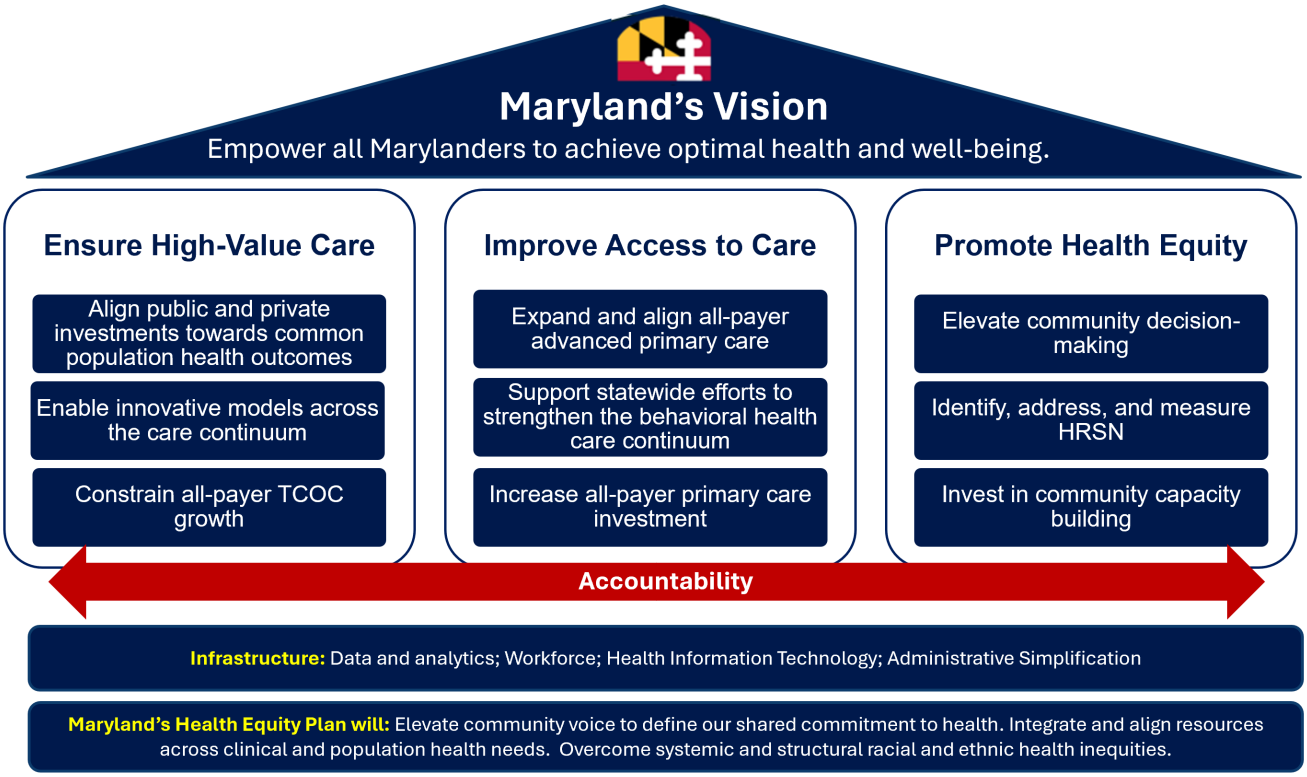
States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model

In March 2024, The Maryland Department of Health (MDH) and the HSCRC applied to participate in the CMS AHEAD Model.

The AHEAD Model advances the vision of empowering all Marylanders to achieve optimal health and well-being. As the end of the TCOC Model approaches, AHEAD will benefit Maryland as the pathway to improving statewide healthcare quality, health outcomes, and health equity - while controlling cost growth. Through AHEAD, Maryland will bridge the health care, population health, and social sectors as well as the public and private sectors to implement the solutions Marylanders need, as identified by community members themselves.

Maryland will leverage AHEAD Model tools to promote health equity, ensure high-value care, and improve access to care, to achieve the vision of high value, equitable, and excellent health delivery system.

Figure 1. Maryland's Vision Under AHEAD



Promoting Health Equity: To promote health equity, the State will elevate community decision-making; identify, address, and measure health-related social needs, and invest in community capacity building.

Driving principles are centering community knowledge and solutions, empowering community voice, and prioritizing community-based alternative funding models.

Ensuring High-Value Care: To ensure high-value care, the State will align public and private investments towards common population health outcomes, incentivize innovative models across the care continuum, and constrain all-payer TCOC growth to sustainable levels.

The State's driving principles include benchmarking our success according to outcomes, evolving and evaluating all-payer hospital global budgets to align with equity-centered population health goals inclusive of community health needs, and addressing challenges across the health care system such as post-acute care quality and alignment.

Improving Access to Care: To improve access to care, the State will expand and align all-payer advanced primary care, support statewide efforts to strengthen the behavioral health care continuum, and increase all-payer primary care investment.

Driving principles include recognizing primary care as the foundation of our health care delivery system; integrating behavioral health into primary care; and growing, attracting, and retaining a diverse primary care workforce through investment in provider support multi-payer alignment.

The principle of **accountability** will underlie the approach to all three of these strategies. **Infrastructure** investments will support the actions needed to achieve the State's vision, including:

- **Workforce,** a foundational issue to promote health equity, ensure high-value care, and improve access to care.
- **Health information technology, data, and analytics.** The State will strengthen and grow this area to achieve intentionality, transparency, and collaboration across the care continuum.
- **Administrative simplification for health care providers,** supported by multi-payer alignment across payment models and quality measurement.

Maryland's Health Equity Plan is the foundation for all actions and investments under AHEAD. Maryland will develop the State Health Equity Plan to elevate community voice in defining shared commitment to health; integrate and align resources across clinical and population health needs; and work to overcome systemic and structural racial and ethnic health inequities.

Maryland's request for AHEAD Model Cooperative Agreement funding focuses on health equity and health-related social needs. This includes funding for: (1) Five regional community-based population health hubs to support community-level population health investment and efforts to address health-related social needs; (2) Community grants to address population health and health-related social needs; and (3) Technology for statewide coordinated health-related social needs screening and referral.

For more information regarding the AHEAD Model, please visit CMS's model webpage.

AHEAD Advisory Committees

The Maryland Department of Health (MDH) and the Maryland Health Services Cost Review Commission (HSCRC) convened three committees from January to April 2024 to advise the State on the future of Maryland's agreement with CMS, including evaluating the AHEAD Model. The Population Health, Healthcare, and Primary Care Program Transformation Advisory Committees (H-TAC, P-TAC, and PCP-TAC) helped advise the State in the development of the AHEAD NOFO response and provided advisory support related to population health and health equity, primary care, and health care delivery transformation.

Next Steps

Maryland anticipates that CMS will make decisions on Maryland's application to the model this summer. MDH and HSCRC plan to begin policy development and decision making for the Model in July 2024 and

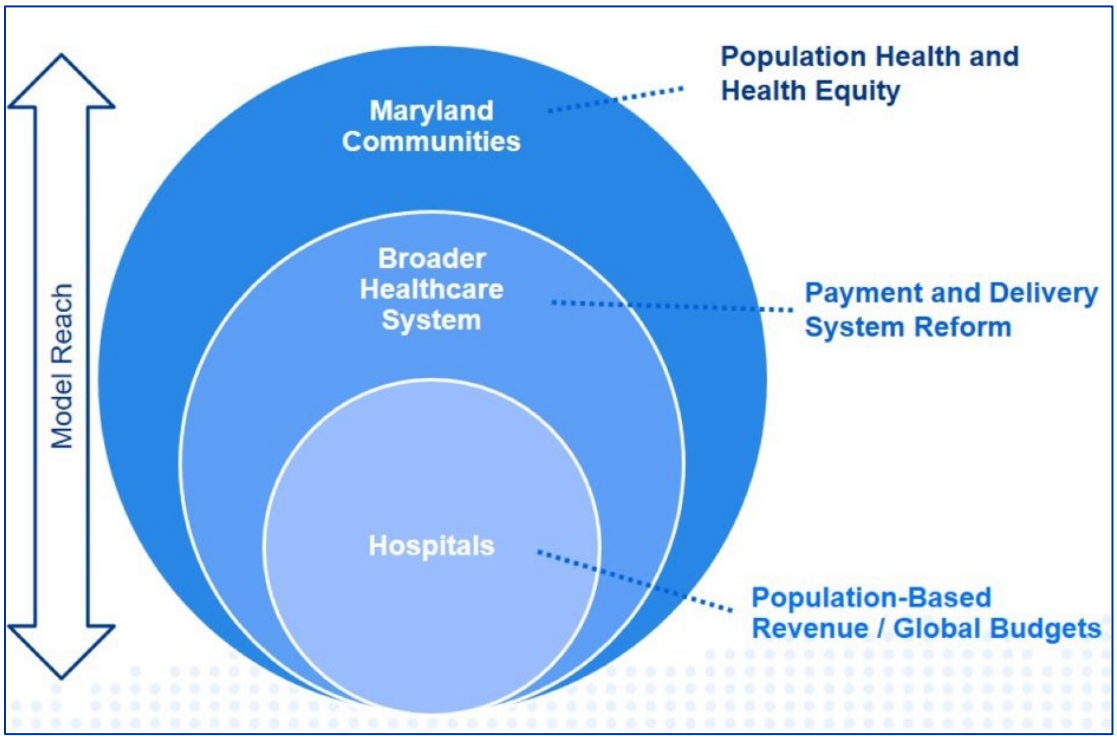
continue through December 2025, during which time the State and CMS will execute a contractual agreement for the AHEAD Model. Maryland's Implementation is expected to begin in 2026. Maryland remains committed to engaging key partners and the public at large as it continues to plan the state's implementation strategy. For all stakeholder information, please visit HSCRC's AHEAD Model webpage.

Section I: Overview of TCOC Model and Key Requirements

In 2018, the State of Maryland entered into an agreement with CMS to run a demonstration program called the TCOC Model. The TCOC Model aims to coordinate care, implement broad healthcare delivery reform, and improve quality and reduce costs across both hospital and non-hospital settings. The TCOC Model includes financial and quality targets that the State must meet to continue the Model agreement with CMMI.

The TCOC Model has three components: hospital population-based revenue, payment and delivery system reform, and population health and health equity.

Figure 2. TCOC Model Components



- **Hospital Population-Based Revenue:** The Model allows the State to set hospital payments for Medicare. Under the TCOC Model agreement, hospitals are subject to global budgets, which set an annual payment limit for hospitals regardless of the hospital utilization rate. Global budgets, which have been in place for all general acute hospitals since 2014, have fundamentally changed

hospitals' incentives from increasing fee-for-service volume to improving population health and driving toward value-based outcomes. The hospital rate-setting system is discussed in Section VII.

- **Payment and Delivery System Reform:**
    - **Care Redesign and Transformation Programs:** These programs foster care transformation across the health system by expanding incentives for hospitals to work with other providers and creating opportunities for value-based care programs for non-hospital providers. These programs are discussed in Section V.
    - **Maryland Primary Care Program**: The Maryland Primary Care Program (MDPCP) enhances chronic care and health management for Medicare enrollees through advanced primary care. This program is discussed in Section V.
- **Population Health and Health Equity:** The TCOC Model encourages programs and provides financial credit for improvement in population health. In addition, HSCRC and CMMI are committed to improving health equity. These initiatives are discussed in Section IV.

CMS Evaluation of the Maryland Model

CMS released a progress report for the Model's First Four Years in April 2024[2]. This evaluation focused on Maryland's performance under the Model in calendar years (CY) 2019 through 2022. The evaluation report was generally positive, noting that the State:

1. Reduced Medicare spending by limiting growth in hospital budgets, which rewards hospital efforts to reduce potentially preventable care;
2. Created $689 million in net savings to Medicare over the TCOC Model's first three years by reducing total Medicare spending, hospital spending, and non-hospital spending;
3. Increased MDPCP beneficiaries receiving care management services from 1 percent in 2019 to 14 percent in 2022;
4. Reduced disparities by race and place. Disparities decreased by 19 percent to 40 percent on unplanned admissions, preventable admissions and timely follow-up after hospital discharge;
5. Improved quality of care in hospitals by reducing hospital admissions, outpatient ED visits, and preventable admissions; and
6. Improved timely follow-up after exacerbation of chronic conditions.

The evaluation will continue to examine the model's impacts on spending, service use, and quality.

[2] Report is available on CMMI's website, https://www.cms.gov/priorities/innovation/data-reports

Performance Targets

Under the TCOC Model, Maryland is accountable for total cost of care savings under Medicare (for care provided by both hospital and non-hospital providers), hospital quality outcomes, population health goals (focused on diabetes, opioid use, and maternal and child health), advanced primary care (the MDPCP program), and other innovative program development for hospitals and non-hospital providers.

Maryland is required to meet the following six annual performance targets:

- **Annual Medicare Total Cost of Care Savings Target**: Each year Maryland must generate savings for the Medicare program on a total cost of care basis. In 2023, the annual savings target was $300 million.
- **TCOC Guardrail Test:** Maryland must not exceed national Medicare spending per beneficiary growth rate by more than 1 percent in any year and/or exceed that national growth rate by any amount for two years in a row.
- **All-Payer Hospital Revenue Growth Per Capita:** Maryland must keep all-payer hospital revenue growth equal to or below a compounded average of 3.58 percent per capita annually throughout the term of the contract.
- **Readmissions Reductions for Medicare:** Maryland must match or exceed national and prior Maryland Medicare readmissions rates.
- **All-Payer Reductions in Hospital- Acquired Conditions:** The State must match or exceed previous Maryland performance on all-payer potentially preventable condition (PPC) measures.
- **Hospital Revenue under Population-Based Payment Methodology:** Maryland must have at least 95 percent of hospital revenue under a population-based payment methodology (i.e., global budget revenue) over the course of the Model.

Maryland performance between CY 2019 and CY 2023 is shown in the table below.

Table 1. TCOC Model Performance, 2019-2023

Performance Measures	Annual Targets	2019	2020	2021	2022	2023
Annual Medicare TCOC Savings	$120M (2019), $156M (2020), $222M (2021), $267M (2022), $300M (2023) in annual Maryland Medicare TCOC per Beneficiary of savings	✓	✓	✓	✓	✓
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					
All-Payer Revenue Limit	All-payer growth ≤ 3.58% 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)	✓	✓	✓	✓	✓
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	✓	✓	×[3]	×	✓
Hospital Population Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	✓	✓	✓	✓	✓

In 2019 and 2020, Maryland met or exceeded all TCOC contractual annual performance targets. Maryland did not meet the Medicare readmissions reductions test in 2021, which requires the State to be below the National Medicare unadjusted readmission rate. HSCRC staff believe the unadjusted readmission rate has increased due to higher patient acuity over time. CMMI granted an exogenous factor request for missing the 2021 target. In 2022, the State met four of the six contractual requirements. The State did not meet the requirements for the TCOC Guardrail Tests and the Readmissions Reductions for Medicare. Model performance results for 2022 are presented in the table above and have been certified by CMMI. Last year's report discusses the factors influencing the State's performance and actions taken to address performance challenges in 2022.

In 2023, the State met all six contractual requirements under the TCOC Model. Notably, the State generated $476 million in annual Medicare TCOC savings, far surpassing the $300 million annual savings requirement. Additionally, Maryland met the annual readmissions reduction test for the first time since 2020. In 2023, the HSCRC and CMMI negotiated the use of a risk-adjusted readmissions measure which had previously been unadjusted. HSCRC believed that the State's unadjusted readmission rate increases in 2021 and 2022 were a result of higher patient acuity over time, a natural result of the TCOC Model which seeks to retain only the sickest patients in hospitals and direct less-acute care to more appropriate, lower-

[3] *HSCRC staff believe unadjusted readmission rate has increased due to higher patient acuity over time. CMMI granted an exogenous factor request for missing the 2021 target.

cost settings. CMMI concurred with the HSCRC's position and agreed to use a risk-adjusted readmissions measure for the first time in 2023.

In addition to the requirements described above, the State is required to achieve specific milestones under the Statewide Integrated Health Improvement Strategy (SIHIS) which was developed in partnership with CMMI in 2020 and approved in 2021. Progress under SIHIS is discussed in Section IV.

Section II: Total Cost of Care Financial Performance (Calendar Year 2023)

Total Hospital Per Capita Cost Growth

The Maryland TCOC Model agreement requires the State to limit its compounded average annual all-payer hospital per capita revenue growth rate to 3.58 percent. This number is based on the average growth in per capita gross state product (GSP) for the period 2002 through 2012. Through 2023, Maryland has an average per capita cost growth of 2.68 percent since 2013, 0.90 points below the 3.58 percent limit. From 2019 to 2023, Maryland had an average per capita all-payer revenue growth of 3.59 percent, barely above the 3.58 percent target. This higher growth rate is primarily due to disruptions caused by the pandemic. During CY 2022, considerable revenue was provided to hospitals through pandemic-related policies. This revenue was one-time in nature. In 2023, revenue returned to normal levels resulting in a CY 2023 per capita growth rate of 3.47 percent (compared to 6.06 percent in CY 2022), falling below the 3.58 percent annual growth target.

Medicare Savings & TCOC Performance

Maryland was required to generate an annual $300 million in TCOC savings in CY 2023. Maryland surpassed this requirement in CY 2023, achieving $476 million in annual savings.

Table 2. Annual Medicare TCOC Savings (in millions)

	2019	2022	2021	2022	2023	2024	2025	2026
Target	$120	$156	$222	$267	$300	$336	$372	$408
Actual	$365	$391	$378	$269	$476	TBD	TBD	TBD

Under the TCOC Model, the total cost of care growth for Maryland Medicare beneficiaries may not exceed the national growth rate by more than one percent in any given year and may not exceed the national growth for two consecutive years. Additionally, Maryland must build to an annual $408 million in TCOC

savings by the eighth year of the Model (CY 2026). The target was $300 million in 2023 and will be $336 million in CY 2024.

In CY 2023, hospital spending per capita ended favorably when compared with the nation. Non-hospital spending per capita was on trend compared to the nation during CY 2023. These trends continue to be monitored monthly. Data through December of 2023 shows Maryland achieved annual TCOC savings of approximately $476 million.

Policies Influencing Financial Performance and TCOC

Medicare Performance Adjustment (MPA)

The HSCRC implemented the Medicare Performance Adjustment (MPA, or "MPA Traditional") to assist the State in managing both hospital and non-hospital costs under the TCOC Model. The MPA adjusts hospital Medicare payments based on Medicare total cost of care performance. Medicare Payment adjustments began in July 2019 (Rate Year 2020). In 2021, the TCOC Workgroup conducted a comprehensive review of the MPA policy, and the 2022 Commission Recommendation overhauled the MPA policy to make the measurement more stable and valid from year to year. The CY 2022 to CY 2023 changes were purposefully limited and this year's recommendation continues this approach by making only minor technical changes to the methodology. HSCRC is not contemplating any major changes for CY 2025.

Update Factor

The Update Factor policy is an annual system-wide update to the hospital's Global Budget Revenue (GBR). It incorporates quality, volume, and other adjustments that determine the reasonableness of hospital prices. The HSCRC staff considers the following conditions to balance when considering the update: meeting the requirements of the TCOC Model agreement:

1. providing hospitals with the necessary resources to keep pace with changes in inflation and demographics;
2. ensuring that hospitals have adequate resources to invest in care coordination and population health strategies for long-term success under the TCOC Model; and
3. incorporating quality performance programs (discussed in Section III).

The Fiscal Year (FY) 2024 Update Factor was implemented on July 1, 2023, and included the following policy recommendations:

- An overall increase of 3.58 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.75 percent per capita revenue increase for hospitals under Global Budgets.
- All hospitals will receive a base inflation increase of 3.35 percent.

- Provide an overall increase of 3.35 percent for inflation to rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mount Washington Pediatric Hospital).

HSCRC staff is currently developing the FY 2025 Update Factor, which HSCRC Commissioners will vote on in June 2024 for a July 1, 2024, implementation date. The Commission will continue to closely monitor performance targets for Medicare, including Medicare's growth in TCOC and Hospital Cost of Care per beneficiary during the performance year. As always, the Commission has the authority to adjust rates as it deems necessary.

Section III: Hospital Quality Programs & Performance

HSCRC has four programs for measuring hospital quality of care and incentivizing improved outcomes. These includes the quality-based reimbursement program, the readmission reduction incentive program (including a measure to reduce socioeconomic disparities), the Maryland hospital acquired conditions program, and the potentially avoidable utilization savings program. Each of these programs is described below. HSCRC also continues work on analyzing emergency department wait times and improvement opportunities.

Quality-Based Reimbursement (QBR) Program

Established in FY 2010, the QBR program adjusts hospital payments based on their performance on a number of quality-of-care measures. These include clinical care measures, patient and community engagement measures, and safety measures. Each domain is then weighted to determine hospitals' final scores on the program (Table 3).

Table 3. QBR Measure Domain Weights for FY 2020-FY2025

Measure Domain	Weight
Safety (Healthcare-Associated Infections and FY 2023 NEW measure: Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) 90 Composite measure.	0.35
Clinical Care (Inpatient Survival and Hip/Knee Replacement Complication Rates)	0.15
Patient and Community Engagement (HCAHPS survey and Timely Follow Up after Acute Exacerbation of Chronic Conditions).	0.50

In FY 2025, the HSCRC maintained the measurement domains and weights from the policy approved for FYs 2020-2024 to be as consistent as possible with the CMS Value-Based Purchasing (VBP) Program, while also targeting areas of needed improvement for Maryland. In FY 2025, the amount of total hospital inpatient revenue at-risk for scaling was held to a two percent maximum penalty, and the maximum reward

was correspondingly maintained at two percent. Maryland does not include an efficiency measure as a component of the QBR Program, but it does apply a Potentially Avoidable Utilization (PAU) savings adjustment to hospital global budgets and evaluates Medicare payments based on hospitals' Total Cost of Care performance under the MPA.

Since FY 2019, the QBR reward and penalty adjustments to global budgets have been determined based on a preset scale rather than relatively ranking hospital performance and penalizing those with less than average performance. This was designed to provide hospitals with predictable revenue adjustments and predetermined quality improvement targets.

Updated Data Trends

Maryland's QBR program is similar in design and detail to the federal Medicare Value-Based Purchasing Program. Data trends for the most recently available specified performance periods are presented below. Staff notes that the performance periods differ across measures based on data availability.

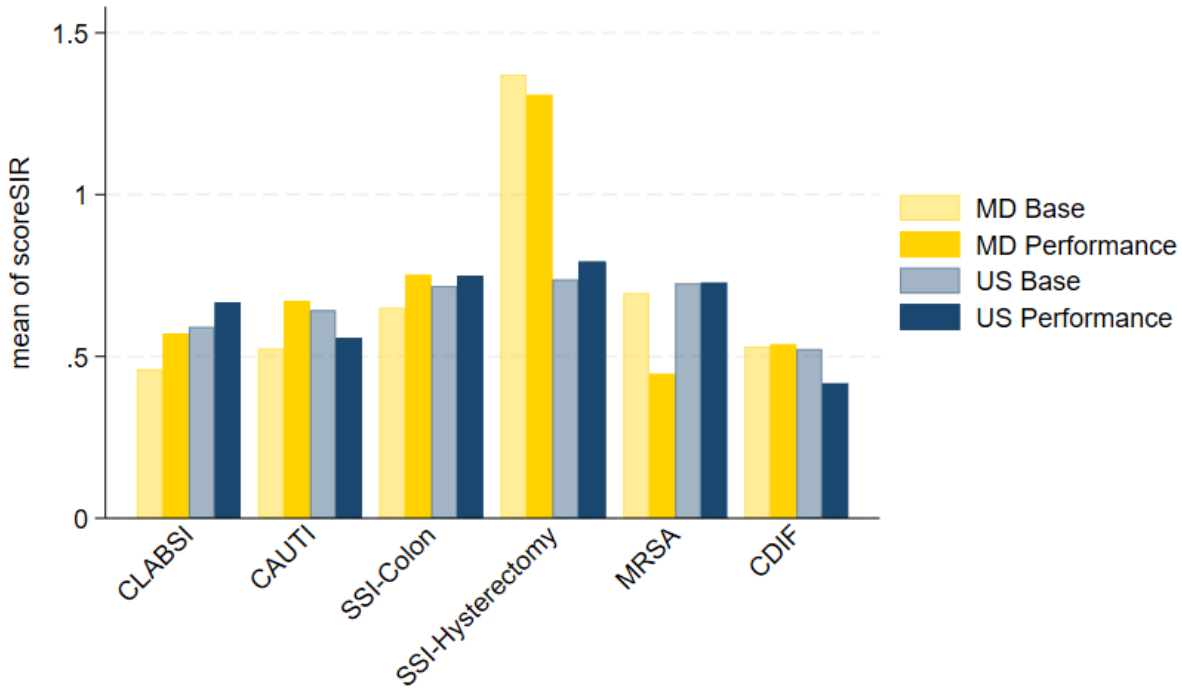
Safety Domain

For the healthcare-associated infection measures in the Safety domain, as illustrated in Figure 4 below, Maryland is performing worse (lower rate is better) than the nation on CAUTI, SSI-Hysterectomy, and C.Diff, performs better than the nation on CLABSI and MRSA, and performs on par with the nation on SSI-Colon.[4]

Figure 3. Maryland Performance VS Nation on Healthcare Associated Infections

***Base Year**: CY 2019 **Performance Year**: CY 2021Q2-CY 2023Q1*

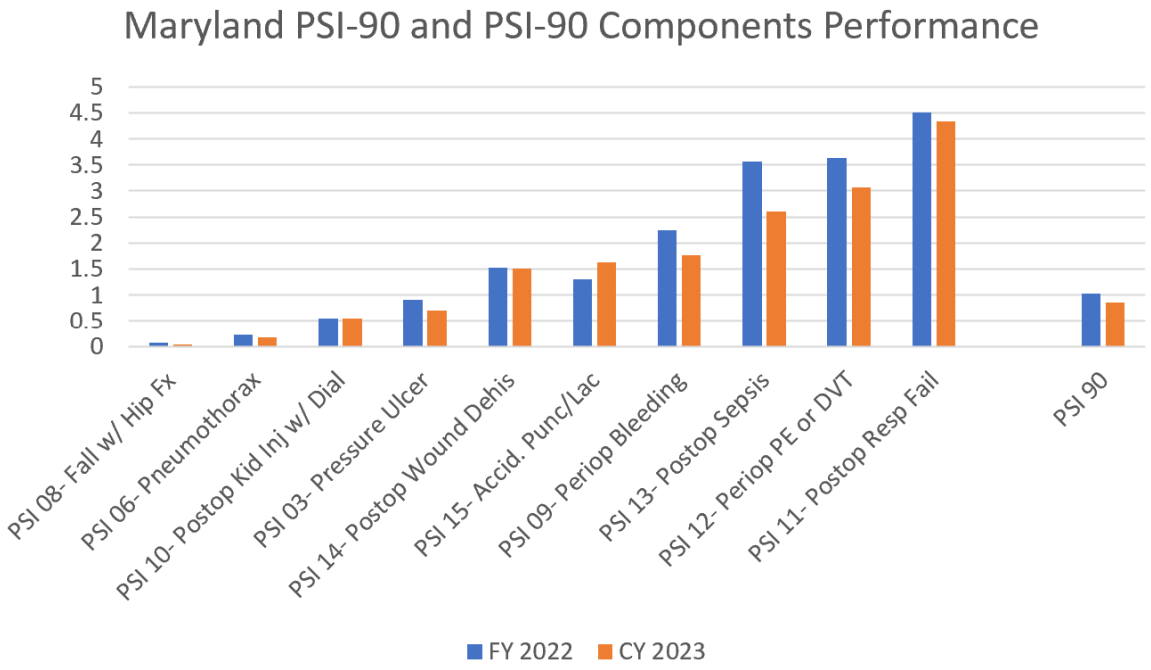
[4] Catheter-associated urinary tract infections (CAUTI), Surgical Site Infection (SSI) - Colon, Clostridioides difficile (C. Diff), Central Line-associated Bloodstream Infection (CLABSI), Surgical Site Infection (SSI) - Hysterectomy, and Methicillin-resistant Staphylococcus aureus (MRSA).



Source: CMS Care Compare Data

On the all-payer PSI-90 composite measure and the component indicators, Maryland's statewide performance has improved (lower rate is better) from FY 2022 compared to CY 2023 for all measures except PSI15- Unrecognized Abdominopelvic Accidental Puncture or Laceration as illustrated in Figure 5 below. Improvements have been made on the other nine components of PSI-90 and the composite PSI-90 rate.

Figure 4. Maryland All-Payer, AHRQ PSI 90 Composite Measure Performance FY 2023 VS CY 2023

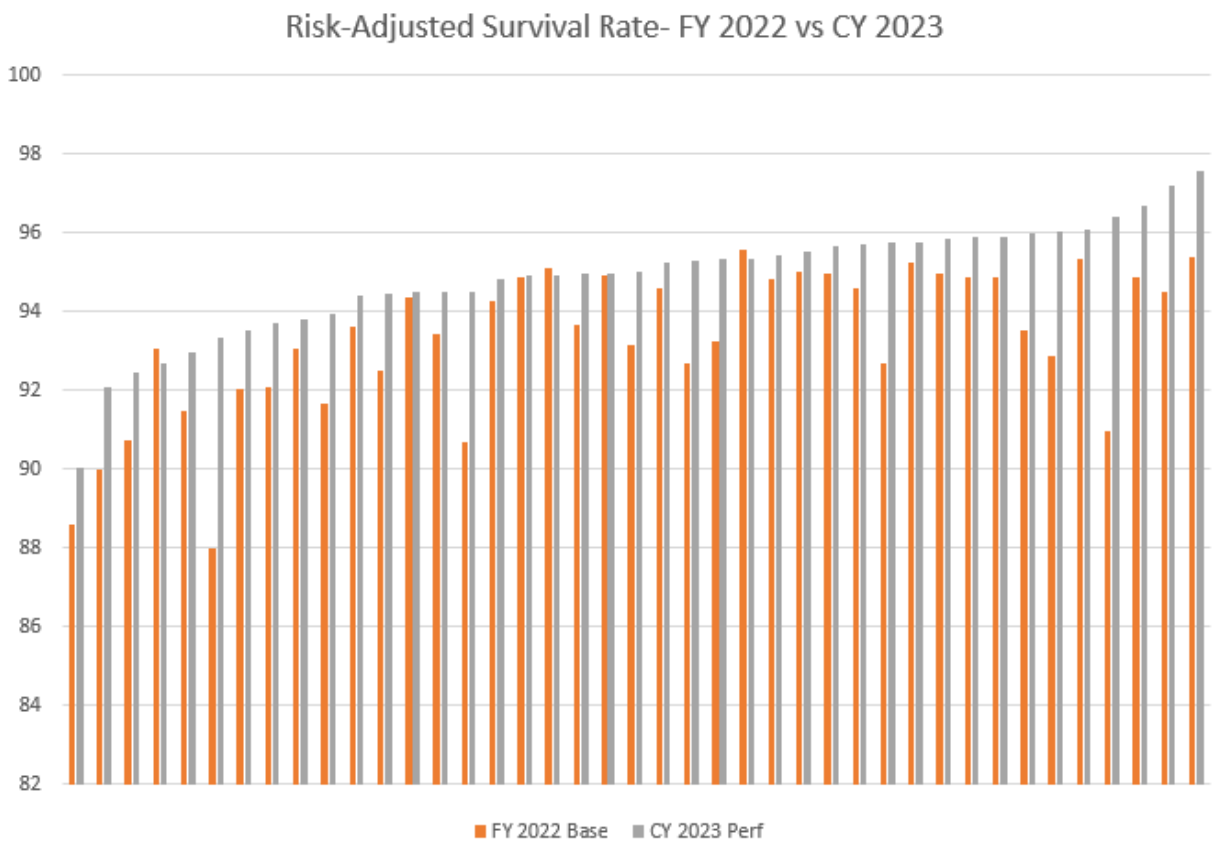


Source: HSCRC Case-Mix Data

Clinical Care Domain

The Clinical Care domain consists of Inpatient Mortality and the Medicare Total Hip and Knee Arthroplasty (TKA) Complication measure. Two of 41 hospitals have worsened slightly in CY 2023 when compared to FY 2022 on the inpatient mortality measure (Figure 6).

Figure 5. RY 2025 QBR Risk-Adjusted Survival Rate

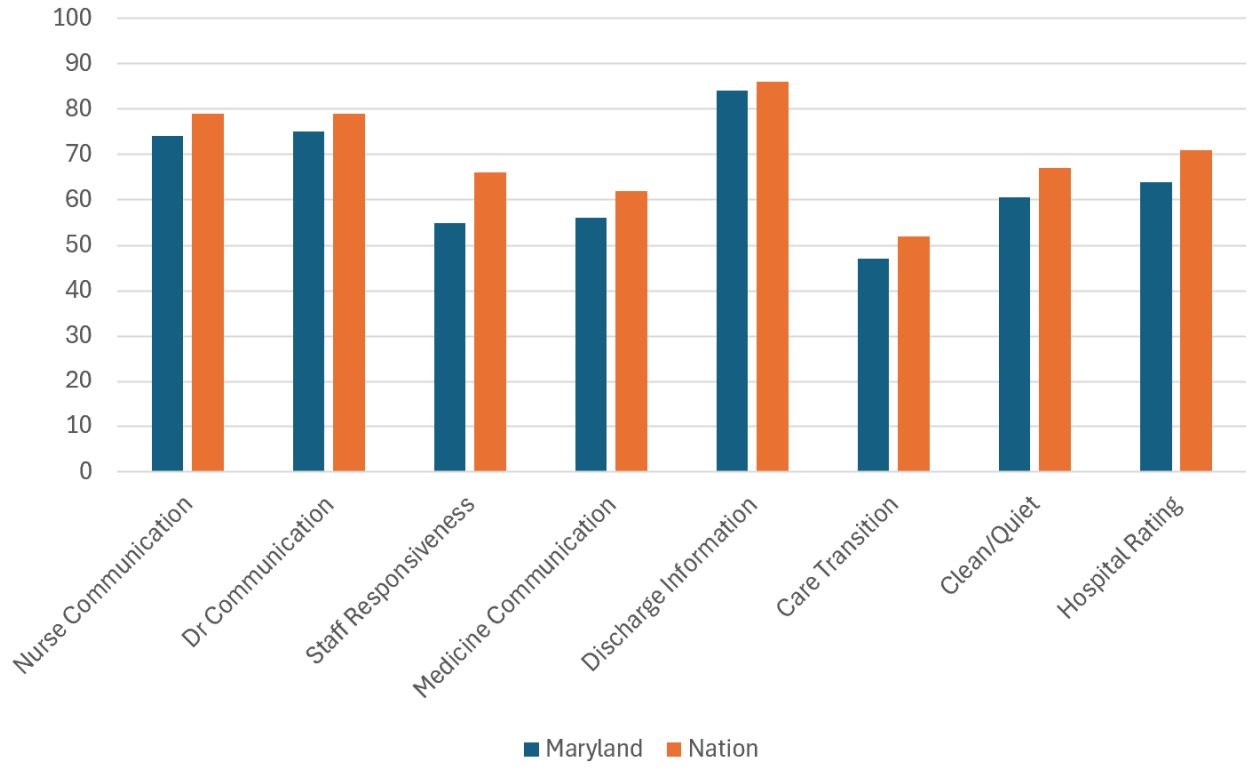


Source: HSCRC Case-Mix Data

Patient and Community Engagement (PCE) Domain

Maryland continues to lag the nation in performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience measures (Figure 7). HSCRC staff remains concerned about Maryland HCAHPS performance. In the FY 2018 QBR policy, the HSCRC increased the weighting of the HCAHPS measures in determining hospitals' overall scores to incentivize improvement in patient satisfaction and has kept this domain weighting through the subsequent QBR policy annual updates. To incentivize incremental improvements, the HSCRC incorporates the use of linear scores weighted at 10 percent of the PCE domain.

Figure 6. HCAHPS - Maryland HCAHPS Top Box Scores Compared to the Nation, April 2022-March 2023

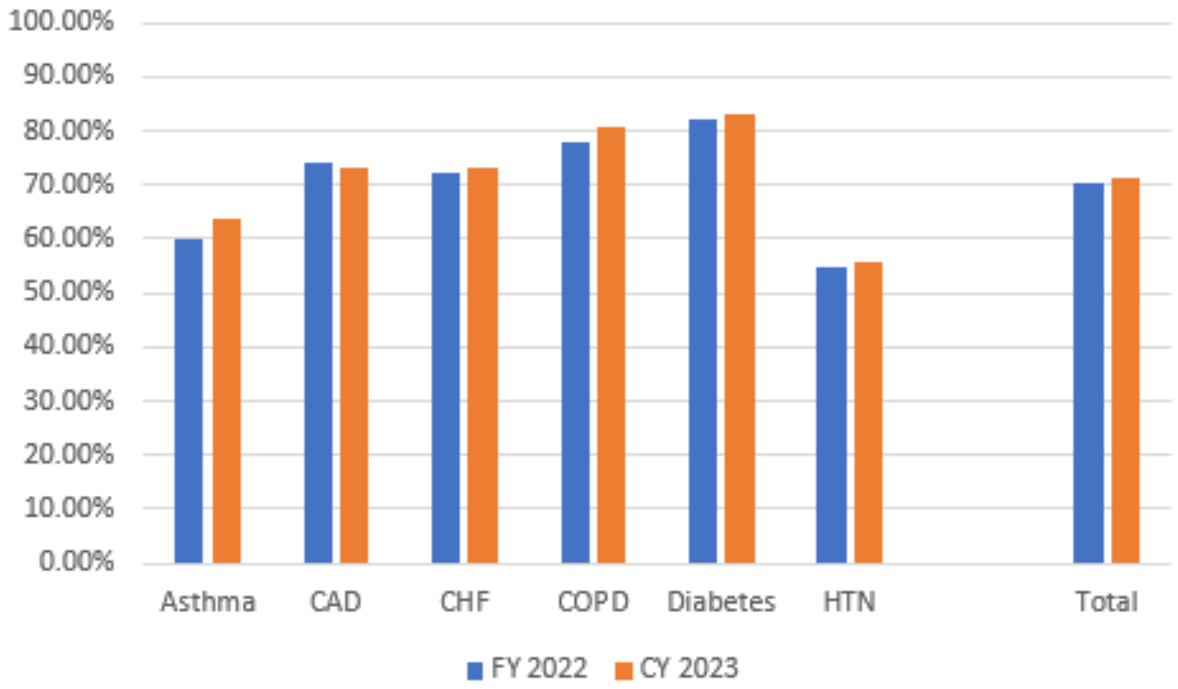


Source: CMS Compare Data

On the Timely Follow-Up (TFU) measure, Maryland's CY 2023 performance improved overall and for all chronic conditions, except Coronary Artery Disease (CAD), compared to FY 2022 performance (Figure 8).

Figure 7. Timely Follow-Up Following Acute Exacerbation for Patients with Chronic Conditions[5]

[5] Chronic Condition Acronyms: Coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypertension (HTN)



Source: CMS Claims and Claims Line Feed (CCLF) Data

Maryland Hospital Acquired Conditions (MHAC) Program

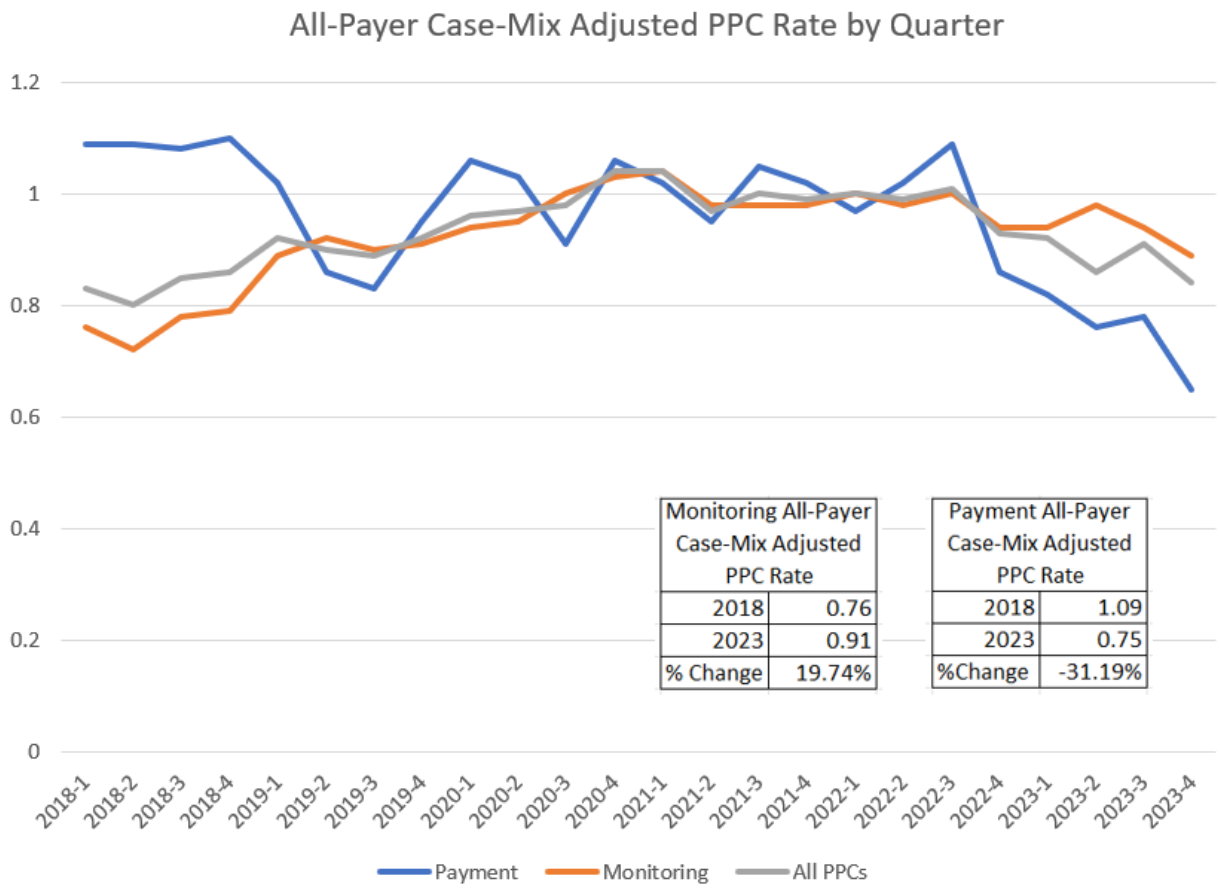
Maryland measures Hospital Acquired Conditions (HACs) using a list of potentially preventable complications (PPCs) developed by 3M Health Information Systems (HIS). PPCs are defined as post-admission harmful events (e.g., accidental laceration during a procedure) or negative outcomes (e.g., hospital-acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease. The MHAC program calculates hospital rewards and penalties for case-mix adjusted rates of PPCs.

By the end of the APM in 2018, Maryland had achieved a 51.50 percent reduction in all-payer, case-mix adjusted PPC rates, far exceeding the required 30 percent reduction requirement. The HSCRC worked with hospitals to build on the State's commendable work under the APM to incentivize further reductions in PPCs under the TCOC Model in the updated RY 2021 MHAC Policy. During CY 2019, the overhauled MHAC policy focuses\d on a narrower list of clinically recommended PPCs that in general have higher statewide rates and variation across hospitals. Beginning in RY 2021, the MHAC policy also only rewards hospitals for achieving low PPC rates and no longer rewards them for improvements in PPC rates over time. The approved RY 2022 policy maintained the methodology updates of the RY 2021 policy and extended the performance period to two years for small hospitals. The approved RY 2025 policy maintains

the methodology updates of RY 2022 but includes Encephalopathy as the 15th PPC due to increases in the observed to expected (O/E) ratio since CY 2016.

Based on CY 2023 final data, there has been an improvement in the PPCs included in the payment program, with fewer PPCs overall compared to the 2018 base year.[6] However, there have also been increases in the case-mix adjusted PPC rate for monitoring PPCs (i.e., those removed from payment). While this is not surprising, since the monitoring PPCs generally have lower numbers or clinical/coding concerns, staff continue to monitor all PPCs and will add back into payment PPCs that meet the inclusion criteria (as was done in RY25 with the reinclusion of encephalopathy).

Figure 8. Case-Mix Adjusted PPC Rate CY 2018-CY 2023



Monitoring All-Payer Case-Mix Adjusted PPC Rate	
2018	0.76
2023	0.91
% Change	19.74%

Payment All-Payer Case-Mix Adjusted PPC Rate	
2018	1.09
2023	0.75
%Change	-31.19%

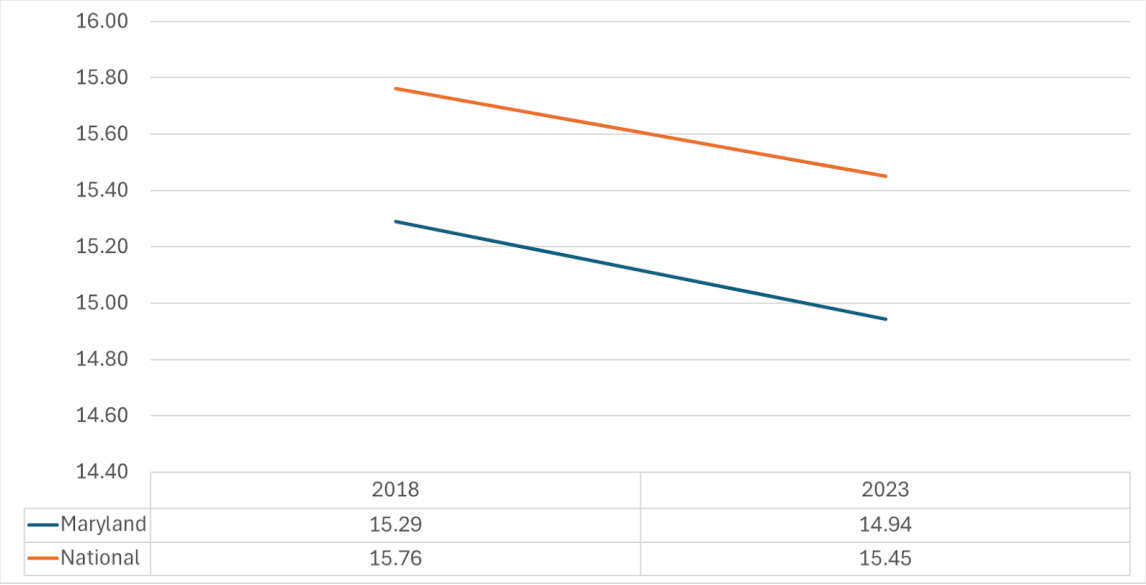
Source: HSCRC Case-Mix Data

[6] There has been a 31.19% decrease in the ratio based on the most recent data available (CY 2018 O/E ratio = 1.09 and CY 2023 YTD O/E ratio = 0.75). A ratio lower than one means that fewer PPCs than expected were observed.

Readmission Reduction Incentive Program (RRIP)

The All-Payer Model Agreement (APM) required Maryland's hospital readmission rate for Medicare FFS beneficiaries to be at or below the national readmission rate by the end of 2018, which Maryland successfully achieved. When the APM concluded in December 2018, the Maryland Medicare FFS Readmission Rate was 0.05 percentage points lower than the National Medicare FFS Readmission Rate (Maryland: 15.40 percent; Nation: 15.45 percent). In 2019 and 2020, Maryland maintained the State's achievements under the APM. However, starting in CY 2021 the Maryland Medicare unadjusted readmission rate was above the nation. This increase in the unadjusted readmission rate over the course of the model was not unanticipated given that Maryland hospitals had strong incentives to care for lower acuity patients outside of the inpatient setting when appropriate. Thus, the HSCRC staff had been in discussions with CMMI since the start of the TCOC model to move to a risk-adjusted measure. Starting in CY 2023, CMMI moved to a risk-adjusted measure similar to the CMS Hospital-Wide Readmission (HWR) measure with a few modifications. As shown in Figure 10, Maryland performed better than the nation on a risk-adjusted basis in 2018 and 2023. While the contractual test does not require Maryland to be statistically better than the nation, the analysis by CMMI found that Maryland was statistically better than the nation in CY 2023. Starting in CY 2025, HSCRC staff believe that CMMI will further modify this measure to include observation revisits as well as inpatient readmissions. This aligns with the HSCRC staff's strategic plan to monitor both observation and emergency department revisits as part of the all-payer Readmission Reduction Incentive Program (RRIP).

Figure 9. Maryland vs National Risk-Adjusted Readmission Rates, CY 2018 and -CY 2023



	2018	2023
Maryland	15.29	14.94
National	15.76	15.45

Potentially Avoidable Utilization (PAU) Shared Savings Policy

The PAU Savings policy measures the revenue associated with readmissions as well as per capita avoidable admissions as defined under the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI) logic. For FY 2024, the Commission implemented an incremental prospective savings requirement of 0.49 percent of total hospital revenue, which is distributed to hospitals based on a hospital's share of revenue deemed to be potentially avoidable. Staff are currently developing the PAU Savings policy for FY 2025 as part of the FY 2025 Update Factor that will be considered at the June 2024 Commission meeting.

Emergency Department (ED) Analysis

The HSCRC has prioritized examining root cause drivers of ED wait times, as well as opportunities for driving improvement. The Emergency Department Dramatic Improvement Effort (EDDIE) is a Commission-developed quality improvement initiative that began in June 2023 to drive improved ED experience for patients. As part of the EDDIE Initiative, hospitals must submit monthly data to the HSCRC, which staff present in the monthly public HSCRC meetings. The HSCRC approved the addition of an Emergency Department Length of Stay (ED LOS) measure into the RY 2026 QBR program in December 2023, in recognition of the need for Maryland to reduce ED LOS. Since the Commission approval, staff convened a data subgroup to develop the data submission requirements and a measure and incentive methodology subgroup. This measure will capture the time of ED arrival to the time of physical departure from the ED room for patients admitted to the facility from the ED or observation. Future reports will provide data on ED LOS, as well as report on the newly required ED Wait Time Commission.

Section IV: Population Health

Statewide Integrated Health Improvement Strategy

In 2021, CMMI approved Maryland's Statewide Integrated Health Improvement Strategy (SIHIS). This Strategy was designed to improve health outcomes, achieve health equity, and control the total cost of care for Marylanders. The SIHIS aligns statewide efforts across three domains, with specific goals for each domain.

Table 4. SIHIS Goals and 2022 Milestone Progress

Domain Area	Goal(s)
Domain 1 – Hospital Quality	Reduce avoidable admissions and readmissions

Domain 2 – Care Transformation Across the System	Increase the amount of Medicare TCOC or number of Medicare beneficiaries under Care Transformation Initiatives (CTIs), Care Redesign Program, or successor payment model Improve care coordination for patients with chronic conditions
Domain 3 – Total Population Health "Diabetes"	Reduce the mean Body Mass Index (BMI) for adult Maryland residents
Domain 3 - Total Population Health "Opioids Use Disorder"	Improve overdose mortality
Domain 3 - Total Population Health "Maternal and Child Health"	Reduce severe maternal morbidity rate Decrease asthma-related emergency department visit rates for ages 2-17

For each domain, the SIHIS proposal provided a Model Year 3 milestone that was measured on CY 2021 data, a Model Year 5 interim target that will be measured on CY 2023 data, and a Model Year 8 final target that will be measured on CY 2026 data. The State met all but one 2021 milestone and is waiting for 2023 performance data to be finalized. More information on 2022 performance and 2023 activities to achieve SIHIS goals is included in the SIHIS annual report attached as an appendix and on the HSCRC website.[7]

Outcomes Based Credits

Under the TCOC Model, the State can receive credit for savings generated by addressing health conditions that affect Marylanders in large numbers. By improving the health of our population, the State can also reduce all-payer healthcare spending, a key goal of the Model. This unique opportunity recognizes that the State is investing in programs that prevent and delay chronic health conditions over the long term but may not immediately result in cost savings. Under the Model, if Maryland is able to address diabetes, opioid use disorder, and hypertension as outlined below, the State will receive financial credit to offset federal investment in Maryland. This innovative approach supports Maryland's efforts to further incentivize health system transformation and public health intervention alignment.

Diabetes

Slowing or reducing the growth in diabetes incidence represents a huge opportunity for the State. Type 2 Diabetes is a high-burden, high-cost condition that is avoidable with medical, lifestyle, and other

[7] Statewide Integrated Health Improvement Strategy Proposal and Annual Reports. https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx.

interventions. Nearly 490,000 Maryland adults were estimated to have been diagnosed with diabetes in 2017 and Maryland is projected to spend $11.1 billion annually by 2025.

Importantly, a reduction in diabetes incidence represents a statewide opportunity to improve health equity as acknowledged in nearly all community health needs assessments and hospital community benefit reports. Successful interventions can promote healthy lifestyles, address economic barriers to adequate health care, and improve primary care access. HSCRC is working to incentivize hospitals to work with community partners, including local health departments and other healthcare focused organizations, to prevent diabetes, which will ultimately help hospitals reduce healthcare spending under the TCOC Model.

In July 2019, CMS approved Maryland's first outcomes-based credit (OBC) for aversion of diabetes incidence. Under the OBC methodology, if the diabetes incidence rate changes from baseline more favorably in Maryland than in a group of control states, Maryland is eligible to receive a financial credit that will help the State meet its TCOC savings targets. The State of Maryland was not entitled to a diabetes outcomes-based credit in 2022 based on the established methodology, but did potentially qualify for an alternate credit from CMS under the Complementary Measure Supplement due to reductions in statewide Body Mass Index (BMI). Resolution on the outcome for the alternate credit is still pending.

Opioids

The misuse and addiction to opioids is a public health and economic crisis, with increased costs in healthcare, lost productivity, and criminal justice involvement. Maryland continues a statewide focus on addressing the State's opioid epidemic. Recognizing the impact of opioid misuse on the healthcare system, the HSCRC is developing an outcome-based credit methodology focused on opioid use disorder (OUD). As in the diabetes credit, CMS would provide the State with financial credit for federal TCOC Model investments if Maryland can make progress on reducing opioid use disorder (OUD). The credit will enable hospitals to invest additional dollars into OUD prevention and treatment as part of their global budgets, which may be reinforced with additional pay-for-performance measures related to substance use. The OUD credit methodology involves two workstreams: a cost-per-case analysis, and an approach to measuring OUD performance over time against a control group. The HSCRC's cost methodology contractor, Advanta Government Services, has completed work on the cost methodology. The HSCRC retained Mathematica to develop the performance methodology. The team ran into significant data access challenges due to the COVID pandemic but has recently acquired national all-payer opioid-related claims data. The HSCRC anticipates submitting the opioid methodology to CMS in 2024.

Hypertension

Hypertension, and chronic diseases that are sequelae of hypertension, represent a major source of disease burden and cost in Maryland. During 2021, the HSCRC applied a credit selection methodology that

evaluated diseases and risk factors across four domains: burden, preventability, cost, and health equity impact. That analysis, along with conversations with stakeholders, resulted in identification of hypertension as the State's third outcome credit focus. HSCRC and its contractors have concluded that analyzing all-payer, all-setting claims is the most feasible way to track year-to-year changes in hypertension incidence. The State is in the final phase of acquiring data to complete development on the methodology and expects to submit a credit proposal in 2024.

Revenue for Reform

Revenue for Reform was approved as part of the HSCRC Integrated Efficiency Policy (discussed in Section VII) in July 2023. The primary goal of Revenue for Reform is to direct hospital retained revenue to community-based population health investments and to drive population health improvement. The policy is intended to safe harbor population health investments from the HSCRC Integrated Efficiency Policy, which would otherwise withhold dollars from hospitals deemed inefficient relative to their peers. In FY 2024, hospitals could make investments under two tracks:

- Community Health: Spending must be directed to unmet community health needs identified in the hospital's community health needs assessment (CHNA); or implementing one of the Centers for Disease Control's (CDC) Healthy People 2030 interventions.
- Physician Spending: Spending must be directed to primary care, mental health, or dental providers in a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA).

In FY 2024, $26.1 million was directed to community health and expanding and maintaining access to physicians in Baltimore City, Prince George's County, Montgomery County, and the Eastern Shore. Hospitals are funding a wide range of interventions. Examples of approved intervention goals are shown in Table 5 below.

Table 5. Revenue for Reform Approved Intervention Goals

Category	Intervention Goal
Health Behaviors	• Reduce substance use disorder and overdose deaths • Increase patient-self management of chronic diseases • Reduce diabetes incidence through community exercise and nutrition education
Social & Economic	• Increase job opportunities through career training and continuing education • Expand supportive services for victims of intimate partner violence • Reduce health disparities in LGBTQIA+ population • Increase SDOH screening and community referral partners
Clinical Care (non-hospital based)	• Increase the number of primary care providers and patients served in HPSAs/MUAs • Expand telehealth access

	• Expand access to post-acute care for uninsured and underinsured patient populations • Reduce childhood asthma ED visits through mobile health
Physical Environment	• Expand permanent supportive housing services (Medicaid ACIS pilot) • Expand temporary housing for high-needs patients with housing instability/no housing

Under the current policy, these investments must be maintained annually by hospitals in perpetuity, although how hospitals direct those dollars may change. The HSCRC is refining program expectations for FY 2025 and will offer a third track wherein hospitals can direct dollars to pre-approved community partners selected by the HSCRC and MDH. Pre-approved community partners must have proven experience implementing effective population health interventions. The HSCRC intends to make substantive policy revisions for the FY 2026 performance period that drive regional and statewide alignment around population health priorities and investments. Staff will conduct a stakeholder engagement process as part of the policy redesign in fall 2024.

Section V: Care Transformation & Partnership Programs

Provider Alignment Programs

A key strategy to achieving the goals of the TCOC Model is implementing care redesign strategies to help hospitals and other providers gain access to new tools and resources so that they can better meet the needs of patients and improve population health. To achieve this, the HSCRC develops, operates, and supports Provider Alignment Programs to foster collaboration between hospitals and non-hospital providers (e.g., physicians, skilled-nursing facilities, home health agencies, nurses, etc.), payers (e.g., Medicare Advantage plans), and community-based organizations (e.g., non-profits, faith-based organizations, etc.)

Care Redesign Program (CRP)

The Maryland Care Redesign Program (CRP) aims to support effective care management and population health activities and deliver high quality, efficient, well-coordinated episodes of care, with a focus on high and rising-risk populations. CRP is designed for hospitals to engage non-hospital providers, such as physicians and post-acute care providers, to improve care delivery, quality of care, and control TCOC growth. The Chesapeake Regional Information System for our Patients (CRISP) serves as the administrator of CRP. During 2023, the State operated two care redesign tracks: the Episode Care Improvement Program (ECIP) and the Episode Quality Improvement Program (EQIP). During 2023, 17 unique hospitals participated in ECIP. A new performance period began January 1, 2024, with a total of 16 unique hospitals participating in ECIP (although one of these 16 is planning to leave ECIP mid-year).

The HSCRC discontinued the Hospital Care Improvement Program (HCIP) track for CY 2023 after only one hospital participated in CY 2022. The HSCRC believes the declining participation in HCIP, which began in 2017, is a natural result of hospitals strategically choosing how to best expend their resources. Hospitals are opting to participate in newer programs, such as Care Transformation Initiatives (discussed below), and support participation in EQIP for affiliated physicians.

ECIP allows a hospital to link payments across providers during an episode of care. Maryland modeled ECIP on CMS's Bundled Payments for Care Improvement Program Advanced (BPCI-Advanced) Model. Episode payment models bundle payments to health care providers for certain items and services furnished during an episode of care. ECIP's bundled payment approach aligns incentives across hospitals, physicians, and post-acute care facilities to generate savings and improve quality through better care management during episodes, eliminating unnecessary care, and reducing post-discharge emergency department visits and hospital readmissions.

ECIP provides hospitals with the opportunity to provide incentive payments to care partners that help achieve these goals. ECIP began on January 1, 2019, with nine hospital participants. ECIP participation hit its highest level to date in CY 2022, with 24 hospitals. In CY 2024 16 hospitals are participating, although one of these 16 is planning to exit ECIP mid-year. The HSCRC made policy changes to ECIP for CY 2023, aligning ECIP with Care Transformation Initiatives and requiring hospitals to share incentives with care partners and/or provide significant resource sharing to care partners.

Hospitals have elected to engage a variety of provider types as care partners in 2024. The table below represents the type of providers that are eligible to become care partners under ECIP and the number of hospitals that selected them as potential care partners in CY 2024.

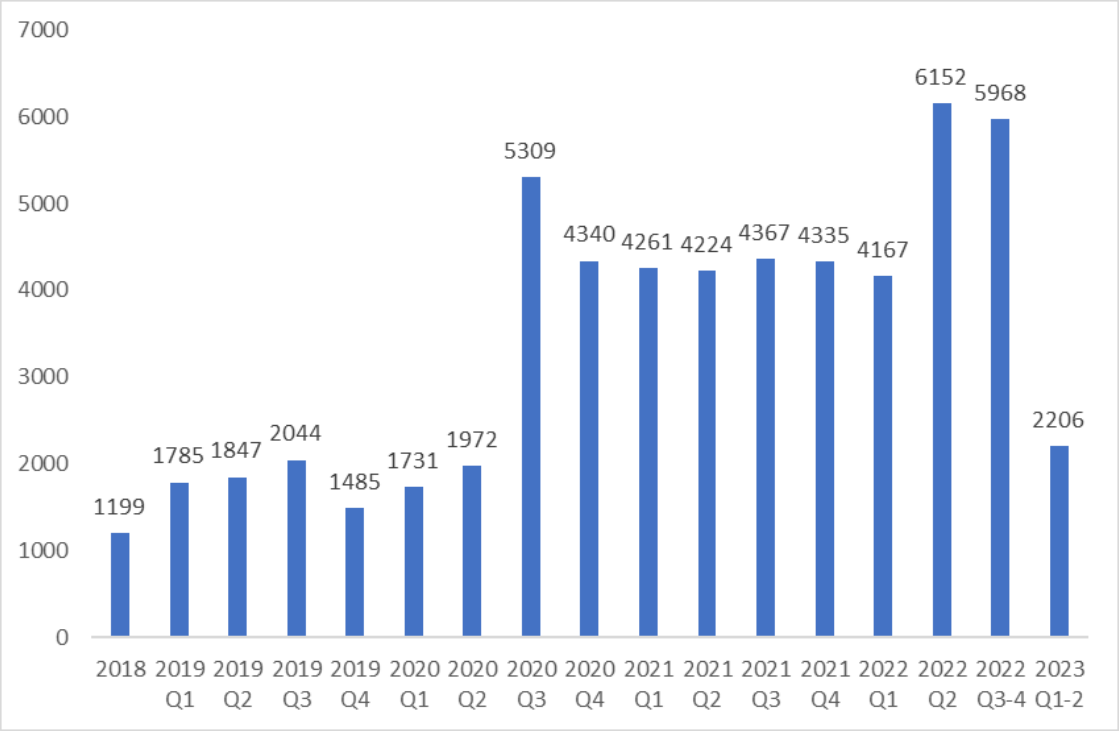
Table 6. ECIP Hospital Care Partner Selections, CY 2024

Care Partner Type	# Of Hospitals
Physician	16
Nurse	9
Physician Assistant	8
Home Health Agency	6
Skilled Nursing Facility	6
Inpatient Rehabilitation Facility	1
Hospice	2

Care partner engagement, a key element of CRP implementation, is robust. For the first half of CY 2024, the unduplicated care partner count across ECIP was 2,939 individuals and 9 facilities. Clinicians

participating in CRP may receive incentive payments from hospitals and are eligible to become Qualified Practitioners (QPs), under CMS' Quality Payment Program (QPP). Clinicians who meet CMS' requirements under the QPP may be eligible for an additional bonus on all Medicare payments, as authorized by the Medicare Access and CHIP Reauthorization Act (MACRA). Figure 11 shows unduplicated care partner counts, including HCIP through 2023.

Figure 10. CRP Care Partner Counts - Clinicians, 2018-2023 (Q1-Q2)



Hospitals in ECIP seek to drive quality improvements, increase efficiency of care, and improve the patient experience on an ongoing basis. The HSCRC continues to explore options for additional CRP tracks to support provider alignment based on stakeholder interest and policy needs.

Episode Quality Improvement Program (EQIP)

The Episode Quality Improvement Program (EQIP) is a voluntary program that engages specialist physicians who treat Maryland Medicare beneficiaries in care transformation and value-based payment through an episode-based approach. This program is specific to Maryland and customized to meet the needs of Maryland's health care delivery system and specialist physicians. EQIP offers Maryland providers the opportunity to coordinate care through clinical episodes focused on increasing accountability for patients throughout specialty-led disease courses and treatments. Participating providers elect to have their performance on improving quality and reducing costs of care across an episode measured and can earn incentive payments based on positive performance. The first Performance Year of EQIP began on January

1, 2022, focused on the specialty areas of cardiology, gastroenterology, and orthopedics. The second Performance Year, which began January 1, 2023, expanded the program to include Allergy, Dermatology, Emergency Department, Ophthalmology and Urology episodes. EQIP leverages the Prometheus Episode Grouper as part of an effort to align the program with CareFirst's commercial Episodes of Care Program. HSCRC, CMS, and CareFirst agree that this alignment creates stronger incentive to participate and behavioral change among providers, strengthening outcomes for Marylanders with both Medicare and CareFirst health coverage.

HSCRC has engaged stakeholders to develop and refine this program. MedChi leads an EQIP workgroup that meets to discuss technical details of the program, including policy design. Workgroup membership includes hospitals, specialist physicians, health policy leaders, and industry representatives.

As of January 1, 2024, there are a total of 119 EQIP entities and 3,217 care partners enrolled. EQIP entities may be practitioner groups or administrative organizations that facilitate practitioner participation in the program. Over forty practitioner specialties are represented in the program and there is participation in all 50 available EQIP episodes.

Table 7. EQIP Clinical Episode Categories, CY 2024

Prometheus Clinical Episode Categories:

Specialty	Episode	Specialty	Episode
Allergy	Allergic Rhinitis/Chronic Sinusitis	**Ophthalmology**	Cataract Surgery
	Asthma		Glaucoma
	COPD	**Orthopedics**	Accidental Falls
	Pneumonia		Hip Replacement & Hip Revision
	Sepsis		Hip/Pelvic Fracture
Gastroenterology	Colonoscopy		Knee Arthroscopy
	Colorectal Resection		Knee Replacement & Knee Revision
	Gall Bladder Surgery		Low Back Pain
	Upper GI Endoscopy		Lumbar Laminectomy
Urology	Catheter Associated UTIs		Lumbar Spine Fusion
	Transurethral Resection Prostate		Osteoarthritis
	Urinary Tract Infection		Shoulder Replacement
	Prostatectomy	**Cardiology**	Acute CHF/Pulmonary Edema
Dermatology	Cellulitis, Skin Infection		Acute Myocardial Infarction
	Decubitus Ulcer		CABG and/or Valve Procedures
	Dermatitis, Urticaria		Coronary Angioplasty
			Pacemaker/Defibrillator

Orthopedics	Musculoskeletal	**Emergency Department**	Fever, Fatigue or Weakness
Emergency Department	Abdominal Pain & Gastrointestinal Symptoms		Hyperglycemia
	Asthma/COPD		Nephrolithiasis
	Atrial Fibrillation		Pneumonia
	Chest Pain		Shortness of Breath
	Deep Vein Thrombosis		Skin & Soft Tissue Infection
	Dehydration & Electrolyte Derangements		Syncope
	Diverticulitis		Urinary Tract Infection

EQIP Primary Care

The EQIP Primary Care (EQIP PC) is a program the State is piloting which expands the existing EQIP program to address primary care availability in underserved areas of the state as a complement to the Maryland Primary Care Program (MDPCP). Under this program selected organizations will be able to access additional funding to subsidize efforts to increase access to advanced primary care in currently underserved areas. The proposed start date is January 1, 2025.

Care Transformation Initiatives (CTIs)

In FY 2022, the HSCRC launched Care Transformation Initiatives Care Transformation Initiatives (CTI). CTIs assign Medicare beneficiaries to hospitals that have enrolled those beneficiaries in a care management program. The CTI holds hospitals accountable for the total cost of care for those beneficiaries assigned to them and rewards hospitals for any savings created by their care management programs. The program ensures that a single entity is accountable for managing patient care across the delivery system and that providers are paid on a population specific-basis, rather than on fee-for-service. The program allows HSCRC to develop a systematic understanding of best practices for improving care, account for the savings and improvements attributed to care transformation, incentivize initiatives that produce savings under the TCOC Model, and articulate Maryland's success stories in transforming care. To date, HSCRC in collaboration with its stakeholder workgroups has approved six CTI categories: (1) Care Transitions, (2) Palliative Care, (3) Primary Care, (4) Geographic, (5) Emergency Care and (6) Hospital Outpatient Services. Forty-three hospitals participated in a cumulative total of 107 CTIs in FY 2022 and generated $127 million in Medicare savings. Forty-three hospitals are participating in 101 CTIs in FY 2023. FY 2023 performance will be available in late Spring 2024.Forty-three hospitals are participating in 160 CTIs in FY2024.

Maryland Primary Care Program (MDPCP)

Maryland is also continuing efforts to implement the Maryland Primary Care Program (MDPCP), which is a component of the TCOC agreement with CMS. The MDPCP is voluntary to all qualifying Maryland primary

care practices and provides funding and support for the delivery of advanced primary care throughout the State. The MDPCP supports the overall health care transformation process and allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization. The program is governed by CMMI with support from the State Maryland Primary Care Program Management Office (PMO) in the MDH. The PMO works closely with CMMI on policy and operations, while providing resources to practices including leadership, data analytics, coaching, and integration with the State's public health priorities including diabetes, opioids, and COVID-19. The Health Services Cost Review Commission (HSCRC) provides support as needed.

As of January 2024, there are 511 participating practices (588 sites) participating in the program with approximately 362,000 attributed Medicare FFS beneficiaries. In 2024, MDPCP welcomed one new Federally Qualified Health Center (FQHC), for a new total of 13 participating FQHC organizations representing 77 sites from across the State. In total, these practices employ approximately 2,300 providers including physicians, clinical nurse specialists, nurse practitioners, and physician assistants across all 24 Maryland counties. Since 2020, the PMO has been working closely with CareFirst, which joined MDPCP for its commercial population to align its advanced primary care programs and share resources with practices.

A key component of the MDPCP is Care Transformation Organizations (CTOs), which were formed to provide infrastructure support to practices. CTOs provide technical support and resources to practices, such as practice transformation guidance, data analytics, and multi-disciplinary care management staff. There are currently 26 CTOs, with a minimum of seven providing services in each county Statewide. Seventeen CTOs are hospital-based.

The MDPCP continues to support statewide population health goals through its diabetes- and opioid-related initiatives. All MDPCP practices tracked four electronic clinical quality measures (eCQM) related to diabetes control (CMS122), hypertension control (CMS165), BMI screening and follow-up (CMS69), and depression screening and follow-up (CMS2) in 2023. These measures are also included in MDPCP's Track 3, which launched in 2023 and now has 272 practices as of January 2024 In 2023, the MDPCP Management Office implemented key elements of the MDPCP Comprehensive Diabetes Strategy which included quality improvement support to practices as well as partnerships with payers and other state offices.

One of the core features of advanced primary care within the MDPCP is the integration of behavioral health services within the primary care setting to respond more proactively to patients' behavioral health needs. As of Q4 2023, 100% of MDPCP practices reported developing a strategy for integrating behavioral health into their practice workflows via the Care Management or Collaborative Care Model, Primary Care Behaviorist Model, or other approaches for addressing behavioral health needs. As of Q4 2023, over 375 MDPCP practices have implemented Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify and appropriately refer patients with substance use disorders, far exceeding the 2021 SIHIS goal of

implementing SBIRT in 200 MDPCP practices. In addition, approximately 90 practices have implemented the Collaborative Care Model.

The PMO provides the education infrastructure of the program through a variety of activities. A key component of the education is live, virtual learning events connecting back to MDPCP's mission and vision; examples of these events include the Care Manager Affinity Group (designed for Care Managers to get together and discuss best practices and share case studies), Office Hours (designed for CMMI and PMO staff to discuss programmatic requirements and updates), and Staff Training Academy (designed for primary care practice staff to gain skills and knowledge through a half-day training event). Another key component of this education infrastructure is technical assistance, which the PMO provides to MDPCP participants through: quality improvement initiatives, process improvement efforts, and educational material creation and design. Much of this technical assistance is done by the PMO's team of Practice Transformation Coaches that provide this hands-on assistance. The PMO continues to collaborate with CMMI on shared events and communications, such as the *MDPCP Today* monthly newsletter, a work group for the HEART payment, as well as program guides and resources.

In addition to its aims to reduce avoidable hospitalizations, improve quality, and reduce costs, MDPCP has a concerted focus on advancing health equity and reducing disparities at the primary care level. Beginning in 2022, MDPCP began pioneering a payment to primary care based on beneficiary social risk level, called the Health Equity Advancement Resource and Transformation (HEART) Payment. The HEART Payment provides additional resources to practices each quarter to support social needs of patients with high clinical and social risk. Approximately $30.5 million was being invested in this effort in 2023. Outside of this investment, MDPCP is focusing on health equity through a robust reporting suite including outcomes data stratified by socio-demographic variables; an emphasis on social needs screening and referrals; and more.

Special Funding Programs

Maryland's ability to transform its statewide healthcare delivery system is critical to the success of the TCOC Model. This requires hospitals and their community partners to focus on initiatives that reduce avoidable hospital utilization, improve access to key healthcare services designed to address chronic conditions, and create innovative partnerships that emphasize community-based services. Maryland's unique hospital finance system enables special funding programs that direct funds from the hospital rate setting system to target specific goals of the TCOC Model. These special funding programs provide seed funding for numerous initiatives and enable hospitals and their partners to collaborate on statewide delivery system transformation activities.

Regional Partnership Catalyst Program

In November 2020, the Health Service Cost Review Commission (HSCRC) originally approved $165.4 million in five-year cumulative funding for the Regional Partnership Catalyst Program to support population health investments. The Regional Partnership Catalyst Program provides funding to hospital-led teams that work across statewide geographic regions to build infrastructure for interventions that align with goals of the Total Cost of Care (TCOC) Model and support population health goals in the SIHIS. The SIHIS population health domain contains the following focus areas: diabetes, opioid overdose mortality, and maternal and child health. The Regional Partnership Catalyst Program funds program development focused on two priorities: diabetes prevention and management programs and behavioral health crisis programming. For diabetes, the HSCRC focused the Regional Partnership Catalyst Program on the implementation of the National diabetes prevention program (DPP) and diabetes self-management education training (DSMES).

The HSCRC funding was intended as seed funding, an initial investment in program development and growth. The HSCRC expected Regional Partnership programs to develop sustainable funding streams to support the programs after the HSCRC funding ended. At the end of CY 2023, the HSCRC made a difficult decision to end funding for diabetes programs early due to concerns over the long-term sustainability of the programs; however, hospitals may continue to support these programs independently using the infrastructure developed since 2021. Funding to Regional Partnerships will end June 30, 2024, but Regional Partnerships will have the full calendar year to transition their programs to a self-sustaining model or wind-down their programs if they determine they will not support them without the dedicated HSCRC funding. The HSCRC and its State partners remain committed to providing technical assistance to Regional Partnerships that will continue operating their programs after funding expires. At this time, all Regional Partnerships have indicated they intend to continue offering some form of diabetes management or prevention programming after the HSCRC funding expires.

Six Regional Partnerships were initially selected to provide diabetes prevention and management activities across Maryland. The award recipients self-selected ZIP codes with disproportionate rates of diabetes or in vulnerable communities more likely to have higher rates of prediabetes. The awardees and final revised funding amounts are listed below in Table 8 and 9.

Table 8. Regional Partnerships (Diabetes) Revised Funding Amounts

Regional Partnership	Originally Awarded Total Funding Amount	Revised Total Funding Amount	Program End Date
Baltimore Metropolitan Diabetes Regional Partnership	$43,299,986	$32,730,418	June 30, 2024

Western Regional Partnership	$15,717,413	$10,996,156	June 30, 2024
Nexus Montgomery	$11,876,430	$4,121,123	December 31, 2022
Totally Linking Care - Maryland	$7,379,620	$4,463,519	June 30, 2024
St. Agnes and LifeBridge Health Diabetes Care Collaborative	$5,962,333	$4,081,555	June 30, 2024
Full Circle Wellness for Diabetes in Charles County	$2,124,862	$1,425,078	June 30, 2024
Total	**$86,360,644**	**$57,817,849**	

Table 9. Regional Partnerships (Behavioral Health) Funding Amounts

Regional Partnership	Total Funding Amount	Program End Date
Greater Baltimore Region Integrated Crisis System (GBRICS)	$44,862,000	December 31, 2025
Totally Linking Care (TLC)	$22,889,722	December 31, 2025
Tri-County Behavioral Health Engagement (TRIBE)	$11,316,332	December 31, 2025
Total	**$79,069,054**	

In 2023, Regional Partnerships receiving behavioral health funding met significant infrastructure and programmatic milestones. On the Eastern Shore, TRIBE continued to grow patient volumes for its two crisis centers. GBRICS and TLC both launched care traffic control software as part of their local 988 call centers and expanded mobile response teams in their areas. GBRICS, through their Open Access Pilot, has increased access to same day behavioral health appointments by providing technical support to 17

behavioral health sites. TLC is scheduled to open the first 24/7/365 crisis stabilization center in Prince George's County in summer 2024. In addition, Regional Partnerships have actively participated in efforts (e.g. workgroups and advocacy) to ensure the programs they implement into communities are aligned with sources of funding to support long term sustainability.

Maternal and Child Health Funding Initiative

In 2021, the Health Services Cost Review Commission (HSCRC) approved cumulative funding of $40 million across four years (FY 2022 – FY 2025) to support maternal and child health (MCH) investments led by Medicaid and the Prevention and Public Health Administration (PHPA) under the Maryland Department of Health (MDH or the Department), in conjunction with the Medicaid HealthChoice Managed Care Organizations (MCOs). This funding will scale existing statewide evidence-based programs and promising practices and support the expansion of new services for mothers and children.

Funding supports the following MCH initiatives within Maryland Medicaid:

- Home Visiting Services pilot expansion;
- Reimbursement for doula services;
- CenteringPregnancy, a clinic-based group prenatal care model;
- HealthySteps, a clinic-based intensive prenatal and postpartum case management framework; and
- Maternal Opioid Misuse (MOM) model expansion/intensive case management for high-risk pregnancies.

Funding to PHPA supports the expansion and/or implementation of mutually reinforcing programs:

- Medicaid's asthma home visiting program
- Community-based asthma home visiting initiatives (all-payer)
- Community-based home-visiting services and CenteringPregnancy implementation (all-payer)

In FY 2023, Medicaid and MDH prioritized implementing enhanced infrastructure necessary to expand these programs and interventions. Medicaid and MDH recently released the Maternal and Child Health Population Health Improvement Fund Annual Report (FY 2023) showing the impact to date. Through 2025, the HSCRC will continue to monitor and support MDH and Medicaid as they implement the programs listed above that have been strategically designed to provide services to underserved populations and those who are at greater risk of being affected by severe maternal morbidity and severe asthma.

Stakeholder Engagement

HSCRC Workgroup Activities

The HSCRC continues to engage broadly with stakeholders in guiding policy and methodology development through various workgroup meetings throughout CY 2023. All workgroups are comprised of a wide range of healthcare industry stakeholders, including hospitals, clinicians, payers, consumer representatives, and community organizations. All workgroup meetings are conducted in public sessions, and comments are solicited from the public at each meeting. There are also several sub-workgroup meetings and task forces to discuss technical, data-driven matters related to specific policies, which report back to the larger workgroups. Input is also solicited in informal meetings with stakeholders. All proceedings and reports of workgroup activities, as well as membership rosters, may be found on the Workgroups page on the HSCRC website.[8]

Payment Models Workgroup

The Payment Models Workgroup is charged with vetting potential recommendations for HSCRC consideration on the structure of payment models and how to balance its approach to payment updates. Staff and workgroup members meet between January to June of each calendar year to discuss the annual update factor policy (discussed in Section II). This policy is voted on by the Commission in the June meeting and provides updates to hospitals that includes: inflation, volume, quality, and other adjustments while considering and projecting that the update will meet the financial requirements of the TCOC Model.

Performance Measurement Workgroup

The Performance Measurement Workgroup (PMWG) develops recommendations for HSCRC consideration on pay-for-performance quality measures that are important, reliable, informative, and feasible for assessing a number of important quality and efficiency issues. Throughout the fall of 2022 and into the spring of 2023, the Workgroup reviewed and has updated the MHAC and QBR program RY 2025 policies and will continue to implement the RY 2023 RRIP policy for RY 2025. In CY 2023, PMWG has been tasked with proposing quality, health equity, and population health program recommendations for the future model.

Total Cost of Care Workgroup

The Total Cost of Care Workgroup is charged with providing feedback to the HSCRC on the development of specific methodologies for managing the Medicare Total Cost of Care, as required by the contract with CMS. The TCOC Workgroup met throughout 2023 to further refine methodologies related to Medicare

[8] HSCRC Workgroups. https://hscrc.maryland.gov/Pages/Workgroups-Home.aspx

TCOC policy. Additionally, the TCOC Workgroup discussed the source of cost drivers in Maryland and future benchmarking methodologies.

Section VII: Methods of Rate Determination

Global Budget Overview

Under the TCOC Model, 95 percent of regulated hospital revenues must remain under global (or "population-based") budget structures. With 98 percent of regulated hospital revenues under global budget structures since CY 2016, Maryland currently exceeds this target level. The two percent of revenue not included in GBR accounts for drug costs, which are based on volume. All regulated acute-care Maryland hospitals operate under Global Budget Revenue (GBR) agreements. The HSCRC continues to work with stakeholder workgroups (discussed in Section VI) to refine the GBR methodology and develop a number of policies discussed in this section.

Volume Methodologies

Market Shift Policy

The Market Shift Adjustment (MSA) provides criteria for increasing or decreasing the approved regulated revenue of Maryland hospitals operating under global revenue caps. Specifically, the MSA provides the criteria to reallocate funding to account for shifts in cases between regulated hospitals, with the objective of ensuring that funding follows the patient and that hospitals continue to have a competitive interest in serving patients efficiently and effectively. The MSA does not currently address all volume changes, only those the Commission can quantify as shifts between hospitals and only volume the Commission deems appropriate to evaluate, i.e., the Commission does not evaluate readmissions and preventable admissions in the MSA because doing so would incentivize competing for care that is potentially avoidable.[9]

The MSA works by first defining distinct markets and then evaluating growth and declines in those markets among hospitals that provide services in those areas. To do so, the HSCRC developed an algorithm to calculate MSAs for a specific service area (e.g., orthopedic surgery) and a defined geographic location (e.g., ZIP code). The algorithm compares the growth in volumes at hospitals with utilization increases to the decline in volumes at hospitals with utilization decreases. Adjustments are capped at the lesser of the growth for volume gains or the decline for volume losses, i.e., what can be quantified as a market shift

[9] The Market Shift evaluates about 70% of all hospital revenues attributable to in-state hospital volume only. Volumes attributable to Potential avoidable Utilization (PAU) 11%, Non-Maryland Residents 9%, Outpatient Oncology 8%, Categorical Exclusions 2% and Chronic 0.4% are not evaluated within the Market Shift Policy. These volumes, however, get accounted for in other methodologies and policies.

versus overall changes in utilization. As such, the net MSA for the State is typically near breakeven, with funds awarded to hospitals receiving cases and funds taken from hospitals losing cases.

Demographic Adjustment

The Demographic Adjustment methodology provides funding increases or decreases to recognize anticipated changes in hospital volume based upon projected age-adjusted population changes at the ZIP code level, while disallowing increases in utilizations due to potentially avoidable utilization (PAU). This adjustment is used to prospectively amend acute hospitals' GBRs for the forthcoming fiscal year and capped by the Maryland Department of Planning estimates of statewide population changes to align with the per capita constraint of the TCOC Model parameters.

Deregulation of Services

Deregulation is the movement of a hospital service from an HSCRC regulated space to an unregulated space. Deregulation is a desirable outcome of the TCOC Model as it moves services to less costly settings for patients, reduces total cost of care and can reduce the burden on hospital emergency rooms. Service movement can be initiated by payers, the hospital itself, or physician practices. In some cases, the deregulation may simply be a function of service discontinuation or cross-border movement to an unregulated setting. If services are shifted to an unregulated setting, global budgets generally must be reduced to prevent excess billing. HSCRC staff have worked with hospitals to make necessary adjustments to their global budgets when necessary. The Commission suspended deregulation adjustments in FY 2021 and FY 2022 due to the COVID-19 public health emergency. The Commission recognized that hospitals had to suspend certain services and that the public was reluctant to use hospital services during the pandemic. The HSCRC reinstated deregulation adjustments in FY 2023.

CDS-A Drug Funding

As stated previously, 98 percent of hospital revenue is currently under the global budget system. The remaining two percent of revenue accounts for drug costs, which are funded based on volume. For the past seven years, the HSCRC has provided funding prospectively for the utilization of certain high-cost, physician-administered outpatient oncology and infusion drugs. The HSCRC provides this prospective funding as a portion of the annual update factor which enables hospitals to afford these high-cost drugs. The HSCRC also makes retrospective adjustments to hospital GBRs based on changes in volume between expected and actual utilization during the prior year in order to address any under or overpayment that may have occurred. While the FY 2024 Update Factor is still being developed, a portion of that funding has been earmarked to continue funding these high-cost drugs.

Integrated Efficiency Policy

HSCRC staff developed an Integrated Efficiency (IE) Policy to evaluate and scale global budgets based on hospital efficiency. The policy evaluates hospital cost per case and total cost of care efficiency and then formulaically penalizes or rewards hospitals based on that performance. Overall, this policy will ensure that the limited resources of the GBR system are distributed to cost-efficient hospitals that are advancing the goals of the TCOC Model.

The IE Policy was approved in 2021 and was subsequently used to scale the FY 2022 and FY 2023 Annual Update Factor. In effect, inefficient hospitals received a reduced inflation factor for FY 2022 and 2023. This funding was then redistributed to efficient hospitals. Staff also used IE Policy to assess budget enhancement requests from efficient hospitals that sought additional funding. The criteria hospitals submit must demonstrate that they have been financially disadvantaged by a Commission methodology or will make population health investments that will further reduce TCOC.

In July 2023, Commissioners approved an updated IE policy that incorporated the Revenue for Reform policy (discussed in Section IV). The Revenue for Reform policy safe harbors dollars that would otherwise be removed from hospitals deemed inefficient under the IE policy if those dollars are directed to population health investments.

Capital Policy

Over the course of the HSCRC's 40-year rate setting history, allotments have been made in rates to fund large-scale capital replacement projects to ensure that hospitals can provide high-quality care and have updated, modern infrastructure. The need for this policy is greater under the GBR system because hospitals can no longer grow volume to fund capital projects and instead must reduce avoidable utilization, which is not an opportunity that is spread evenly among all hospitals.

As such, the Commission has adopted a capital methodology that will utilize various evaluations of capital cost efficiency, hospital cost per case efficiency, total cost of care efficiency, presence of potentially avoidable utilization (or lack thereof) and excess capacity, to determine the reasonableness of a hospital's capital request. Capital funding is restricted to the most efficient hospitals to ensure that the best-performing hospitals are recapitalized. Additionally, to ensure that hospitals expend funding from capital reserves when implementing large scale capital projects, capital funding is limited to major capital projects that are 35 percent of the hospital's permanent revenue for hospitals larger than the average global budget (~$300 million) and 50 percent of the hospital's permanent revenue for hospitals smaller than the average global budget (~$300 million).

Full Rate Reviews

Historically, the HSCRC has had a full rate application methodology to assess hospitals' efficiency. The methodology allowed staff to review a hospital's entire regulated rate structure and was employed:

- When a hospital submitted a full rate application for an increased rate structure; or
- When HSCRC staff identified a hospital with high-cost inefficiency in order to reduce the hospital's rate structure.

Full rate application assessments have historically been based on the Interhospital Cost Comparison (ICC) methodology, which measures a hospital's cost per case efficiency relative to a peer group standard, i.e., a hospital's revenue base compared to average peer group cost per case with profit removed. However, given the incentives of the TCOC Model and the broader cost accountability hospitals now face, the Commission developed total cost of care metrics that complement the Commission's cost review methodology in a TCOC Model. These metrics adhere to the Commission's statutory mandate (Maryland Health-General Article, An. Code Ann. § 19-219(a)) to assure each purchaser of hospital services that:

1. The total costs of all hospital services offered by or through a facility are reasonable;
2. The aggregate rates of the facility are related reasonably to the aggregate costs of the facility and;
3. The rates are set equitably among all purchasers or classes of purchasers without undue discrimination or preference.

Specifically, the Commission developed a TCOC algorithm that assesses total cost of care performance relative to attainment and growth standards that then modifies a hospital's ICC result.

Complexity and Innovation Policy

The cornerstone methodology of the TCOC Model is the hospital GBR system, which reimburses hospitals for baseline volume plus or minus market shifts and demographic changes. This methodology removes incentives for hospitals to increase utilization in order to drive profitability. Historically, hospitals had funded high-intensity cases or health care innovation, such as organ transplants or gene therapies, by increasing lower-acuity volume, thereby generating more revenue while maintaining the same fixed costs.

This economic behavior has been particularly important for the State's two academic medical centers, the University of Maryland Medical Center and the Johns Hopkins Hospital. To ensure that these two national leaders in academic research and innovation remain at the forefront of quaternary care, the HSCRC developed a standalone volume policy that reimburses the academic medical centers for growth deemed to be high complexity and/or innovative.

Funding for Complexity and Innovation is provided prospectively in rates through the annual update factor and is established by the historical average growth rate of these services. Allotted funding reflects increases due to emerging technologies and declines as these services shift to community hospitals once procedures become more mainstream. In a given fiscal year, academic medical centers are at financial risk should the prospective budgeted amounts diverge from actual experience; however, future budgetary allotments will account for changes in historical growth rates, thereby providing a stable funding source that comports with the tenets of a population-based system.

Section VIII: Reporting Requirements to CMS

Under the TCOC Model, the HSCRC is required to report to CMS on relevant policy and implementation developments. The HSCRC provides two annual monitoring reports to CMS on patient experience of care, population health and health care expenditures. The HSCRC submitted an annual report on CY 2023 healthcare expenditures to CMS in July 2023. The HSCRC submitted a second report on the State's CY 2023 performance on quality measures, inclusive of measures on patient experience of care and population health performance, in March 2024. As mentioned earlier in this report, the State also submitted an annual report to CMMI on 2023 progress under SIHIS. The following reports are included with this submission.

1. Annual Monitoring Report - Expenditures
2. Annual Monitoring Report – Quality
3. SIHIS Annual Report – 2023

Section IX: Adverse Consequences

At this time, the HSCRC has not observed any adverse consequences on patients or the public generally as a result of the implementation of the TCOC Model.

A number of policies developed over the course of the Model guard against potential adverse consequences that HSCRC staff and stakeholder workgroups identified as possible unintended outcomes of implementation. For example, the GBR agreements initiated by the HSCRC to implement the global budgets contained consumer protection clauses. In addition, the HSCRC implemented a Market Shift Policy (discussed in Section VII) and a Transfer Adjustment Policy to help ensure that "the money will follow the patient" when shifts in utilization occur between hospitals or other health care settings. These policies aim to guard against hospitals inappropriately limiting the number of high-cost, high-risk cases admitted and to provide open access and resources when patients need to be transferred to receive highly specialized care offered in academic medical centers.

As mentioned earlier in the report, one area of caution for our current contract is the fluctuation in trends of the total cost of care. Under the TCOC Contract, CMMI monitors the total cost of care in Maryland to ensure

that reductions in hospital potentially avoidable utilization do not result in unreasonable increases in the total cost of care. More detail on total cost of care performance is provided in Section II.

Section X: Hospital Financial Performance

Hospital Profitability

The HSCRC monitors hospital financial performance of regulated hospitals through hospital financial data submissions. Specifically, the HSCRC conducts monthly monitoring of unaudited data and annual monitoring of audited data. The financial data provide a metric to monitor the efficiency and effectiveness of hospitals, pursuant to the HSCRC's statutory charge. While each hospital may adjust and correct its unaudited data throughout the year, the unaudited data provide a good indicator of the direction of trends in statewide hospital revenue, expenditures, utilization, and profitability. Below is a summary of key data regarding the profitability of hospitals on an audited basis in FY 2023 and on an unaudited basis for FY 2023 through February of 2024.

The HSCRC only regulates inpatient and outpatient hospital services located at the hospital. The HSCRC does not regulate the rates of physicians. It also does not regulate revenue-producing activities which, while not related directly to the care of patients, are business-like activities commonly found in hospitals for the convenience of employees, physicians, patients, and/or visitors (e.g., parking garages and gift shops).

Audited Financial Data – FY 2023

Data for FY 2023 show an increase in margins for services regulated by the HSCRC, but an overall decrease in operating margins due to increasing losses on unregulated services. Positive results in non-operating margins, driven by investment income, results in total operating and non-operating margins improving over FY 2022.

Profitability based on audited data for total operations (hospital operations regulated by the HSCRC plus unregulated hospital operations), and for total hospital activities (both operating and non-operating activities) is presented below:

- The total combined audited regulated and unregulated operating margin was 0.01 percent (0.80 percent in FY 2022).
- The total margin, i.e., the combined operating and non-operating margins, was 2.36 percent (-2.01 percent in FY 2022).
- The operating margin for services regulated by the HSCRC was 6.62 percent (6.48 percent in FY 2022).

Maryland's regulated hospital industry remained profitable despite low total operating margins. Both the regulated operating and total profit margin increased over FY 2022.

Unaudited Financial Data – FY 2024

FY 2024 total operating margin for both services regulated by the HSCRC and services not regulated by the HSCRC increased over FY 2023, as shown by unaudited year-to-date financial data. Total profit margins increased by 2.29 percentage points versus unaudited results for the same period last year due to better non-operating returns so far in FY 2024. Hospital total margins are shown below. Final audited data, when available, may result in adjustments to these margins:

- The total combined unaudited regulated and unregulated operating margin was 1.31 percent (0.2 percent for the equivalent YTD FY 2023 unaudited results).
- The total margin, (the combined operating and non-operating margins), was 4.64 percent (2.35 percent for the equivalent YTD FY 2023 unaudited results).
- The operating margin for services regulated by the HSCRC was 5.90 percent (2.85 percent for the equivalent YTD FY 2023 unaudited results).

Uncompensated Care

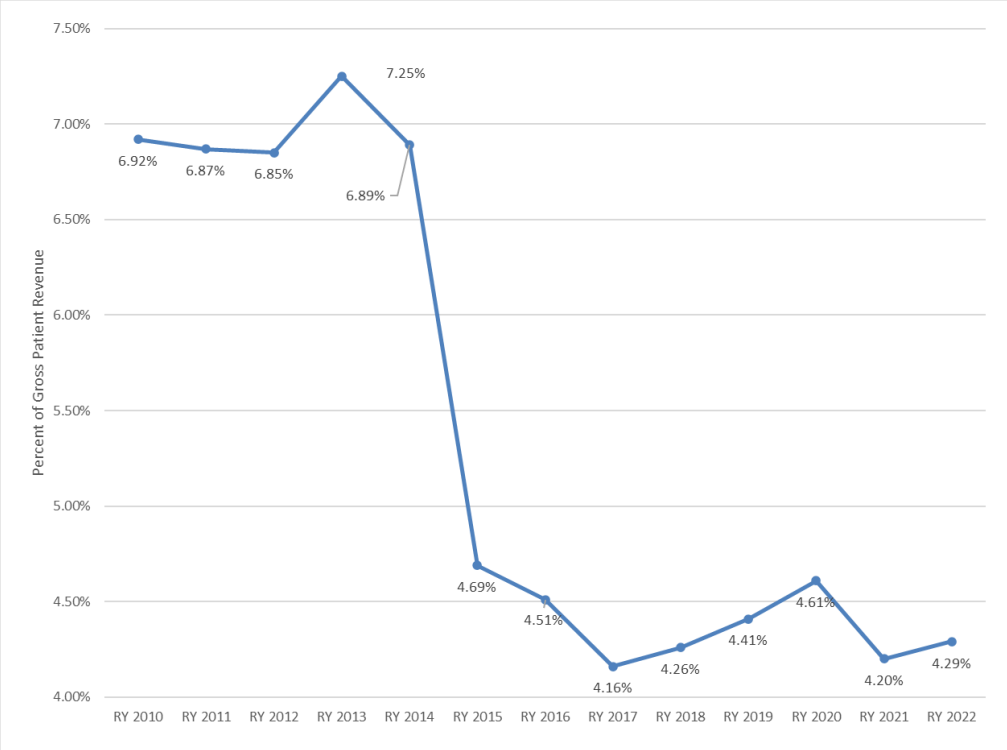
Uncompensated Care (UCC) is care provided for which no compensation is received (typically a combination of charity care and bad debt). Maryland recognizes the financial burden hospitals take on when providing quality care to patients who are unable to pay. Unlike in other states, Maryland's rate setting system factors the cost of UCC into the State's hospital rate setting structure. This provision increases access to hospital services for patients who cannot readily pay for care while hospitals get credited for the care provided.

The HSCRC's current policy provides for uncompensated care statewide at the level of the most recent year's actual statewide experience. Hospital-specific UCC provisions are determined by a blend of a hospital's most recent year's actual experience and its predicted performance determined by way of a regression analysis.

Figure 12 below shows the actual total UCC rate for all regulated Maryland hospitals between FY 2010 and FY 2022. Uncompensated care steadily declined between FY 2010 and FY 2012; however, FY 2013 saw a 0.40 percent increase in uncompensated care. The HSCRC believes this can be partially explained by the increasing prevalence of commercial health insurance plans with high deductibles, coinsurance- and copayments, which leave patients to pay a higher portion of a bill out-of-pocket. Additionally, outpatient hospital service utilization, for which commercially insured patients tend to be responsible for paying a higher portion of the bill out-of-pocket, has increased in recent years. Periods of low UCC rates occurred from FY 2014 and continued to FY 2017, driven by coverage expansions brought on with the

implementation of the Affordable Care Act (ACA). From FY 2018 to FY 2020, there was a slight uptick in uncompensated care rates as the effects of the ACA appear to have mitigated. The probability of a patient subsequently deemed as having UCC is historically highest amongst commercial patients presenting though the ED. Thus, the significant declines in ED utilization by commercial patients having a write-off to UCC during the pandemic subsequently resulted in the decline in UCC experienced in FY 2021. UCC seem to be levelling back up to pre-pandemic levels in FY 2022 given the slight up-tick.

Figure 11. Uncompensated Care as a Percentage of Gross Patient Revenue, FY 2010-2022



Source: HSCRC Case-mix and Financial Data

Community Benefits

The Internal Revenue Code requires nonprofit organizations to report the amount of community benefits that they provide in exchange for not having to pay federal, state, or local taxes. Maryland law also requires hospitals to report similar data and qualitative information on community benefit expenditures and operations to the HSCRC. Community benefits are defined as activities that are intended to address community needs and priorities primarily through disease prevention and improvements in health status, including:

- Health services provided to vulnerable or underserved populations
- Financial or in-kind support of public health programs

- Donations of funds, property, or resources that contribute to a community priority
- Health education screening and prevention services

HSCRC posts the data provided by hospitals, along with a summary report on hospital community benefit activities on the HSCRC website. The most recently available data reflects community benefits for FY 2022. In that year, Maryland hospitals expended just over $1.21 billion in community benefits, or 6.2 percent of total hospital operating expenses, after offsetting expenditures related to amounts that are included in rates and not generated through hospital resources.

Since 2012, federal law requires nonprofit hospitals to conduct a community health needs assessment every three years. Beginning with FY 2022 data, the Commission required hospitals to submit to HSCRC annual information on each hospital's community health needs assessments and how their community benefits expenditures relate to their community health needs assessment. Hospitals reported that 37.2% of their community benefits spending in FY 2022 was associated with their Community Health Needs Assessments.

Section XI: Statutory and Regulatory Updates

2023 Legislative Updates

2023 Reports Required by the Joint Budget Committees' Report

HSCRC completed the following reports in 2023, required by the "Report on the Fiscal 2024 State Operating Budget (HB 200) And the State Capital Budget (HB 201) And Related Recommendations".

1. **Evaluation of the Maryland Primary Care Program:** This report evaluates the effectiveness of the Maryland Primary Care Program (MDPCP or Program) with a comparison between cost savings, utilization, and the additional payments provided to primary care practices, in addition to focusing on racial equity within the Program and primary care in general. The Joint Chairmen's Report (JCR) also asked HSCRC to describe the relationship between outcome-based credits and MDPCP. This report was submitted in October 2023.

2023 Reports Required by Legislation of Legislature Committees

The HSCRC completed the following legislatively-required reports during 2023:

1. Annual Governors Report, required by Health-General §19-207(b)(9);
2. Summary of UMMS Board of Directors Financial Disclosure, required by Education Article §13-304(l)(4);
3. Maryland Hospital Community Benefit Report: FY 2022, required by Ch. 437, 2020; and

2024 Statutory Updates

During the 2024 Legislative Session, the Legislature passed a number of bills with a direct impact on HSCRC operations.

Budget Bill (SB 360)

The Budget Bill for Fiscal Year 2025 funds HSCRC's operations, including the uncompensated care fund. The Budget Bill also requires HSCRC to submit a report evaluating findings and recommendations from the Commission to Study Trauma Center Funding in Maryland. The Budget bill conditions $125,000 of HSCRC's budget on the submission of this report, which is due October 1, 2024

Trauma Funding and Reports (SB 360, HB 1439, and SB 1092)

Three bills increased funding for trauma services in the State, the Budget Reconciliation and Financing Act (SB 362), Funding for Trauma Centers and Services (HB 1439), and Emergency Medical System Surcharge - Increase and Distribution of Funds (SB 1092). This legislation increases a surcharge on motor vehicle registration and fines for driving under the influence. This revenue is used, in part, to increase funding for the Maryland Trauma Physician Services Fund, which is administered by the Maryland Healthcare Commission and HSCRC. The legislation also increases funding for Shock Trauma at the University of Maryland Medical System, one of the hospitals that HSCRC regulates. The legislation amended the components of the required annual report on the Maryland Trauma Physician Services Fund, which will require additional data from HSCRC.

Maryland Emergency Department Wait Time Reduction Commission (HB 1143)

This bill establishes the Maryland Emergency Department Wait Time Reduction Commission to address factors throughout the healthcare system that contribute to increased emergency department wait times. This will be co-chaired and staffed by HSCRC, which will develop and implement the work plan. The Commission will report annually on its activities, findings, and recommendations, including an update on development, implementation, and impact of the recommended policies and programs developed to improve emergency department wait times.

Hospitals – Financial Assistance Policies – Revisions (HB 328)

This bill removes language from existing law that allows hospitals to restrict eligibility for reduced cost care to patients in their hospital service area (a geographic area surrounding the hospital). The bill also prohibits hospitals from using asset tests for monetary assets under $100,000 or for any nonmonetary assets.

Outpatients Facility Fees (SB 1103)

This bill strengthens consumer notice requirements for outpatient facility fees for hospital outpatient clinic services. HSCRC is required to convene a workgroup and conduct a study to make recommendations including whether notices should be expanded to all outpatient services and the effectiveness of the current notice provided to consumers. HSCRC will submit reports to the legislature by December 1, 2024 and December 1, 2025.

Maryland Commission on Health Equity (MCHE) (HB 1333)

The CMS's AHEAD Model specifies the membership of the entity that provides AHEAD Model governance in the State. The Maryland Department of Health and HSCRC worked together on this bill which modifies the membership of the existing Maryland Health Equity Commission to allow it to play a key role in AHEAD governance. The bill also modifies the MCHE's duties to include development of a State Health Equity Plan, which is a requirement of the AHEAD model. The Secretary of Health and the Executive Director of HSCRC will co-chair the MCHE. MCHE will submit reports to the legislature in 2024 and 2025.

Health Commissions and Maryland Insurance Administration – Study (SB 694 / HB 1887)

This bill requires the Maryland Department of Health to hire an independent consultant to conduct a study of the HSCRC, the Department, Maryland Health Care Commission, Maryland Community Health Resource Commission, and Maryland Insurance Administration. The study will identify and examine any overlap of duties and make recommendations for increased alignment and efficiencies. HSCRC will provide any requested information to the consultant.

Regulatory Updates

The Commission proposed and/or adopted amendments to the following existing regulations in 2023:

COMAR 10.37.01.02, Accounting System; Hospitals

On January 27, 2023, the Commission proposed to amend regulation .02 under COMAR 10.37.01 for the purpose of updating the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operation Management (August 1987)." This regulation became effective 12/11/23.

COMAR 10.37.10.26, Rate Application and Approval Procedures – Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies

On August 26, 2022, the Commission proposed to amend Regulation .26 under COMAR 10.37.10. The purpose of this action was to have the Commission's existing regulations on Patient and Obligations -

Hospital Credit and Financial Assistance Policies conform to legislation enacted in the 2021 Maryland General Assembly legislative session. Based on public comments, HSCRC made substantial changes to the regulation. In 2023, the Commission approved the publication of the revised regulations as proposed. The Commission anticipates adoption of the proposed regulations in 2024.

COMAR 10.37.01.02 Uniform Accounting and Reporting System for Hospitals and Related Institutions (ELF Docket #23-162)

On January 27, 2023, the Commission proposed to amend regulation .02 under COMAR 10.37.01 for the purpose of updating the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operation Management (August 1987)." This is an annual update to this manual for hospitals.

Section XII: Commission Infrastructure

Commissioners

The HSCRC is the only agency in the country with the mission of setting all-payer rates for hospital services within a state. The HSCRC functions as an independent Commission within MDH. Seven Governor-appointed Commissioners oversee the HSCRC. Below is a list of current Commissioners.

Table 10. Current HSCRC Commissioners

Commissioner	Term Start Date	Term End Date
Joshua Sharfstein, MD, Chairman	July 1, 2023	June 30, 2026
Joseph Antos, PhD	July 1, 2016	June 30, 2024
James N. Elliott, MD	July 1, 2018	June 30, 2026
Ricardo Johnson, JD	July 1, 2023	June 30, 2027
Maulik Joshi, DrPH	July 1, 2021	June 30, 2025
Adam Kane	July 1, 2017	June 30, 2025
Nicole McCann	July 1, 2023	June 30, 2027

Staff

The State charges the HSCRC with regulatory authority over the rates and revenues of Maryland's 44 acute care hospitals, seven Freestanding Medical Facilities, three psychiatric hospitals (commercial rates only), and one pediatric specialty hospital (commercial rates only), an industry with annual revenues in excess of $20 billion. This responsibility is accomplished by a relatively small and highly skilled staff of 47 full-time

equivalents and several contractual employees. To meet the demands of the TCOC Model, the Commission organized its staff structure under five centers:

1. Medical Economics and Data Analytics
2. Hospital Rate Revenue and Regulations
3. Quality and Population-Based Methodologies
4. Healthcare Data Management and Integrity
5. Administration and Operations

As the State continues under the TCOC Model, the HSCRC continues to hire new staff to provide needed expertise and support to design and implement new programs, methodologies, and analyses.

Budget

A small user fee assessed on hospital rates in Maryland supports Commission staff salaries and operations. Due to the technical nature of the work of the Commission, expenses are driven primarily by personnel costs and contracts. The total user fee assessment in FY 2023 was $19.6 million and the fund balance at the end of the fiscal year was $9.2 million, which will be reduced in the following year by lowering user fees assessed on hospitals in FY 2024.

Section XIII: Future Outlook

In 2024 and throughout FY25, HSCRC will continue to support and expand the unique Maryland Model while preparing for its next iteration - States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. HSCRC collaborated with MDH to respond to CMMI's Notice of Funding Opportunity for the AHEAD Model, and the agency will continue to work with the Governor's Office, the Maryland Department of Health, and stakeholders on the development of the new model. While the current TCOC agreement with CMS ends December 2026, with a two-year transition period, HSCRC anticipates transitioning to the AHEAD Model in advance of that date, by January 2026.

The TCOC agreement with CMS, combined with HSCRC's hospital rate-setting authority, continues to support private and public efforts to improve the health and lives of Marylanders through innovative healthcare reforms. Maryland is increasing accountability for hospitals on health equity. Hospitals and the State are using the Maryland Model to invest in population health (including investments in crisis support for behavioral health, maternal health, and childhood asthma). The goal is to invest "upstream" from traditional hospital care to further limit growth in future healthcare expenditures as people live healthier lives. HSCRC continues to work to develop and implement policies that enhance the quality of healthcare and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders. The HSCRC will continue to lead efforts to meet the ambitious goals of the TCOC and

AHEAD Model. Achieving these goals is a collaborative effort between the State, hospitals, non-hospital providers, payers, and a broad spectrum of community partners, all working together to create long-term health improvements and cost savings for Marylanders.

Appendices

1. Annual Monitoring Report – Expenditures
2. Annual Monitoring Report – Quality
3. SIHIS Annual Report – 2023
4. Maternal and Child Health Improvement Fund Report – FY2023