maryland
health services
cost review commission

**603rd Meeting of the Health Services Cost Review Commission**
**February 8, 2023**

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

**EXECUTIVE SESSION**
**11:00 am**

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104
2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104
3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104
4. Discussion of Tidal Health's Petition for Declaratory Ruling - Authority General Provisions Article, §3-305(7)

**PUBLIC MEETING**
**1:00 pm**

1. Review of Minutes from the Public and Closed Meetings on January 11, 2023
2. Docket Status – Cases Closed
3. Docket Status – Cases Open
   2603R - Luminis Anne Arundel Medical Center
   2608R - Shady Grove Adventist Medical Center
4. Disposition of Tidal Health's Petition for a Declaratory Ruling
5. Traditional MPA - CY 2023 Performance - Final Recommendation
6. Emergency Department Challenges and Strategies
7. Analysis of Utilization Trends under the TCOC Model
8. Policy Update
   a. Model Monitoring
   b. Legislative Update
   c. Analysis of Hospital Funding in Rural and High Poverty Areas
9. Hearing and Meeting Schedule

maryland
health services
cost review commission



# MINUTES OF THE
# 602nd MEETING OF THE
# HEALTH SERVICES COST REVIEW COMMISSION
# January 11, 2023

Chairman Adam Kane called the public meeting to order at 11:37 am. In addition to Chairman Kane, in attendance were Commissioners Joseph Antos, PhD, Victoria Bayless, James Elliott, M.D., and Sam Malhotra. Upon motion made by Vice Chairman Antos and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:25 p.m.

## REPORT OF JANUARY 11, 2023, CLOSED SESSION

Mr. William Hoff, Chief, Audit & Compliance, summarized the minutes of the January 11, 2023, Closed Session.

## ITEM I
## REVIEW OF THE MINUTES FROM THE DECEMBER 14, 2022, CLOSED SESSION, AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the December 14, 2022, Public Meeting and Closed Session.

## ITEM II
## CLOSED CASES

2609A- Johns Hopkins Health System
2610A- Johns Hopkins Health System

## ITEM III
## OPEN CASES

2603R- Luminis Anne Arundel Medical Center
2608R- Shady Grove Adventist Medical Center
2611A- Johns Hopkins Health System
2612A- Johns Hopkins Health System
2613A- Johns Hopkins Health System

## ITEM IV
## CONFIDENTIAL DATA REQUEST
**The University Maryland School of Medicine Shock Trauma and Anesthesiology Research Center, and National Study Center for Trauma and EMS**

Ms. Claudine Williams, Deputy Director, Clinical Data Administration, presented staff's recommendation on granting The University of Maryland School of Medicine (UMSOM), and the National Study Center for Trauma and EMS (NSC), access to the Health Services Cost Review Commission (HSCRC) Inpatient and Outpatient Hospital data. (see "Final Staff Recommendation or the Release of HSCRC Confidential Patient Level Data to The University of Maryland School of Medicine (UMSOM), and the National Study Center for Trauma and EMS (NSC) available on the HSCRC website)

UMSOM, and the NSC, are requesting access to the HSRC's Inpatient and Outpatient Hospital data, which includes limited confidential information ("the Data") for the Injury Outcome Data Evaluation System (IODES).

The IODES project is designed to make data related to injury available for analysis. The Data will be used for analysis of injuries to persons treated at Maryland hospitals. To fulfill a key component of the IODES effort, the Data will be linked (where possible) to police crash reports, EMS run sheets, and other datasets as required for further analysis. The NSC has been working with the Maryland Department of Transportation, Maryland Highway Safety Office (MDOT MDHSO) and other partners on the Crash Outcome Data Evaluation Systems (CODES) project for more than a decade.

Investigators received approval from the Maryland Department of Health (MDH) IRB on October 25, 2022, and the MDH Strategic Data Initiative (SDI) office on December 5, 2022.

The Data will not be used to identify individual hospitals or patients. This project is designed as an umbrella project that will continue to address individual approved projects and tasks to improve the public health of Marylanders with injuries and has no end date. However, the Project Principal Investigator will notify the HSCRC if the project was terminated, and at that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee is composed of representatives from HSCRC and the MDH Environmental Health Bureau.

Staff Recommendations are as follows:

1. HSCRC staff recommends that the request by UMSON for the Data for Calendar Year 2020 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.

Commissioners unanimously voted in favor of Staff's recommendation.

**The Johns Hopkins University Center on Aging and Health**

Ms. Williams presented staff's recommendation on granting The Johns Hopkins University (JHU) Center on Aging and Health access to HSCRC Inpatient and Outpatient Hospital data ("the Data") through CRISP (see "Final Staff Recommendation or the Release of HSCRC Confidential Patient Level Data to The University of Maryland School of Medicine (UMSOM), and the National Study Center for Trauma and EMS (NSC) available on the HSCRC website)

The JHU Center on Aging and Health is requesting access to HSCRC Inpatient and Outpatient Hospital data ("the Data") through CRISP, containing limited confidential information to conduct a study looking at whether increased social engagement in Experience Corps examined in the Baltimore Experience Corps Trial (BECT), led to long-term reductions in medical care expenditures, as well as, lower risk for Alzheimer's disease, physical frailty, and mortality.

The BECT was the first large-scale, randomized trial of 702 older adults to show that productive social engagement (as volunteers in elementary schools) increased lifestyle activity, generative purpose, and improved cognition and brain biomarkers for Alzheimer's disease over two years of exposure. JHU is submitting a panel of patients to CRISP to append case mix data for those in the study. Investigators received approval from the Maryland Department of Health (MDH) IRB on September 1, 2022, and the MDH Strategic Data Initiative (SDI) office on December 16, 2022. The Data will not be used to identify individual hospitals or patients. The Data will be retained by JHU until September 12, 2027; at that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee is composed of representatives from HSCRC and the MDH Environmental Health Bureau.

Staff Recommendation

1. HSCRC staff recommends that the request by JHU for the Data for Calendar Year 2013 through 2022 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.

Commissioners unanimously voted in favor of Staff's recommendation.

**ITEM V**
**REPORT EXTENDING THE READMISSION REDUCTION INCENTIVE POLICY**

Alyson Schuster Ph.D., Deputy Director Quality Methodologies, presented a final recommendation for extending the Readmission Reduction Incentive Program for RY 2025 (see "Final Recommendation for the Readmission Reduction Incentive Program for Rate Year 2023" available on the HSCRC website)

The quality programs operated by the Health Services Cost Review Commission, including the Readmission Reduction Incentive Program (RRIP), are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in worsened quality of care. Quality programs are intended to reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model while guarding against unintended consequences and penalizing poor performance.

The RRIP policy is one of several pay-for performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care over time. The RRIP policy currently holds 2 percent of hospital revenue at-risk for readmissions occurring within 30- days of discharge for all payers and all causes.

The broader RRIP policy continues to reward or penalize hospitals on the better of improvement and attainment. There is an additional component of the policy that provides further payment incentive (up to 0.5 percent of inpatient revenue) for reductions in within-hospital disparities.

Maryland made incremental progress each year throughout the All-Payer Model (2014-2018), ultimately achieving the Model goal for the Maryland Medicare FFS readmission rate to be at or below that of the nation by the end of Calendar Year 2018. Maryland had historically performed poorly compared to the nation on readmissions, ranking 50th among all states in a study examining Medicare data from 2003-2004. To meet the All-Payer Model requirements, the Commission approved the RRIP program in April 2014 to further bolster the incentives to reduce unnecessary readmissions.

As recommended by the Performance Measurement Workgroup, the RRIP is more comprehensive than its federal counterpart, the Medicare Hospital Readmission Reduction Program (HRRP), as it is an all-cause measure that includes all patients and all payers

In Maryland, the RRIP methodology evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (such as planned readmissions) from consideration, due to data issues and clinical concerns. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR DRG) severity of illness (SOI), and the policy determines a hospital's score and revenue adjustment by the better of improvement or attainment, with scaled rewards and penalties of up to 2 percent of inpatient revenue.

The RY 2023 final recommendation, in general, maintained the measure updates and methodology determinations that were developed and approved for RY 2022. For RY 2024 the RY 2023 policy was extended with no significant changes. The staff is recommending that the Commission extend the policy again for RY 2025.

The final recommendations, as approved by the Commission for RY 2023 and extended to RY 2024, will continue for RY 2025 and are summarized here:

1. Maintain the 30-day, all-cause readmission measure.

2. Improvement Target - Maintain the RY 2022 approved statewide 5-year improvement target of -7.5 percent from 2018 base period.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue,
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years, capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
6. Continue development of an all-payer Excess Days in Acute Care measure in order to account for readmission, emergency department, and observation revisits post-discharge.
7. Adjust the RRIP pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report to Commissioners.

Commissioners voted unanimously in favor of Staff's recommendation.

## ITEM VI
## QUALITY PROGRAMS PERMFORMANCE UPDATE

### Hospital Quality Program Exemption for FFY 2023

Dr. Schuster presented an update the hospital quality program exemption for FFY 2023 (see "Hospital Quality Program Exemption for FFY 2023" available on the HSCRC website)

Dr. Schuster stated that on December 29, 2022, the Staff received a letter from the Centers for Medicare and Medicaid Services (CMS) exempting Maryland hospitals from the following CMS national programs:

- Hospital Value-Based Purchasing (HVBP) program
- Hospital Acquired Conditions Reduction (HAC)
- Hospital Readmissions Reduction program (HRRP)

Based on CMS's analysis of Maryland's hospital quality performance which took into consideration the State's response to requests made by CMS in past exemption request approvals, analysis of CY 2021 performance, and exogenous factors impacting CY 2021 performance, CMS uses its discretion to grant the State of Maryland's exemption from HVBP, HAC, and HRRP for FFY 2023. However, CMS strongly encourages the State to consider the feedback regarding inpatient readmissions , as well as other opportunities to continue to improve quality across the Model.

CMS letter to Staff emphasized:

- Continued HCAHPS performance concerns.
- Expectation that Maryland continue to expand on hospital quality improvement, total population

health, and health equity
- Still reviewing Medicare Performance Adjustment proposal.

## Update on Population Health Quality Measures

Geoff Dougherty Deputy Director, Population Health, presented an update on Diabetes A1c Population Health screening measure (see "Update on Population Health Screening Measure" available on the HSCRC website).

Dr. Dougherty stated that Staff received has received several comment letters about the Diabetes A1C Population Health Screening. Some of the comments are as follows:

- Diabetes Program is better suited to primary care.
- Emergency Room (ED) lacks resources to effectively run program.
- May adversely impact ED patient experience.
- Diabetes Program may result in excess testing.

Based on stakeholders' comments HSCRC proposes the following changes to the Diabetes A1C Population Health Screening policy:

- Monitoring the MDPCP A1c control measure during CY23
- Focusing CY23 hospital A1c screening measure on admitted patients as suggested in UMMS/MedStar/Hopkins comment letter.
- Piloting broader ED A1c measure among willing hospitals
- Considering hospital-initiated submission of additional measures.

Dr. Dougherty noted that the draft of the hospital-initiated measure submission deadline is to be determined. Draft criteria are as follows:

- Targets primary/secondary diabetes prevention
- Targets defined population of size similar to ED measure.
- Reasonable expectation of meaningful improvement in diabetes incidence or screening prevalence
- Relies on existing data/does not require prospective monitoring.

Dr. Dougherty stated that measures will be evaluated by panel of pop health/diabetes experts, and that selected measures may be implemented statewide if concerns regarding A1c measures arise during monitoring or if need for additional measures arises.

Dr. Dougherty noted that Staff will monitor the program's unintended consequences as follows:

- ED throughput
    - ❖ Monitoring of OP18b
    - ❖ Monitoring of MIEMSS EMS ED handoff delay data

- Length of Stay extension
- Patients follow up/program impact on diabetes control.
    - ❖ Currently, we have data to track outpatient follow-up for Medicare/Medicaid patients with diabetes diagnosed in ED.
    - ❖ Structure similar to timely follow up quality measure.
    - ❖ Need to identify data sources for patients with commercial coverage.

Dr. Dougherty noted that the next steps are as follows:

- Finalize data collection approach.
- Develop reporting for hospital A1c screening and MDPCP A1c measures.
- Develop monitoring for unintended consequences.

## ITEM VII
## Policy Update and Discussion

### Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 8 months ending September 2022. Maryland's Medicare Hospital spending per capita growth was unfavorable when compared to the nation. Ms. Joyce noted that Medicare Nonhospital spending per-capita was trending closer to the nation. Ms. Joyce noted that Medicare Total Cost of Care (TCOC) spending per-capita was unfavorable when compared to the nation. Ms. Joyce noted that the Medicare TCOC guardrail position is 2.54% above the nation through September. Ms. Joyce noted that Maryland Medicare hospital and non-hospital growth through September shows a run rate erosion of $210,804,000.

### Commission Policy Overview

Ms. Katie Wunderlich, Executive Director, led a discussion on the Maryland Total Cost of Care (TCOC) Model (see " HSCRC Policy Discussion" available on the HSCRC website)

Ms. Wunderlich stated that the Maryland Model (Model), stabilizing and embracing a population health approach for all providers, will serve as the nation's leader in enhancing health equity, quality, access, total cost, and consumer experience by leveraging value-based payment methodologies across all payers.

Ms. Wunderlich stated that the TCOC goals achieve person-centered care, foster clinical innovation and excellence in care, improve population health, and moderate the growth in costs, on a statewide basis and in the all-payer environment through the transformation of the health care delivery system.

Ms. Wunderlich stated the HSCRC plans to achieve its vision by working toward three key goals:

1. Improve population health;
2. Improve outcomes for individuals; and

3. Control growth of total cost of care.

Ms. Wunderlich stated that Mathematica concluded an evaluation of the Model for the period of 2019 to 2021. Mathematica's results are as follows:

- The Model reduced total Medicare fee-for-service Part A and Part B spending by 2.5% which created a $781 million reduction in total spending.
- Several quality of care measures improved under the Model

    - ❖ 16.1% decrease in potentially preventable admissions
    - ❖ 9.5% decrease in unplanned hospital readmissions
    - ❖ 2.5% increase in timely follow up after hospital discharge.

Ms. Wunderlich questioned whether the Model was achieving the Broad Mandate as follows:

- Foster accountability and aligns incentives across delivery systems.
- Transform care.
- Drives affordable healthcare.
- Improves population health.

Ms. Wunderlich asked if the Staff has the right policies in place to achieve the broad mandate.

Future work by Staff is as follows:

- Analysis of historic TCOC savings to-date and opportunities for future utilization reductions/savings and de-regulation (Winter 2023)
- Evolution of hospital quality programs to measure disparities and population health (Winter/Spring 2023)
- Revisit Revenue for Reform to clarify expectations around retained revenue and exemptions from IE (buy out) (Winter/Spring 2023)
- Modify Integrated Efficiency policy to align with goals of Model and broad mandate (Winter-Spring 2023)
- Revise hospital cost schedules to better understand unregulated expenses, including physicians (Spring/Summer 2023)
- Engage in future Model consideration with broad stakeholder groups (Fall-Spring 2023)

## Revenue for Reform and Integrated Efficiency Discussion

Mr. Allan Pack, Director, Population Based Methodologies, led a discussion on Revenue for Reform and Integrated Efficiency (see "Revenue for Reform and Integrated Efficiency discussion" available on the HSCRC website.
The principal aim of the Integrated Efficiency Policy (IEP) is to formulaically penalize, and reward hospitals based on their performance in controlling TCOC (as measured through Medicare and Commercial TCOC benchmarks) and cost-per-case efficiency (as measured through the Inter-Hospital

Cost Comparison, or ICC). HSCRC designed these tools with consideration of the Model's incentives to reduce avoidable utilization, ensure costs are reasonable, and ensure charges are reasonably related to costs.

The IEP is intended to correct the maldistribution of global budgets rather than produce Model savings. This is done by reducing the amount of inflation provided to poorly performing outliers through the Annual Update Factor and making portions of these reductions available to excellent performers for population health investments.

Over the last twelve months, HSCRC Staff presented multiple draft recommendations of the Revenue for Reform Policy, which aims to incentivize population health spending through the use of retained revenues generated by reductions in utilization. Without Revenue for Reform or a similar policy, an unintended consequence of the IEP is that hospitals may be deemed inefficient due to higher levels of retained revenue and population health spending. In its latest draft form, the Revenue for Reform Policy aims to correct this by allowing hospitals to safe-harbor their population health spending from the ICC, and thus be held harmless by the IEP for retained revenue used as a means to improve population health.

Mr. Pack stated that Staff is considering a supplemental component of the IEP that would allow hospitals to reduce efficiency penalties if they have improved their TCOC and / or ICC position since FY2013. Mr. Pack said this would have the greatest impact on Baltimore City hospitals and rural hospitals.

Mr. Pack stated there are two potential alternatives for the IEP:

1. Create a zero-base budget for redistributing hospital revenues on a population basis so that GBR could be adjusted using the update factor alone, eliminating the need for supplemental policy
2. Dramatically increase the impact of the Medicare Performance Adjustment policy to more than 1% of Medicare Revenue; potentially expand this to an all-payer approach

Mr. Pack acknowledged that some level of unregulated physician subsidies is necessary to operate a hospital and is working on reporting improvements to obtain a better idea of appropriate levels of losses

## ITEM VIII
## HEARING AND MEETING SCHEDULE

| | |
|---|---|
| February 8, 2023, | Times to be determined- 4160 Patterson Ave<br>HSCRC Conference Room |
| March 8, 2023, | Times to be determined- 4160 Patterson Ave.<br>HSCRC Conference Room |

There being no further business, the meeting was adjourned at 4:34 pm.

**Closed Session Minutes**
**of the**
**Health Services Cost Review Commission**

**January 11. 2023**

Upon motion made in public session, Chairman Kane called for adjournment into closed session:

The Closed Session was called to order at 11:37 A.M.

In attendance, in addition to Chairman Kane were Commissioners Antos, Bayless, Elliott, and Malhotra.

In attendance representing Staff were Katie Wunderlich, Jerry Schmith, Allan Pack, William Henderson, Geoff Dougherty, Ph.D., Will Daniel, Alyson Schuster, Ph.D., Claudine Williams, Megan Renfrew, Bob Gallion, Erin Schurmann, and William Hoff. Dennis Phelps, participated via conference call.

Also attending were Eric Lindemann, Commission Consultant, Ari Elbaum, Commission Counsel. Stan Lustman, Commission Counsels, participated via conference call.

**Item One**

Katie Wunderlich, Executive Director, presented and the Commission discussed Tidal Health Petition for Declaratory Ruling on Benchmarking. Legal counsel was provided to the Commission.

**Item Two**

Katie Wunderlich, Executive Director, updated the Commission and the Commission discussed CMMI updates.

**Item Three**

Megan Renfrew, Associate Director, External Affairs, presented and the Commission discussed the Legislative Priorities for 2023.

**Item Four**

Eric Lindemann, Commission Consultant, updated the Commission and the Commission discussed Maryland's Model Performance.

**Item Five**

William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, presented and the Commission discussed Maryland Hospitals Monthly Unaudited Financial Performance

The Closed Session was adjourned at 1:14 P.M.

# Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF JANUARY 30, 2023

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

| Docket Number | Hospital Name | Date Docketed | Purpose | Analyst's Initials | File Status |
|---|---|---|---|---|---|
| 2603R | Luminis Anne Arundel Medical Center | 7/22/2022 | FULL | KW | OPEN |
| 2608R | Shady Grove Adventist Medical Center | 7/18/2022 | CAPITAL | GS | OPEN |

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

# Final Recommendation for CY 2023 Medicare Performance Adjustment

maryland health services cost review commission

# CY 2023 Final Recommendation

In 2020, the TCOC Workgroup conducted a comprehensive review of the MPA policy and the 2021 Commission Recommendation overhauled the MPA policy to make the measurement more stable and valid.

One of the findings from the review was that the MPA policy should be more stable from year to year. Therefore, Staff recommends maintaining the MPA policy except for three incremental changes which are necessary to conform with broader policy developments.

1. Revise the geographic attribution methodology;
2. Eliminate the MDPCP Supplemental Adjustment; and
3. Slightly increase the Quality Adjustment.

# New PSAP Algorithm

The CY 2022 MPA policy recommendation instructed Staff to revise the geographic assignment of beneficiaries to hospitals. Staff recommend formalizing that attribution methodology.

- Based on MHA feedback, PSAs will be determined mathematically to include those zip codes which account for 60% of a hospital's FY19 ECMADs when sorted from highest to lowest volume
- Remaining zip codes are then assigned, and shared zip codes are split to create the PSAP, no change to this process except FY19 ECMADs will now be used
- Other HSCRC processes will follow this change on the same timeline: PQIs, Benchmarking etc.
- The AMCs (UMMC & JHH) have different use patterns given their role providing tertiary care statewide. As such the 60% algorithm does not work well for the AMCs. Staff therefore recommend negotiating an assignment of Baltimore City zip codes to the AMCs instead.

# Elimination of MDPCP Supplemental Adjustment

In 2021, the Commission created a ‘Supplemental MDPCP Adjustment’ to hold hospitals accountable for managing the TCOC of the beneficiaries assigned to their MDPCP practices.

- The Supplemental Adjustment was intended to continue until the MDPCP program itself incorporated a component of TCOC risk.
- Track 3 of MDPCP includes downside risk based on the TCOC that is equal to 10% of the practice’s revenue.
- Staff therefore recommend eliminating the MDPCP Supplemental Adjustment.

# Proposed MPA Quality Calculation

In approving the CY 2022 MPA policy, CMS instructed the State to increase the amount of revenue at risk based on quality measures and the development of a population health measure in the MPA. Staff is therefore proposing a modest change to the MPA quality methodology.

- Double the quality weighting and apply the quality adjustment after the TCOC cap and add population health score once approved in CY 2024.
- Proposed MPA Quality Adjustment
    - Step 1: MPA TCOC x 1/3 result subject to +/- 1% cap.
    - Step 2: Step 1 x (1+ 2 x (RRIP + MHAC + Pop Health Reward/Penalty))
    - Where:
        - MPA result is expressed as percentage points above or below target
        - RRIP and MH are each up to +/- 2%
        - Population health is worth +/- 4% (once approved by the Commission and CMMI)
        - Calculation is reversed if MPA TCOC result is a penalty
        - Total adjustment can not exceed +/- 1.16% of Medicare payments (once the population health measure is approved)
    - % of MPA reward at risk for quality in CY 2023 = 8%
    - % of MPA reward at risk for quality in CY 2024, once population health is included = 16%
- Capture results from new all-payer population health measures in CY 2024
    - Set maximum value to +/- 4% as that sets population health weight equal to the value of traditional programs
    - Exact translation from all-payer population health measures to MPA value of 4% will be determined once measures and scoring are established*.

*The payment model workgroup will be reviewing all-payer related rewards and penalties for the selected population health measures within the base HSCRC quality program. The MPA will use the same measures, but the penalty/reward will be applied to the MPA, as defined in the MPA recommendation, regardless of the application in the quality program.

# Stakeholder Comments: CMMI

- CMMI approved the MPA for CY 2023. However, they also indicated that:
  - "CMS expects the State to increase the revenue at risk (± 1%) under the traditional MPA in 2024."
  - "CMS believes that increased financial risk tied to quality measures is key to driving improvement, and we strongly encourage Maryland to consider further increasing the level of risk associated with quality programs in PY 2024."
  - "[CMS] we look forward to the inclusion of population health measures as a component of the MPA in PY 2024."
- Staff plan to discuss an increase in the revenue at risk with the TCOC Workgroup over the upcoming year.
- Staff will continue to advocate with CMMI that quality adjustments should be made on an all-payer basis and not Medicare specific as part of the MPA.
- Staff will continue to work with the Performance Measurement Workgroup on the population health measure for CY24.

# Stakeholder Comments: Attribution and MDPCP Supplemental

- The Maryland Hospital Association, MedStar Health, and Luminis Health all supported using geographic attribution for the MPA.
  - But stakeholders emphasized that geographic attribution was not perfect and recommended that Staff continue to explore additional attribution algorithms.
  - Staff believe that a geographic attribution is the best blend of simplicity, consistency, and predictability that we are likely to find in an attribution algorithm. We recognize that the geographic attribution does not capture hospital specific initiatives to improve population health and for that reason plan to continue the Care Transition Initiative component of the MPA.
  - Stakeholders expressed disappointment that CMMI did not approve the CTI buyout for future years. Staff share in their disappointment.
- The Maryland Hospital Association, MedStar Health, and Luminis Health all supported removing the MDPCP Supplemental Adjustment.

# Stakeholder Comments: Population Health Measures

- The Maryland Hospital Association and MedStar Health urged HSCRC to adopt hemoglobin A1C control in hospitals' affiliated practices as the population health performance.
- Luminis Health emphasized that the population health measures should be brought to the Commission for approval.
- Staff are engaged in a stakeholder workgroup process to develop and implement the population health measures. This policy will be brought to the Commission for approval.
- Staff included a reference to a future population health measure in the MPA given that CMMI has emphasized its importance.

# Stakeholder Comments: Tidal Health

- Tidal Health expressed continuing concern about the HSCRC benchmarking methodology. Namely:
  - Tidal Health believes that the benchmarking should use a direct wage adjustment as a measure of labor costs instead of median income; AND
  - Tidal Health believes that the benchmarking should incorporate population health outcomes.
- Staff Response
  - The Medicare hospital wage index is historically unreliable for Maryland hospitals. Staff do not believe that the results would be reliable to use in a benchmarking methodology and could produce inaccurate outcomes.
  - Establishing a population health target for hospitals is an interesting concept but the benchmarking methodology was never designed to assess the level of costs needed to achieve a certain level of population health or health outcome. The benchmarking was designed to determine which areas of the State are more expensive relative to their national peers in order to manage the waiver test.

maryland
health services
cost review commission

# Medicare Performance Adjustment

## Final Recommendation

February 8, 2023

This document contains the final staff recommendations for the CY 2023 Medicare Performance Adjustment.

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

maryland
health services
cost review commission

# Table of Contents

# Recommendations For CY 2023 MPA Policy

Staff recommend the following incremental revisions to the Medicare Performance Adjustment (MPA) policy for calendar year 2023 (CY2023) to align with State and federal policy directives:

1. Formalize the geographical attribution algorithm;
2. Remove the Supplemental Maryland Primary Care Program adjustment; and
3. Increase the amount of revenue at risk by increasing the weight of the MPA quality adjustment.

In 2021, Staff completed a major policy review of the MPA. As a result of the review, the Commission revised the attribution algorithm and the methodology for calculating the rewards / penalties under the MPA. During the review, stakeholders emphasized that the MPA policy had changed numerous times and stressed the need for consistency in the future. Correspondingly, Staff recommend keeping the majority of the MPA unchanged. However, Staff are recommending the minor changes described above to keep the MPA aligned with other State and federal policymaking. The following discussion provides rationale and detail on each of these recommendations.

# Policy Overview

| Policy Objective | Policy Solution | Effect on Hospitals | Effect on Payers/Consumers | Effect on Health Equity |
|---|---|---|---|---|
| The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1) Attribute 95 percent of all Maryland Medicare beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed | This MPA recommendation fulfills the requirements to determine an MPA policy for CY 2023 and makes incremental improvements to the current policy. | The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care. Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by CMS and not on the amount charged by the hospital. In other words, this policy does not change the GBR or any other | This policy does not affect the rates paid by payers. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area. | This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care. |

| | | | | |
|---|---|---|---|---|
| TCOC and the benchmark. | | rate-setting policy that the HSCRC employs and – uniquely – is applied only on a Medicare basis. | | |

# Overview of the MPA Policy

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area. In recognition of the large risk borne by the hospitals collectively through the GBR, the MPA has a relatively low amount of revenue at risk (1 percent of Medicare fee-for-service revenue).

The MPA includes two "components": a Traditional Component, which holds hospitals accountable for the Medicare total cost of care (TCOC) of an attributed patient population, and an Efficiency Component, which rewards hospitals for the care redesign interventions. These two components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount to the amount that Medicare pays on each claim submitted by the hospital.

## Traditional Component

Currently, the HSCRC assigns patients to hospitals based on their geographic residence. In CY22, the Commission assigned patients to hospitals based on the hospital's Primary Service Areas (PSAs) as designated in the original hospital GBR agreements. However, based on industry feedback, Staff proposed to move towards a geographic algorithmic PSA Definition. For CY 2023, Staff recommends using the revised geographic attribution algorithm going forward, as described below.

1. Hospitals are attributed the costs and beneficiaries in zip codes that comprise 60% of their volume. Beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share of equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMADs are calculated from Medicare FFS claims for Calendar Year 2019. ECMADs are also used in calculating the volumes in the 60% test.

2. Zip codes not assigned to any hospital under step 1 are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed a 30 minute drive-time from the hospital's PSA.

3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.

4. An alternative attribution approach for the AMCs will be used, consistent with that approved for CY2022, where beneficiaries with a CMI of greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as the hospital under the standard attribution. AMCs will also be assigned all zip codes for Baltimore City for their geographic attribution.[1]

The MPA then penalizes or rewards hospitals based on their attributed TCOC. Hospitals are rewarded if the TCOC growth of their attributed population is less than national growth. Beginning in 2021, the HSCRC scales the growth rate target for hospitals based on how expensive that hospital's service area is relative to other geographic areas elsewhere in the nation. This policy is intended to ensure that hospitals which are expensive relative to their peers bear the burden of meeting the Medicare savings targets, while hospitals that are already efficient relative to their peers bear proportionally less of the burden. This approach and calculation are the same as was used in CY2022. The TCOC growth rate adjustments are shown in Table 1 below.

*Table 1: Scaled Growth Rate Adjustment*

| Hospital Performance vs. Benchmark | TCOC Growth Rate Adjustment |
|---|---|
| 1st Quintile (-15% to + 1% Relative to Benchmark) | 0.00% |
| 2nd Quintile (+1% to +10% Relative to Benchmark) | -0.25% |
| 3rd Quintile (+10% to +15% Relative to Benchmark) | -0.50% |
| 4th Quintile (+15% to +21% Relative to Benchmark) | -0.75% |
| 5th Quintile (+21% to +28% Relative to Benchmark) | -1.00% |

Historically, hospitals were required to beat the national TCOC growth rate each year. But in 2021, the HSCRC changed the way that the TCOC is calculated for hospitals. The HSCRC will trend the hospital's baseline TCOC forward based on the national growth rate and the TCOC adjustment factors. This was intended to create more predictability for hospitals. A hospital can now predict what their target will be two or three years out. An example of the methodology to calculate the TCOC targets is shown in Table 2 below.

[1] Additionally, Staff recommend dropping the University of Maryland Rehabilitation and Orthopedic Institute (UMROI) from the MPA. Traditionally, UMROI has been grouped with the University of Maryland Medical Center or given a special attribution. Staff do not believe that either of these approaches work well, given the unique patient mix seen by UMROI.

*Table 2: Calculation of the MPA Targets*

| Variable | Source |
|---|---|
| A = 2019 TCOC | Calculation from attributed beneficiaries |
| B = 2020 National TCOC Growth | Input from national data |
| C = 2021 National TCOC Growth | Input from national data (assumed to be 3% in example below) |
| D = Growth Rate Adjustment Factor | From Growth Rate Table (applies to 2021 and all subsequent years) |
| E = MPA TCOC Target | A x (1 + B) x (1 + C - D) |

**Example Calculation of MPA Targets**

| Hospital | Quintile | Target Growth Rate | 2019 TCOC | 2020 MPA Target | 2021 MPA Target |
|---|---|---|---|---|---|
| **Hospital A** | 1 | 3% - 0.00% = 3.00% | $11,650 | $12,000 | $12,359 |
| **Hospital B** | 2 | 3% - 0.25% = 2.75% | $11,193 | $11,529 | $11,846 |
| **Hospital C** | 3 | 3% - 0.50% = 2.50% | $11,169 | $11,504 | $11,792 |
| **Hospital D** | 4 | 3% - 0.75% = 2.25% | $11,204 | $11,540 | $11,800 |
| **Hospital E** | 5 | 3% - 1.00% = 2.00% | $10,750 | $11,073 | $11,294 |

The hospital is rewarded or penalized based on how their actual TCOC compares with their TCOC target. The rewards and penalties will be scaled such that the maximum reward or penalty is 1% which will be achieved at a 3% performance level. Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage. The amount of revenue at risk under the MPA policy is capped at 1% of the hospital's Medicare fee-for-service revenue. An example of the hospital's rewards/penalties is shown in the table below.

*Table 3: Example of MPA Reward & Penalty Calculations (excluding quality adjustments)*

| Variable | Input |
|---|---|
| E = MPA Target | See previous section |
| F = 2021 MPA Performance | Calculation |
| G = Percent Difference from Target | (E - F) / E |
| H = MPA Reward or Penalty | (G / 3%) x 1% |
| I = Revenue at Risk Cap | Greater / lesser of H and + / - 1% |

| Example MPA Performance Calculations | | | | |
|---|---|---|---|---|
| **Hospital** | **MPA Target** | **MPA Performance** | **% Difference** | **Reward (Penalty)** |
| **Hospital A** | $12,359 | $12,235 | -1.00% | 0.30% |
| **Hospital B** | $11,846 | $11,941 | 0.80% | -0.30% |
| **Hospital C** | $11,792 | $11,556 | -2.00% | 0.70% |
| **Hospital D** | $11,800 | $12,154 | 3.00% | -1.00% |
| **Hospital E** | $11,294 | $11,859 | 5.00% | -1.00% |

In addition, the agreement with CMS requires that a quality adjustment be applied that reflects hospital quality outcomes. Revisions to the quality adjustment for CY 2023 are outlined below.

### Efficiency Component

The MPA includes additional rewards and penalties for hospitals that reduce the TCOC through care redesign programs, including the Episode Care Improvement Program (ECIP), the Care Transformation Initiatives (CTI), and the Maryland Primary Care Program (MDPCP). The HSCRC increases the MPA reward or penalty based on the success of these programs. The HSCRC developed the Efficiency Component because the Traditional MPA was not targeted well enough to reward a hospital for a specific target population. A hospital would only be rewarded for a successful care redesign effort under the Traditional Component of the MPA, if every beneficiary included in the effort was attributed to the hospital and if the impact of the program was not washed out by the impact on other beneficiaries who were also attributed to the hospital. Historically, the Traditional MPA has not been well aligned with individual hospital care redesign efforts which necessitated the development of the Efficiency Component.

# Public Comments

Staff received public comments on the draft CY 2023 MPA proposal from the Maryland Hospital Association (MHA), MedStar Health, Luminis Health, and TidalHealth. The Maryland Hospital Association, MedStar Health, and Luminis Health were supportive of removing the MDPCP Supplemental Adjustment and generally supportive of using the geographic attribution in the MPA for CY 23, although all three indicated that geographic attribution was not a perfect attribution algorithm and suggested that staff and the industry continue to investigate potential improvements in the attribution algorithm. Staff agree that geographic attribution is not perfect; however, Staff believe that the attribution algorithm is the best of the algorithms investigated by the TCOC Workgroup. Namely, the geographic attribution has three major advantages: it is

simple, it is predictable, and it is consistent. Staff will continue to investigate alternative attribution algorithms but expect to maintain the geographic attribution for the foreseeable future.

MHA, MedStar Health, Luminis Health, each indicated support for deferring the inclusion of the population health measures for future years and have suggested alternatives to the proposed ED Diabetes Screening Measure. Staff note that CMMI have approved the MPA without the inclusion of the population health measure in CY 23 but have expressed their expectation that the State include these measures in CY 24. Staff anticipate using the remainder of CY 23 to finalize the population health measures prior to CY 24.

TidalHealth expressed a concern regarding the TCOC benchmarking methodology that is used in the MPA and other HSCRC policies. First, TidalHealth believes that the TCOC benchmarks are flawed because they do not incorporate the CMS hospital wage index that is used to set IPPS rates nationally; second, TidalHealth believes that the benchmarks are flawed because they do not incorporate an adjustment for health outcomes. Staff do not agree with either objection. Regarding the first concern, the CMS hospital wage index is widely acknowledged to be inaccurate for Maryland hospitals.[2] Matching inaccurate Maryland numbers to accurate national numbers would produce inaccurate results. Instead, Staff used median income to measure a hospital's labor costs, which addresses the concern raised by TidalHealth without the data integrity issues of the CMS hospital wage index. Staff also tested other measures of wage costs and did not find a material difference[3]. Regarding the second concern, the benchmarks were designed to measure the relative level of costs in Maryland and demographically similar regions in the rest of the country. The benchmarks were not designed to determine the level of spending necessary to achieve a certain level of health outcomes. While the latter question is academically interesting and may be pertinent to other HSCRC policy goals, the State is required to meet the savings target in the Maryland Total Cost of Care Model Agreement, which is accomplished in part through the MPA. The MPA uses the benchmarks to determine which Maryland hospitals have relatively high per capita spending and thus most need to reduce costs in order to meet the statewide savings target in a manner proportional to their opportunity. The implementation of the differential targets is gradual and limited by the 1% revenue at risk and therefore does not result in a substantially greater hardship for hospitals with high per capita TCOC.. The HSCRC has other policies (PAU, MHAC, RRIP) that financially support hospitals which improve quality.

[2] See for instance: Committee on Geographic Adjustment Factors in Medicare Payment, Board on Health Care Services, Institute of Medicine. Geographic Adjustment in Medicare Payment: Phase I: Improving Accuracy. Second edition. Edited by M. Edmunds and F.A. Sloan. Washington, DC: National Academies Press, 2011. Available at https://www.ncbi.nlm.nih.gov/books/NBK190074/.
And see the discussion in the Congressional Research Service. "Medicare Hospital Payments: Adjusting for Variation in Geographic Area Wages." March 3, 2021. Available at https://crsreports.congress.gov/product/pdf/R/R46702.

[3] See Staff memo on additional testing of benchmarks at:
https://hscrc.maryland.gov/Documents/Memo%20on%20Additional%20Benchmarking%20Considerations-2-4-22%20FINAL.pdf

# MPA Final Recommendations

Staff recommends three changes to the MPA for CY2023: 1) formalize the revision of the geographic attribution algorithm as described above; 2) eliminate the Supplemental MDPCP Adjustment; and 3) increase the weight placed on quality measures. Once those changes are made, Staff recommends maintaining the MPA for CY2023 and CY2024, in order to create as much stability for hospitals as possible.

### *Revised Attribution*

In CY22, the Commission moved to a geographic attribution algorithm to assign beneficiaries to hospitals under the MPA (in addition to a separate attribution tier for the state's two Academic Medical Centers). Geographic attribution was based on hospital primary service areas (PSAs) listed in hospitals' Global Budget Revenue (GBR) agreements. During a review of the MPA Policy in CY21, Staff and the industry concluded that the PSAs in the GBR had become dated and the industry suggested adopting a more algorithmic approach. The CY 2022 Recommendation directed the Staff to develop a standardized approach to assigning zip codes to hospitals. Staff recommend that hospitals should be assigned the zip codes that constitute 60% of the hospital's volumes, as determined by ranking each zip code from largest volume to least and assigning the zip codes to the hospitals until 60% of the hospital's volume has been attributed. Further specifics of the approach are described above.

### *Supplemental MDPCP Accountability*

In 2021, the Commission directed Staff to increase the accountability for managing the TCOC in the MDPCP since the MDPCP program itself did not include direct TCOC risk. Therefore, HSCRC added a supplemental MPA adjustment for hospitals that are affiliated with practices that are participating in MDPCP. The MCPCP supplemental adjustment rewards / penalizes hospitals for the relative success of their MDPCP programs. However, in CY 2022, CMS announced a Track 3 of MDPCP for CY 2023 that includes direct TCOC risk. Therefore, the Supplemental MDPCP Adjustment is redundant. Staff recommend eliminating the MDPCP Supplemental Adjustment.

### *Increased Quality Adjustment*

In its approval of the CY 2022 MPA, CMMI indicated that they would like to see an increase to the revenue at risk in the MPA and a greater focus on population health. Currently, the MPA quality adjustment is equal to the sum of the hospitals Readmission Reductions Incentive Program (RRIP) and Maryland Hospital Acquired Conditions (MHAC) program. The percentage for the two quality programs is summed and multiplied by the amount that the hospital is above or below the MPA target. That is, the MPA adjustment is equal to the TCOC result x 1/3[4] x (1+ RRIP + MHAC Reward/Penalty). Since the RRIP and the MHAC

[4] The TCOC results is the % by which the hospital exceeds or falls short of target to a maximum of 3%. The fraction of 1/3rd is applied to translate the result into a maximum penalty of ±1%.

programs have a maximum revenue at risk of 2%, at this point the maximum adjustment is ±1.04%. Finally, the MPA is capped at 1% reducing the final maximum to ±1.00%. Since the cap occurs after the application of the quality adjustment, a hospital already at the limits of the financial adjustment may have no additional impact from their quality adjustment.

In order to meet CMMI's request to increase the revenue at risk, Staff recommend applying the 1% revenue at risk cap earlier in the calculation and doubling the weight of the quality adjustment. Therefore, the calculation would be TCOC results x 1/3 (capped at 1% of Medicare revenue) x (1 + 2 x (RRIP + MHAC Reward/Penalty)). This will modestly increase the maximum adjustment to ±108%, or ±1.08% of the hospital's Medicare revenue as opposed to 1.00% under the current approach.

Finally, Staff recommend including a population health quality measure in the MPA, once approved by CMS and the Commission. Staff have been working on an all-payer measure for diabetes screening with the Performance Measurement Workgroup for monitoring purposes in CY 2023. Staff have proposed measuring the rates of diabetes screening but deferring any adjustment on payment rates until the following year. Staff are also considering potential alternative monitoring measures. In CY 2024, once that measure, or an alternative population quality health measure, is fully developed and incorporated into our quality programs, Staff recommends including that measure into the MPA Quality Adjustment with a weight of 4%. The MPA adjustment would be TCOC results x 1/3 (capped at 1% of Medicare revenue) x (1 + 2 x (RRIP + MHAC Reward/Penalty + population health quality measure)). This will increase the maximum adjustment to 1.16% of the hospital's Medicare revenue and reflect the dual desire to increase revenue at risk and incorporate additional SIHIS-related population health quality measures into Maryland's hospital quality program.

Maryland
Hospital Association

December 21, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on the Commission's proposed Medicare Performance Adjustment (MPA) policy for 2023. MHA generally supports the draft recommendation. Below is our feedback on each component.

**Attribution**

MHA supports using a formula to assign beneficiaries to hospitals under the geographic attribution. However, we remain concerned that strict geographic attribution does not capture hospital initiatives to transform care delivery. MHA is disappointed the Centers for Medicare & Medicaid Services (CMS) only approved the Care Transformation Initiative (CTI) buyout for calendar year (CY) 2021. The buyout mitigates removing the physician-based methodology. Due to claims run-out, the financial impact of CTIs is still largely unknown. MHA encourages HSCRC to share CTI data as soon as practicable to understand revenue adjustments and possible overlapping incentives.

HSCRC plans to use a different attribution methodology for academic medical centers since the geographic approach does not reflect tertiary care service use patterns. HSCRC should share impact modeling prior to the final recommendation.

**Removing MDPCP Supplemental Adjustment**

MHA supports removing the Maryland Primary Care Program (MDPCP) supplemental adjustment. MDPCP Track 3 features downside risk for both physician practices and hospital Care Transformation Organizations beginning in CY 2023. The MDPCP supplemental adjustment in MPA would duplicate this provision.

**Population Health Adjustment**

MHA applauds HSCRC staff and CMS for not implementing a CY 2023 population health measure because a workable measure is not final. The population health measure should be

removed from the 2023 final MPA recommendation and revisited when the measure and details are proposed.

In our November letter, MHA expressed serious concerns with HSCRC's proposal to screen hospital emergency department (ED) patients for diabetes. While additional screening is valuable to identify previously undiagnosed diabetes, there is significant potential for added cost of care without the added benefit of getting individuals into a regular system of care to manage diabetes. Hospital ED clinicians are already overburdened, and their urgent work would be disrupted if they were required to add this procedure.

Instead, MHA urges HSCRC to adopt **hemoglobin A1C control in hospitals' affiliated practices** as the population health performance measure in HSCRC payment policy. Screening is much better suited to ambulatory care settings.

We appreciate your time and attention to this important matter. Should you have any questions please contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
James N. Elliott, M.D.
Maulik Joshi, Dr.P.H.
Willem Daniel, Deputy Director, Payment Reform and Stakeholder Alignment

MedStar Health

10980 Grantchester Way
Columbia, MD 21044
410-772-6500 PHONE
410-715-3754 FAX
MedStarHealth.org

**December 22, 2022**

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich:

On behalf of the MedStar Maryland hospitals, we appreciate the opportunity to provide comments on the HSCRC's proposed Medicare Performance Adjustment (MPA) Policy for calendar year 2023.

**Attribution Adjustment**
MedStar Health commends the HSCRC's recognition that the primary service areas defined in hospital global budget agreements are an outdated methodology for attribution. While MedStar Health supports a change to the currently outdated attribution methodology, we remain concerned about the pitfalls of a strictly geographic-based attribution, particularly in metropolitan areas where there are overlaps. We believe the Commission and the industry at-large should continue its efforts in pursuit of more refined attribution methodologies that appropriately align hospital resources with the communities they serve.

**Removing the MDPCP Supplement Adjustment**
MedStar Health concurs with the Maryland Hospital Association's position in support of removing the Maryland Primary Care Program (MDPCP) supplemental adjustment.

**Population Health Adjustment and ED Diabetes Screening**
MedStar Health supports deferring the inclusion of a population health measure into the MPA policy beyond CY2023. Any proposal to include population health measures should first be studied within appropriate HSCRC workgroups prior to inclusion in any draft or final policy recommendation. MedStar Health recognizes and appreciates the importance of population health and believes future policy recommendations deserve careful time and attention.

In a letter to Mr. Allan Pack, dated December 2, 2022, MedStar Health joined with Johns Hopkins Health System and University of Maryland Medical System to express concerns with the proposed ED Diabetes Screening Program, which we believe would cause delays in patient care, as well as add costs and erode patient trust in our healthcare system. As discussed in this letter, MedStar Health supports the alternate approach of offering testing for **hemoglobin A1C levels** on patients being admitted to the hospital. Further information on the collective position of MedStar Health, Johns Hopkins Health System and University of Maryland Medical System on the topic of diabetes screening is contained within the aforementioned letter dated December 2, 2022.

Thank you for the opportunity to provide comments.

Sincerely,

Susan K. Nelson
Executive Vice President and Chief Financial Officer
MedStar Health, Inc.

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
James N. Elliott, M.D.
Maulik Joshi, DrPH
Sam Malhotra

TidalHealth™

Executive

100 E. Carroll St.
Salisbury, MD 21801

O 410-543-7111
F 410-543-7102

December 27, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich:

TidalHealth Peninsula Regional appreciates the opportunity to provide comments on the Medicare Performance Adjustment draft recommendation. This draft recommendation proposes relatively minor modifications to the geographic attribution methodology along the elimination of the MDPCP adjustment and with minimal changes to the revenue at risk in response to Innovation Center requirements. These changes are minimal and appear to offer little disruption to the current structure of the MPA methodology.

Our specific concern with this draft MPA proposal is with an issue that was not addressed by the draft recommendation. Our concern is the role that continues to be played by the Total Cost of Care (TCOC) benchmarks in in the MPA methodology. As we have noted in a variety of forums, the Medicare TCOC benchmarks have serious shortcomings. From a strategic standpoint, these benchmarks fail to establish equitable outcomes for the state's rural communities by imposing upon Maryland financial standards that reflects the poor financial performance of rural hospitals nationally. From a technical standpoint, the benchmarks fail to account for the type of adjustments routinely made in the Commission's usual methodologies in establishing financial standards, such as a direct wage adjustment. Furthermore, the benchmarks ignore the consistently poor health outcomes in the counties used to construct these standards. The HSCRC scales the growth rate target for hospitals based on how expensive that hospital's service area is relative to other geographic areas elsewhere in the nation. For hospitals which are expensive relative to their peers as established by this methodology, they bear the burden of meeting the Medicare savings targets, while hospitals that are already efficient relative to peers under this methodology bear proportionally less of the burden. To the degree that these benchmarks are erroneous, however, their use misallocates resources within the state in contradiction to the goals of the TCOC Model.

These issues require attention as the benchmarks continue to be used in other Commission methodologies as well. We believe it is urgent to address this issue, given the multiple methodologies in which the benchmarks have been used. We appreciate the opportunity to provide these comments, and we urge expedited consideration of this important issue. Please contact me if you have any questions.

Sincerely,

Steve Leonard, PhD, MBA, FACHE
President/CEO, TidalHealth

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

December 28, 2022

Adam Kane, Esq., Chairman
Katie Wunderlich, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Kane and Ms. Wunderlich,

On behalf of Luminis Health, the purpose of this letter is to provide commentary in response to the Draft CY2023 Medicare Performance Adjustor (MPA) Policy presented at the December 14, 2022, Commission meeting.

Luminis Health supports refining the geographic attribution with a formulaic approach; however, we still have concerns with a strict geographic attribution. A strict attribution methodology does not accurately capture hospital-specific initiatives to improve population health. The CTI buyout mitigated the shift to a geographic attribution from a physician-based methodology; however, CMS only approved the buyout for CY2021. Luminis requests that the HSCRC share CTI results with the industry as soon as it is available and evaluate any overlap with other Commission policies.

Luminis supports eliminating the Maryland Primary Care Program (MDPCP) supplemental adjustment. Including the downside risk in MDPCP Track 3 beginning in CY2023 addresses any unfavorable performance by participating practices; therefore, the continuation of the MDCPC supplemental adjustment would be duplicative.

The draft staff recommendation includes a provision incorporating population health quality measures into the CY2023 MPA policy, pending approval by CMS and the Commission. Luminis requests that population health quality measures be removed and that the CY2023 MPA policy be revisited once the population health quality measures are approved. This will ensure that the policy can be evaluated based on final measures.

Thank you for the opportunity to provide commentary on the draft CY2023 MPA policy. If you have any questions, please do not hesitate to contact me.

Sincerely,

Kevin Smith
Chief Financial Officer
Luminis Health

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850


CENTER FOR MEDICARE AND MEDICAID INNOVATION

January 18, 2023

Katie Wunderlich
Executive Director, HSCRC
4160 Patterson Avenue
Baltimore, Maryland 21215

**RE: Medicare Performance Adjustment Proposal for PY2023**

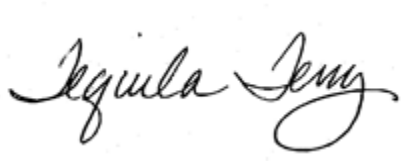
The purpose of this letter is to inform the Health Services Cost Review Commission (HSCRC) and the State of Maryland that the HSCRC's Medicare Performance Adjustment (MPA) Proposal for Performance Year (PY) 2023 submitted to the Centers for Medicare & Medicaid Services on December 19, 2022 has been approved. CMS finds the MPA Proposal satisfies all requirements in accordance with Section 8.c of the Maryland Total Cost of Care Model State Agreement and has provided additional feedback below.

In reference to the Savings Component section of the MPA Proposal, the State is requesting to implement a savings reduction of $64 million across all regulated hospitals for CY2023 using the MPA to make up for a portion of the anticipated CY 2022 Medicare savings shortfall, effective February 1, 2023. CMS has reviewed this request and approves the proposed savings reduction of $64 million; however, CMS does not have sufficient time to implement the updates effective February 1, 2023. As a result, CMS will implement the Savings Component MPA updates effective March 1, 2023. **CMS requests that the HSCRC provide an updated MPA adjustment file by February 1, 2023 to reflect the new effective date of March 1, 2023.**

Additionally, it is CMS's understanding, based on the supplemental materials included with the MPA proposal, that the State is requesting to eliminate the MDPCP Supplemental Adjustment. CMS approves this request as the MDPCP Supplemental Adjustment was expected to continue until MDPCP incorporated downside risk, which was accomplished with the implementation of Track 3 on January 1,2023.

As stated in the MPA PY 2022 CMS response letter issued October 10,2021, CMS expects the State to increase the revenue at risk (± 1%) under the traditional MPA in 2024. CMS appreciates HSCRC's continued effort to improve quality of care using the MPA as a tool to incentivize continued improvement, and approve the modest increases to maximum revenue at risk in PY 2023 to allow quality measures to have a greater impact. However, CMS believes that increased financial risk tied to quality measures is key to driving improvement, and we strongly encourage Maryland to consider further increasing the level of risk associated with quality programs in PY 2024. Additionally, we look forward to the inclusion of population health measures as a component of the MPA in PY 2024. CMS will heavily weigh a further increase of the maximum revenue at risk and the inclusion of population health measures when considering the MPA Proposal for 2024.

Sincerely,



Tequila Terry
Director, State Population Health Group
Center for Medicare and Medicaid Innovation

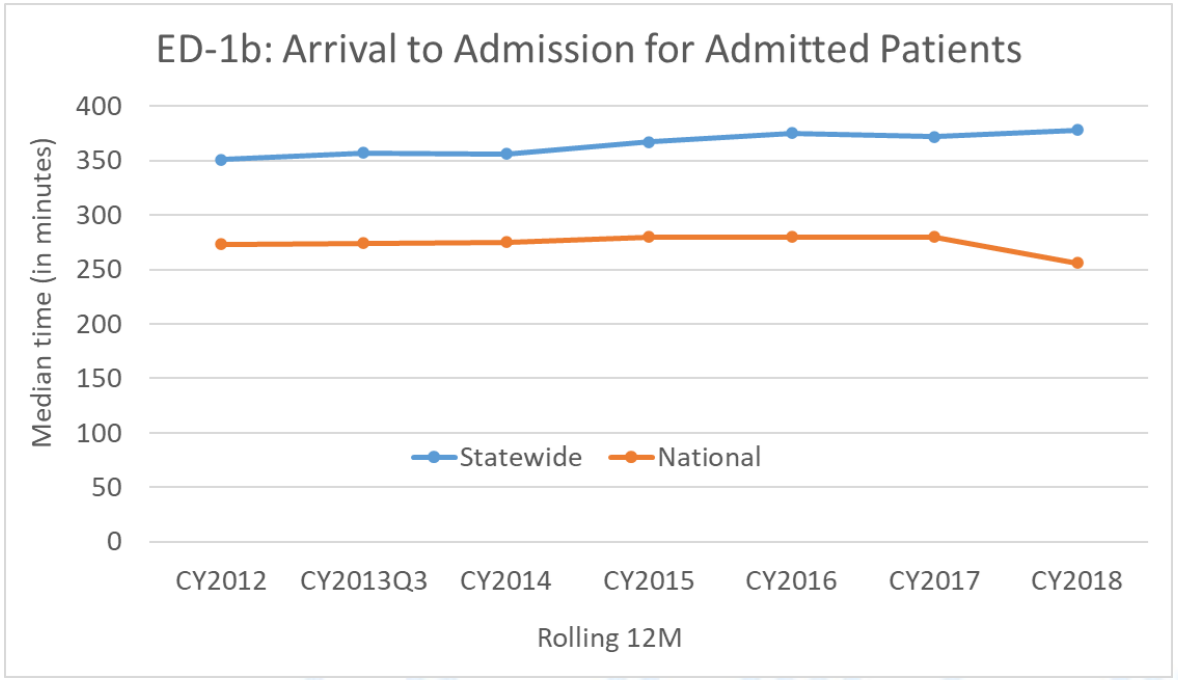
maryland
health services
cost review commission

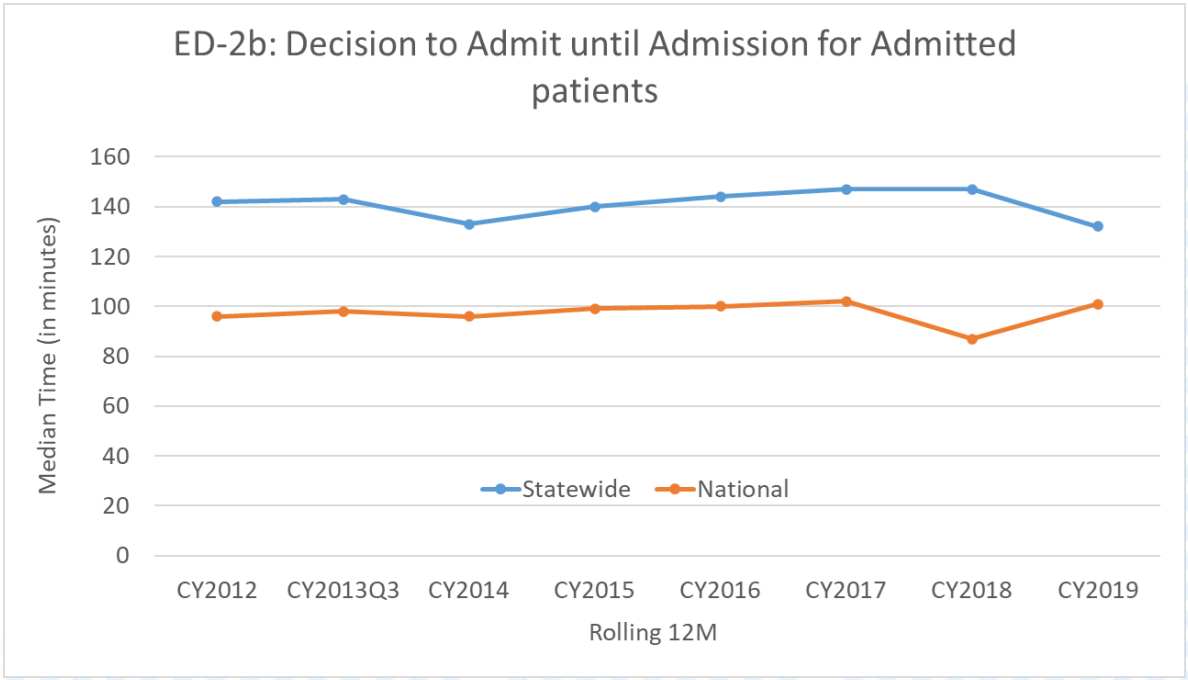
# Emergency Department Challenges and Strategies

## February Commission Meeting

# Inpatient Emergency Department Wait Times

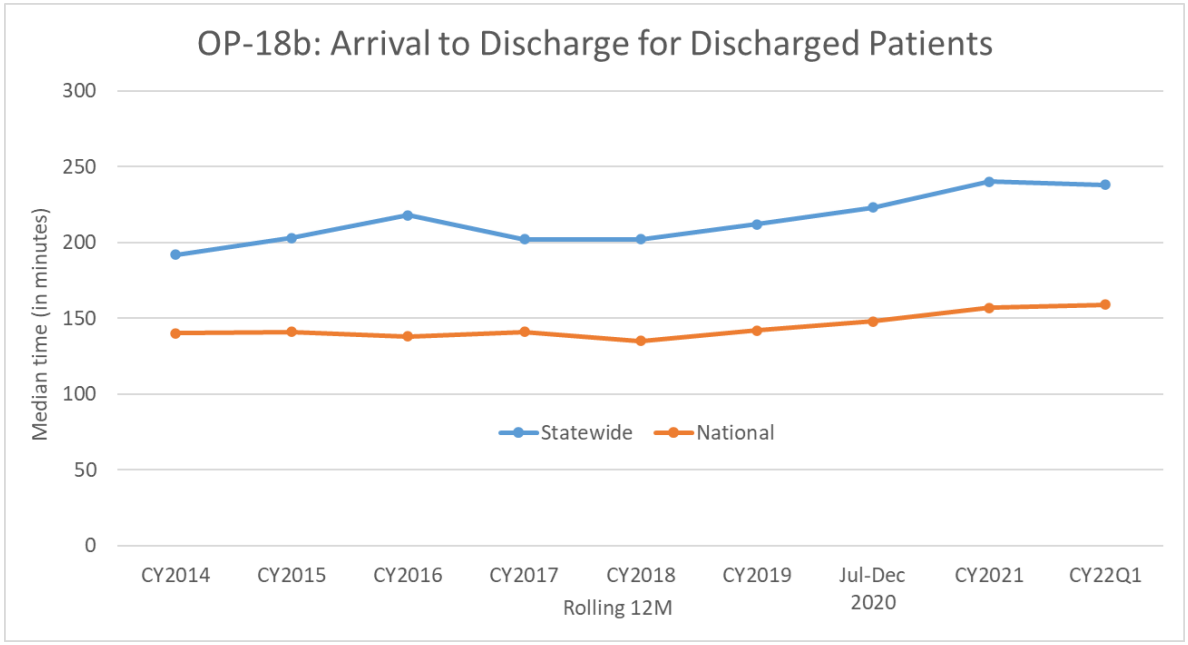
- ED wait times in Maryland have been consistently higher than the nation since before the start of the All-Payer model
  - Inpatient ED wait times added to QBR program in RY 2020 (CY 2018 performance)
  - ED-1b and ED-2b were discontinued in 2019 and 2020, respectively

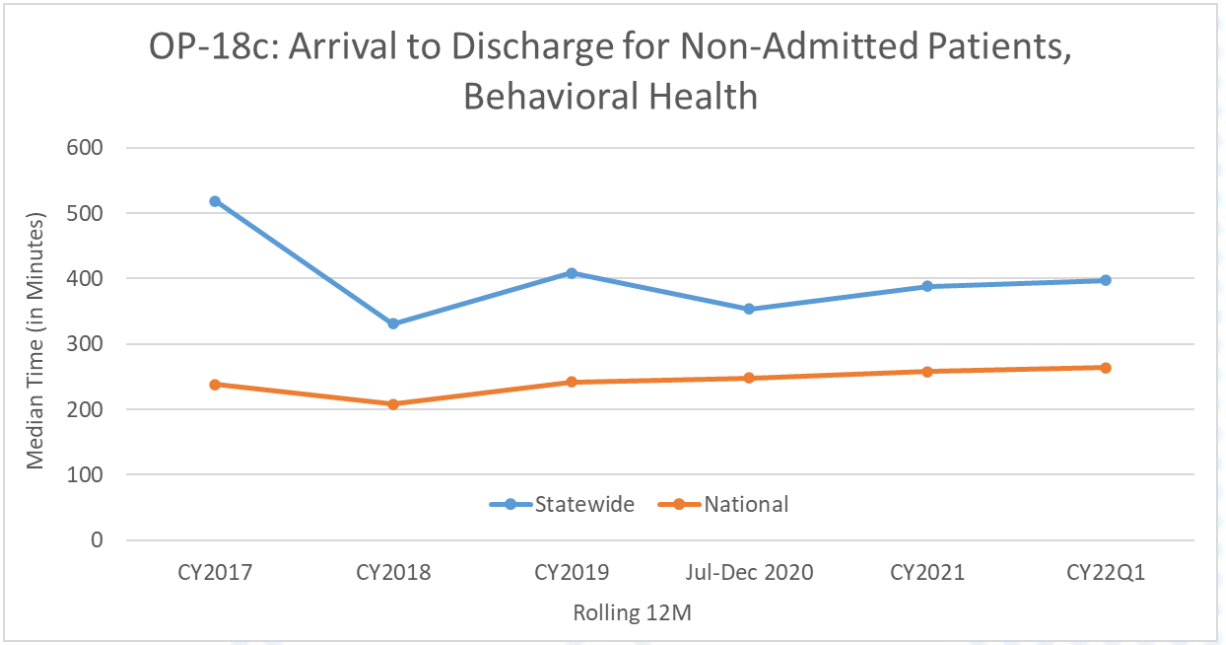


# Outpatient Emergency Department Wait Times

- Outpatient ED wait times in Maryland are also higher than the nation
  - Data prior to CY 2014 is not available
  - CMS continues to collect outpatient ED wait times; outpatient ED wait times are correlated with IP wait times

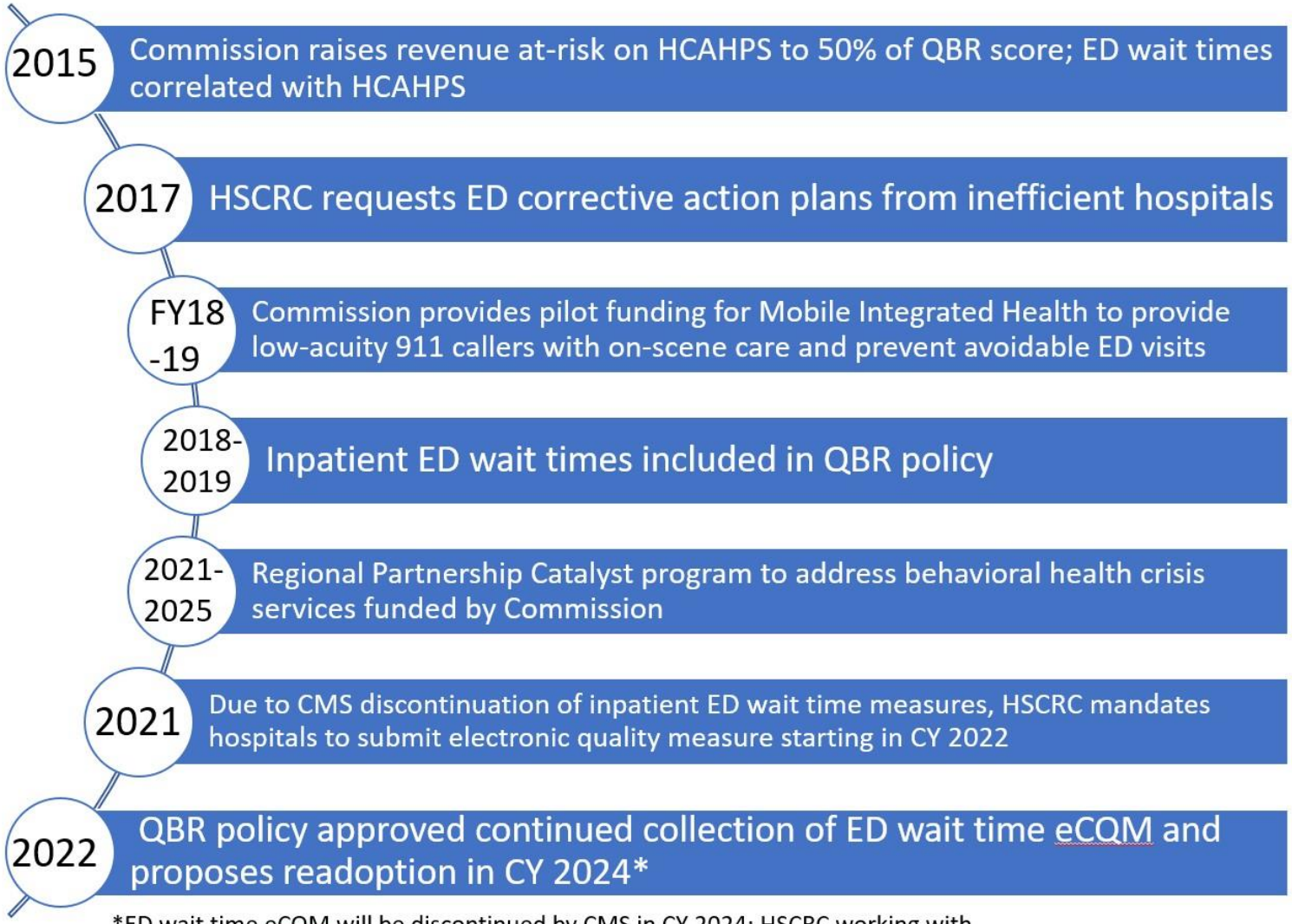


# Commission Actions that Address ED Wait Times

Despite multiple actions by the Commission, ED wait times continue to be worse than the nation.

Multipronged strategy to address ED wait times is needed, including initiatives to address ED overcrowding




*ED wait time eCQM will be discontinued by CMS in CY 2024; HSCRC working with vendor to require continued submissions

# Ongoing Strategic Policy Development

Multi-pronged approach must consider aspects of the delivery system

1. Increase access points outside of the hospitals for patients to manage care before the need for an ED visit (PCP, FQHC, Urgent Care Clinics, MIH, ED Diversion strategies)
    a. Example: MDPCP incentives for ED utilization reduction (i.e., PQI-like events)
2. Continue to invest in behavioral health crisis services and other access points to address critical behavioral health patient needs
3. Increase accountability for hospitals to improve throughput and reduce ED overcrowding and wait times
    a. QBR pay-for-performance programs
    b. Investigate EMS turnaround measurement and incentives
    c. Identification of high utilizers to prevent potentially avoidable/unnecessary ED utilization

# HSCRC Workgroup Activities and Next Steps

# Background

- In CY2021, Commissioners asked staff to evaluate expansion of PAU to emergency room utilization
- Staff analysis of 2.4M ED observations containing triage rating identified numerous patient chief complaints that are high volume and low acuity
  - Ear pain
  - Dental problems
- Initial policy recommendations focused on incentivizing reduced volume in those categories
- Stakeholders concerns
  - Unclear what the opportunity/intervention is for hospitals
  - Low-acuity categories may contain some patients who need emergent care

# Exploration of High Utilizers

- Stakeholders suggested focusing on frequent ED visitors
- Easier to intervene on patients with pre-existing relationship with a hospital
- Addresses low-acuity visits and those preventable with better primary care
- Several studies have focused on programs that reduce ED utilization by intervening on frequent visitors
- Interventions include case management, improving primary care access
- Case management may reduce ED use

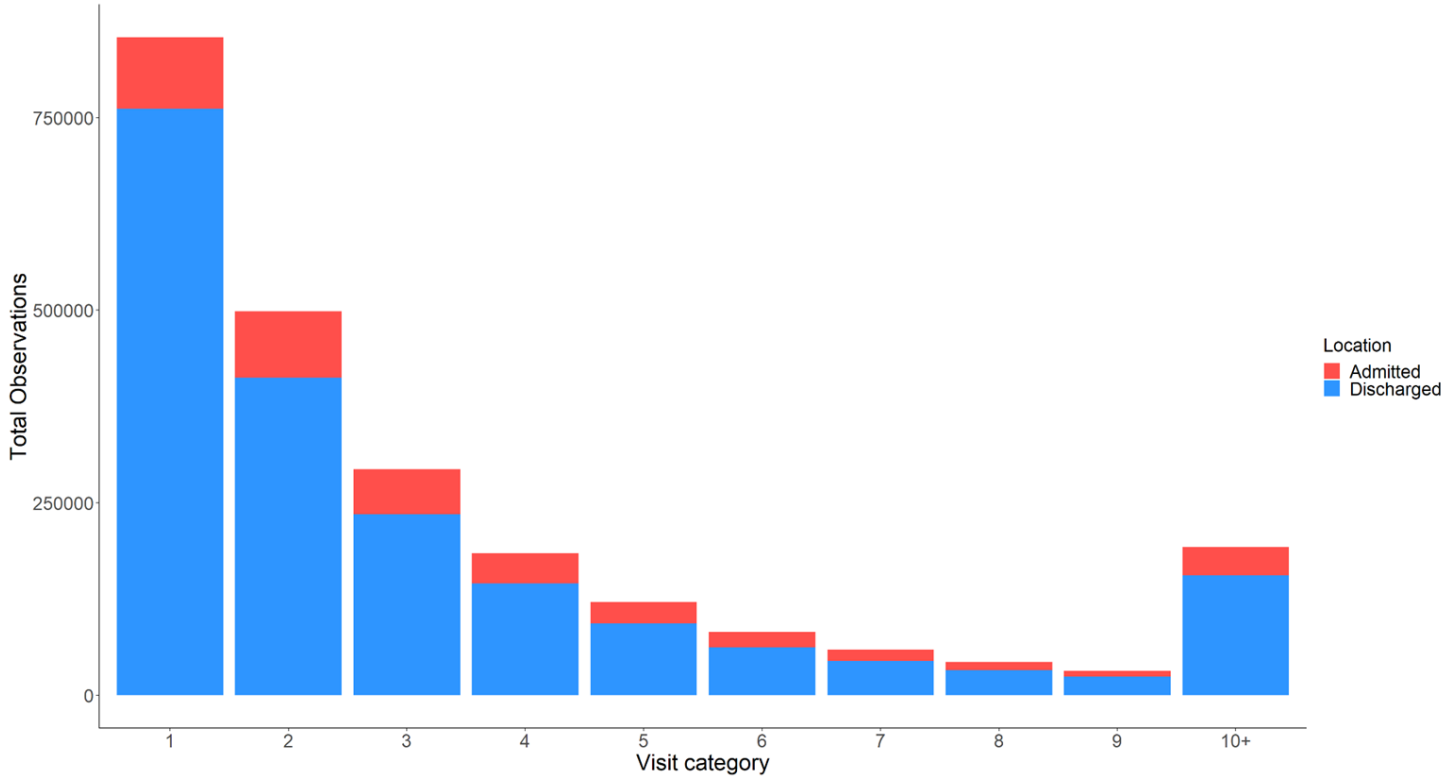

- Althaus et al. 2010. Effectiveness of interventions targeting frequent users of emergency departments: A systematic review. Annals of Emergency Medicine. Vol 58. pg 41-52
- Tsai et al. 2018. Reducing high-users visits to the emergency department by a primary care intervention for the uninsured:A retrospective study. Inquiry. Vol 55.
- Soril et al. 2015. Reducing frequent visits to the emergency department: A systematic review of interventions. PLoS One. 10(4)

# Assessing Opportunity Related to High Utilizers

Staff sought to understand volume and cost related to patients that frequented the Emergency Department, as well as overlap with PAU, payer and demographic patterns, and variability across hospitals

- Analyzed OP/IP across several years to understand frequent flier patterns
- Results are based primarily on CY 2019 OP casemix data. This year was chosen because COVID could skew the 20/21 data
- Staff categorized individuals with 4+ visits in a year as a “high utilizer”

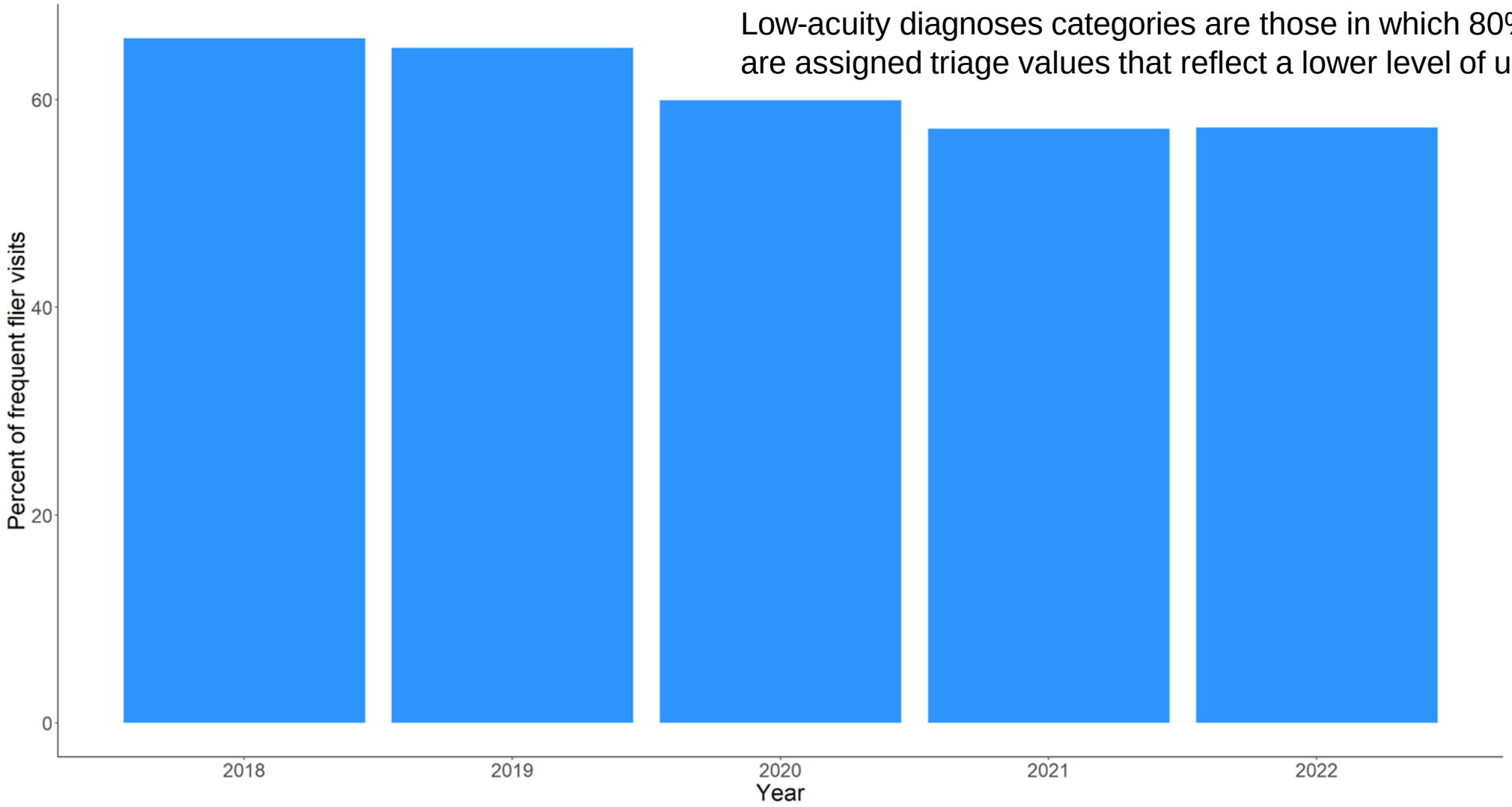
# Frequent fliers accounted for 30% of all ED visits in 2019



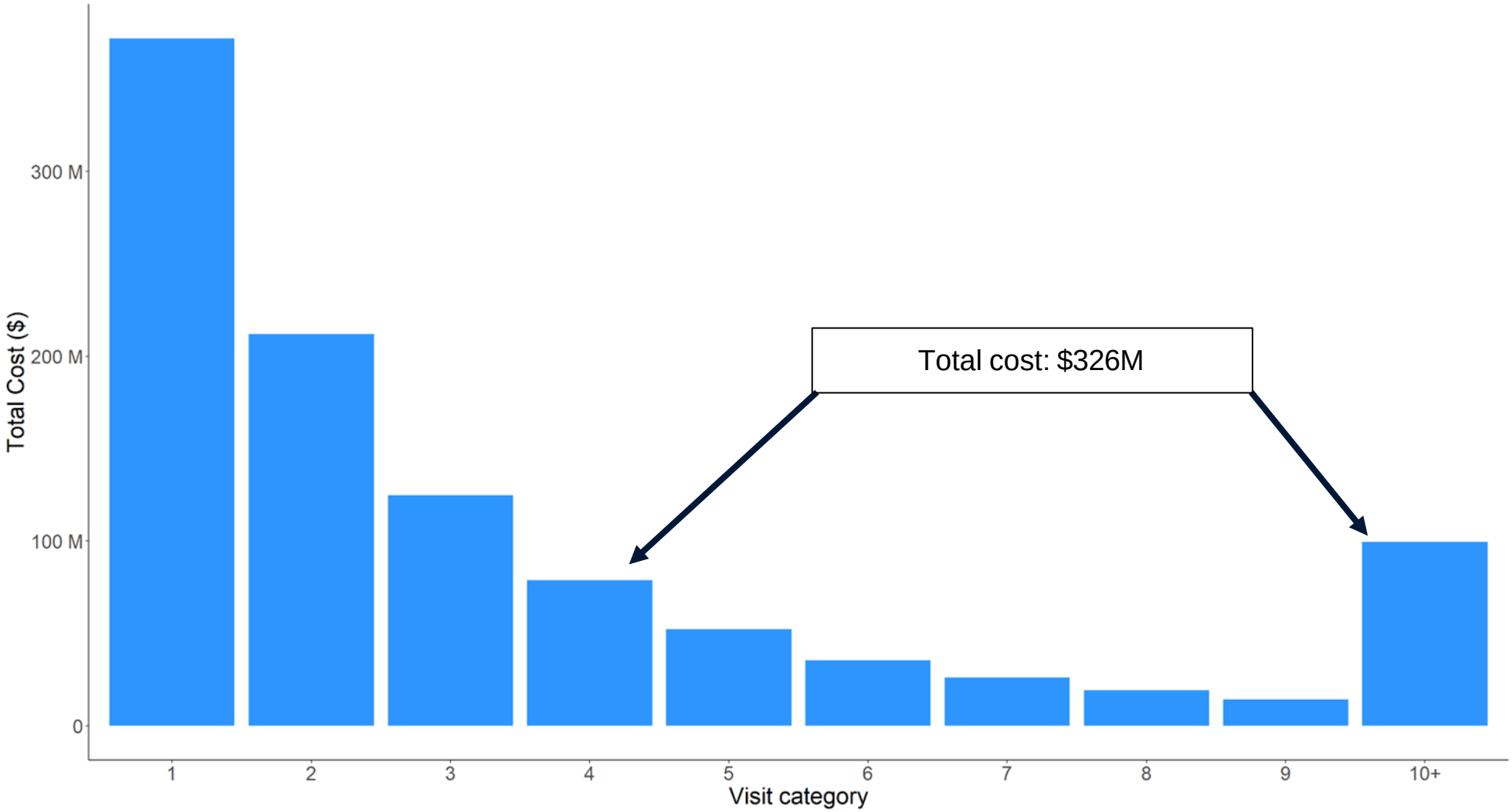

- Bulk of frequent flier visits are discharged from ED
- Indicates lower-acuity problems are common in frequent flier population
- Limited overlap with PAU

# Of outpatient visits by high utilizers, 62% are for low-acuity principal diagnoses

Low-acuity diagnoses categories are those in which 80% of visits are assigned triage values that reflect a lower level of urgency



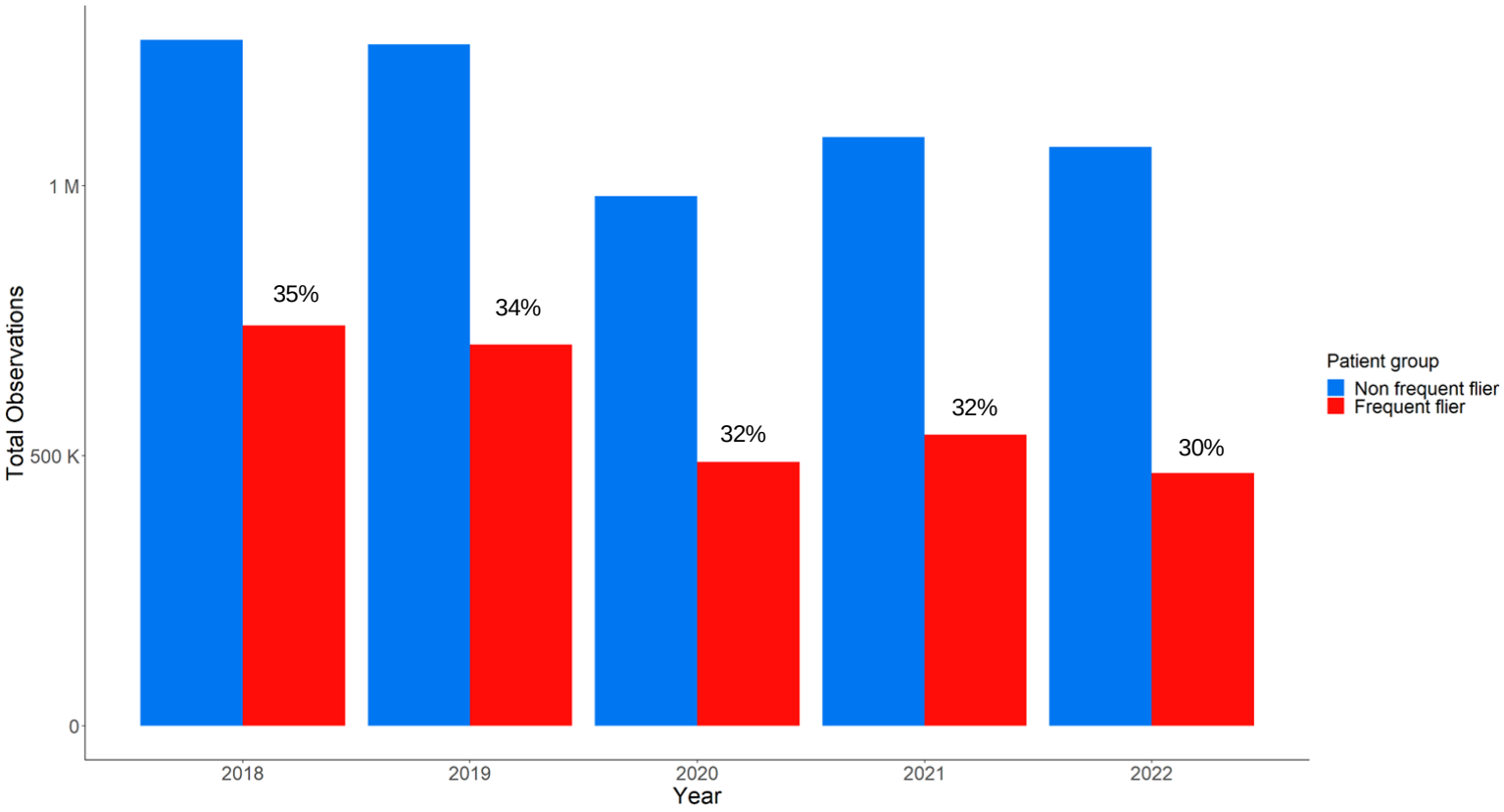
# High Utilizers accounted for 32% of discharged ED costs in 2019



# Characteristics of High Utilizers Visits in 2019

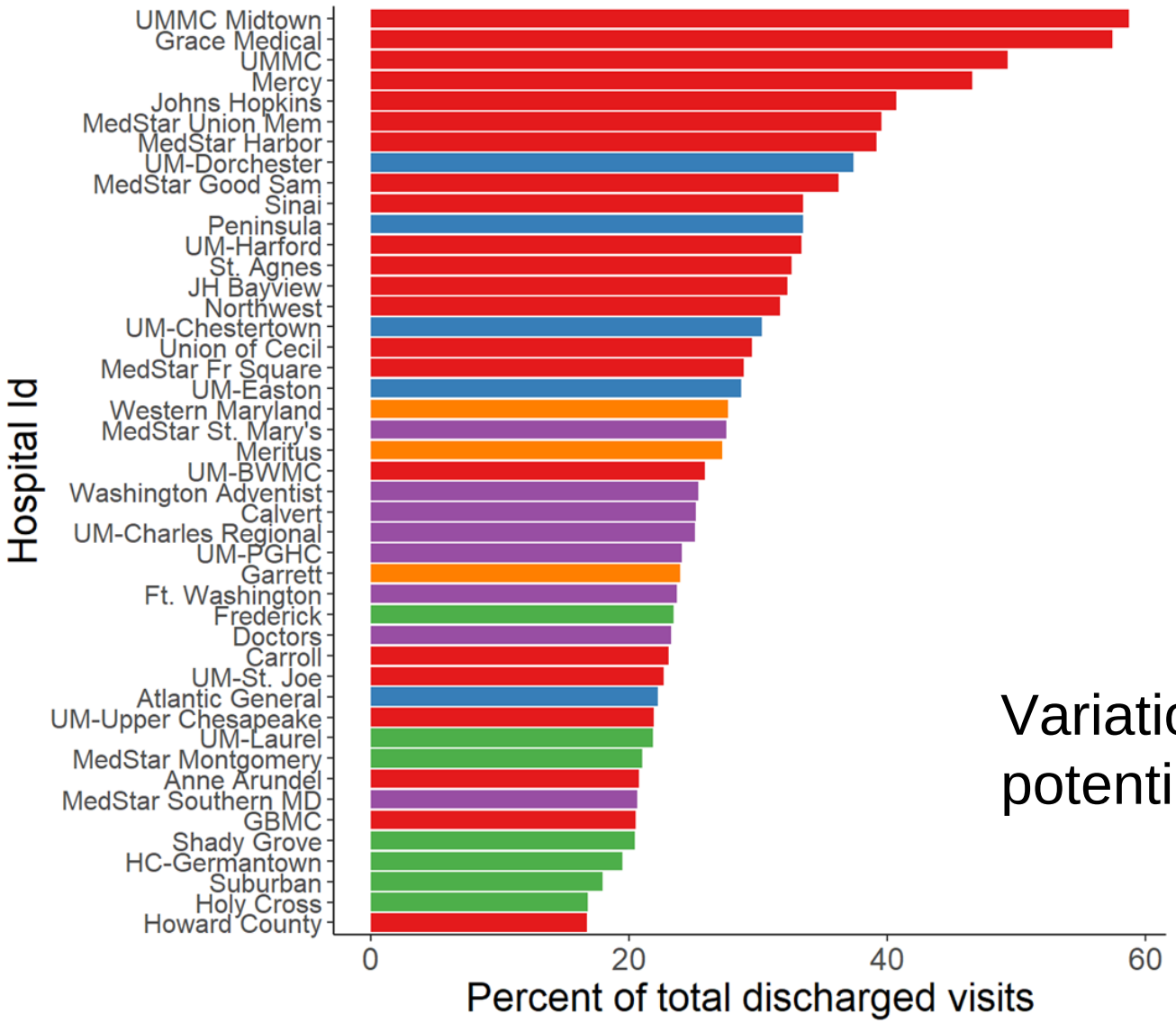
- 40% are covered by Medicaid
- 37% involve patients in the top quartile of Area Deprivation Index
- 41% involve Black patients
- 1% involve homeless patients
- 38% (of admitted visits) are also flagged as PQI’s

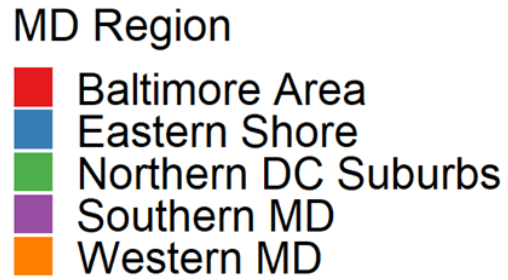
# High Utilizer volume fell during the pandemic




- We believe volume is high enough to create incentives around high utilizer volume

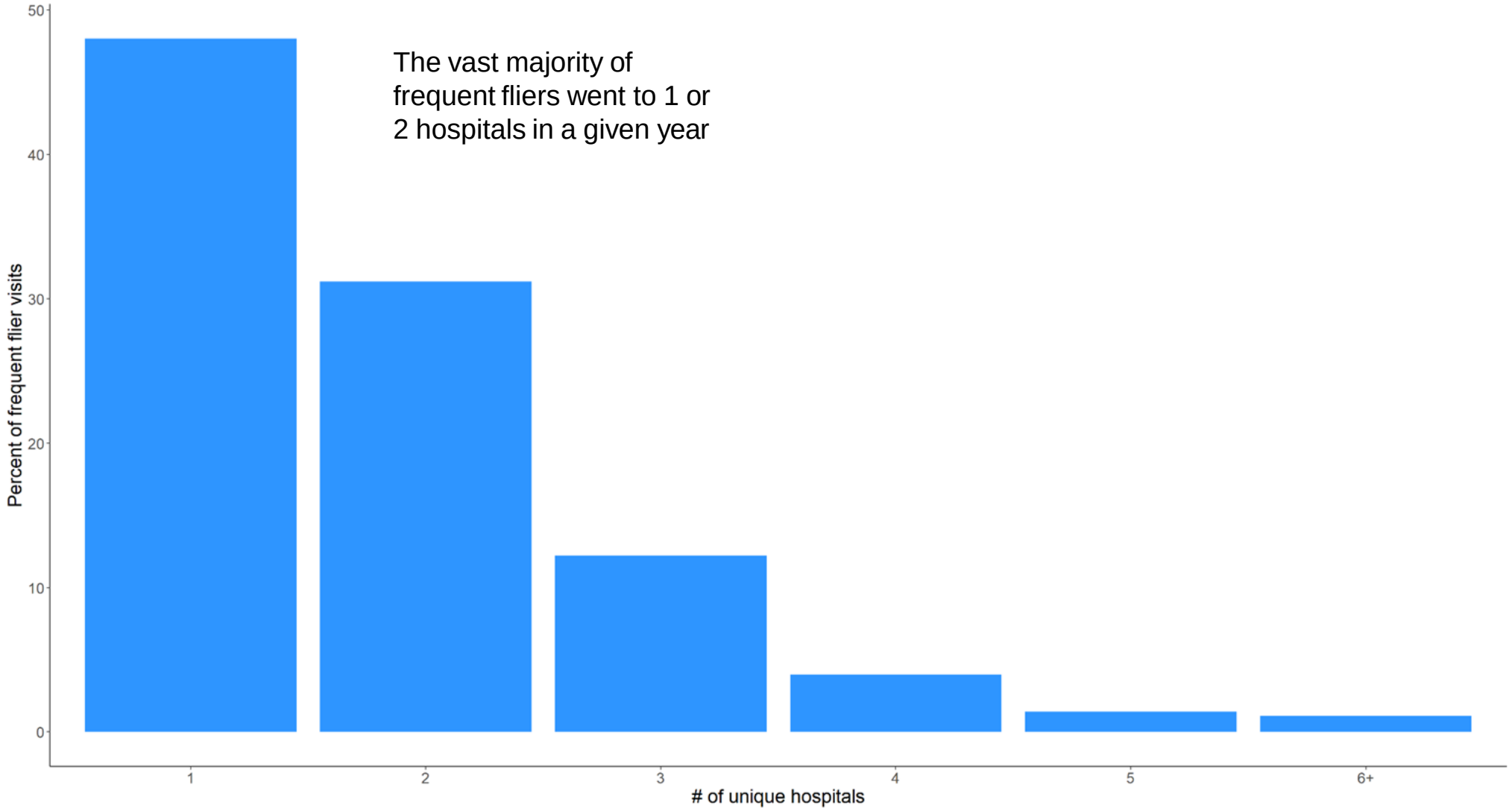
# Frequent flier visit percentage in 2019 by hospital




Variation across hospitals suggests potential for improvement

# Over 45% of high utilizers went to the same Emergency Room




The vast majority of frequent fliers went to 1 or 2 hospitals in a given year

# Next steps

1. Discuss with PMWG
2. Further explore measure definition based on Commission, stakeholder feedback
3. Assess the possibility of future monitoring

maryland
health services
cost review commission

# Utilization Opportunity Analysis

02/03/23

# IP Utilization Reductions over Time

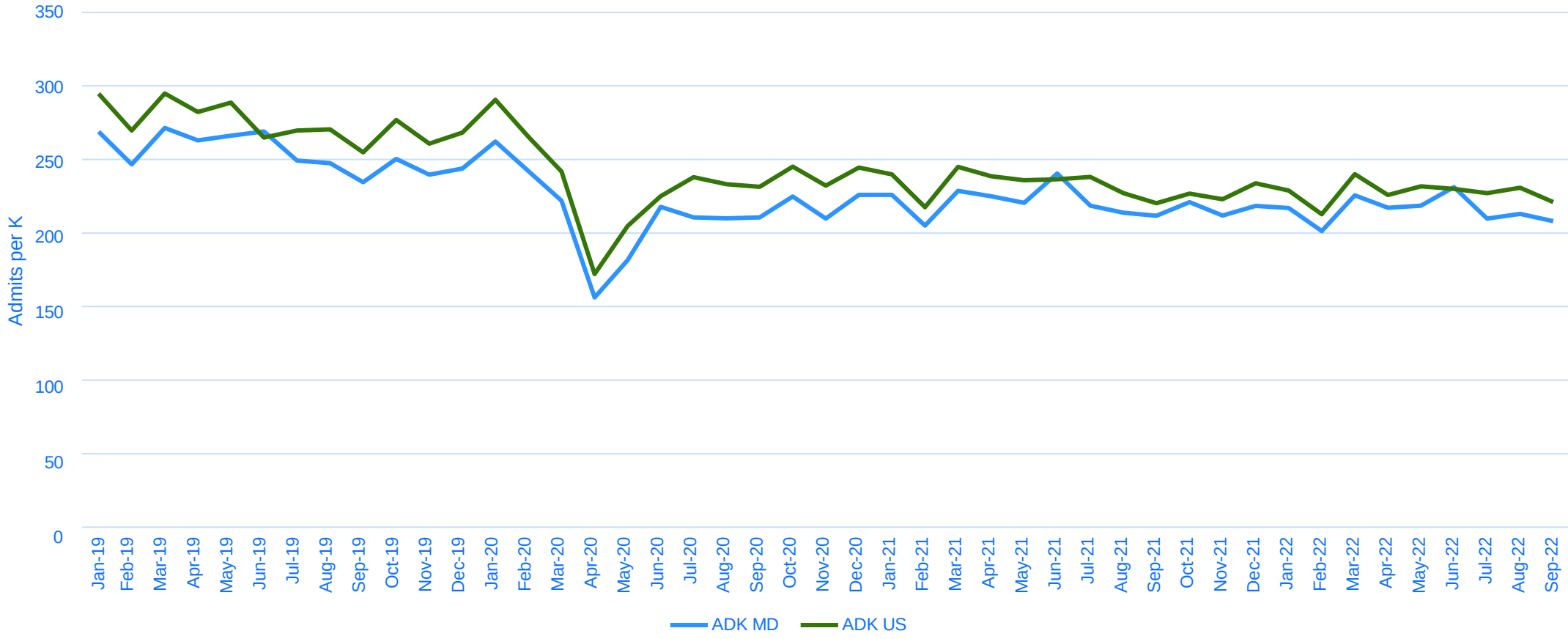
| | 2019 Vol. as a Percent of 2013 Vol. | Annualized Growth Rate |
|---|---|---|
| Maryland | 77% | -3.76% |
| National | 89% | -1.85% |

| | 2021 Vol. as a Percent of 2019 Vol. | Annualized Growth Rate |
|---|---|---|
| Maryland | 86% | -7.03% |
| National | 84% | -7.78% |

| | 2021 Vol. as a Percent of 2013 Vol | Annualized Growth Rate |
|---|---|---|
| Maryland | 67% | -4.2% |
| National | 75% | -3.1% |

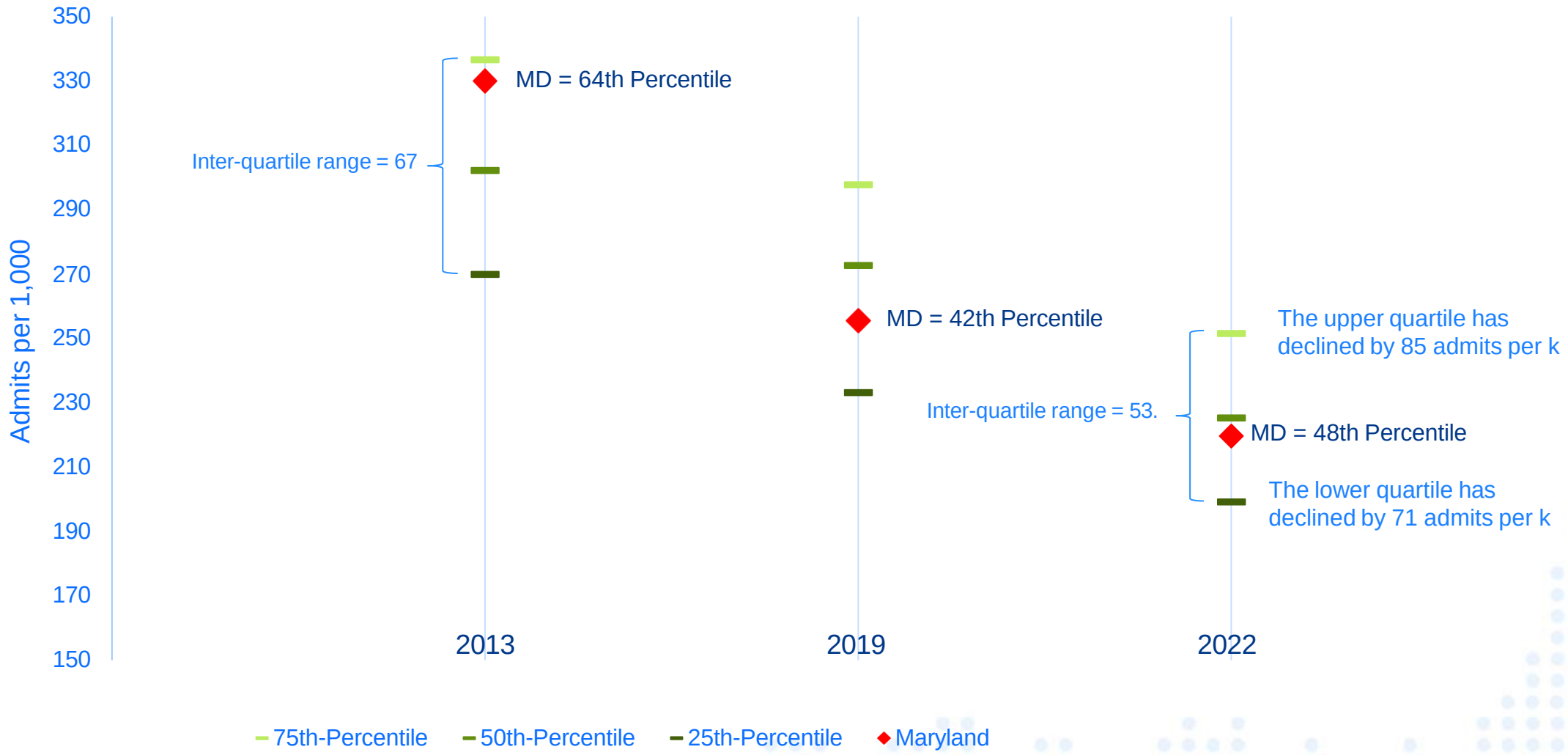
- There has been a long-term secular decline in IP utilization. Prior to 2019, Maryland has reducing IP utilization about twice as fast.
- There have been similar reductions in the PAU admissions. Maryland PAU volume declined by 19.6 in 2019 over 2013 and declined by 21.3 percent in 2021 over 2019.
- COVID accelerated the trend. Dissipation in IP utilization accelerated by a factor of 4 nationally.

# Dissipation in IP Utilization Persists into the Most Recent Months




maryland health services cost review commission

# Maryland IP Utilization in Context




maryland health services cost review commission

# Comparison to Peer States

| Nearest Neighbors | 2019 Stays Per K | 2021 Stays Per K |
|---|---|---|
| Virginia | 262 | 211 |
| South Carolina | 256 | 218 |
| Maryland | 256 | 220 |
| Minnesota | 254 | 215 |
| Iowa | 245 | 200 |

| Nearest Neighbors | 2019 Stays Per K | 2021 Stays Per K |
|---|---|---|
| California | 238 | 200 |
| North Dakota | 237 | 217 |
| 25th Percentile Target | 233 | 200 |
| Wyoming | 233 | 195 |
| Wisconsin | 232 | 200 |

- Currently, Maryland's utilization per k is average. Reducing utilization to the 25th percentile would require achieve a utilization rate similar to California and Wisconsin.
- These states achieve this level of utilization without causing any access problems.

# Outpatient Utilization, 2013 to 2019

| | Maryland | | | National | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2013 Visits Per K | 2019 Visits Per K | Change | 2019 Visits Per K | 2021 Visits per K | Change | MD 13 / NTL 13 | MD 19 / NTL 19 | Diff |
| Proc-Ambulatory | 92.9 | 73.2 | 78.7% | 127.3 | 139.8 | 109.8% | 73.0% | 52.3% | -20.7% |
| Proc-Major Cardiology | 44.9 | 37.0 | 82.4% | 53.9 | 49.2 | 91.2% | 83.3% | 75.3% | -8.0% |
| Proc-Major Other | 33.6 | 46.8 | 139.2% | 45.3 | 61.1 | 134.8% | 74.3% | 76.6% | 2.4% |
| Proc-Eye | 26.6 | 15.5 | 58.3% | 31.1 | 32.7 | 105.0% | 85.6% | 47.5% | -38.0% |
| Proc-Endocrinology | 83.3 | 80.2 | 96.3% | 122.3 | 133.2 | 108.9% | 68.1% | 60.2% | -7.9% |
| Proc-Major Orthopedic | 4.8 | 14.0 | 292.2% | 6.9 | 14.5 | 208.7% | 69.2% | 96.8% | 27.7% |
| Proc-Oncology | 149.9 | 160.4 | 107.0% | 155.4 | 219.0 | 141.0% | 96.5% | 73.2% | -23.3% |
| Proc-Dialysis | 2.4 | 1.9 | 79.7% | 2.1 | 2.4 | 109.8% | 111.3% | 80.8% | -30.5% |

- Over the first 6 years some OP areas grew as volumes shifted from IP while other shrank as volumes moved to ASC or physician's office.
- But generally MD volumes shrank relative to national – particularly in the lower acuity services.
- The exception is orthopedic utilization. We believe is due to orthopedic procedures moving from inpatient to outpatient as a result of leaving the inpatient only list.

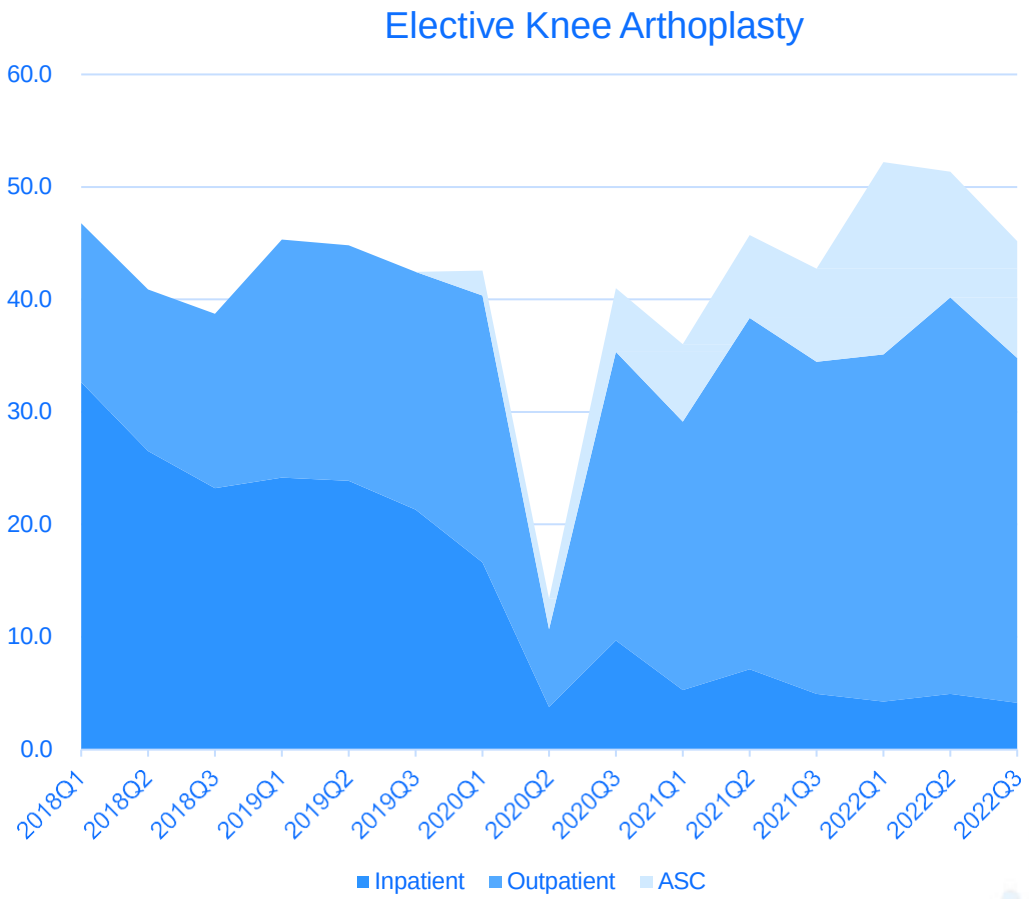
# Outpatient Utilization, 2019 to 2021

| | Maryland | | | National | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2019 Visits Per K | 2021 Visits Per K | Change | 2019 Visits Per K | 2021 Visits per K | Change | MD 19 / NTL 19 | MD 21 / NTL 21 | Diff |
| Proc-Ambulatory | 73.2 | 43.8 | 59.9% | 139.8 | 87.9 | 62.9% | 52.3% | 49.8% | -2.5% |
| Proc-Major Cardiology | 37.0 | 24.7 | 66.7% | 49.2 | 32.5 | 66.2% | 75.3% | 75.9% | 0.5% |
| Proc-Major Other | 46.8 | 28.6 | 61.2% | 61.1 | 42.9 | 70.3% | 76.6% | 66.8% | -9.9% |
| Proc-Eye | 15.5 | 9.2 | 59.3% | 32.7 | 21.2 | 64.9% | 47.5% | 43.5% | -4.1% |
| Proc-Endocrinology | 80.2 | 47.8 | 59.6% | 133.2 | 85.0 | 63.8% | 60.2% | 56.3% | -3.9% |
| Proc-Major Orthopedic | 14.0 | 14.1 | 100.9% | 14.5 | 17.0 | 117.6% | 96.8% | 83.1% | -13.7% |
| Proc-Oncology | 160.4 | 90.9 | 56.7% | 219.0 | 144.3 | 65.9% | 73.2% | 63.0% | -10.2% |
| Proc-Dialysis | 1.9 | 0.8 | 41.5% | 2.4 | 1.1 | 46.2% | 80.8% | 72.6% | -8.2% |

- Assessing the more recent outpatient utilization is trickier. But in general, outpatient hospital utilization remains at around 60-70% of 2019 volumes.
- Utilization reduction is slightly larger in Maryland but the big gains in high volume, low acuity areas like Ambulatory and Eye slowed down significantly.

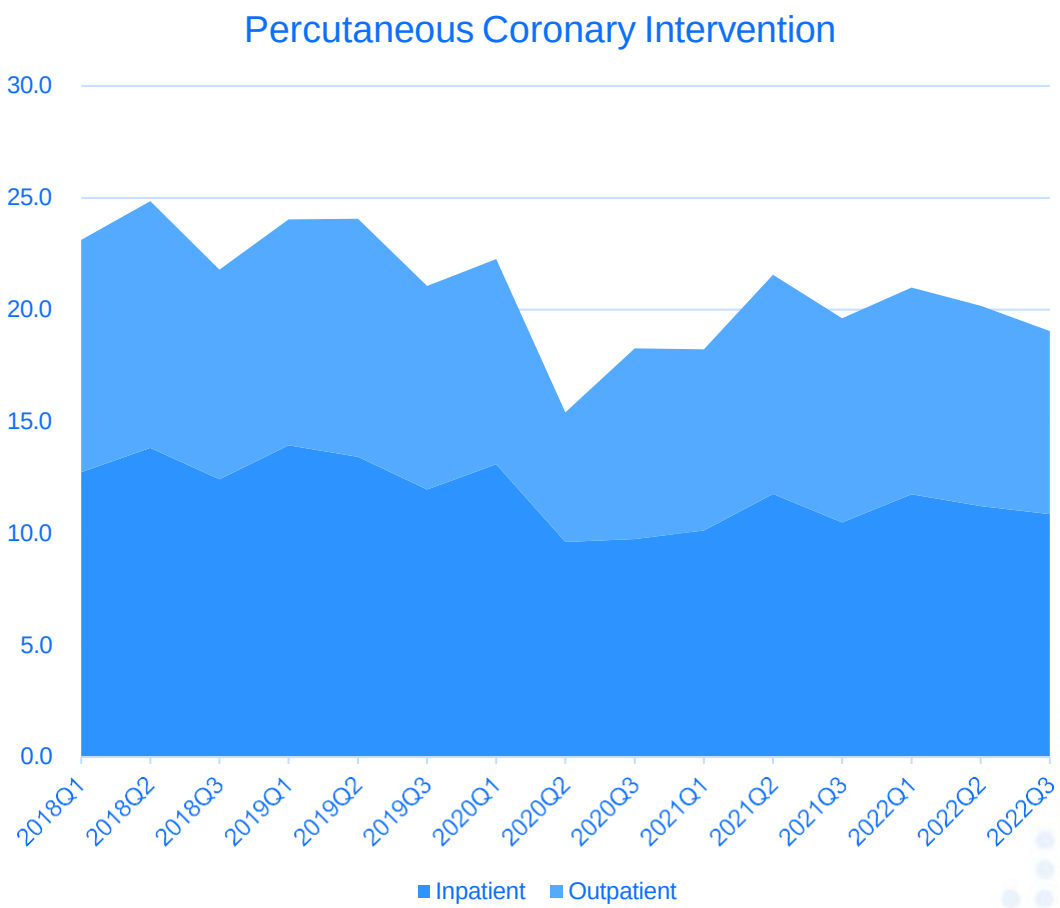
# Likely Permanent Utilization Declines

- Some utilization declines are likely to be permanent.
- For example: Knee Arthroplasty (and other orthopedic procedures) are moving to outpatient settings.
  - Inpatient utilization has declined substantially.
  - These trends started pre-COVID but accelerated in the pandemic.



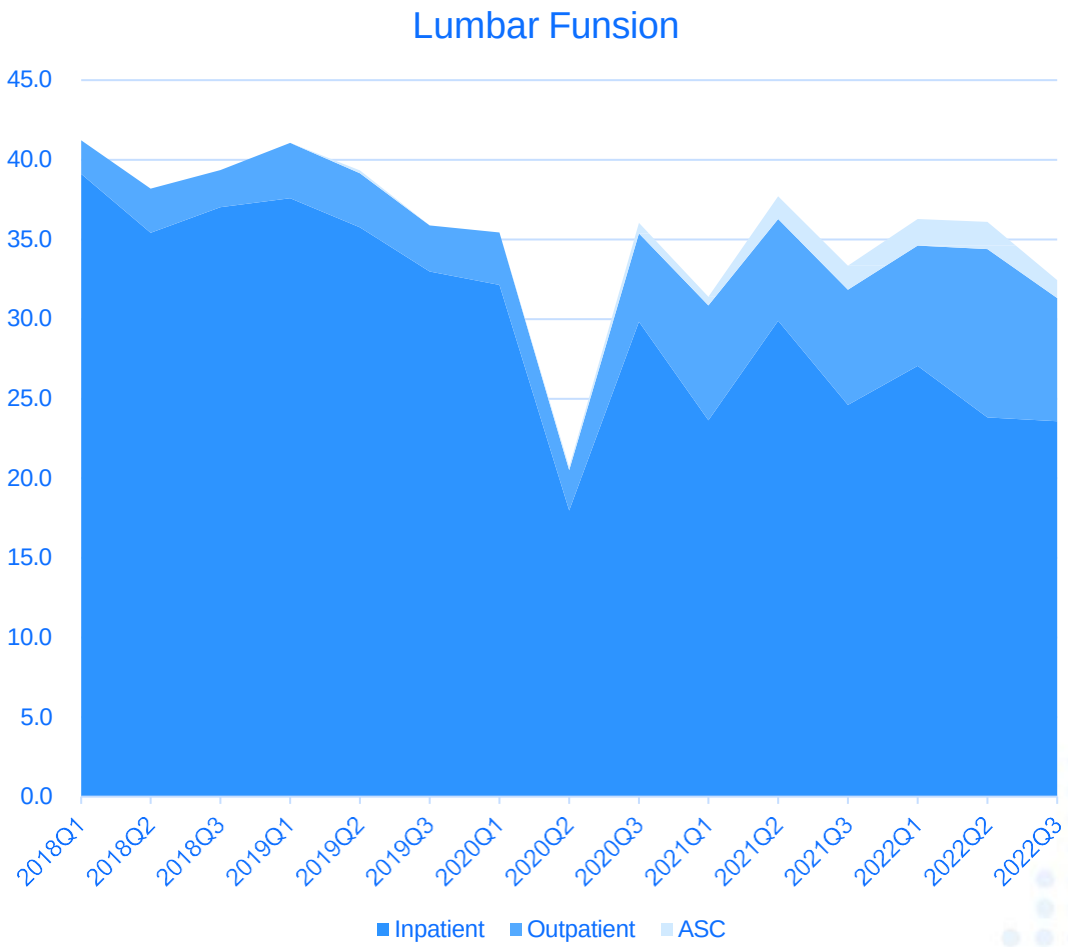
# Possibly Temporary Utilization Declines

- Other utilization is less clear.
- For example: PCI volumes are down but…
  - There is no shift in the setting of care.
  - The trend pre-COVID was moderate.
- This could reflect changes in practice patterns or treatment of underlying conditions.



# Continuing utilization declines

- Some utilization was declining and has accelerated as a result of COVID.
  - Shifts in settings of care started prior to COVID, in addition a secular trend started prior to the COVID dissipation.
  - There was a rebound followed by further utilization reductions and a continuing mix shift.
- Its unclear whether these utilization trends will continue, accelerate, or reverse.



# Change in Utilization Patterns of All Chronic Conditions

| | Maryland | | | Nation | | | MD % Above (Below) Nation | |
|---|---|---|---|---|---|---|---|---|
| | 6 Months Ended 6/30/2019 | 6 Months Ended 6/30/2022 | Increase (Decline) | 6 Months Ended 6/30/2019 | 6 Months Ended 6/30/2022 | Increase (Decline) | 6 Months Ended 6/30/2019 | 6 Months Ended 6/30/2022 |
| **Chronic Beneficiary Profile** | | | | | | | | |
| % Chronic | 67.15% | 59.87% | -10.8% | 59.70% | 39.25% | -34.3% | 12.5% | 52.5% |
| Average Age | 73.0 | 75.1 | 2.8% | 72.7 | 74.8 | 2.8% | 0.4% | 0.4% |
| Aver # of Conditions | 3.78 | 3.81 | 0.9% | 3.73 | 3.76 | 0.9% | 1.2% | 1.2% |
| **Utilization Indicators** | | | | | | | | |
| % of Benes w/Admit | 11.1% | 7.7% | -30.2% | 11.5% | 7.9% | -31.0% | -3.3% | -2.1% |
| Admits/Bene | 0.20 | 0.14 | -31.1% | 0.19 | 0.13 | -33.2% | 2.2% | 5.4% |
| % with Any PAC | 8.8% | 6.7% | -23.3% | 10.1% | 7.1% | -30.0% | -13.3% | -5.0% |
| % with Institutional PAC | 3.7% | 2.7% | -26.6% | 3.9% | 2.8% | -29.7% | -6.5% | -2.5% |
| **Mortality** | | | | | | | | |
| % Deaths | 2.5% | 2.3% | -7.8% | 2.6% | 2.3% | -10.0% | -4.8% | -2.5% |

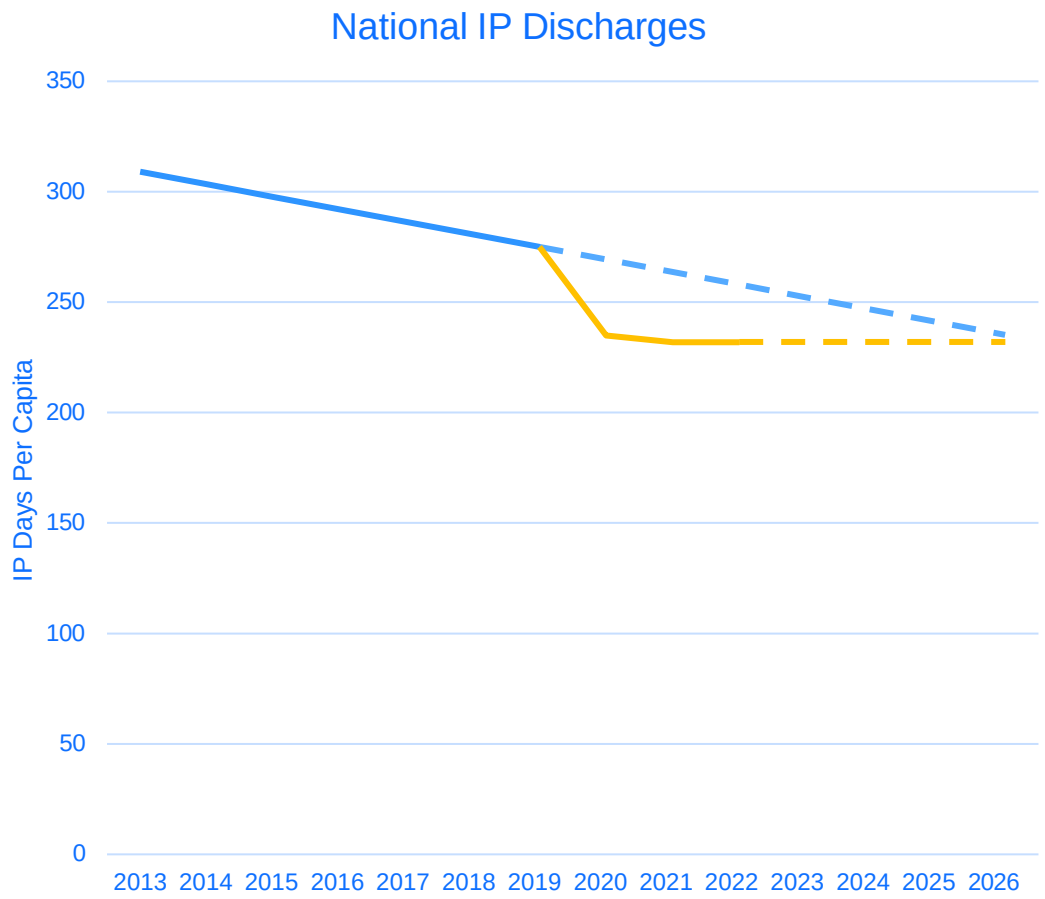
From: "Maryland Model Analytics Consultant - Evaluation of Maryland Medicare Spending on Chronic Conditions". Acumen, November 2022

# Change in Utilization Patterns of Ischemic Heart Disease

| | Maryland | | | Nation | | | MD % Above (Below) Nation | |
|---|---|---|---|---|---|---|---|---|
| | 6 Months Ended 6/30/2019 | 6 Months Ended 6/30/2022 | Increase (Decline) | 6 Months Ended 6/30/2019 | 6 Months Ended 6/30/2022 | Increase (Decline) | 6 Months Ended 6/30/2019 | 6 Months Ended 6/30/2022 |
| **Chronic Beneficiary Profile** | | | | | | | | |
| % Chronic | 12.41% | 11.40% | -8.2% | 11.81% | 7.94% | -32.8% | 5.1% | 43.6% |
| Average Age | 76.0 | 77.2 | 1.7% | 75.9 | 77.1 | 1.6% | 0.1% | 0.1% |
| **Utilization Indicators** | | | | | | | | |
| % of Benes w/Admit | 18.9% | 13.1% | -30.9% | 19.4% | 13.3% | -31.6% | -2.6% | -1.6% |
| Admits/Bene | 0.37 | 0.25 | -32.9% | 0.36 | 0.24 | -34.4% | 4.0% | 6.3% |
| % with Any PAC | 15.9% | 11.4% | -28.2% | 18.2% | 12.0% | -33.7% | -12.5% | -5.2% |
| % with Institutional PAC | 7.1% | 4.7% | -33.9% | 7.4% | 4.9% | -33.7% | -4.0% | -4.3% |
| **Mortality** | | | | | | | | |
| % Deaths | 4.9% | 4.2% | -15.2% | 4.9% | 4.1% | -15.8% | 0.1% | 0.9% |

From: "Maryland Model Analytics Consultant - Evaluation of Maryland Medicare Spending on Chronic Conditions". Acumen, November 2022

# Rebound or acceleration of existing IP utilization trends?




- The blue lines show the projected utilization level assuming that the 2013-2019 secular trend continued.
- The orange lines show the current utilization level.
- A rebound in volume above the dotted blue line is unlikely unless something has disrupted the structural factors leading to lower hospitalizations.

# Implications Utilization

- If the Nation does bounce back, Maryland will be in a strong position to:
  - Generate savings by retaining new utilization strategies and monetizing savings
  - Generate new utilization advantages while the nation struggles with a return to traditional FFS behavior
- If the Nation does NOT bounce back, Maryland will need to
  - Convert utilization declines into savings more rapidly in order to meet model goals
  - Find new utilization reduction opportunities
- The future of utilization in the nation remains unclear
  - There is little evidence in the data of a bounce back at this point
  - National utilization levels can be seen as just accelerated timing of the historic rate of reduction which would suggest a bounce back is unlikely
  - National providers may be limited in their ability due to staffing and labor challenges in the near term
  - However, the underlying forces that drive utilization growth in a fee-for-service environment remain unchanged

# Policy Update

maryland
health services
cost review commission

maryland
health services
cost review commission

# Update on Medicare FFS Data & Analysis

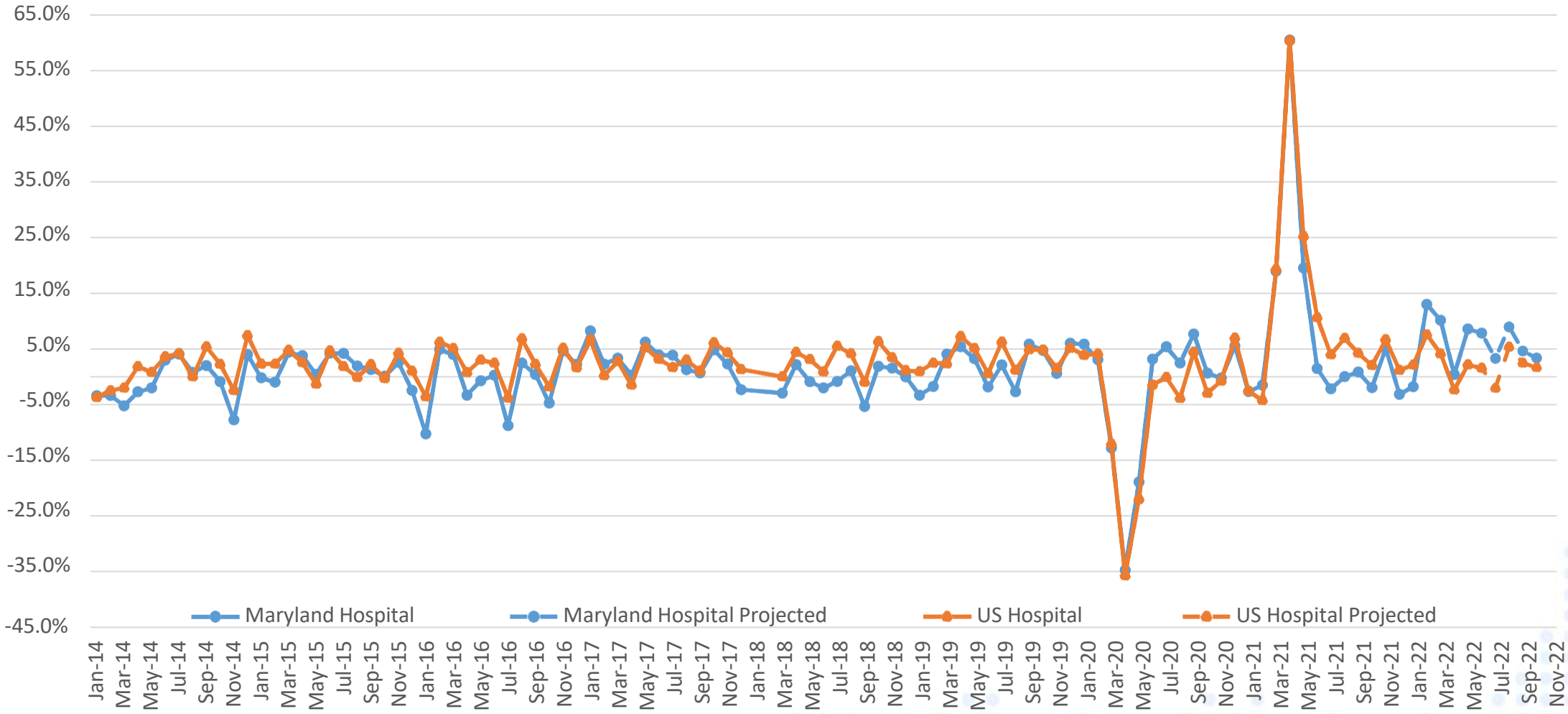
## February 2023 Update

### Data through October 2022, Claims paid through December 2022

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

# Medicare Hospital Spending per Capita

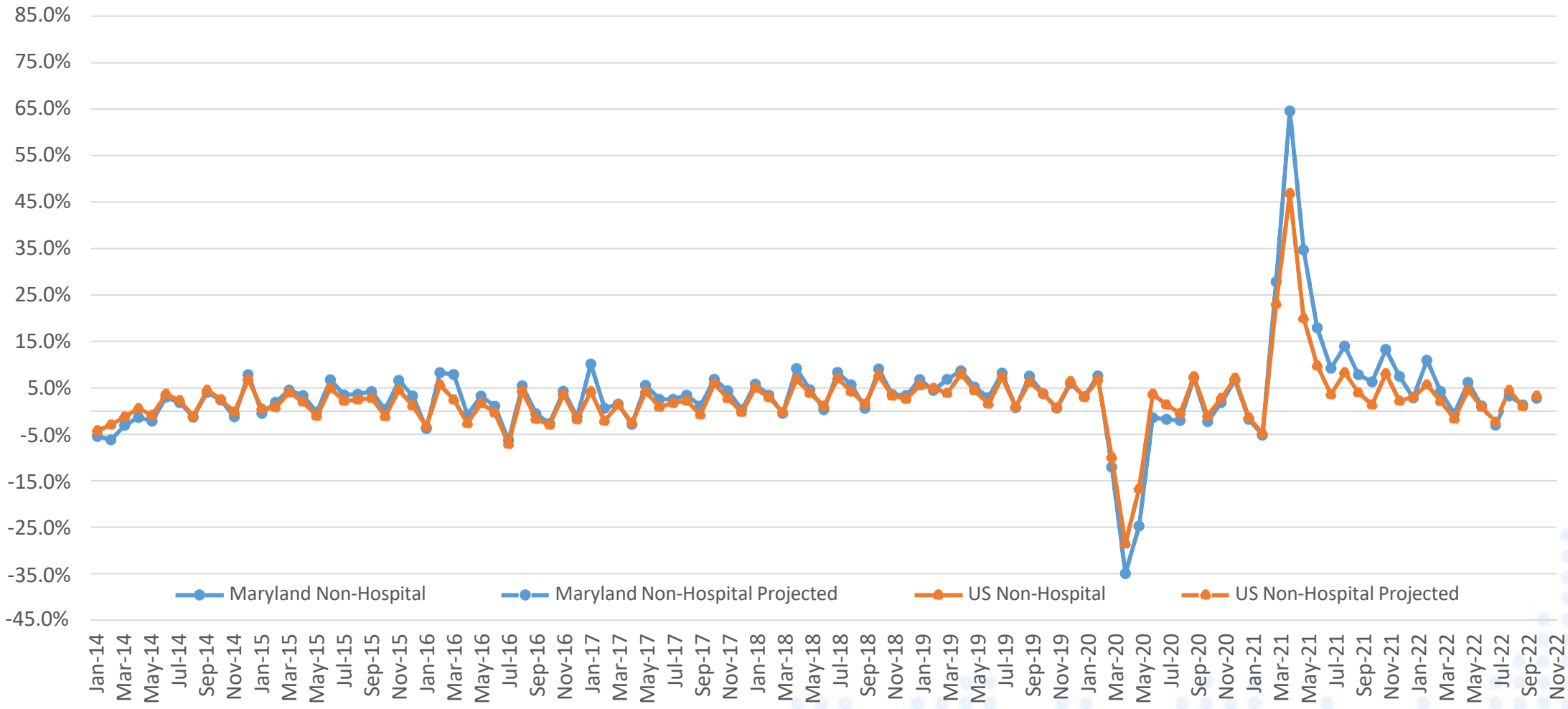
## Actual Growth Trend (CY month vs. Prior CY month)



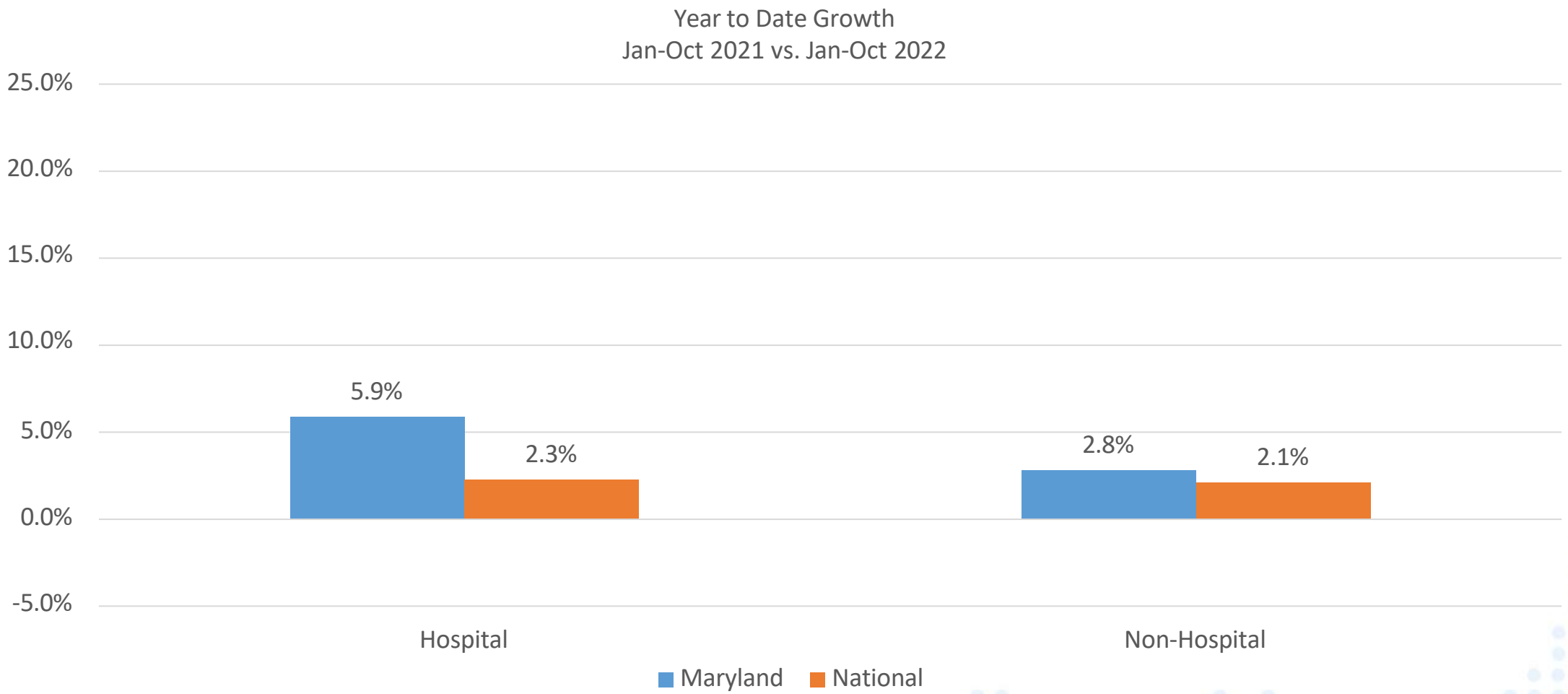

CY16 has been adjusted for the undercharge.

# Medicare Non-Hospital Spending per Capita

## Actual Growth Trend (CY month vs. Prior CY month)

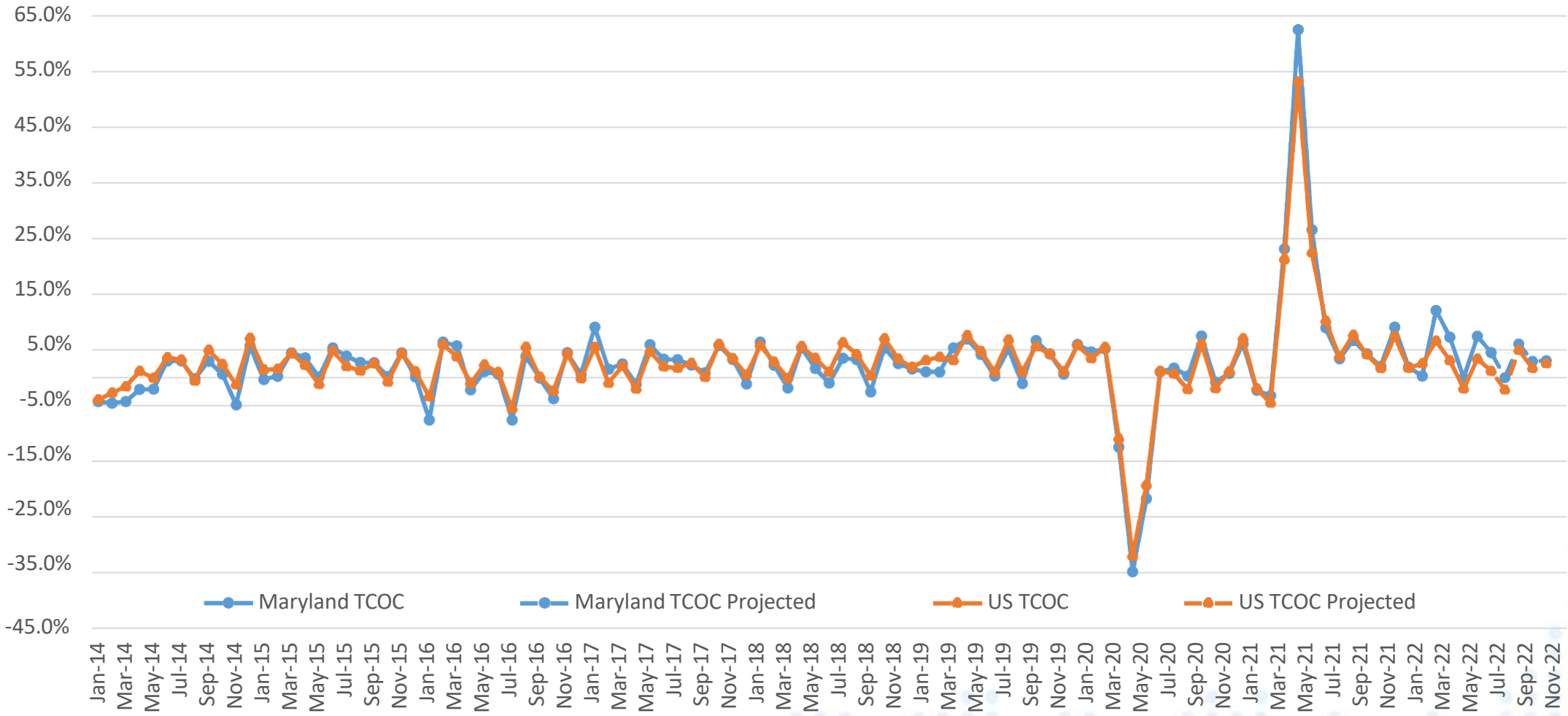


# Medicare Hospital and Non-Hospital Payments per Capita



# Medicare Total Cost of Care Spending per Capita

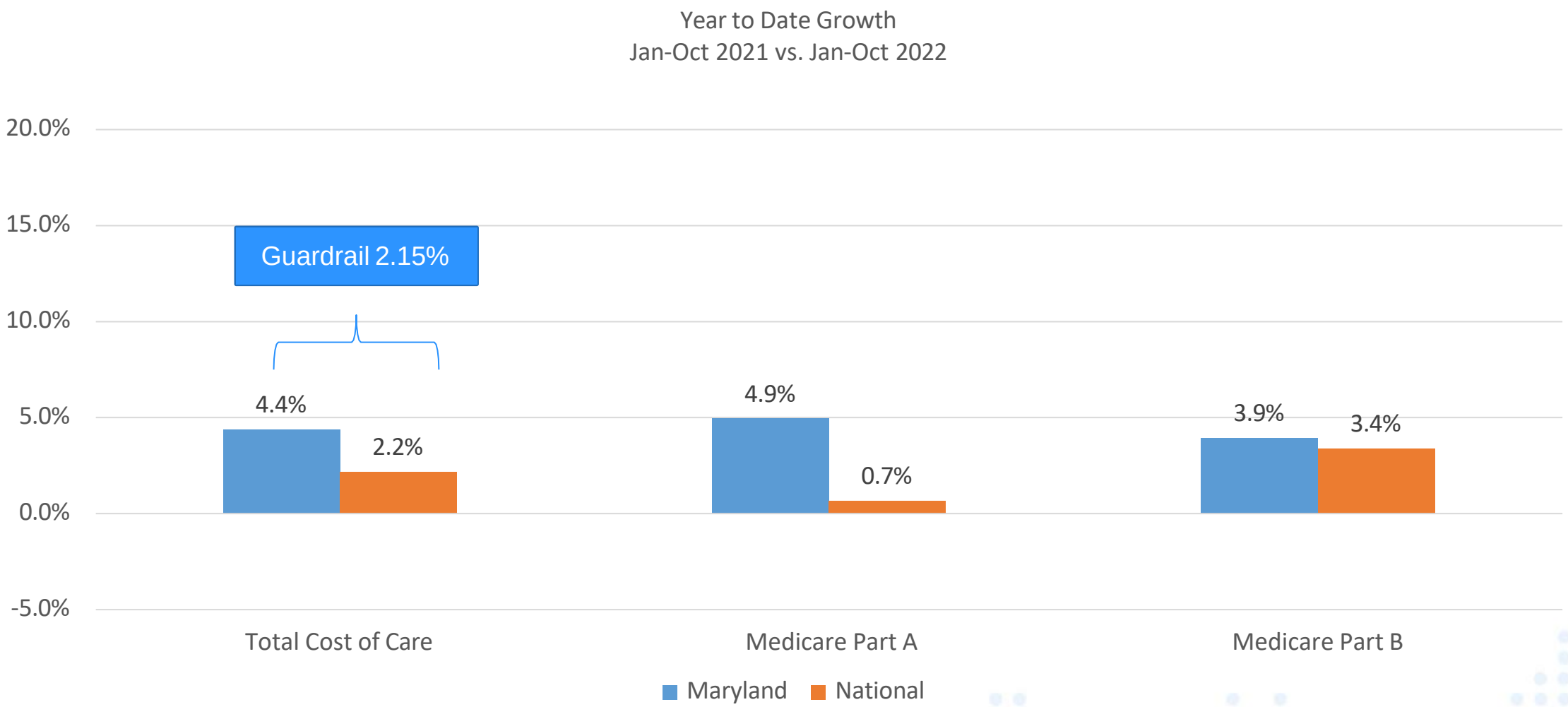
## Actual Growth Trend (CY month vs. Prior CY month)




CY16 has been adjusted for the undercharge

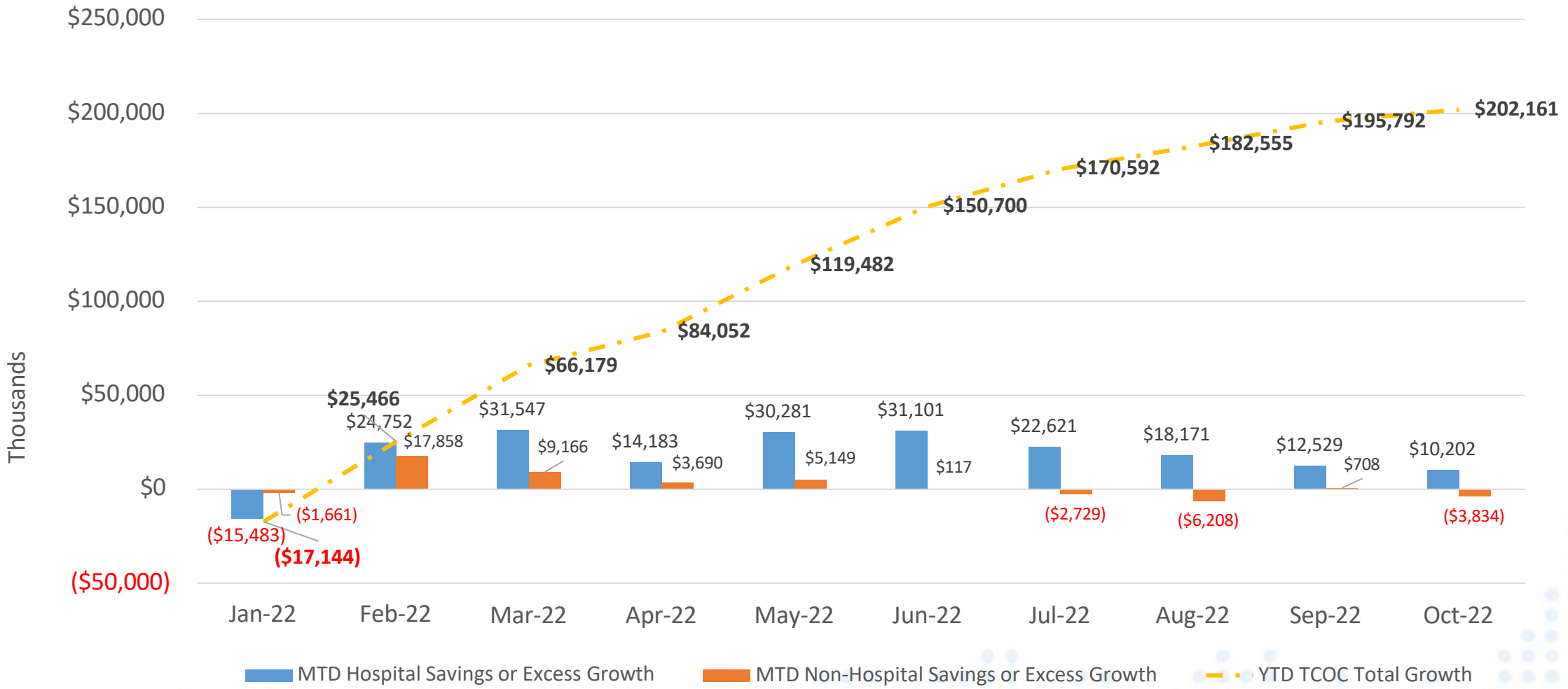
maryland health services cost review commission

# Medicare Total Cost of Care Payments per Capita



# Maryland Medicare Hospital & Non-Hospital Growth

## CYTD through October 2022



maryland
health services
cost review commission

# Legislative Update

## HSCRC February 2023 Commission Meeting

February 8, 2023

# Health Services Cost Review Commission - Hospital Rates - All-Payer Model Contract

| Bill # | Description | Position |
|---|---|---|
| HB 420<br>SB 234 | **Health Services Cost Review Commission - Hospital Rates - All-Payer Model Contract** | Support |

- HSCRC requested this bill to add a reference to the Total Cost of Care Model to our hospital rate setting statute. The statute already requires the Commission to take the TCOC model into account in other aspects of the rate setting process. This amendment will conform with those other references to the model in law. This bill will not change how HSCRC staff review hospital rates, but rather will ensure our statute aligns with those contractual requirements.
- SB 234 had a hearing in the Senate Finance Committee on 2/2 and HB 420 hearing date is TBD

maryland health services cost review commission

# Health Services Cost Review Commission - Hospital Rates - All-Payer Model Contract

| Bill # | Description | Position |
|---|---|---|
| HB TBD | **Health Services Cost Review Commission – Medical Debt and Financial Assistance** | Support |

- HSCRC requested this bill to align the calculation of how income is calculated for financial assistance and income-based payment plans, to edit the definition of “medical debt” and use that term consistently in both the financial assistance and medical debt statute, and to adjust some reporting deadlines.
- Hearing dates are TBD

maryland health services cost review commission

# Budget and BRFA

| Bill # | Description |
|---|---|
| HB 200<br>SB 181 | **Budget Bill for FY 2024 (The Governor's Budget)** |
| HB 202<br>SB 183 | **Budget Reconciliation and Financing Act of 2023** |

- Reduces the Medicaid Deficit Assessment by $50M for FY 24 only.
- HSCRC Budget bill hearings:
  - 2/23– Health and Social Services Subcommittee of the Appropriations Committee (House)
  - 3/6 – Health and Social Services Subcommittees of the Budget and Taxation Committee (Senate)
- BRFA hearings
  - 2/28 – Appropriations Committee (House)
  - 3/01 – Budget and Taxation Committee (Senate)

# Commission on Public Health - Establishment

| Bill # | Description | Position |
|---|---|---|
| HB 214<br>SB 281 | **Commission on Public Health - Establishment** | Support |

- The PH Commission will assess State and local health department ability to provide public health services, with an emphasis on the State's response to COVID-19, overdose deaths, and racial and ethnic disparities in maternal mortality and birth outcomes
- HSCRC is named in the bill and will either be a member of the Commission or will consult with the Department
- HB 214 had a hearing in HGO on 1/26 and SB 281 has a hearing in the Senate Finance Committee on 2/15

# 9-8-8 Trust Fund - Funding

| Bill # | Description | Position |
|---|---|---|
| HB 271<br>SB 3 | **9-8-8 Trust Fund - Funding** | Support |

- Requires the Governor to include $12,000,000 in the annual budget bill for fiscal year 2025 for the 9-8-8 Trust Fund. Designates and maintains 9-8-8 as the universal telephone number for a national suicide prevention and mental health crisis hotline. Develops and implements a statewide initiative for the coordination and delivery of behavioral health crisis response services.
- SB 3 had a hearing in the Senate Budget and Taxation Committee on 1/19 and HB 271 had a hearing in HGO on 2/7

# Task Force on Reducing Emergency Department Wait Times

| Bill # | Description | Position |
|---|---|---|
| HB 274<br>SB 387 | **Task Force on Reducing Emergency Department Wait Times** | TBD |

- Establishes the Task Force on Reducing Emergency Department Wait Times to study best practices for reducing ED wait times; requires the Task Force to report findings/recommendations to the Governor and the General Assembly by January 1, 2024.
- SB 387 has hearing in the Senate Finance Committee on 2/23 and the house hearing date is TBD

# Hospitals - Financial Assistance - Medical Bill Reimbursement Process

| Bill # | Description | Position |
|---|---|---|
| HB 333<br>SB 404 | **Hospitals - Financial Assistance - Medical Bill Reimbursement Process** | Letter of Information |

- This bill makes changes to the law requiring that hospitals provide refunds to certain patients who paid bills but were eligible for financial assistance in 2017-2021 (this law passed last year). State data will be used to identify the patients that qualify for refunds. HSCRC is required to create the process to implement this law.
- SB 404 has hearing in the Senate Finance Committee on 2/23 and the house hearing date is TBD

# Commission to Study Trauma Center Funding in Maryland

| Bill # | Description | Position |
|---|---|---|
| SB 493<br>HB 675 | **Commission to Study Trauma Center Funding in Maryland** | TBD |

- Establishes the Commission to Study Trauma Center Funding in Maryland to study the adequacy of trauma center funding across the State for operating, capital, and workforce costs; and requires the Commission to report its finding and recommendations to the Governor and the General Assembly by December 1, 2023.
- SB 493 has a hearing in the Senate Budget and Taxation Committee on 3/01

# Questions?


## Megan Renfrew

Associate Director of External Affairs

Center for Payment Reform and Provider Alignment

megan.renfrew1@maryland.gov

# Appendix

maryland
health services
cost review commission

# Legislative Briefings

- Overview HSCRC for the House Health Government Operations (HGO) Committee (1/12)
- Total Cost of Care Overview for the HGO Committee (1/24)
- Total Cost of Care Overview for Senate Finance Committee (1/24)

# Staff Activities during Legislative Interim

- HSCRC submitted 8 legislative reports:
  - Behavioral Health Emergency Department Wait Times and Service Improvements in Maryland, Request of HGO Committee
  - Annual Governors Report, required by Health-General §19-207(b)(9)
  - Guidelines for Hospital Payment Plans report, required by Ch. 770, 2021 Md. Laws (House Bill 565)
  - Evaluation of the Maryland Primary Care Program, required by the 2022 JCR
  - The Maryland Model and Hospital Responses to the COVID-19 Pandemic, required by the 2022 JCR
  - Summary of UMMS Board of Directors Financial Disclosure, required by Education Article §13- 304(l)(4)
  - Free Hospital Care Refund Process, required by Health General §19-214.4
  - Maryland Hospital Community Benefit Report: FY 2021, required by Ch. 437, 2020
- Staff continue to work to implement changes to Health General 19-214.2 (Debt Collection)

# Analysis of Funding in Rural and High Poverty Areas

# The Maryland Health Model is important to our State

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

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

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

# Impact of Maryland Model on Hospitals in Rural and High Poverty Areas

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

- In Maryland, all-payers pay the same hospital rates. Hospital rates for public payers (Medicare and Medicaid) are higher than rates at peer hospitals.
- Hospitals in rural and low-income areas have the highest share of public payers, resulting in strong funding for these hospitals compared to peer hospitals.
- Maryland hospitals in disadvantaged areas receive higher total public payer reimbursement per person than peer hospitals in other states, even on a risk-adjusted basis.
  - For rural counties they receive **$238 million** more annually in reimbursement for hospital services delivered to Medicare and Medicaid enrollees when compared to national hospitals in similar rural areas on a risk adjusted basis ($650 per enrollee, rural counties defined as Allegany, Caroline, Dorchester, Garrett, Kent, Somerset, St. Mary's, Talbot, Washington, Wicomico and Worcester).
  - For counties with higher levels of deep poverty hospitals receive **$781 million** more annually in reimbursement for hospital services delivered to Medicare and Medicaid enrollees when compared to national hospitals with areas with similar levels of deep poverty on a risk adjusted basis ($1,392 per enrollee, defined to include counites with greater than 6% deep poverty, includes Allegany, Baltimore City, Caroline, Dorchester, Kent, Somerset, and Wicomico).

# Groupings of Maryland Counties

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

**Counties Summarized By Density**

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

**Counties Summarized By % Deep Poverty**

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

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

# Estimate of Additional Hospital Payments by County

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

| Counties Summarized By Density | | |
|---|---|---|
| Density Category based on RUCC Code | % of Payments from Government Payers | Risk Adjusted Extra Hospital Payments Per Government Enrollee versus National Peers[1] |
| 1 | 63% | $522 |
| 2 | 70% | $577 |
| 3 | 66% | $865 |
| 6 | 71% | $598 |

~367k enrollees, at an average extra payment of $650 = $238 M extra funding

| Counties Summarized By % Deep Poverty | | |
|---|---|---|
| % Deep Poverty | % of Payments from Government Payers | Risk Adjusted Extra Hospital Payments Per Government Enrollee versus National Peers[1] |
| 0.0 – 4.0% | 57% | $153 |
| 4.0 – 6.0% | 64% | $736 |
| 6.0 – 8.0% | 72% | $674 |
| > 8.0% | 75% | $1,576 |

~562k enrollees, at an average extra payment of $1,392 = $781 M extra funding

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

# The Model Creates a Stable and Predictable System for Rural Hospitals

## In Maryland…

"**Sustaining Rural Hospitals After COVID-19**
The Case for Global Budgets"

JAMA Network

"**Saving Rural Hospitals**
**Will Changing Payment Methods Help?**

Washington State should learn from Maryland's experience, closely watch Pennsylvania and Vermont, and continue to pursue global budgets or other multi-payer alternative payment models for rural hospitals."

W CENTER FOR HEALTH INNOVATION & POLICY SCIENCE
UNIVERSITY of WASHINGTON

"It is imperative that we develop a sustainable model for rural health, not just for rural hospitals… Global hospital budgeting offers the potential to reform rural health care in alignment with better population health."

- Pennsylvania Secretary of Health

Rural Health Reform Policy
RESEARCH CENTER

maryland
health services
cost review commission

# Meanwhile, Across the Nation…

"180 Rural Hospital Closures since January 2005"

UNC THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH

"47 hospitals closed, filed for bankruptcy this year"

BECKER'S Hospital CFO Report

"Nearly half of rural hospitals face negative operating margins as COVID-19 hits outpatient revenue"

KHN

This means…

- Reduced access to emergency care (and even primary care in some cases)
- Exacerbated gaps in access to specialty care
- Job losses and other ripple effects in the surrounding community
- Reduced community health investment and resources

maryland
health services
cost review commission



**TO**: HSCRC Commissioners

**FROM**: HSCRC Staff

**DATE**: February 8, 2023

**RE**: Hearing and Meeting Schedule

---

March 8, 2023 To be determined - HSCRC Offices/GoTo Webinar

April 12, 2023 To be determined - HSCRC Offices/GoTo Webinar

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

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