



# MHA PERSPECTIVES



Maryland AAHAM Annual Institute

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Maryland  
Hospital Association

# PRESENTER



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# DISCUSSION OUTLINE

- Background: The Maryland Waiver
- Recent actions taken to improve Maryland Model Performance
- Vision for the future of the Model
- Current regulatory and legislative priorities

# AT THE END OF THIS SESSION, YOU WILL:

- Gain insights into hospital perspectives on Maryland's Model performance and its potential future extension
- Understand recent key policy decisions made by the HSCRC and their impact on the Total Cost of Care (TCOC) Model
- Explore current regulatory and legislative policy issues

## The answer to America's health care cost problem might be in Maryland

Maryland has a health care system unique in the United States: A global hospital budget.



Shirley Crowder speaks with Sinai Hospital's Gwen Mayo during her weekly home care meeting. Mayo visits Crowder frequently to make sure she's caring for her diabetes.

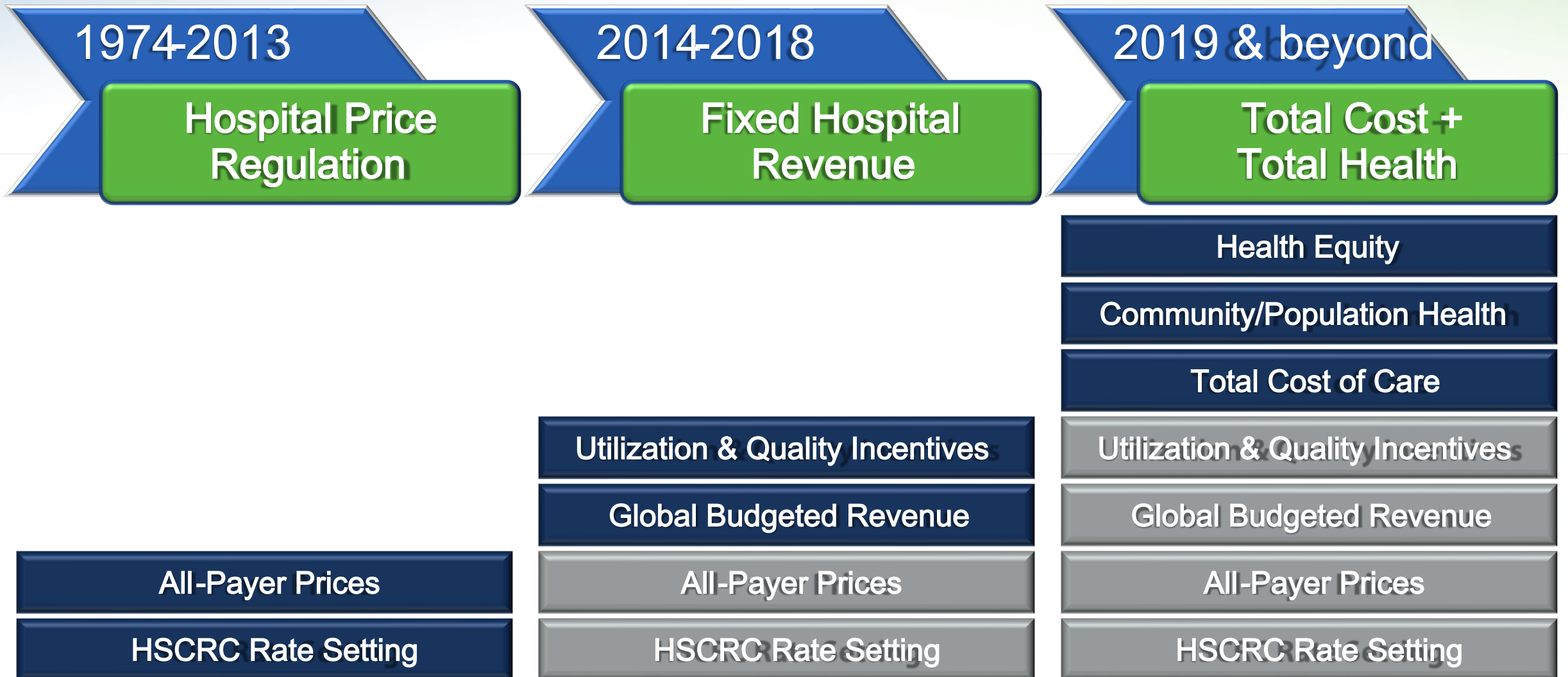
In 49 of the 50 states, more sick patients in hospital beds means more revenue. **Maryland is the exception. Hospitals' budgets are fixed, as are the rates they can charge...** Once they hit their revenue caps, they don't make more money on having patients in the hospital—and there is a carrot-and-stick system to ensure hospitals don't exceed those caps.

By limiting how much revenue hospitals can bring in, **it pushes hospitals to look at sickness as something to be treated not just within their walls, but within their community** : making sure a heart disease patient has access to healthy food, for example.

**"Maryland is doing more and providing better incentives than any other individual state,"** said Gerald Kominski, health policy scholar at UCLA.

The president of one Maryland hospital has an unofficial motto as patients leave his hospital: **"We hope to never see you again."**

# EVOLUTION IN INNOVATION – PROGRESS



# THE MARYLAND MODEL: AGREEMENT WITH CMS

- Exchange “waiver” from Medicare’s prospective hospital payment systems for controlling **total, per capita** spending growth
  - Hospital + nonhospital
  - Price, service use and service mix
- Meet certain financial targets
- Quality performance at or better than the nation (readmissions, hospital acquired conditions)
- All MD acute hospitals on same model rural, urban, academic medical centers, small, large

Enabled under state law, HSCRC enforces performance

# VALUE OF THE MARYLAND MODEL

## EQUITY

Marylanders get great health care—no matter where you live, who you are, or your income. In our hospital payment system, everyone pays the same, sparing Marylanders from cost-shifting and the two-tiered care that burdens patients and worsens outcomes elsewhere. The Maryland Model promotes equitable access and equitable outcomes.

## COMMUNITY

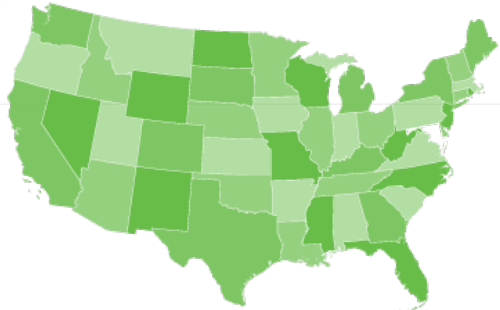
Maryland, under the Total Cost of Care Model, is the **only state where hospitals are accountable for the health of their communities**. Hospitals invest outside their walls, so people do not have to come in to benefit. Focusing on the health of the community, hospitals collaborate more and use their resources to help their neighbors.

## VALUE

Hospitals in Maryland don't dictate prices, and they aren't paid more to do more. **In the Maryland Model, hospitals get a set budget to help keep their communities healthy.** Your hospitals focus on quality and the value of care.

# ALL-PAYER PRICES: NO COST-SHIFTING

OTHER STATES

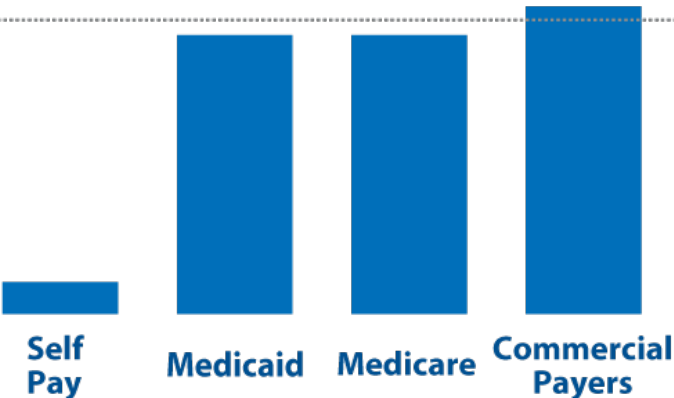
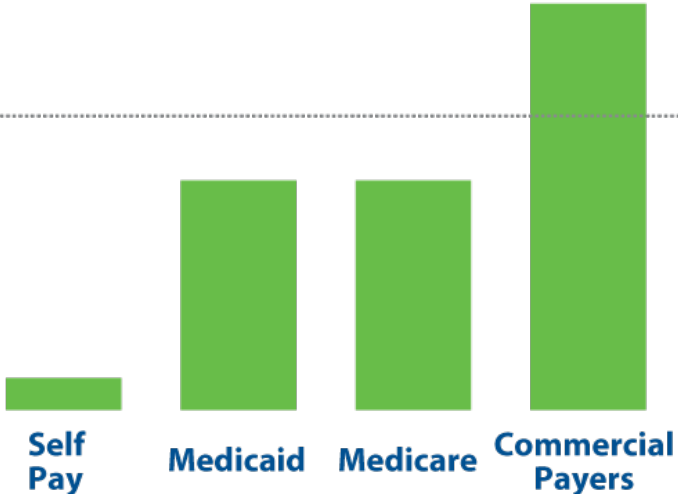


MARYLAND



% of Hospital's Cost

100%

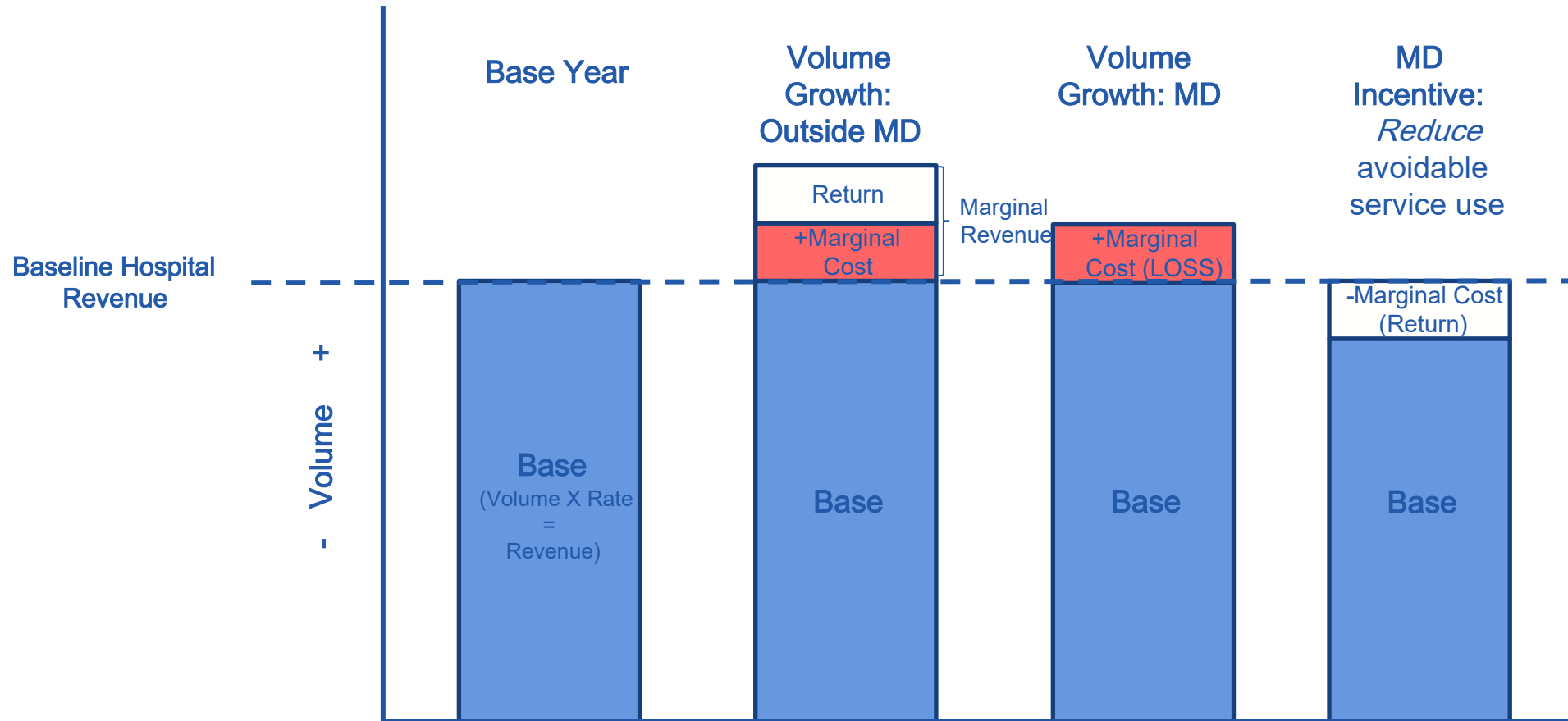


Equitably share burden of uncompensated care

Protect access in rural and vulnerable communities



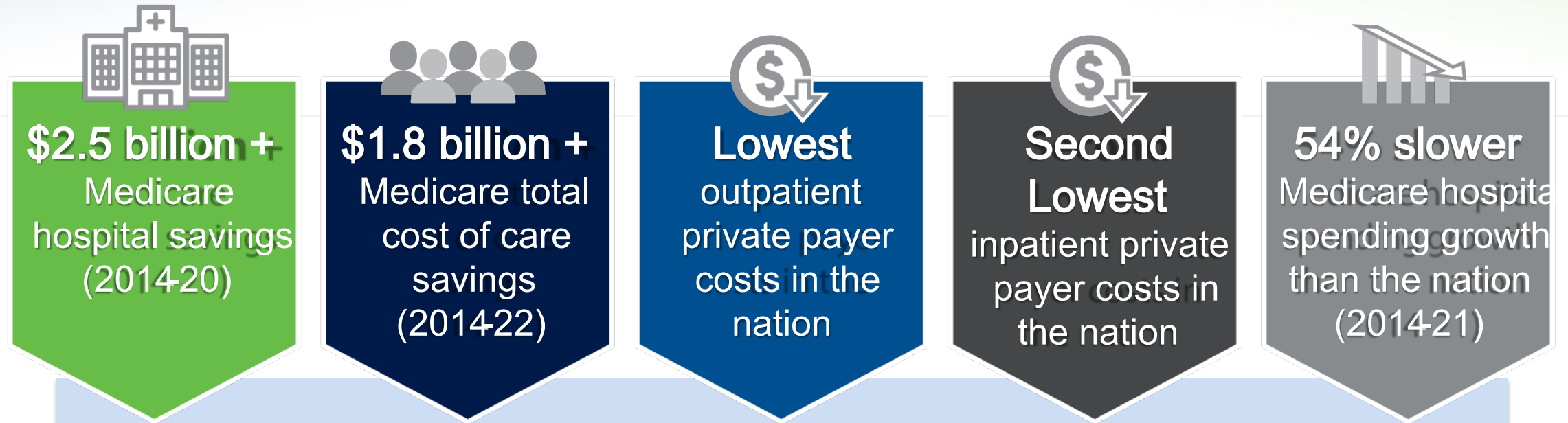
# MARYLAND VS. NATIONAL VOLUME EXAMPLE



# THE MARYLAND MODEL: IMPACT ON HOSPITAL SERVICES

- Global budgets provide stable hospital revenue
- 62 complete, national hospital closures since the Model began
  - More in 2021 and particularly in 2022
  - 46 conversions with some health care services
- Zero Maryland hospital closures
  - 3 conversions into freestanding ED with ancillary services: 1 urban (Bon Secours), 1 suburban (Laurel Regional), 1 rural (UM Shore Regional Dorchester)
  - UM Shore Regional Dorchester 13 miles from Easton, few inpatient beds prior to conversion

# REAL RESULTS

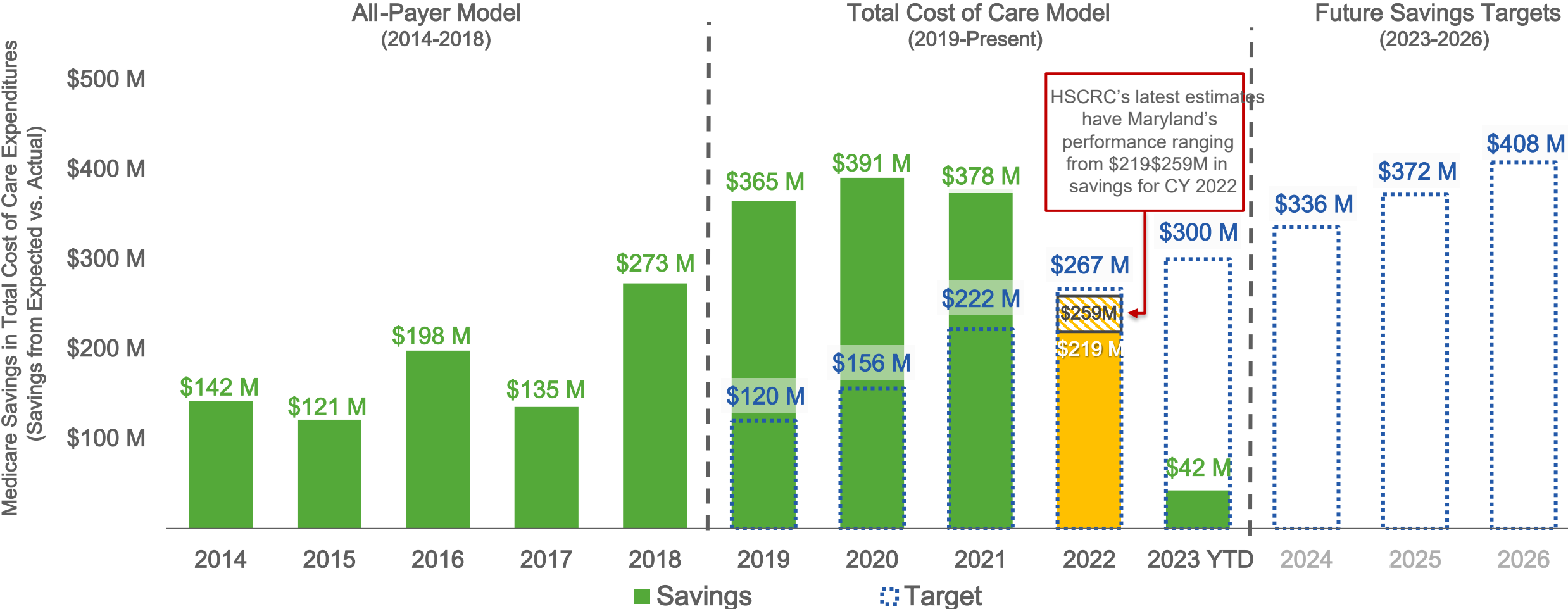


## Quality Results Since 2014

**51%** reduction in hospital preventable complications

**Better** than national Medicare hospital readmission rate

# LATEST CY2022 SAVINGS PROJECTIONS MORE FAVORABLE THAN INITIAL ESTIMATES



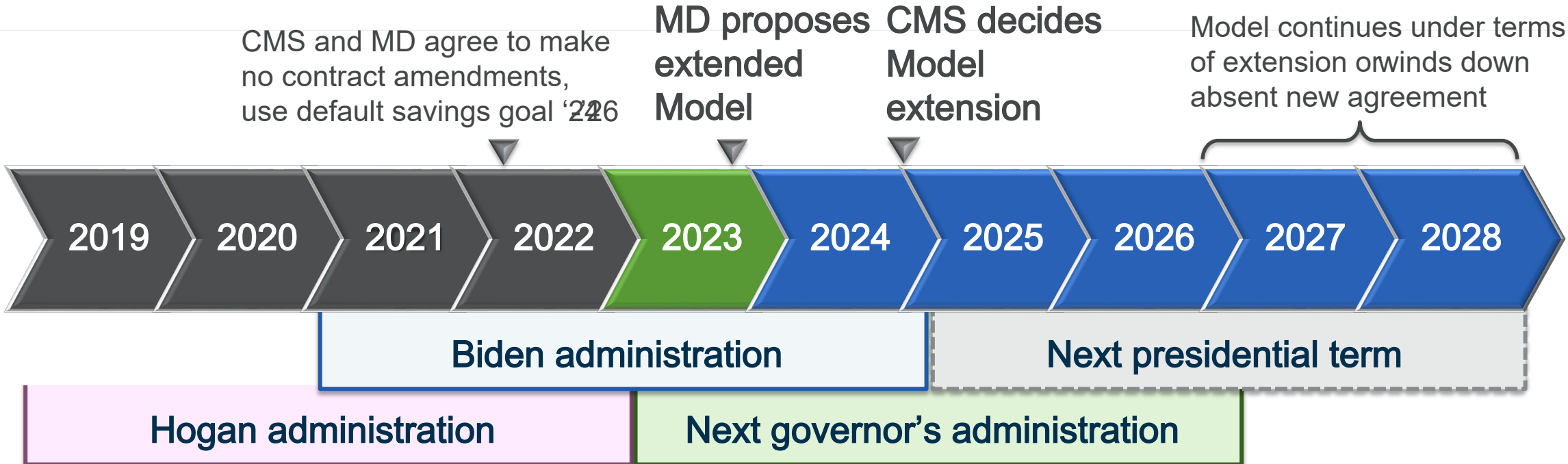
**Savings =** Maryland trended at national growth rate *minus* Maryland actual

Source: CMS/CMMI Monitoring Data  
 Note (1): Data contain summaries prepared by HSCRC and CMS/CMMI; data are preliminary and contain lags in claims when there are material differences in results when final data are received. Savings calculations include addition of Part B nonclaims based payments for MDPCP/CPC+ and Part C MA Growth Adjustment. MSSP and other non-claims based state & national programs will be added at the end of performance period.

# PROGRESSION PLAN



# BIDEN ADMINISTRATION & NEW GOVERNOR KEY TO MODEL EXTENSION



# CMS HAS IMPORTANT EXPECTATIONS

Pursuit of **HEALTH EQUITY** is an *overarching* expectation

- Integrate Medicaid into Model—functionally plus financial goals
- Invest in community health—health resources and social determinants
- Improve quality—especially patients' experience of care
- Incorporate population health measures into hospitals' accountability

# MODEL PRINCIPLES



ADEQUATE,  
STABLE,  
PREDICTABLE  
FUNDING



IMPROVE  
QUALITY &  
HEALTH



SHARED  
ACCOUNTABILITY  
AMONG ALL  
STAKEHOLDERS



PROMOTE  
ACCESS &  
INNOVATION



FLEXIBLE,  
ADAPTABLE &  
RESPONSIVE

# KEY TAKEAWAYS

- Medicare and Medicaid, **pay fairly, and much higher, in Maryland**
- **All payers have benefited** from the Maryland, not just Medicare beneficiaries.
- The Maryland Model **historically provided stable revenue**
- Short-term measures that require the state to achieve retrospectively determined targets introduce unnecessary policy uncertainty. **measures with longer horizons against known, consistent targets** will enhance investment in model goals and promote sustainability.
- Assuming Model continues, CMS wants **more savings, along with quality, equity and population health improvement**

# REGULATORY AND PAYER DRIVEN CHANGES



# PAYMENT PLAN POLICIES

## Timeline:

- **2021**

- The General Assembly passed legislation changing statutory requirements related to payment plans. The legislation also required the HSCRC to issue guidelines for hospitals on how to implement the plans.

- **2022**

- HSCRC convened a workgroup from ~~Jan~~ Feb to seek input from stakeholders in drafting the guidelines
- Guidelines approved in the May 2022 HSCRC Public Commission meeting

- **2023**

- In July- the HSCRC shared a draft of the proposed regulations on financial assistance and medical debt (COMAR 10.37.10.26).
- If approved, the regulations will be published as a proposed rule and open to public comments this Fall
- The new regulations will supplant the existing guidelines that were approved in May 2022

# PAYMENT PLAN POLICIES

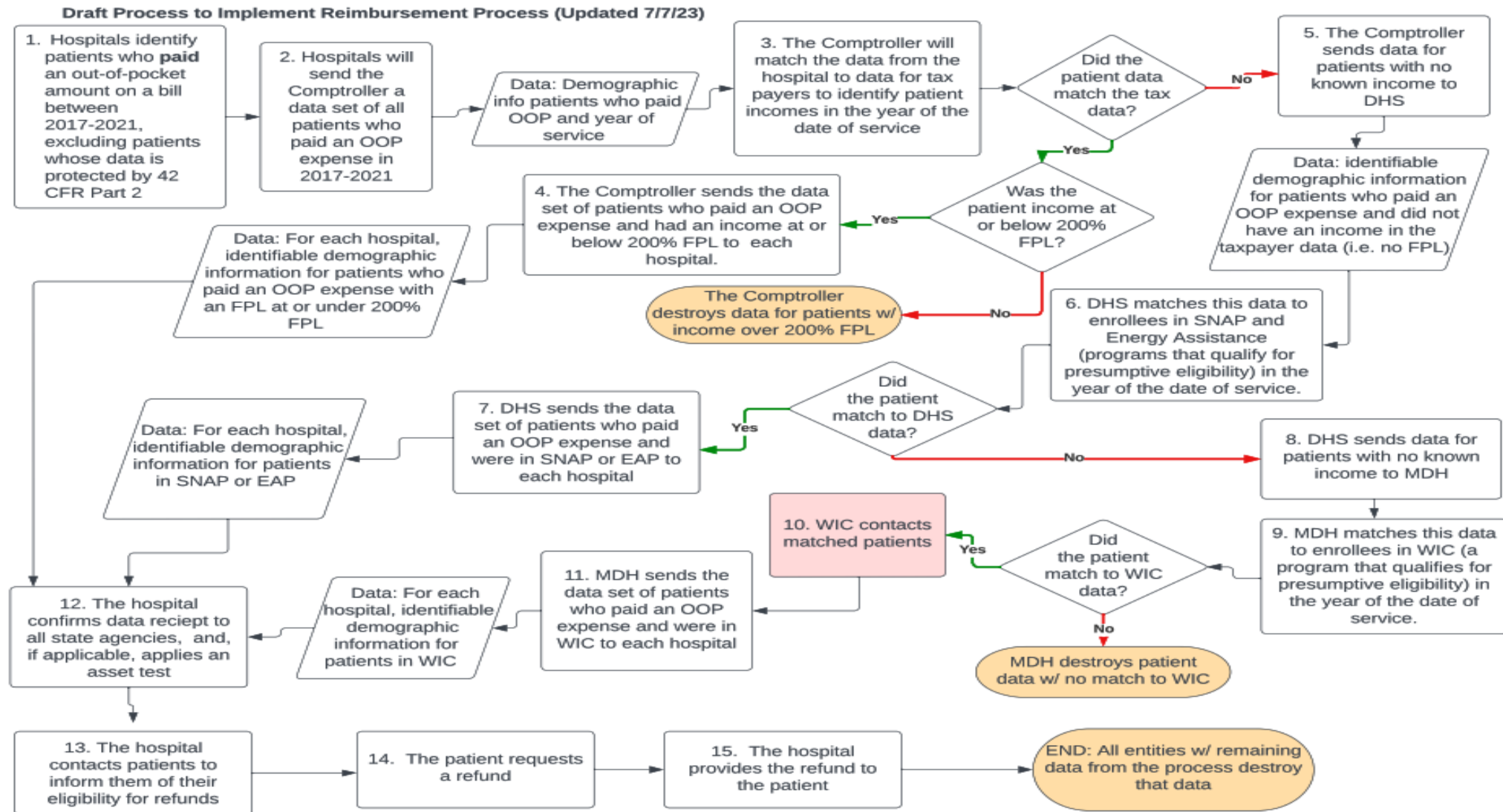
## Legislative highlights:

- Payment Plans
  - Availability of Incomebased Plans
    - Guidelines for calculating income
    - Cannot exceed 5% of the patient's individual income
  - Non-Income based payment plans – Hospital must offer income-based plan first
- Prohibitions
  - No interest for qualified patients
  - No penalties for prepayment or early payment
- Communication
  - Notice requirements (information sheet)
  - Guidelines for missed payment notifications
  - Uniform Financial Assistance Application

# PATIENT REFUND BILL

- The Patient Refund Bill (HB333), passed in the 2023 Legislative Session, requires hospitals to provide refunds to patients who paid out of pocket (OOP) for services but were eligible for free care from 2017 through 2021.
- The law directs the State to develop a process to identify and provide refunds to patients who paid OOP but were eligible for free care
  - Step 1: Hospitals create and send data to Comptroller
  - Step 2: State agencies match and share data
  - Step 3: Hospitals confirm eligibility and contact patients
  - Step 4: Patients request refund and hospitals provide refund

# PATIENT REFUND BILL SCRC'S DRAFT PROCESS



# PATIENT REFUND BILL NEXT STEPS

- **Sept 2022–Feb 2023** HSCRC to host three workgroups to finalize the approach for implementing the Patient Refund Bill
- **Workgroup Details**
  - Data Group *Data template, instructions, matching methodology, secure data exchange, data destruction, etc.*
  - Consumer Messaging & Support Group *Notifications to consumers, hospital web pages, outreach campaigns, etc.*
  - Legal / Policy Group *MOU, DUA, and other policy documents*
- The proposed start date to begin data exchange between hospitals and the Comptroller- **March/April 2024**

# EMERGENCY DEPARTMENT CLAIM (EDC) ANALYZER

## Key Issue:

- United Healthcare (UHC) bypasses the state-mandated HSCRC rate setting for emergency department (ED) visits
- Utilizes proprietary EDC analyzer tool for billing
  - Solely relies on diagnosis and procedure codes
  - Neglects crucial clinical data and HSCRC resource guidelines

## Consequences:

- Increased claim denials and underfunded services
- Additional administrative burden on hospitals
- Erodes the authority of HSCRC's uniform rate setting policies

# EMERGENCY DEPARTMENT CLAIM (EDC) ANALYSIS

## Status:

- MIA Investigation
  - Hospitals filed complaints in 2022
  - MIA found no “inherent” unlawfulness in UCH’s use of the EDC tool
- Recent Update (Aug 29, 2023)
  - UHC discontinued EDC for commercial plans in Maryland
- Exceptions
  - EDC remains in use for self-funded, Medicaid, and Medicare plans

## Next Steps:

- Urge HSCRC to reassert its regulatory authority
- Supply MIA with additional claims, if required

# LEGISLATIVE UPDATE



# MHA 2023 LEGISLATIVE AGENDA



## Strengthen Maryland's Hospital Workforce

- Provide incentives to grow health workforce and faculty pipeline
- Improve licensing process for health care practitioners
- Establish state accountability for health workforce planning & development



## Ensure Access to Care

- Improve behavioral health system of care
- Maintain telehealth flexibilities



## Improve Maryland's Medical Liability Environment

- Senate Liability Work Group Output
- MHA submitted proposals for consideration

# MHA LEGISLATIVE PRIORITIES

## LOOKING AHEAD TO 2024

- New administration and legislature will have a full interim to prepare for the upcoming legislative session
- Budget will be tighter than in previous years; expect the administration to focus more on policy priorities vs. budgetary ones
- Topics expected to return:
  - Medical marijuana in hospitals
  - Hospital workforce
  - Behavioral health
  - Mandated staffing ratios
- New priorities for 2024 are still being evaluated
  - However, one for certain will be improving Maryland's medical liability climate

THANK YOU!

