Maryland AAHAM HSCRC Update

October 27, 2021

Presented by

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Topics

What has the HSCRC been doing this past year?

What are the key focus areas?

What could the future hold?

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Before We Dive In

- New to Maryland and/or not sure what the HSCRC is?
  - You are not alone!
  - HSCRC ⇨ Health Services Cost Review Commission
  - Maryland has been a "waiver state" since 1978, meaning Maryland hospital services are exempt from Medicare payment rates and all payers pay the same price for the same service (with some discounts/exceptions).
  - To keep the waiver, Maryland's rate of change in Medicare hospital spending must be less than the nation.
- Primary goal of the HSCRC: reduce healthcare costs while ensuring high quality healthcare in Maryland.

A Lot Has Changed Since 1978

- The HSCRC was always "hospital-centric" – focused on hospital services that are "regulated" by the state.
- 2014 started a "new model" with the Center for Medicare & Medicaid Innovation (CMMI) which expanded beyond hospitals and looked at all types of care, potential partners in the community, etc.
- In 2019, the "Total Cost of Care Model" (TCOC) began in an effort to "progressively transform care delivery across the health care system with the objective of improving health and quality of care." [https://hscrc.maryland.gov/pages/default.aspx]
  - Focus on "Care Redesign" and "Transformation".

❖ The HSCRC officially announced that all TCOC required metrics were met by Maryland for Calendar Year 2020!

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Who are the Current Commissioners?

Appointed by the Governor

- **Adam Kane**, MBA, JD, MA – Chairman
  Redwood Capital Investments (Government Relations and Regulatory Affairs)
- **Joseph (Joe) Antos**, PhD – Co-Chairman
  American Enterprise Institute
- **Victoria (Tori) W. Bayless**, MHA
  Anne Arundel Medical Center (President and CEO)
- **Stacia Cohen**, RN, MBA
  CareFirst (Executive Vice President of Medical Affairs)
- **James Elliott**, MD
  Doctors Community Hospital (Medical Director)
- **Maulik Joshi**, DrPH
  Meritus Health (President and CEO)
- **Sam Malholtra**
  Subsystem Technologies (Founder and CEO and former Cabinet Secretary of Maryland Department of Human Services)

Who Leads the HSCRC Staff?

- **Katie Wunderlich** – Executive Director
- **Stan Lustman** and **Thomas Werthman** – Legal
- **Jerry Schmith**, **Andrea Strong**, and **Bob Gallion** – Revenue, Regulation, and Compliance
- **Dennis Phelps** – Audit and Compliance
- **Allan Pack** – Population-Based Methodologies
- **Nduka (Andy) Udom** – Financial Methodologies
- **Alyson Schuster**, PhD – Quality Methodologies

Who Leads the HSCRC Staff?

- **William Henderson** and **Claudine Williams** – Medical Economics and Data Analytics
- **Tequila Terry** and **Willem Daniel** – Payment Reform and Stakeholder Alignment
- **Megan Renfrew** – External Affairs
- **Erin Schurmann** – Provider Alignment and Special Projects

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What Has the HSCRC Been Up To?

- From September 2020 to present:
  - Returned to TCOC initiatives after some of the hospital volumes and revenues were close to "pre-pandemic levels".
  - Determined how to treat U.S. Department of Health and Human Services (HHS) Coronavirus Aid, Relief, and Economic Security (CARES) Act federal funding in conjunction with Global Budget Revenue (GBR).
  - Calculated an annual update factor.
  - Progress made with funding multiple programs and updating many methodologies as noted in this presentation.

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Global Budget Updates

- What is a "global budget" or "GBR"?
  - Global budgeted revenue is the total amount of revenue a hospital may **charge**.
  - Does not mean the hospital is **paid** that amount (denials, bad debt, etc.).
  - Revenue is carved into departments, called rate centers, with relative value units and rates for each department.
- The pandemic complicated GBR
  - The HHS CARES Act provided federal funding and Maryland hospitals were not permitted to receive more revenue than their GBR unless their volumes exceeded their GBR budgeted volumes.

Crazy Rates, Not Crazy Eights

- When volumes plummeted, the HSCRC permitted hospitals to temporarily charge above their "normal" rates to avoid huge undercharges (because hospitals were guaranteed their GBRs).
  - This helped ensure more stability than non-Maryland hospitals, but Maryland hospitals were still struggling.
  - A "surge policy" was put in place but was ultimately not needed because volumes declined.
    - This policy would have permitted hospitals to exceed their GBR charges if pandemic volumes exceeded GBR volumes.
  - COVID-related services (such as lab tests, vaccine and monoclonal administration) had prices mirroring Novitas, so revenues were shifted to non-COVID-related services.
- Many hospitals entered FY 2021 with undercharges they were allowed to "carry over" without penalties (not normally the case with undercharges).
  - Once CARES Act funding has been considered, however, the "math" could change dramatically.

FY 2022 Update

- Hospitals under global budgets were to receive an increase of 2.44% overall and 2.43% per capita (with 0.23% earmarked for the rising costs of pharmaceuticals).
- For hospitals not under global budgets, HSCRC temporarily suspended the productivity adjustment as volumes are still relatively uncertain.
- Resulting impacts due to CARES Act funding deductions will be phased into hospital rates.
- FOR THOSE HOSPITALS OVERFUNDED BY THE CARES ACT, THIS COULD MEAN A DECREASE IN RATES FOR FY 2022.

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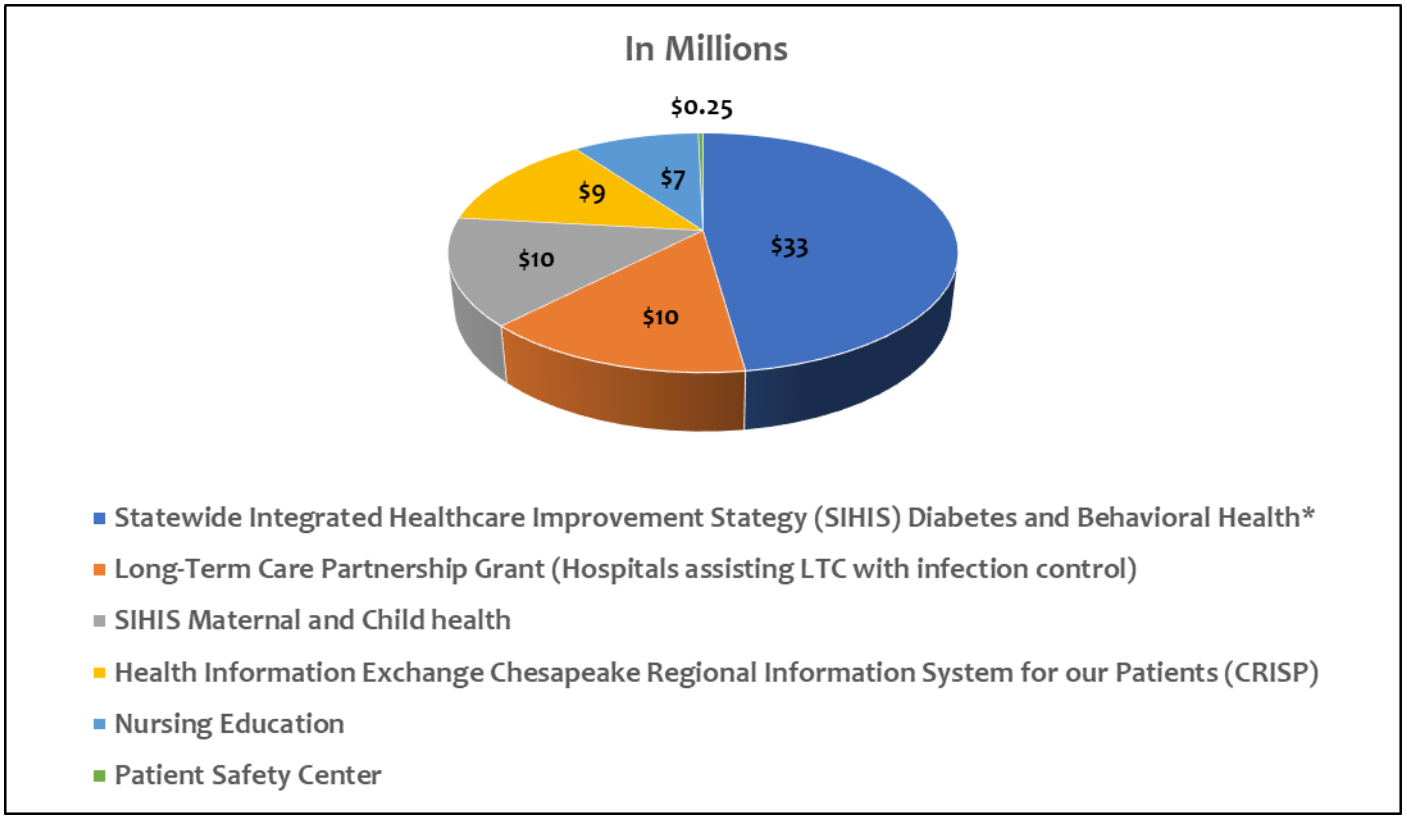
HSCRC Funds Much More Than the "Typical" Hospital Services

- In addition to paying for hospital services, the HSCRC funds:



*=SIHIS has been allocated over 5 years

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Other Funding Consideration: Uncompensated Care

- **What is "uncompensated care" (UCC)?**
  - Bad Debt
  - Charity Care
- **How does Maryland handle it?**
  - All hospitals "pay" a portion of their revenues to the "UCC pool".
  - Hospitals receive money based on a combination of their own UCC and the statewide UCC.
- **Why is it a combination?**
  - Incentivizes hospitals to do the best job possible with collections.
  - Does not penalize hospitals with a patient population that is less able to pay.

Alphabet Soup: HSCRC Initiatives – C Through F

- **Community Benefit Reporting (CBR)**
  - A quantification and narrative regarding how not-for-profit hospitals help their communities and why they should be exempt from taxes.
- **Episode Quality Improvement Program (EQIP)** – NEW
  - An attempt to encourage more efficiency through the continuum of care for certain services, such as a joint replacement.
- **Full Rate Review (FRR)**
  - Hospitals can ask the HSCRC to review their rates if they feel their rates are too low.

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Alphabet Soup: HSCRC initiatives – I through M

- **Integrated Efficiency (IE)**
  - The HSCRC can identify hospitals that appear to be high or low cost compared to other hospitals in the state and adjust their rates accordingly.
- **Maryland Hospital Acquired Conditions (MHAC)**
  - Monitors patients who develop complications after admission to incentivize hospitals to limit these situations. For example, was a bed sore or infection acquired after a patient was admitted or was it already present upon admission?
- **Medicare Performance Adjustment (MPA)**
  - Attempts to "break down" TCOC changes by allocating all Medicare beneficiaries and their associated costs of care to one hospital using geographic location and other allocation methodologies to determine how each hospital is "performing".

Alphabet Soup: HSCRC Initiatives – P Through R

- **Population Health Workforce Support for Disadvantaged Areas (PWSDA)**
  - A demonstration to see if hospitals and other organizations can hire disadvantaged members of the community to help disadvantaged patients navigate their care and improve outcomes.
- **Quality Based Reimbursement (QBR)**
  - Like MHACs, this initiative uses multiple metrics to measure how hospitals are handling certain situations to incentivize high quality. For example, did a patient with chest pain receive an aspirin within a certain time of arrival at the hospital, etc.
- **Readmission Reduction Incentive Program (RRIP)**
  - Incentivizes hospitals to not have patients readmitted within 30 days of their discharge. Some readmissions are unavoidable, but hospitals are supposed to do everything they can to keep patients out of the hospital by helping them get their medications, see their primary care physician, etc.

Telehealth – Good News and Bad News

- The **Preserve Telehealth Access Act** of 2021 (HB 123/SB 3) passed so telehealth and the HSCRC's rate setting authority can stick around, but…
  - Cannot have professional and facility fee for the same virtual service.
  - Payers will often only cover professional telehealth.
  - So, for the facilities with these clinics… ?

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What is the HSCRC's "Key Focus" Now?

- After personally attending the first-ever public strategic planning retreat in Linthicum on August 26th and 27th:
  - HEALTH EQUITY
  - HEALTH EQUITY
  - And…
  - HEALTH EQUITY

(Did we mention they were talking about health equity?)

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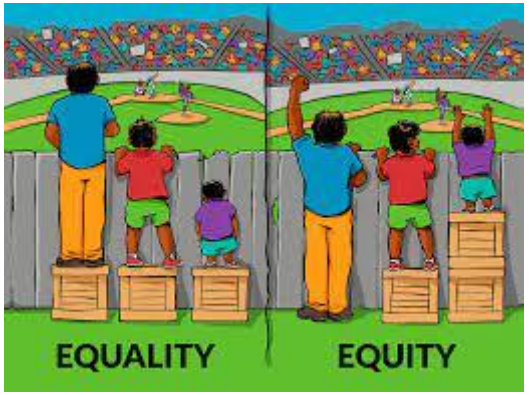
What is "Health Equity"?

- That is one of the first things the HSCRC wants to do – define it in a way that is more understandable and actionable.

  "**Health equity** means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." –The Robert Wood Johnson Foundation (RWJF)

  [https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html]

- What are "barriers to care" certain patients face?
  - Language
  - Education
  - Economics



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What is Already in Place and/or Coming for Maryland?

- Health Equity Commission (HEC)
- Beginning to study new metrics such as:
  - Patient Adversity Index (AVI)
    - What can a race, zip code, and Medicaid status reveal about the risk of uncompensated care and readmissions so additional help can be provided?
  - Area Deprivation Index (ADI) for zip codes
  - Locally-Driven Disparity Reduction Targets can be established for:
    - Admissions
    - Readmissions
    - ER Visits
- What can be done?
  - Hospitals knowing their own HE.
  - More transparency around HE.
  - More provider training around bias.
  - Leveraging of telehealth.
  - Stop "payer-mix-based investments".

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What Are Other Key Areas?

- More accountability for partnership grants (SIHIS).
  - Where is the money going?
  - Is it making a difference with diabetes, overdose deaths, maternal morbidity, and childhood asthma?
- Understanding why costs vary so significantly between hospitals.
- Working towards better definitions and programs for Population Health.
  - The CBR cannot just be "something to check off the list". Community needs must be assessed and addressed to earn tax-exempt status – requiring results without excessive infrastructure.
  - Incentivizing and/or penalizing hospitals not investing in population health.
  - Encouraging an emphasis on population health *before* age 65.
  - Disadvantaged individuals need to be included in the planning. They might not be the ones responding to surveys, but they have ideas that are critical and valuable.

What Could the Future Hold?

- The HSCRC recognizes there is currently much beyond their "regulatory control" as they strive for healthcare efficiency by 2030:
  - Rapid growth of care costs and depletion of the Medicare Trust Fund.
  - Drive for site-neutral payments.
  - Staffing shortages: Physicians, Nurses, etc.
  - New entrants into the Market (such as Amazon).
  - Strong need for transparency, accountability, and improved quality.
    - Consumer expectations are at an all time high, and many consumers are not receiving high quality care from their providers.
  - Significant disparities with health equity.

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Could Regulation Expand?

- Could there be an extension of regulation authority in Maryland?
  - Where physician and other "unregulated" services have some form of regulation?
  - What can other more limited state models teach? (e.g., Vermont, Pennsylvania, Delaware, Massachusetts)
  - What about statutory, political, and staffing barriers?
    - Need for more subject matter expertise and/or access to national resources?
    - Offload more administrative tasks of HSCRC such as CRISP?
  - Better definition of roles between commissioners and staff?
    - More 1:1 time between commissioners and staff?
  - Do current discussions regarding state vs. national licensure come into play?

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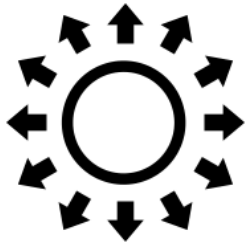

Is Simplification Best?

- Could costs be better controlled and health equity still be addressed with a model that is more simplistic/less complex, so it is more understandable by all stakeholders? Could Maryland:
  - "Lead the way" in quality, access, cost, and patient experience across ALL hospitals?
  - Stop utilization-based payments and funding unnecessary infrastructure?
  - Rethink incentive structures for:
    - Revenue For Reform (R4R)/contracts based on quality?
    - Patient outcomes (P4P – Pay for Performance including 30-day mortality)?
    - Patient satisfaction surveys?
  - Improve technology and platforms?

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Could There Be More Collaboration by the HSCRC With These Agencies/Programs?

- Community Care Systems and Community Health Workers
- Maryland Healthcare Commission (MHCC)
  - Consumer quality website
- Maryland Insurance Administration (MIA)
- Maryland Department of Health (MDH)
  - Increase consumer/patient resources

- Maryland Department of Housing & Community Development (DHCD)
- Maryland Department of Labor, Licensing, and Regulation (DLLR)
  - More vocation education
- Maryland Primary Care Program (MDPCP)

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Tough Questions

- Can initiatives be consolidated into "buckets" where policies clearly identify goals, impacted stakeholders, etc.?
- With near constant price changes under GBR, how can "volatility" be reduced for consumers and cost sharing?
- Medicare costs an estimated $700 million more in Maryland; other states subsidize Medicare shortfalls with other payers.
  - Where can savings come from?
  - Reductions in provider expenses, volumes, revenues?
- Should there be less "unique Maryland" programs? Should Maryland follow the nation more?
  - What is the cost/benefit of that?
  - Should Maryland stop adding programs and start streamlining or removing unsuccessful programs?

Other Thoughts

- How does Maryland address rural behavioral health shortages and other access issues?
- How can funding shift more hospital inpatients and nursing home patients to home-based care?
  - What are the billing implications?
- How can data quality be improved?
  - Are there unnecessary metrics that could be discontinued to mitigate "measurement burden"?
  - Are there other pathways to data?
- How can quality be aligned across payers and providers?
  - Can we have a collective vs. individual approach and avoid silos?

Recap

- Maryland truly is a "petri dish" for the nation where new programs are tested to see if they could work across the U.S. to improve healthcare.
- Watch for strides being made in Maryland with diabetes, mental health, maternal morbidity, and childhood asthma, with a special focus on those geographical areas most in need.
- **Everyone can do their part to help; we are all healthcare consumers *and* patients.**

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NEW VISION STATEMENT

The Maryland Model, stabilized and embracing a population health approach for all providers, will serve as the nation's leader in health equity, quality, access, total cost, and consumer experience by leveraging value-based payment methodologies across all payers.

Acronyms

- AVI → Patient Adversity Index
- ADI → Area Deprivation Index
- CARES → Coronavirus Aid, Relief, and Economic Security
- CBR → Community Benefit Reporting
- CMMI → Center for Medicare & Medicaid Innovation
- CMS → Centers for Medicare and Medicaid Services
- CRISP → Health Information Exchange Chesapeake Regional Informational System
- DHCD → Maryland Department of Housing & Community Development
- DLLR → Department of Labor, Licensing and Regulation
- EQIP → Episode Quality Improvement Program
- FFR → Full Rate Review
- GBR → Global Budget Revenue
- HE → Health Equity
- HEC → Health Equity Commission
- HHS → U.S. Department of Health and Human Services

More Acronyms

- HSCRC → Health Services Cost Review Commission
- IE → Integrated Efficiency
- MDH → Maryland Department of Health
- MDPCP → Maryland Primary Care Program
- MHAC → Maryland Hospital Acquired Conditions
- MHCC → Maryland Healthcare Commission
- MIA → Maryland Insurance Administration
- MPA → Medicare Performance Adjustment
- P4P → Pay for Performance
- PWSDA → Population Health Workforce Support for Disadvantaged Areas
- QBR → Quality Based Reimbursement
- R4R → Revenue for Reform
- RRIP → Readmission Reduction Incentive Program
- SIHIS → Statewide Integrated Healthcare Improvement Strategy
- TCOC → Total Cost of Care

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Want to Learn More?

- **Start exploring here:**
  - https://hscrc.maryland.gov/pages/default.aspx

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Questions

Thank you!

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