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Annual Governor's Report

Fiscal Year 2022 Activities and Calendar Year 2022

Total Cost of Care Model Performance

July 2023

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Introduction

The Health Services Cost Review Commission (HSCRC) is an independent State agency responsible for regulating the quality and cost of hospital services to ensure all Marylanders have access to high quality healthcare through hospital global budgets and innovative efforts to transform the delivery system. The State of Maryland is leading a transformative effort to improve the quality of care and health outcomes, including population health and health equity, while also lowering healthcare spending growth under the unique Maryland Health Model (or “Maryland Model").

The Maryland Health Model—

- Incentivizes better health outcomes through pay-for-performance programs, linking quality and payment;
- Guarantees equitable funding for uncompensated care, ensuring that low-income individuals have access to care at all hospitals;
- Creates a stable and predictable revenue system for hospitals, a benefit of the Model that was particularly important in the pandemic;
- Uses savings generated from reduced hospital utilization to fund investments in population health and health equity; and
- Provides support for state healthcare infrastructure and subject matter expertise on health care financing and reform.

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

The Maryland Health Model has two major components, the Total Cost of Care (TCOC) Model Agreement with the federal government and Maryland’s long standing all-payer hospital rate setting system. The TCOC Model, which began in January 2019, aims to enhance the quality of healthcare and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders. The HSCRC helps direct the State’s innovative efforts to transform the delivery system and achieve goals under the TCOC Model.

This annual report is prepared in accordance with Section 19-207(b)(9) of the Health-General Article of the Annotated Code of Maryland (MSAR #10266). This report includes:

- An overview of the TCOC Model and implementation activities related to the Model;
- A summary of the State’s performance under the TCOC Model; and

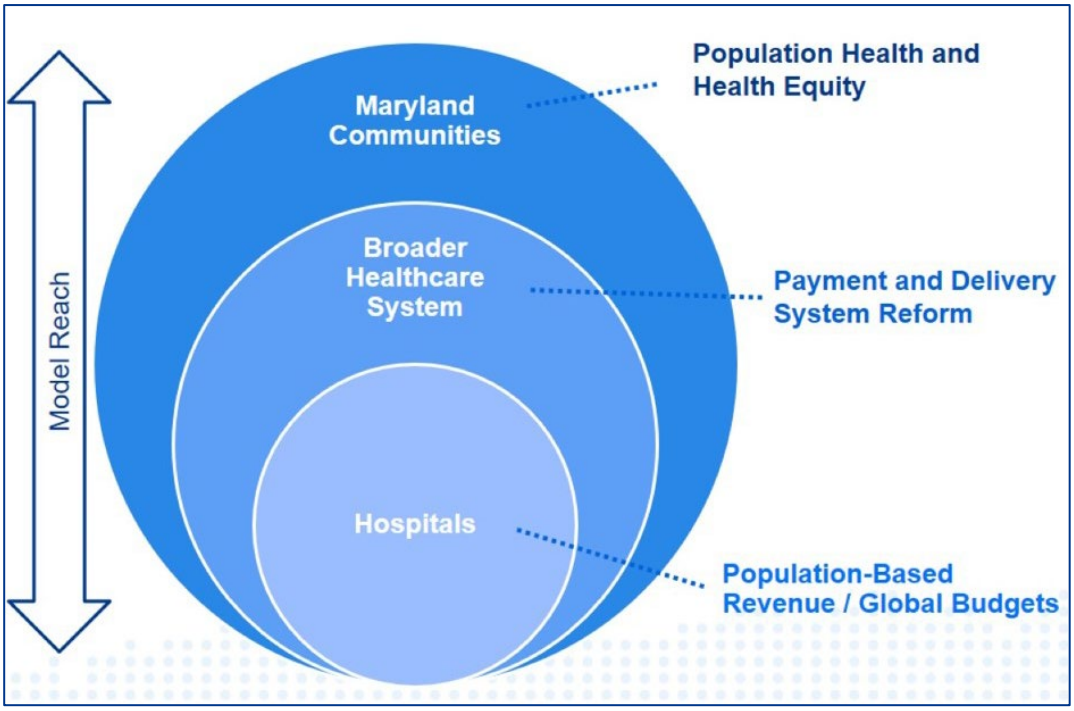
- An update on other HSCRC activities, including care transformation efforts, public and private partnerships, stakeholder engagement, quality initiatives, and rate setting methodology development.

Section I: Overview of TCOC Model and Key Requirements

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

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

Figure 1: TCOC Model Components

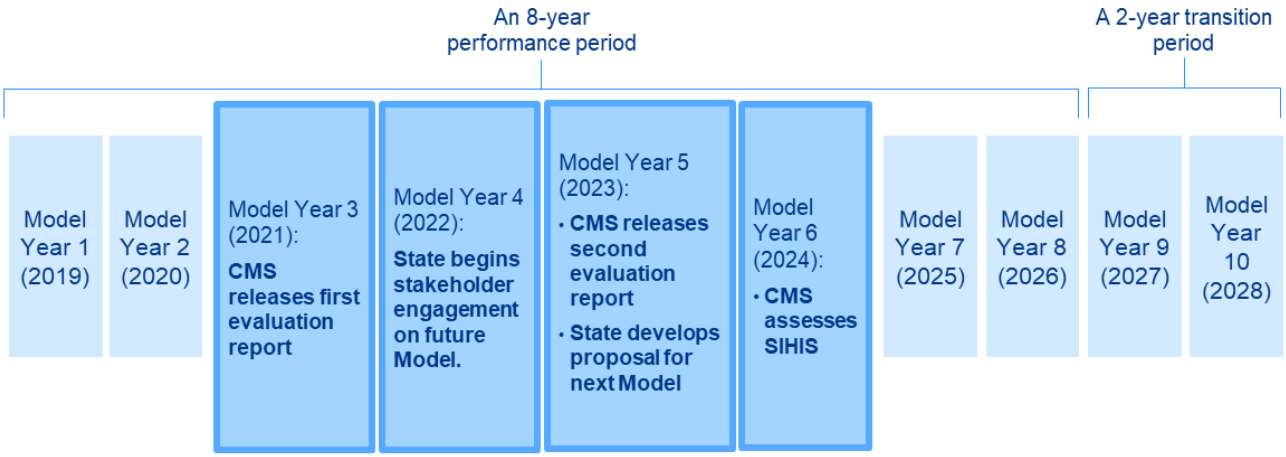


- **Hospital Population-Based Revenue:** The Model allows the State to set hospital payments for Medicare. Under the TCOC Model agreement, hospitals are subject to global budgets, which set an annual payment limit for hospitals regardless of the hospital utilization rate. Global budgets, which have been in place for all general acute hospitals since 2014, have fundamentally changed hospitals' incentives from increasing fee-for-service volume to improving population health and driving toward value-based outcomes. The hospital rate-setting system is discussed in Section VII.
- **Payment and Delivery System Reform:**
    - **Care Redesign and Transformation Programs:** These programs foster care transformation across the health system by expanding incentives for hospitals to work with other providers and creating opportunities for value-based care programs for non-hospital providers. These programs are discussed in Section V.
    - **Maryland Primary Care Program**: The Maryland Primary Care Program (MDPCP) enhances chronic care and health management for Medicare enrollees through advanced primary care. This program is discussed in Section V.
- **Population Health and Health Equity:** The TCOC Model encourages programs and provides financial credit for improvement in population health. In addition, HSCRC and CMMI are committed to improving health equity. These initiatives are discussed in Section IV.

Model Timeline

The TCOC Model Agreement with CMS is a ten-year agreement that began in 2019. The Model ends in 2026, followed by a two-year transition period.

Figure 2: TCOC Model Timeline



In 2022, HSCRC organized stakeholder workgroups to gather input on the future of the TCOC Model beyond 2026. These workgroups ran through the spring of 2023. Workgroups focused on topics to drive continued innovation and improvements under the Maryland Model which include 1) financial targets and cost containment, 2) multi-payer alignment, 3) physician engagement and alignment, 4) post-acute and long-term care, 5) quality, population health, and health equity, and 6) consumer experience. The recommendations from these workgroups will inform priorities on the future of the Maryland Model and serve as a foundation for negotiations with CMMI on a future Maryland Model.

CMS Evaluation of the Maryland Model

CMS released a second evaluation of the TCOC Model in December of 2022.[1] This quantitative evaluation focused on Maryland's performance under the Model in calendar years (CY) 2019 through 2021. The evaluation report was generally positive, noting that the State:

1. Reduced total Medicare fee-for-service (FFS) Part A and B spending by 2.5 percent, a total reduction of $781 million on healthcare spending;
2. Improved several quality-of-care measures, include decreasing potentially preventable admissions by 16.1 percent, decreasing unplanned hospital readmissions by 9.5 percent, and increasing timely follow-up after hospital discharge by 2.5 percent; and
3. Reduced rates of all-cause acute care hospital admissions by 16.1 percent

[1] In 2021, CMS released its first evaluation of the TCOC Model. This evaluation was generally positive and is available on CMMI's website, https://innovation.cms.gov/innovation-models/md-tccm

Additionally, the evaluation indicated that efforts to improve efficiency in care have not resulted in lower patient satisfaction ratings. The next evaluation report from CMS will be released in late 2023.

Performance Targets

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

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

- **Annual Medicare Total Cost of Care Savings Target**: Each year Maryland must generate savings for the Medicare program on a total cost of care basis. In 2022, the annual savings target was $267 million.
- **TCOC Guardrail Test:** Maryland must not exceed national Medicare spending per beneficiary growth rate by more than 1 percent in any year and/or exceed that national growth rate by any amount for two years in a row.
- **All-Payer Hospital Revenue Growth Per Capita:** Maryland must keep all-payer hospital revenue growth equal to or below a compounded average of 3.58 percent per capita annually throughout the term of the contract.
- **Readmissions Reductions for Medicare:** Maryland must match or exceed national and prior Maryland Medicare readmissions rates.
- **All-Payer Reductions in Hospital- Acquired Conditions:** The State must match or exceed previous Maryland performance on all-payer potentially preventable condition (PPC) measures.
- **Hospital Revenue under Population-Based Payment Methodology:** Maryland must have at least 95 percent of hospital revenue under a population-based payment methodology (i.e., global budget revenue) over the course of the Model.

Maryland performance between CY 2019 and CY 2022 is shown in the table below.

Table 1. TCOC Model Performance, 2019-2022

Performance Measures	Annual Targets	2019	2020	2021	2022
Annual Medicare TCOC Savings	$120M (2019), $156M (2020), $222M (2021), $267M (2022) in annual Maryland Medicare TCOC per Beneficiary of savings	✓	✓	✓	✓

TCOC Guardrail Test	Cannot exceed growth in National Medicare TCOC per beneficiary by more than 1% per year and cannot exceed the National Medicare TCOC per beneficiary by any amount for 2+ consecutive years	✓	✓	✓	×
All-Payer Revenue Limit	All-payer growth ≤ 3.58% per capita	✓	✓	✓	✓
Improvement in All-Payer Potentially Preventable Conditions	Exceed the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition program (MHAC)	✓	✓	✓	✓
Readmissions Reductions for Medicare	Maryland's aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate at regulated hospitals ≤ the National Readmission Rate for Medicare FFS beneficiaries	✓	✓	×[2]	×
Hospital Population Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	✓	✓	✓	✓

In 2019 through 2020, Maryland met or exceeded all TCOC contractual annual performance targets. In 2021, Maryland did not meet the Medicare readmissions reductions test in 2021, which requires the State to be below the National Medicare unadjusted readmission rate. HSCRC staff believe the unadjusted readmission rate has increased due to higher patient acuity over time. CMMI granted an exogenous factor request for missing the 2021 target.

In 2022, the State met four of the six contractual requirements. The State did not meet the requirements for the TCOC Guardrail Tests and the Readmissions Reductions for Medicare. Model performance results for 2022 are presented in the table above and have been certified by CMMI. This report discusses the factors influencing the State's performance and actions taken to address these challenges.

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

Memorandum of Understanding and TCOC Agreement Amendments

In 2022, the Center for Medicare and Medicaid Innovation (CMMI) and the State reinforced their mutual support for the Maryland Health Model in 2022 by executing a memorandum of understanding (MOU)

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

specifying savings targets under the TCOC Model for 2024 through 2026, as well as important population health, quality, and health equity goals.

Under the MOU, Maryland is obligated to generate savings for Medicare of $336 million in 2024, $372 million in 2025, and $408 million in 2026. The MOU also affirms the State's commitment to continued improvements in hospital quality performance, population health, and health equity and to the alignment of Medicaid with MDPCP. The State of Maryland looks forward to working with partners throughout the State, including hospitals and physicians, to continue to improve health care for Marylanders.

The agreed-upon amendments to the TCOC Model agreement include further financial accountability for primary care practices in the MDPCP program and new funding for disadvantaged residents served by MDPCP practices. The MDPCP program is administered at the state-level by the Maryland Department of Health.[3]

The State Amendment Agreement and the MOU (with a cover letter from CMS) are available on HSCRC's website.[4]

Section II: Total Cost of Care Financial Performance (Calendar Year 2022)

Total Hospital Per Capita Cost Growth

The Maryland TCOC Model agreement requires the State to limit its compounded average annual all-payer hospital per capita revenue growth rate to 3.58 percent. This number is based on the average growth in per capita gross state product (GSP) for the period 2002 through 2012. Through 2022, Maryland has an average per capita cost growth of 2.77 percent since 2013, 0.81 points below the 3.58 percent limit. From 2019 to 2022, average per capita all-payer revenue growth of 4.13 percent, slightly above the 3.58 percent target. This higher growth rate is primarily due to disruptions caused by the pandemic. During CY 2022, considerable revenue was provided to hospitals through pandemic-related policies. This revenue was one-

[3] The amendment creates a third track within MDPCP, a voluntary program that provides financial and technical support to eligible Maryland primary care practices and Federally Qualified Health Centers (FQHCs) for the delivery of advanced primary care. In Tracks 1 and 2, CMS offers a performance-based incentive payment to health care providers intended to incentivize them to reduce rates of hospital admissions and to improve the quality of care for their attributed Medicare beneficiaries. Track 3 will commence in 2023 and will meet the request from the CMMI to increase financial accountability for primary care practices and to further align with national priorities. The amendment also includes opportunities for FQHCs to participate in Track 1 and Track 2.
The amendment also includes the addition of a new Health Equity Advancement Resource and Transformation (HEART) payment to support residents and to promote the State and CMS' goal of improving the health of all Marylanders. This money can help pay for health-related support or access to food and nutrition care-management services, among other needs for those that qualify.
[4] State Amendment Agreement and MOU. https://hscrc.maryland.gov/Pages/tcocmodel.aspx

time in nature and will not affect CY 2023 revenue. Additionally, Maryland population estimates used to determine per capita cost growth have historically been understated. Maryland population estimates grew after being restated by the 2020 census which will likely result in improve performance on this test. The HSCRC is working to determine actual population growth during the model period and propose appropriate adjustments to the calculation of the all-payer hospital per capita revenue growth to CMMI to reflect the higher estimates.

Medicare Savings Target and Guardrail Performance

Maryland was required to generate an annual $267 million in TCOC savings in CY 2022. Maryland achieved $269.1 million in CY 2022 Medicare TCOC savings, meeting the CY 2022 TCOC savings target of $267 million.

Table 2. Annual Medicare TCOC Savings (in millions)

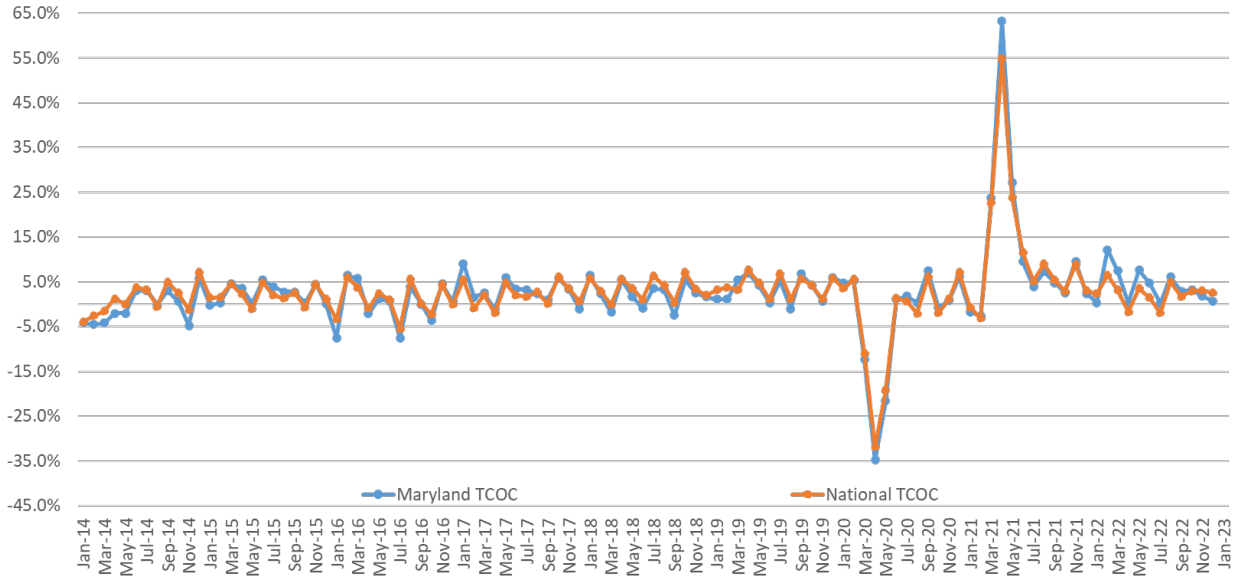
	2019	2022	2021	2022	2023	2024	2025	2026
Target	$120	$156	$222	$267	$300	$336	$372	$408
Actual	$365	$391	$378	$269	TBD	TBD	TBD	TBD

Under the TCOC Model agreement, the total cost of care growth for Maryland Medicare beneficiaries may not exceed the national growth rate by more than one percent in any given year and may not exceed the national growth rate by any amount in two consecutive years. This test is referred to as the "guardrail." Maryland met this model test in 2019, 2020 and 2021. Maryland did not meet the TCOC guardrail test in CY 2022, ending the year 0.9 percent above national Medicare TCOC spending growth and above the national growth for a second year in a row.

During the second half of 2022, HSCRC was concerned about the State's potential performance on these targets. Because of these concerns, HSCRC Commissioners acted in December 2022 to address the anticipated shortfall and missed guardrail test. Those actions are discussed further in this section.

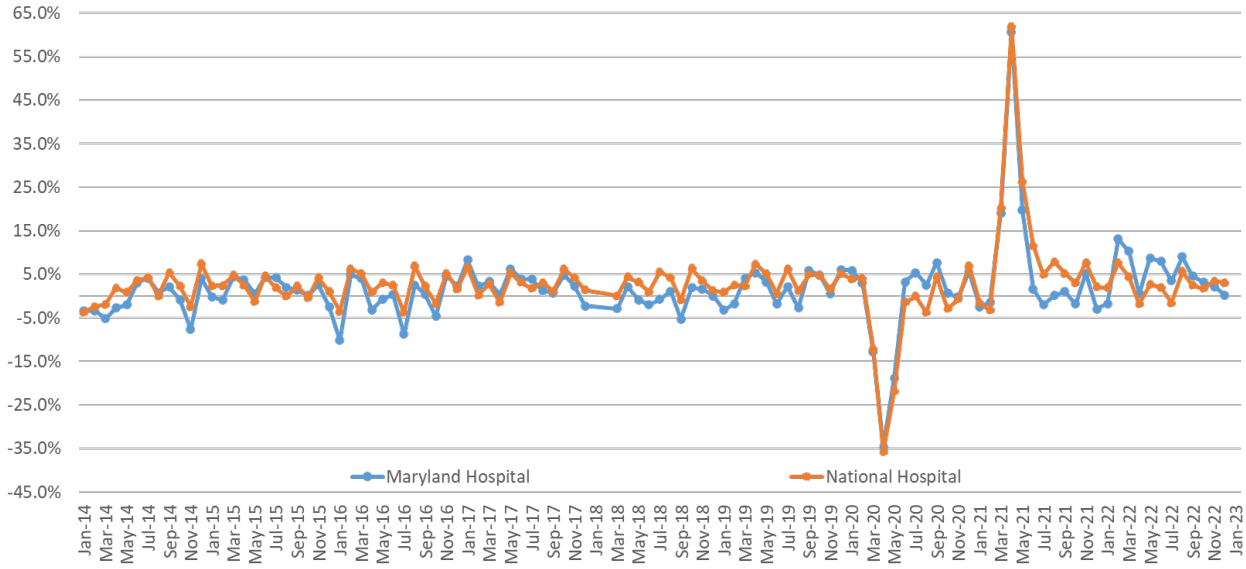
The following figures represent actual growth trends from CY 2014 through CY 2022. The trend measures growth for the current calendar year month versus the prior calendar year month. In CY 2022, Maryland total cost of care per capita spending was above the nation much of the year but ended the calendar year below the nation. Maryland hospital spending per capita also ended the year favorably when compared with the nation, although exceeded the nation throughout most of the calendar year. Non-hospital spending per capita was on trend compared to the nation during CY 2022.

Figure 1. Total Cost of Care per Capita, CY 2014-December 2022



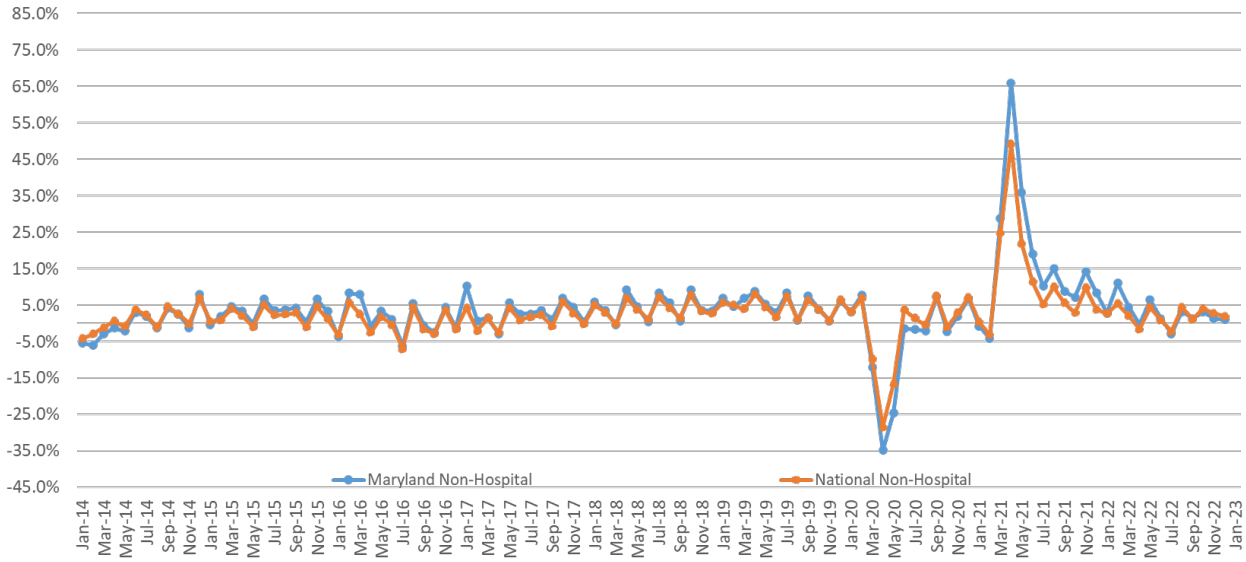
Source: CMMI Monthly Data Reports to HSCRC

Figure 2. Medicare Hospital Spending per Capita, CY 2014- December 2022



Source: CMMI Monthly Data Reports to HSCRC

Figure 3. Medicare Non-Hospital Spending per Capita, CY 2014- December 2022



Source: CMMI Monthly Data Reports to HSCRC

Policies Influencing Financial Performance and TCOC

Medicare Performance Adjustment (MPA)

The HSCRC implemented the Medicare Performance Adjustment (MPA, or "MPA Traditional") to assist the State in managing both hospital and non-hospital costs under the TCOC Model. The MPA adjusts hospital Medicare payments based on Medicare total cost of care performance. Medicare Payment adjustments began in July 2019 (Rate Year 2020). In CY 2022, the MPA policy attribution changed from the traditional primary care-based algorithm to a geographic approach, with an additional attribution layer for Academic Medical Centers. The new approach was approved by Commissioners in December 2021.

Update Factor

The Update Factor policy is an annual, system-wide update to hospital global budget revenue (GBR) that incorporates quality, volume, and other adjustments that determine the reasonableness of hospital prices. HSCRC staff seek to balance the following conditions when considering the update: meeting the requirements of the TCOC Model agreement:

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

The Rate Year (RY) 2023 Update Factor was implemented on July 1, 2022, and included the following policy elements:

- An overall increase of 3.25 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.38 percent per capita revenue increase for hospitals under global budgets.
    - All hospitals were given a base inflation increase of 3.66 percent of revenue. 0.02 percent of the total inflation allowance was allocated based on each hospital's proportion of drug cost to the total cost to adjust hospitals' revenue budgets more equitably for increases in drug prices and high-cost drugs. Furthermore, an additional 0.40 percent to was provided account for the underfunding of inflation though the pandemic from FY2020-FY2022
- An overall increase of 3.66 percent of revenue for inflation and an additional 0.40 percent to account for the underfunding of inflation throughout the pandemic for FY 2020-FY 2022 to the rates of hospitals not under global budgets (freestanding psychiatric hospitals and Mount Washington Pediatric Hospital).

HSCRC approved the RY 2024 Update Factor in June 2023, for a July 1, 2023, implementation date.[5] The Commission will continue to closely monitor performance targets for Medicare, including Medicare's growth in total cost of care during the CY 23 performance year and may further adjust rates as it deems necessary.

Actions to Address CY 2022 Savings and Guardrail Performance

Under the TCOC Model agreement, Maryland was obligated to generate $267 million in Medicare total cost of care savings in CY 2022 and to not exceed national Medicare TCOC growth two years in a row. Despite generating $269.1 million in savings late in CY 2022, HSCRC was concerned that the State would not meet these requirements. In the second half of 2022, early data on Medicare fee-for-service (FFS) spending raised HSCRC concerns that Maryland would miss the 2022 Medicare TCOC savings target and that spending was growing at a rate that would cause the State to fail the 2023 savings target as well. Several exogenous factors associated with the COVID-19 pandemic impacted Maryland's performance on the savings and guardrail measures, including escalating workforce costs and inflation that have constrained volume growth nationally and differing cost trends produced by a volume-based FFS reimbursement system compared to a value-based prospective global budget reimbursement system during periods of declining volumes. As part of HSCRC's pandemic relief policies, HSCRC allowed hospitals to carry-over the difference between their global budgets in 2020 and 2021 and the amount they were able to charge in those years (the "undercharge") to future years, smoothing out the financial impact of the pandemic on

[5] In July 2023, all hospitals will receive a base inflation increase of 3.35 percent and hospitals with GBRs will receive an overall increase of 3.58 percent for revenue.

hospitals while controlling prices for consumers and payers. The last year that the carry-over from past undercharges appeared in hospital rates was 2022. HSCRC's ability to provide financial support to the hospitals during the COVID-19 pandemic is an important feature of Maryland's global budget system, which limits cost increases over time while it also protects hospitals from financial crisis in unusual situations like the pandemic.

In addition, HSCRC relied on a federal estimate of Medicare cost growth from the Office of the Actuary (OACT) when setting the hospital annual update in 2022 that was intended to act as a guard against Maryland revenues increasing faster than national growth. At the time, OACT projected 7.1 percent national Medicare total cost of care growth. The difference between this estimate and the actual national Medicare growth in 2022 (2.6 percent) contributed to concerns about Maryland's savings position.

The HSCRC believed it was important to take proactive steps to address the projected savings shortfall, as opposed to delaying action until CMMI verified final CY 2022 performance in summer 2023. The Commission took actions at the December 2022 public meeting to address the excess Medicare growth in Maryland, with the goal of coming back into compliance with TCOC contract requirements in CY 2023.

Actions taken to generate $103 million in Medicare savings and mitigate the impact of revenue reductions to the hospital field include:

1. **All-Payer Rate Reduction:** Effective January 2023, HSCRC reduced all-payer rates by 0.20 percent. This reduction is expected to generate $40 million in all-payer savings, including $13.5 million in Medicare FFS savings.
2. **Medicare-only payment reductions:** CMMI approved the HSCRC's annual MPA proposal which requested an adjustment that would reduce Medicare payments by an additional $64 million across all hospitals for CY 2023.
3. **Public Payer Differential Adjustment:** CMMI approved the HSCRC's request to increase the Public Payer Differential temporarily by 1 percent for the remainder of FY 2023 (beginning April 2023) and all of FY 2024. The Public Payer Differential reduces Medicare and Medicaid rates, while increasing commercial payer rates by $50 million. The HSCRC expects this to contribute $26 million in savings to Medicare. This has no impact on hospital finances but increases costs to non-public payers.
4. **Medicaid Deficit Assessment Reduction:** The Budget Reconciliation and Financing Act (BRFA) of 2023 included a provision to reduce the Medicaid Deficit Assessment by $50 million in FY 2024. This reduction offsets the reductions to hospital revenues from the adjustments discussed above. It does not generate any savings to Medicare.

Section III: Hospital Quality Programs & Performance

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

Quality-Based Reimbursement (QBR) Program

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

Table 3. QBR Measure Domain Weights for FY 2020-FY 2024

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

In the FY 2024 policy update, the HSCRC piloted the use of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) linear scores to encourage improvement in patient reported experience of care. The goal of this policy update is overall improvements in quality of care. HSCRC staff also selected specific measures to drive improvements in the Patient and Community Engagement domain:

- Nurse Communication
- Doctor Communication
- Staff Responsiveness
- Care Transition

The HSCRC aligns the QBR program measures and weights, to the extent possible, with the CMS Value-Based Purchasing (VBP) Program, while also targeting areas of needed improvement in Maryland.

Updated Data Trends

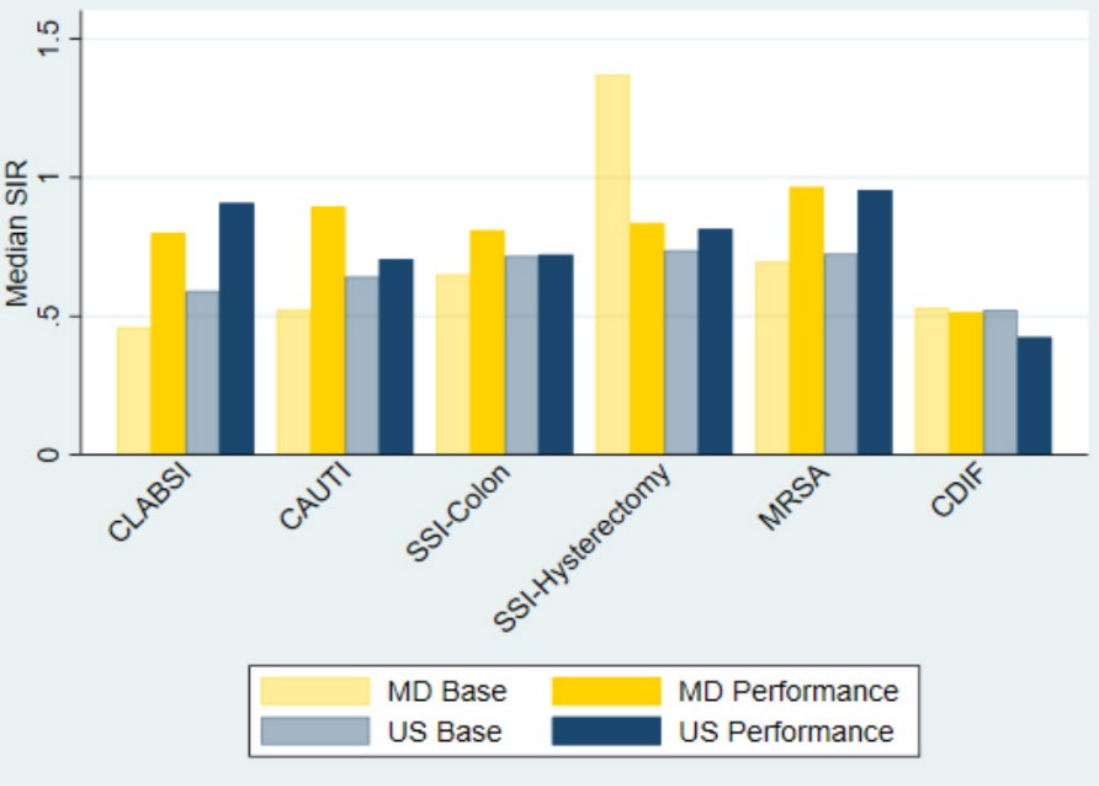
Maryland's QBR program is similar in design and detail to the federal Medicare VBP Program. Data trends for the most recently available specified performance periods are presented below. Staff notes that the performance periods differ across measures based on data availability.

Safety Domain

For the healthcare-associated infection measures in the Safety domain, as illustrated in Figure 4 below, Maryland is performing worse (i.e. a lower rate is better) than the nation on CAUTI, SSI- Colon, and C.Diff, better than the nation on CLABSI, and on par with the nation on SSI-Hysterectomy and MRSA.[6] Staff notes that performance for both Maryland and the Nation has worsened compared to the timeframe prior to the COVID-19 pandemic.

Figure 4. Maryland Performance vs Nation on Healthcare Associated Infections

***Base Year**: CY 2019 **Performance Year**: CY2021Q2-CY2022Q1*

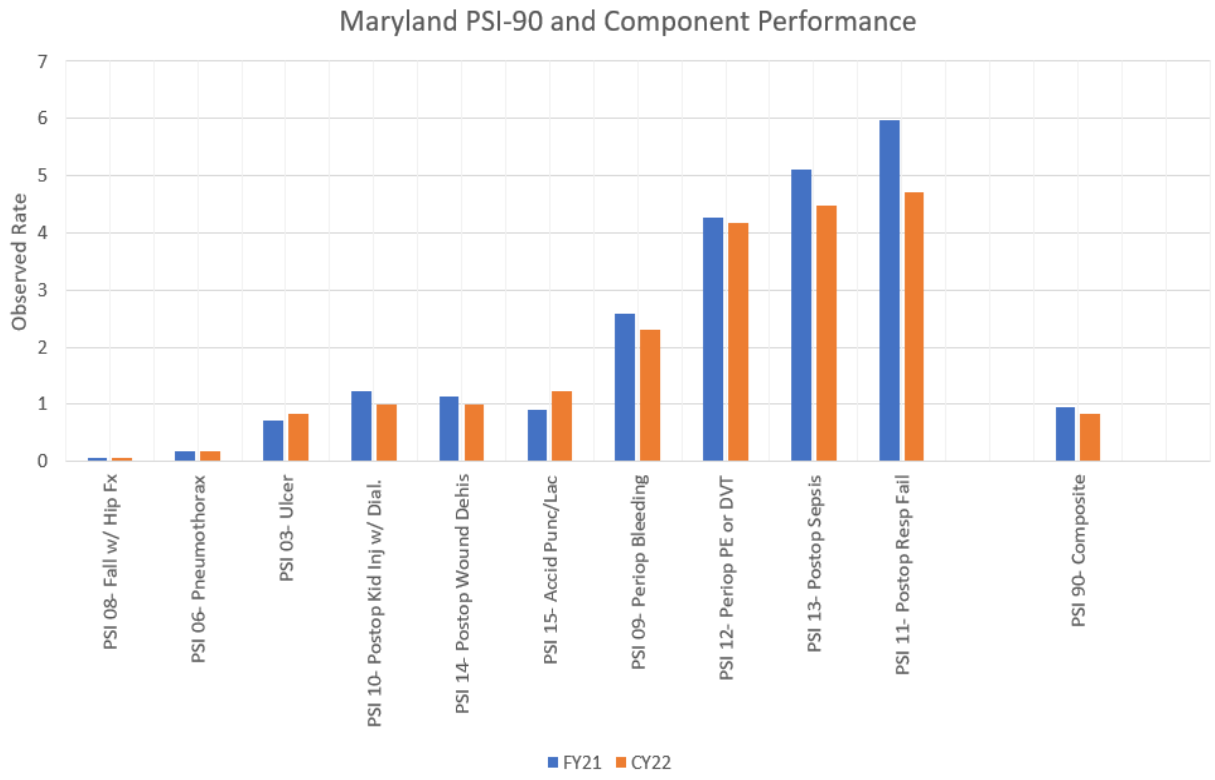


[6] Catheter-associated urinary tract infections (CAUTI), Surgical Site Infection (SSI) - Colon, Clostridioides difficile (C. Diff), Central Line-associated Bloodstream Infection (CLABSI), Surgical Site Infection (SSI) - Hysterectomy, and Methicillin-resistant Staphylococcus aureus (MRSA).

Source: CMS Care Compare Data.

On the all-payer Patient Safety Index (PSI)-90 composite measure and the component indicators, Maryland's statewide performance has improved (lower rate is better) from FY 2021 compared to CY 2022 for all measures except PSI 03- Pressure Ulcer, PSI 60- Iatrogenic Pneumothorax, PSI 08- In Hospital Fall with Hip Fracture, and PSI 15- Unrecognized Abdominopelvic Accidental Puncture or Laceration as illustrated in Figure 5 below. While these four measures saw worsened performance, the composite measure improved slightly.

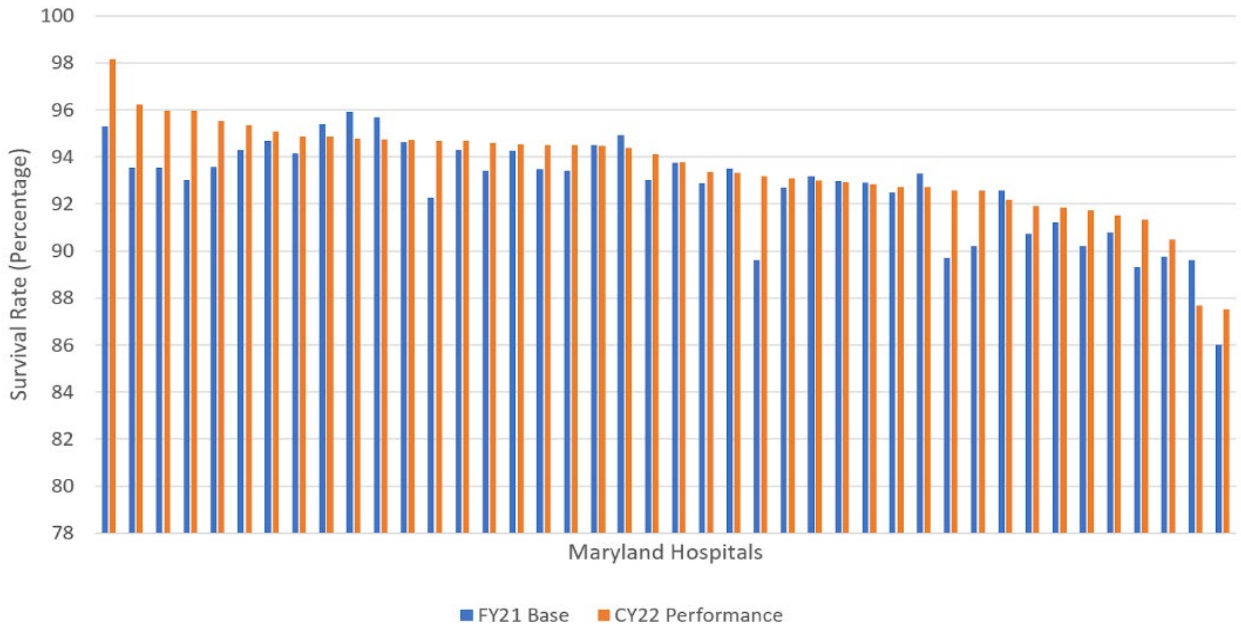
Figure 5. Maryland All-Payer, AHRQ PSI 90 Composite Measure Performance FY 2021 vs. CY 2022



Source: HSCRC Case-mix Data

Clinical Care Domain

The Clinical Care domain consists of Inpatient Mortality and the Medicare Total Hip and Knee Arthroplasty Complication measure. On inpatient survival, 12 of 42 hospitals have worsened slightly in CY 2022 when compared to FY 2021 with the statewide survival rate being 93.55 percent (i.e., mortality rate is 6.45 percent) (Figure 6). Figure 6. RY 2024 QBR Risk-Adjusted Survival Rate

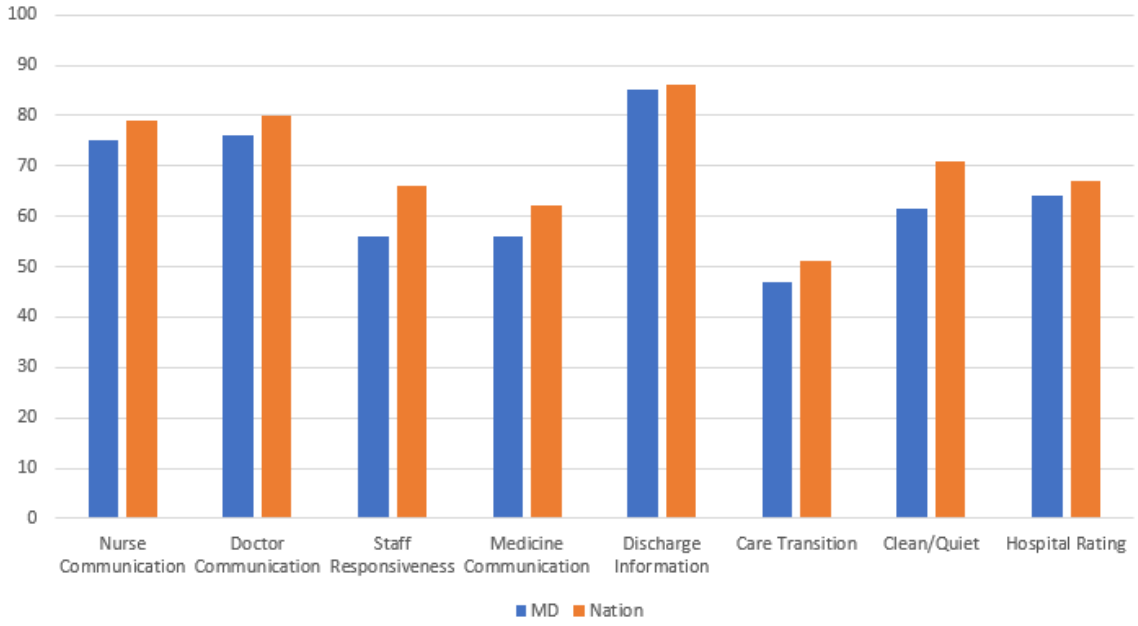


Source: HSCRC Case-mix Data

Patient and Community Engagement Domain

Maryland continues to lag behind the nation in performance on the HCAHPS patient experience measures (Figure 7). In the FY 2018 QBR policy, the HSCRC increased the weighting of the HCAHPS measures in determining hospitals' overall scores to further incentivize hospitals to improve in patient satisfaction. To incentivize incremental improvements, the HSCRC piloted the use of linear scores weighted at 10 percent of the PCE domain.

Figure 7. HCAHPS – Maryland HCAHPS Top Box Scores Compared to the Nation, April 2021 -March 2022

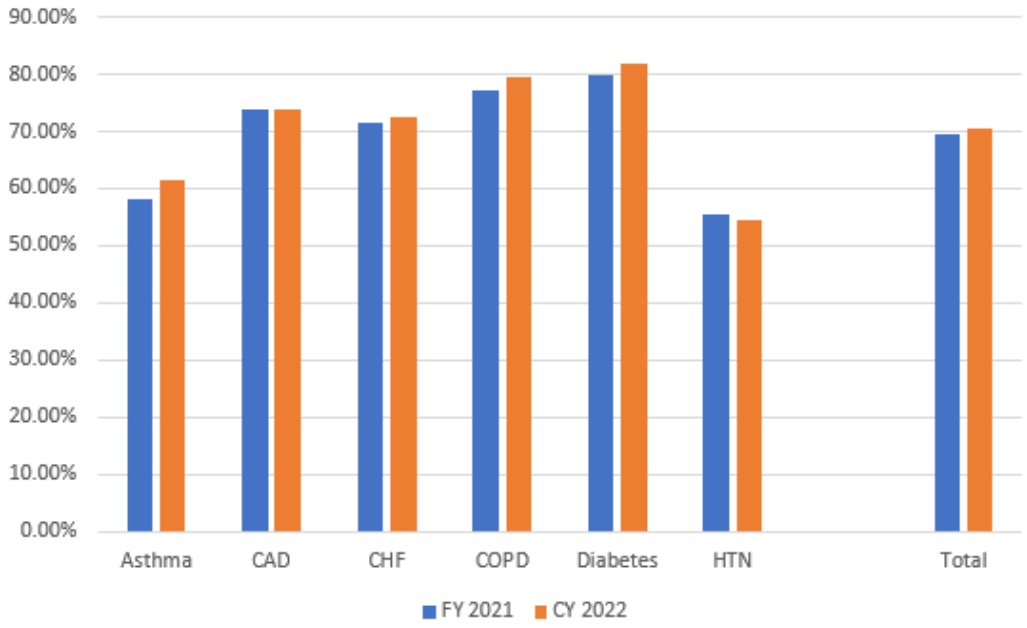


Source: CMS Care Compare Data

On the Timely Follow-Up measure, Maryland's CY 2022 performance is slightly improved overall and for all chronic conditions, except hypertension, compared to FY 2021 performance (Figure 8).

Figure 8. Timely Follow-Up Following Acute Exacerbation for Patients with Chronic Conditions[7]

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

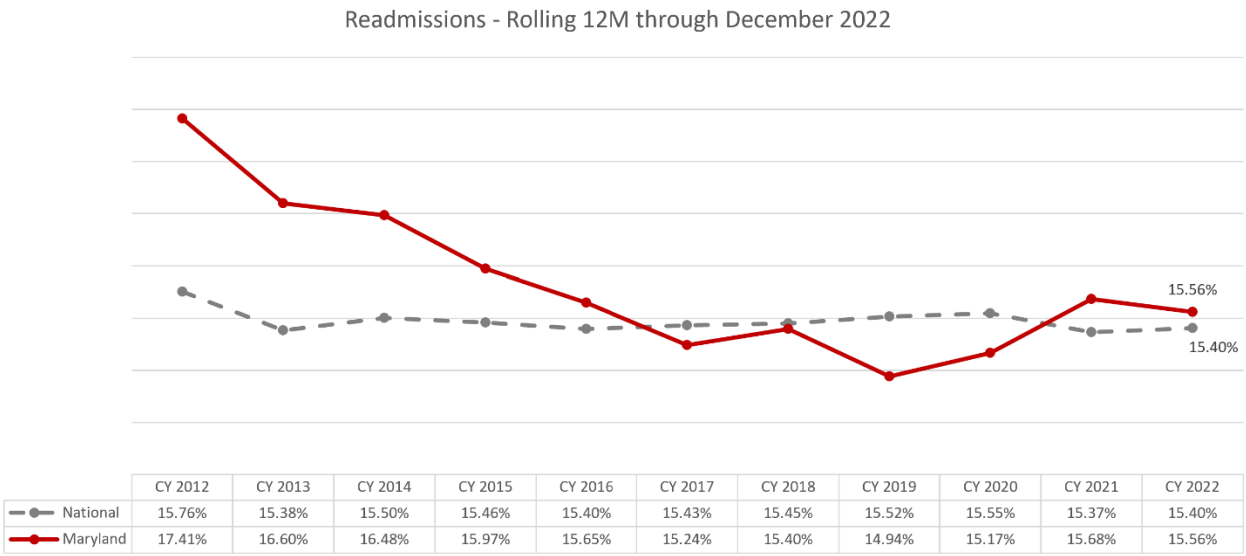


Source: CMS Claims and Claims Line Feed (CCLF) Data

Readmission Reduction Incentive Program (RRIP)

Under the TCOC Model agreement, Maryland must match or exceed national reductions in hospital readmissions rates. In 2019 and 2020, Maryland met this target. Data for CY 2022 year-to-date through November showed that Maryland's rate has improved since 2021 but is slightly above the Nation, with Maryland readmissions at 15.56 percent compared to the national rate of 15.40percent (Figure 9). HSCRC staff notes that the rate is unadjusted and therefore does not account for the mix of patients in Maryland versus Nation. HSCRC is in discussions with CMMI to move to a risk-adjusted readmissions rate target.

Figure 9. Medicare Readmissions - Rolling 12 Months Trend, CY 2012 – Dec 2022

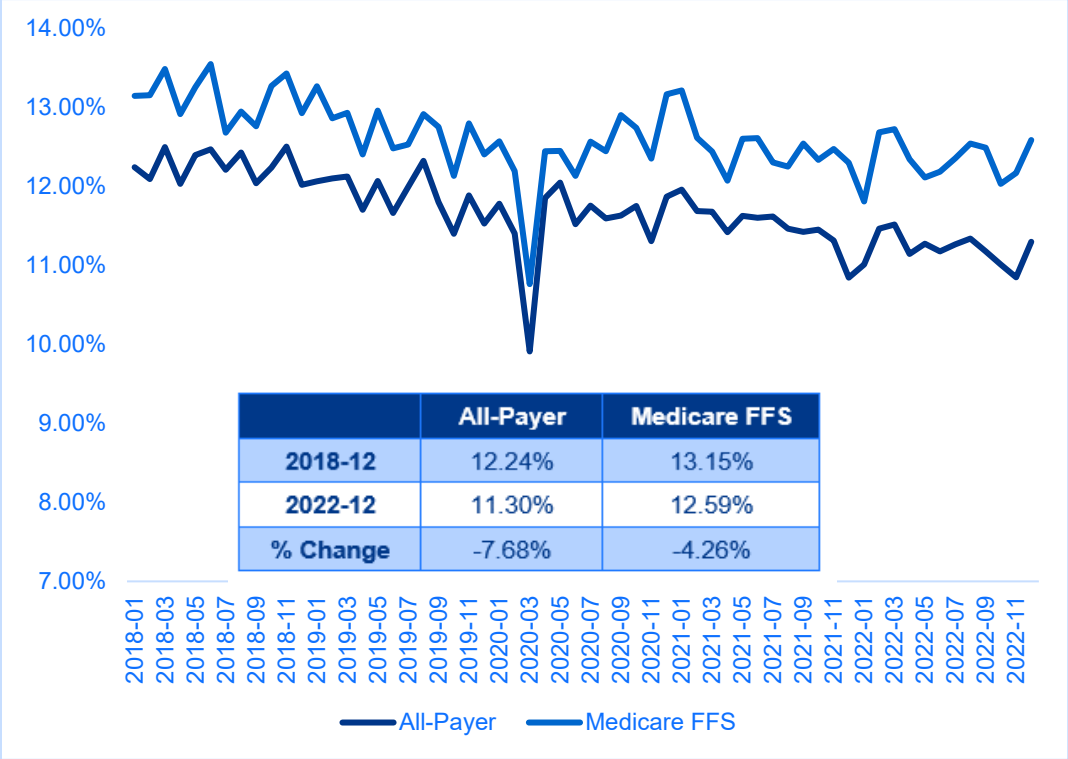


	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%

Source: CMS Monthly Data File

HSCRC's hospital data show that the monthly case-mix adjusted readmission rate through December 2022 continued to improve when compared to CY 2018 (Figure 10). This analysis includes all Maryland inpatient stays, including Medicare FFS. Based on these HSCRC data, the all-payer, case-mix adjusted readmission rate in CY 2022 was 11.22 percent, compared to 12.27 percent in CY 2018 - a 8.55 percent reduction. The corresponding readmission reduction for Medicare FFS beneficiaries was 5.66 percent. These reductions are notable given the difficulty and time involved in reducing readmissions, which requires sustained effort, investment, and coordination across providers.

Figure 10. Case-Mix Adjusted Readmissions in Maryland, CY 2018- CY2021



	All-Payer	Medicare FFS
2018-12	12.24%	13.15%
2022-12	11.30%	12.59%
% Change	-7.68%	-4.26%

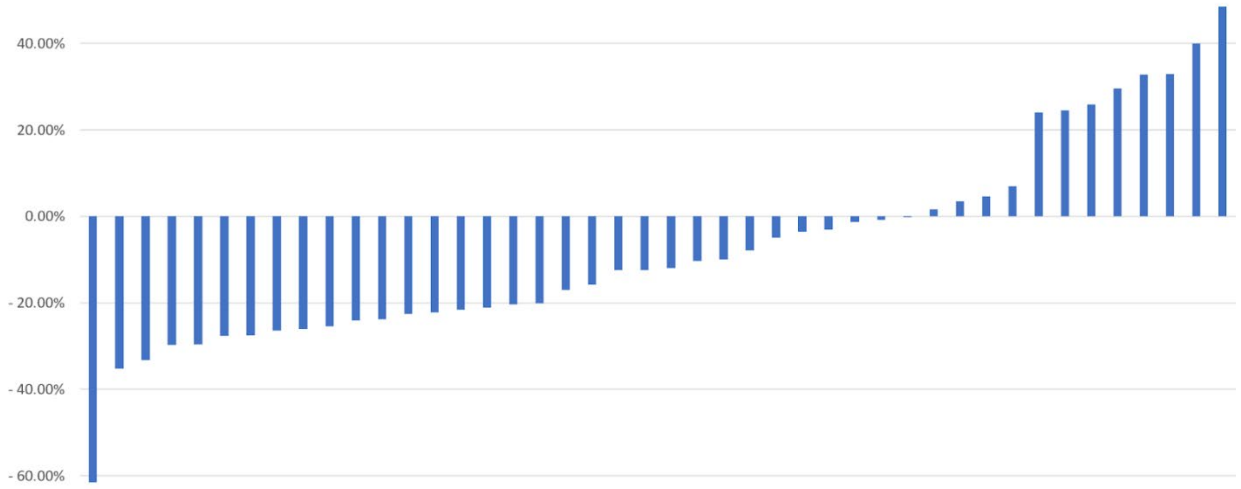
Source: HSCRC Case-Mix Data

In the RY 2024 policy, hospital performance on readmissions continues to be measured based on improvement and attainment. To help readmission reduction efforts, the HSCRC continues to improve its readmission reporting capability by leveraging resources available in the State-designated Health Information Exchange (HIE) and providing timely, monthly, and patient-specific data to hospitals.

The RY 2024 readmissions policy continues a component developed for RY 2022 that incentivizes hospitals to reduce socioeconomic disparities in readmission rates. The incentives are calculated in three steps: 1) measure patient socioeconomic exposure[8]; 2) assess the change in readmission rates across socioeconomic exposure, or "gap" measure for each hospital; 3) reward hospitals up to 0.50 percent of inpatient revenue that are on track to reduce their readmission disparities by 50 percent in CY 2026. In CY 2022, nine hospitals were rewarded for reducing disparities in readmissions.

Figure 11. Change in Readmission Disparities by Hospital, CY 2018 – CY 2022

[8] The HSCRC assesses patient socioeconomic exposure with the Patient Adversity Index (PAI), a measure developed by the HSCRC. The PAI is calculated for each discharge record. It relies on the patient's Medicaid status, race, and Area Deprivation Index score as reported on the claim. Each of the three items is given a weight that reflects the strength of its association with readmission. The weight for each item is multiplied against the value reported on the claim, and those products are summed together.



Source: HSCRC Case-Mix Data

Maryland Hospital Acquired Conditions (MHAC) Program

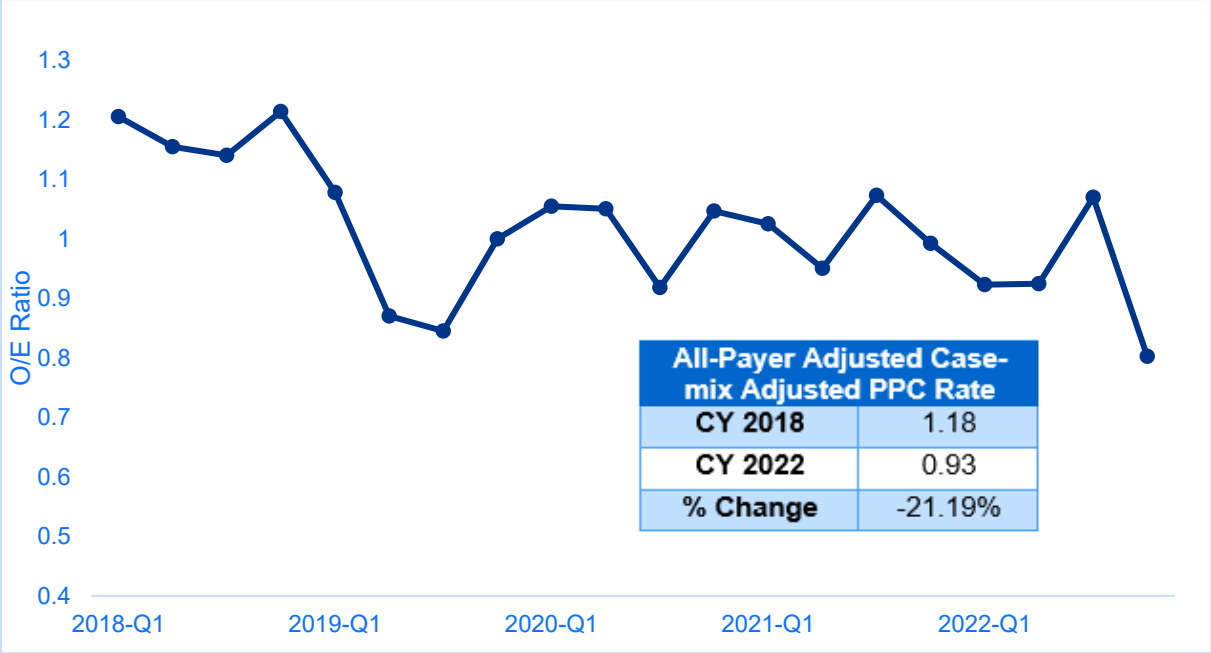
Maryland measures Hospital Acquired Conditions (HACs) using a list of potentially preventable complications (PPCs) developed by 3M Health Information Systems (HIS). PPCs are defined as post-admission harmful events (e.g., accidental laceration during a procedure) or negative outcomes (e.g., hospital-acquired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

The MHAC policy focuses on a list of clinically recommended PPCs that in general have higher statewide rates and variation across hospitals. The MHAC policy also only rewards hospitals for achieving low PPC rates and does not reward hospitals for improvements when PPC rates are worse than the attainment standards. The performance period is two years for small hospitals. The approved RY 2024 policy is unchanged from the RY 2022 policy.

Based on CY 2022 final data, there has been an improvement in the PPC measure, with fewer PPCs compared to the 2018 base year[9]. Staff will continue to monitor the impacts of the revised MHAC policy as more data becomes available.

Figure 12. Observed-to-Expected Ratios in Maryland, CY 2018 – CY 2021 YTD as of June

[9] There has been a 21.19% decrease in the ratio based on the most recent data available (CY 2018 O/E ratio = 1.18 and CY 2022 YTD O/E ratio = 0.93). A ratio lower than one means that fewer PPCs than expected were observed.



All-Payer Adjusted Case-mix Adjusted PPC Rate	
CY 2018	1.18
CY 2022	0.93
% Change	-21.19%

Source: HSCRC Case-Mix Data

Potentially Avoidable Utilization (PAU) Savings Program

The HSCRC adopted a final PAU Savings policy for FY 2023 as part of the FY 2023 Update Factor in June 2022. The PAU Savings policy measures the revenue associated with readmissions as well as per capita avoidable admissions as defined under the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI) logic. For FY 2023, the Commission implemented an incremental prospective savings requirement of 0.32 percent of total hospital revenue, which is distributed to hospitals based on a hospital's share of revenue deemed to be potentially avoidable. Staff is currently developing the PAU Savings policy for FY 2024 as part of the FY 2024 Update Factor that will be considered at the June 2023 Commission meeting.

Section IV: Population Health

Statewide Integrated Health Improvement Strategy

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

- Domain 1: Hospital Quality –
    - Reduce avoidable hospital admissions.

- Improve readmissions rates by reducing within-hospital disparities.

- Domain 2: Care Transformation Across the System –
  - Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models.[10]
  - Improve care coordination for patients with chronic conditions.
- Domain 3: Total Population Health – The State selected three priority population health topics:
  - Priority Area 1 (Diabetes): Reduce the mean BMI for adult Maryland residents.
  - Priority Area 2 (Opioids): Improve overdose mortality.
  - Priority Area 3 (Maternal and Child Health):
    - Reduce severe maternal morbidity rate.
    - Decrease asthma-related emergency department visit rates for ages 2-17.

For each domain, the SIHIS proposal provided a Model Year 3 milestone was measured on CY 2021 data, a Model Year 5 interim target that will be measured on CY 2023 data, and a Model Year 8 final target that will be measured on CY 2026 data. The State is pleased to report that all 2021 milestones, except for one goal, have been met. Performance results are summarized in Table 4 below. More information on the 2021 milestones is included in the SIHIS annual report attached as an appendix and on the HSCRC website.[11]

Table 4. SIHIS Goals and 2021 Milestone Progress

Domain Area	Goal(s)	Milestones Met
Domain 1 – Hospital Quality	Reduce avoidable admissions and readmissions	2021 Milestone Met
Domain 2 – Care Transformation Across the System	Increase the amount of Medicare TCOC or number of Medicare beneficiaries under Care Transformation Initiatives (CTIs), Care Redesign Program, or successor payment model	2021 Milestone 1 Met
	Improve care coordination for patients with chronic conditions	2021 Milestone 2 Not Met
Domain 3 – Total Population Health "Diabetes"	Reduce the mean Body Mass Index (BMI) for adult Maryland residents	2021 Milestones Met

[10] Value-based models including the Care Redesign Program (including EQIP), Care Transformation Initiatives, and the MDPCP program.
[11] Statewide Integrated Health Improvement Strategy Proposal and Annual Reports. https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx.

Domain 3 - Total Population Health "Opioids Use Disorder"	Improve overdose mortality	2021 Milestones Met
Domain 3 - Total Population Health "Maternal and Child Health"	Reduce severe maternal morbidity rate Decrease asthma-related emergency department visit rates for ages 2-17	2021 Milestones Met

Outcomes Based Credits

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

Diabetes

Slowing or reducing the growth in diabetes incidence represents a huge opportunity for the State. Type 2 Diabetes is a high-burden, high-cost condition that is avoidable with medical, lifestyle, and other interventions. Nearly 490,000 Maryland adults were estimated to have been diagnosed with diabetes in 2017 and Maryland is projected to spend $11.1 billion annually by 2025.

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

In July 2019, CMS approved Maryland's first outcomes-based credit (OBC) for aversion of diabetes incidence. Under the OBC methodology, if the diabetes incidence rate changes from baseline more favorably in Maryland than in a group of control states, Maryland is eligible to receive a financial credit that will help the State meet its TCOC savings targets. Diabetes performance during 2021 improved in Maryland, although incidence in the control group dropped more quickly than it did in Maryland. Thus, Maryland was not entitled to a diabetes credit in 2021.

Opioids

The misuse and addiction to opioids is a public health and economic crisis, with increased costs in healthcare, lost productivity, and criminal justice involvement. Maryland continues a statewide focus on addressing the State's opioid epidemic. Recognizing the impact of opioid misuse on the healthcare system, the HSCRC is developing an outcome-based credit methodology focused on opioid use disorder (OUD). As in the diabetes credit, CMS would provide the State with financial credit for federal TCOC Model investments if Maryland can make progress on reducing opioid use disorder (OUD). The credit will enable hospitals to invest additional dollars into OUD prevention and treatment as part of their global budgets, which may be reinforced with additional pay-for-performance measures related to substance use. The OUD credit methodology involves two workstreams: a cost-per-case analysis, and an approach to measuring OUD performance over time against a control group. The HSCRC's cost methodology contractor, Advanta Government Services, has completed work on the cost methodology. The HSCRC retained Mathematica to develop the performance methodology. The team ran into significant data access challenges due to the COVID pandemic but has recently acquired national all-payer opioid-related claims data. The HSCRC anticipates submitting the opioid methodology to CMS in 2023.

Hypertension

Hypertension, and chronic diseases that are sequelae of hypertension, represent a major source of disease burden and cost in Maryland. During 2021, the HSCRC applied a credit selection methodology that evaluated diseases and risk factors across four domains: burden, preventability, cost, and health equity impact. That analysis, along with conversations with stakeholders, resulted in identification of hypertension as the State's third outcome credit focus. HSCRC and its contractors have concluded that analyzing all-payer, all-setting claims is the most feasible way to track year-to-year changes in hypertension incidence. The State is in the final phase of acquiring data to complete development on the methodology and expects to submit a credit proposal in late 2023 or early 2024.

Section V: Care Transformation and Partnerships Across the System

The TCOC Model requires care transformation across the healthcare continuum. Hospitals, physicians, post-acute providers, and other provider types are expected to work together to improve the health of Marylanders and control healthcare spending. Additionally, the Model creates opportunities for healthcare providers to drive innovation in the system and lead transformation efforts. To encourage these efforts, the HSCRC is designing and implementing programs that incentivize providers to achieve savings and quality improvements for the system by implementing best practices.

Care Redesign and Transformation Programs/Provider Alignment Programs

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

Care Redesign Program (CRP)

The Maryland Care Redesign Program (CRP) aims to support effective care management and population health activities and deliver high quality, efficient, well-coordinated episodes of care, with a focus on high and rising-risk populations. During 2022, the State operated three care redesign tracks: the Episode Care Improvement Program (ECIP), the Hospital Care Improvement Program (HCIP), and the Episode Quality Improvement Program (EQIP). The Chesapeake Regional Information System for our Patients (CRISP) serves as the administrator of CRP.

This program is designed for hospitals to engage non-hospital providers, such as physicians and post-acute care providers, to improve care delivery, quality of care, and control TCOC growth. During 2022, there were a total of 24 unique hospital participants across HCIP and ECIP, with one hospital participating in HCIP and 24 hospitals participating in ECIP. A new performance period began January 1, 2023, with a total of 17 unique hospitals participating in ECIP. The HSCRC discontinued the HCIP track for CY 2023 after only one hospital participated in CY 2022. The HSCRC believes the declining participation in HCIP, which began in 2017, is a natural result of hospitals strategically choosing how to best expend their resources. Hospitals are opting to participate in newer programs, such as ECIP and care transformation initiatives (discussed below), and support participation in EQIP for affiliated physicians.

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

ECIP provides hospitals with the opportunity to provide incentive payments to care partners that help achieve these goals. ECIP began on January 1, 2019, with nine hospital participants. ECIP participation

grew to 24 hospitals in CY 2022. Seventeen hospitals have signed up for ECIP for CY 2023. The HSCRC made policy changes to ECIP for CY 2023, requiring hospitals to share incentives with care partners and/or provide significant resource sharing to care partners. These changes influenced hospital participation decisions. Some hospitals ended participation in 2022, while other hospitals are participating in 2023 for the first time.

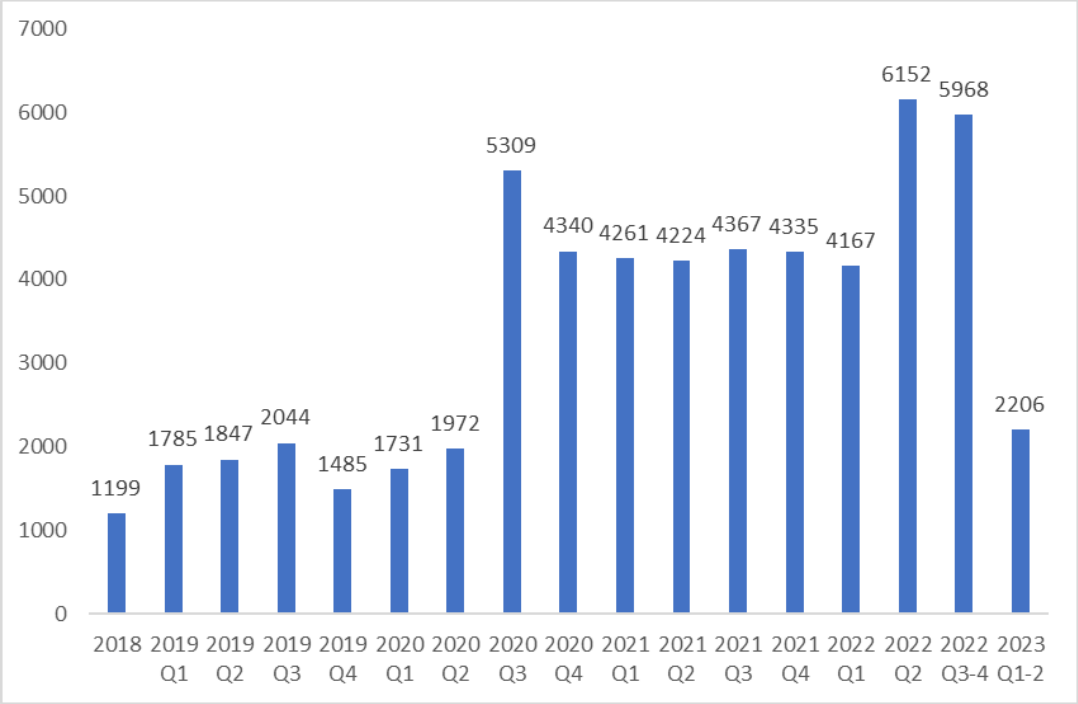
Hospitals have elected to engage a variety of provider types as care partners in 2023. The table below represents the type of providers that are eligible to become care partners under ECIP and the number of hospitals that selected them as potential care partners in CY 2023.

Table 5. ECIP Hospital Care Partner Selections, CY 2023

Care Partner Type	# Of Hospitals
Physician	17
Nurse	10
Physician Assistant	9
Home Health Agency	6
Skilled Nursing Facility	6
Inpatient Rehabilitation Facility	3
Hospice	2

Care partner engagement, a key element of CRP implementation, is robust. For the first half of CY 2023, the unduplicated care partner count across ECIP and HCIP was 2,206 individuals and 9 facilities (facilities are applicable to ECIP only). Clinicians participating in CRP may receive incentive payments from hospitals and are eligible to become Qualified Practitioners (QPs), under CMS' Quality Payment Program (QPP). Clinicians who meet CMS' requirements under the QPP may be eligible for an additional 5 percent bonus on all Medicare payments, as authorized by the Medicare Access and CHIP Reauthorization Act (MACRA). While care partner engagement in HCIP and ECIP grew significantly between 2019 and the end of 2022, the sharp decline in care partner participation in CY 2023 (Figure 13) is partially attributable to some hospitals ending participation in ECIP and opting to direct their focus on CTIs and EQIP, discussed below.

Figure 13. CRP Care Partner Counts - Clinicians, 2018 - 2023 (Q2)



Hospitals remaining or re-engaging in ECIP are expanding their programs and engaging new care partners to drive quality improvements, increase efficiency of care, and improve the patient experience. The HSCRC continues to explore options for additional CRP tracks to support provider alignment based on stakeholder interest and policy needs.

Episode Quality Improvement Program (EQIP)

The Episode Quality Improvement Program (EQIP) is a voluntary program that engages specialist physicians who treat Maryland Medicare beneficiaries in care transformation and value-based payment through an episode-based approach. This program is specific to Maryland and customized to meet the needs of Maryland's health care delivery system and specialist physicians. EQIP offers Maryland providers the opportunity to coordinate care through clinical episodes focused on increasing accountability for patients throughout specialty-led disease courses and treatments. Participating providers elect to have their performance on improving quality and reducing costs of care across an episode measured and have the opportunity to earn incentive payments based on positive performance. The first Performance Year of EQIP began on January 1, 2022, focused on the specialty areas of cardiology, gastroenterology, and orthopedics. The second Performance Year, which began January 1, 2023, expanded the program to include Allergy, Dermatology, Emergency Department, Ophthalmology and Urology episodes. EQIP leverages the Prometheus Episode Grouper as part of an effort to align the program with CareFirst's commercial Episodes of Care Program. HSCRC, CMS, and CareFirst agree that this alignment creates stronger

incentive to participate and behavioral change among providers, strengthening outcomes for Marylanders with both Medicare and CareFirst health coverage.

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

As of January 1, 2023, there are a total of 62 EQIP entities and 2,787 care partners enrolled. EQIP entities may be physician groups or administrative organizations that facilitate physician participation in the program. Over forty physician specialties are represented in the program and there is participation in all 45 available EQIP episodes.

Table 6. EQIP Entity and Care Partner Enrollment, CY 2023

Clinical Episode Categories	Number of EQIP Entities	Number of Care Partners
Allergy	14	1461
Cardiology	24	1570
Dermatology	5	1201
Emergency Care	11	1703
Gastroenterology	21	1545
Ophthalmology	7	1171
Orthopedics	33	2097
Urology	6	238

Care Transformation Initiatives (CTIs)

In FY 2022, the HSCRC launched Care Transformation Initiatives (CTI), a new value-based payment program. CTIs assign Medicare beneficiaries to hospitals that have enrolled those beneficiaries in a care management program. The CTI holds hospitals accountable for the total cost of care for those beneficiaries assigned to them and rewards hospitals for any savings created by their care management programs. The program ensures that a single entity is accountable for managing patient care across the delivery system and that providers are paid on a population specific-basis, rather than on fee-for-service. The program allows HSCRC to develop a systematic understanding of best practices for improving care, account for the savings and improvements attributed to care transformation, incentivize initiatives that produce savings under the TCOC Model, and articulate Maryland's success stories in transforming care. HSCRC staff regularly receive feedback from the Care Transformation Steering Committee, which prioritizes, develops, and finalizes each CTI proposed by hospitals. To date, the Steering Committee has approved five CTI categories: (1) Transitions of Care, (2) Palliative Care, (3) Primary Care Transformation, (4) Community-

Based Care, and (5) Emergency Care. Forty-three hospitals participated in a cumulative total of 107 CTIs in FY 2022 and generated $127 million in Medicare savings. Forty-three hospitals are participating in 99 CTIs in FY 2023. FY 2023 performance will be available in Spring 2024.

Maryland Primary Care Program (MDPCP)

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

As of January 2023, there are 538 participating practices (537 sites) participating in the program with approximately 385,000 attributed Medicare FFS beneficiaries. In 2023, MDPCP welcomed five new Federally Qualified Health Centers (FQHCs) representing 17 site locations, for a new total of 12 participating FQHC organizations representing 61 sites from across the State. In total, these practices employ over 2,300 providers including physicians, clinical nurse specialists, nurse practitioners, and physician assistants across all 24 Maryland counties. Since 2020, the PMO has been working closely with CareFirst, which joined MDPCP for its commercial population to align its advanced primary care programs and share resources with practices.

A key component of the MDPCP is Care Transformation Organizations (CTOs), which were formed to provide infrastructure support to practices. CTOs provide technical support and resources to practices, such as practice transformation guidance, data analytics, and multi-disciplinary care management staff. There are currently 25 CTOs, with a minimum of seven providing services in each county Statewide. Seventeen CTOs are hospital-based.

The MDPCP continues to support statewide population health goals through its diabetes- and opioid-related initiatives. All MDPCP practices tracked four electronic clinical quality measures (eCQM) related to diabetes control (CMS122), hypertension control (CMS165), BMI screening and follow-up (CMS69), and depression screening and follow-up (CMS2) in 2022. These measures are also included in MDPCP's new Track 3, which launched in January 2023 with 154 Track 3 practices. Due to national issues with the measure specifications, CMS suppressed the BMI, depression, and hypertension measures for PY 2022, but the PMO is optimistic that the issue will be resolved for PY 2023. The program is also working to increase

referrals from primary care practices to Diabetes Prevention Programs (DPP) via the CRISP referral tool. Additionally, the PMO has been working closely with CareFirst to plan a coordinated strategy to address diabetes in practices participating in both the MDPCP and the CareFirst PCMH programs.

One of the core features of advanced primary care within the MDPCP is integration of behavioral health services within the primary care setting to respond more proactively to patients' behavioral health needs. As of Q3 2022, 100% of MDPCP practices reported developing a strategy for integrating behavioral health into their practice workflows via the Care Management or Collaborative Care Model, Primary Care Behaviorist Model, or other approaches for addressing behavioral health needs. As of Q4 2022, over 350 MDPCP practices have implemented Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify and appropriately refer patients with substance use disorders, far exceeding the 2021 SIHIS goal of implementing SBIRT in 200 MDPCP practices. In addition, approximately 90 practices have implemented the Collaborative Care Model.

The PMO provides technical assistance and education infrastructure of the program through activities such as virtual education on key MDPCP concepts through redesigned learning event structures (i.e., round tables, panels, workshops), peer-to-peer opportunities (e.g., networking), and targeted quality improvement initiatives (e.g., Plan-Do-Study-Act (PDSA) cycles for key quality measures). The PMO continues to collaborate with CMMI on shared events and communications, such as a monthly newsletter, quarterly Office Hours presentations, a work group for the HEART payment, and program guides and resources. Additionally, the PMO provides a team of Practice Transformation Coaches that provide hands-on technical assistance to all MDPCP participants.

In addition to its aims to reduce avoidable hospitalizations, improve quality, and reduce costs, MDPCP has a concerted focus on advancing health equity and reducing disparities at the primary care level. Beginning in 2022, MDPCP began pioneering a payment to primary care based on beneficiary social risk level, called the Health Equity Advancement Resource and Transformation (HEART) Payment. The HEART Payment provides additional resources to practices each quarter to support social needs of patients with high clinical and social risk. More than $7.7 million is being invested in this effort in Q1 of 2023 alone. Outside of this investment, MDPCP is focusing on health equity through a robust reporting suite including outcomes data stratified by socio-demographic variables; an emphasis on social needs screening and referrals with technical assistance to practices to support these workflows; and more.

Special Funding Programs[12]

Maryland's ability to transform its statewide healthcare delivery system is critical to the success of the TCOC Model. This requires hospitals and their community partners to focus on initiatives that reduce

[12] These have previously been referred to as HSCRC Grant Programs.

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

Regional Partnership Catalyst Program

The HSCRC is issuing $157.6 million in five-year cumulative funding for the Regional Partnership Catalyst Program[13] to support population health investments. The Regional Partnership Catalyst Program provides funding to hospital-led teams that work across statewide geographic regions to build infrastructure for interventions that align with goals of the TCOC Model and support population health goals in the SIHIS (discussed in Section IV of this report). The SIHIS population health domain contains the following focus areas: diabetes, opioids, and maternal and child health. The Regional Partnership Catalyst Program supports the diabetes and opioids priorities through the funding of diabetes prevention and management programs and behavioral health crisis services. The HSCRC funding is intended as seed funding - an initial investment in program development and growth. The HSCRC expects Regional Partnership programs to develop sustainable funding streams to support the programs after the HSCRC funding ends on December 31, 2025.

For diabetes, the HSCRC focused the Regional Partnership Catalyst Program on the implementation of the CDC-recognized Diabetes Prevention Program (DPP) and Diabetes Self-Management Education and Support (DSMES). The HSCRC is issuing $78.5 million to five Regional Partnerships to provide diabetes prevention and management activities across Maryland.[14] The award recipients self-selected ZIP codes with disproportionate rates of diabetes or in vulnerable communities more likely to have higher rates of prediabetes. The awardees and funding amounts are listed below.

Table 7. Regional Partnership (Diabetes) Jurisdictions and Funding Amounts

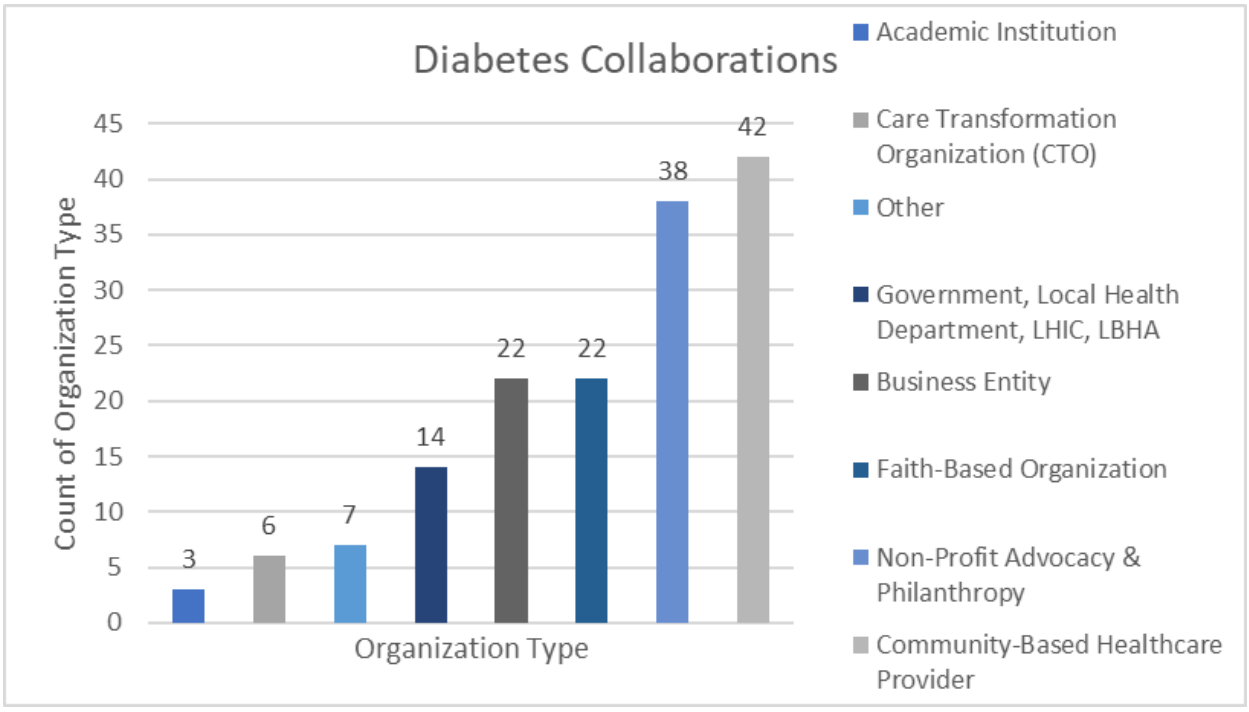
Regional Partnership	Jurisdiction	Total 5-Year Funding
Baltimore Metropolitan Diabetes Regional Partnership	Baltimore City	$43,299,986
Western Regional Partnership	Allegany, Frederick, and Washington Counties	$15,717,413

[13] HSCRC Regional Partnership Catalyst Program. https://hscrc.maryland.gov/Pages/regional-partnerships.aspx
[14] The HSCRC discontinued one Regional Partnership's participation in the program at the end of 2022. Funding amounts have been adjusted to reflect those changes.

Totally Linking Care - Maryland	Prince George's, Charles, and St. Mary's Counties	$7,379,620
St. Agnes and LifeBridge Health Diabetes Care Collaborative	Baltimore City/County	$5,962,333
Full Circle Wellness for Diabetes in Charles County	Charles County	$2,124,862

A core goal of the Regional Partnership Catalyst Program is to foster widespread collaboration between hospitals and community partners. To aid in improving population health, hospitals are partnering with neighboring hospitals and diverse community organizations including local health departments (LHDs), managed care organizations (MCOs), provider organizations, and non-profits to implement diabetes interventions and expand behavioral health crisis services infrastructure. Regional Partnerships receiving diabetes funding identified a total of 154 community partners to support the implementation of DPP and DSMES in their communities.

Figure 14. Regional Partnership Diabetes Collaborator Types and Counts



Source: Regional Partnership Annual Reports, CY 2022

The second year of the program ended December 31, 2022. The diabetes Regional Partnerships recently submitted annual reports which HSCRC staff is currently reviewing. In CY 2021, Regional Partnerships prioritized building relationships with existing DPP and DSMES providers, contracting with existing or

establishing new programs, formalizing referral workflows, and developing infrastructure to bill for services to provide a sustainable source of funding for the programs in the future. In CY 2022, Regional Partnerships significantly scaled up referral workflows, referring over 7,400 patients to participating DPP providers. Regional Partnerships utilized a variety of strategies to drive patient referrals, including educating physician practices on the value of DPP for pre-diabetic patients, partnering with Medicaid HealthChoice Managed Care Organizations to refer Medicaid beneficiaries, customizing health information technology and electronic health record (EHR) tools to identify eligible patients, and refining workflows with community partners. Regional Partnerships used similar strategies to refer diabetic patients into DSMES programs. In addition to referring and enrolling eligible patients into DPP and DSMES programs, Regional Partnerships focused on identifying social needs of participants and connecting individuals with wraparound services, such as food access programs and transportation, to maximize patient success. Finally, Regional Partnerships prioritized standing up billing operations for DPP and DSMES to support long-term sustainability of the programs beyond 2025 when HSCRC funding expires.

The Regional Partnership Catalyst Program also supports the implementation and expansion of an evidence-based behavioral health crisis management model called "Crisis Now".[15] Funding recipients are implementing and expanding at least one of the three main elements of the Crisis Now Model: 1) crisis call centers and "Air Traffic Control" services, 2) community-based mobile crisis teams, and 3) short-term, "sub-acute" residential stabilization programs. In 2020, the HSCRC allocated $79.1 million to three Regional Partnerships to implement and expand behavioral health crisis services infrastructure. The awardees and funding amounts are listed below.

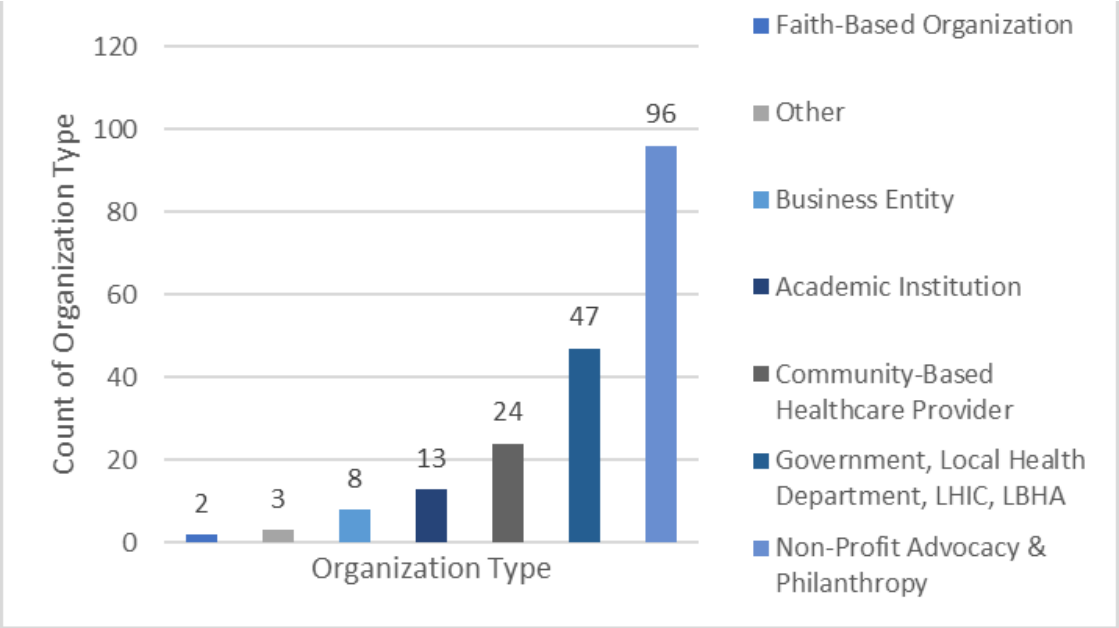
Table 8. Regional Partnership (Behavioral Health) Jurisdictions and Funding Amounts

Regional Partnership	Jurisdiction	5 Year Funding Amount
Greater Baltimore Regional Integrated Crisis System (GBRICS)	Baltimore City/County, Howard, Carroll Counties	$44,862,000
Totally Linking Care (TLC)	Prince George's County	$22,889,722
Tri-County Behavioral Health Engagement (TRIBE)	Lower Eastern Shore	$11,316,332

[15] The Crisis Now model is described in "Crisis Now: Transforming Services is Within Our Reach" action plan developed by the National Action Alliance for Suicide Prevention.

Regional Partnerships are expected to partner with diverse community organizations including LHDs, Local Behavioral Health Authorities (LBHAs), healthcare provider organizations, and non-profits to implement and expand behavioral health crisis services. The three Regional Partnerships receiving behavioral health funding identified a total of 193 community partners to support the expansion of behavioral health crisis services in their communities.

Figure 15. Regional Partnership Behavioral Health Collaborator Types and Counts



Source: Regional Partnership Annual Reports, CY 2022

As with the diabetes funding stream of the Regional Partnership Catalyst Program, the second year of the behavioral health Regional Partnership program ended December 31, 2022. In CY 2022, GBRICS and TLC each launched “air traffic control” systems and launched mobile response teams in their service areas. TRIBE opened their satellite behavioral health crisis center at Atlantic General Hospital in February 2022 and primary behavioral health crisis center at Tidal Health Peninsula Regional on August 4, 2022.

Maternal and Child Health Funding Initiative

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

Funding supports the following MCH initiatives within Maryland Medicaid:

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

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

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

In FY 2022, Medicaid and MDH prioritized establishing and enhancing the infrastructure necessary to expand these programs and interventions. Through 2025, the HSCRC will continue to monitor and support MDH and Medicaid as they implement the programs listed above that have been strategically designed to provide services to underserved populations and those who are at greater risk of being affected by severe maternal morbidity and severe asthma.

Medicare Advantage Partnership Program

The Medicare Advantage Partnership (MAP) Funding Program was developed to foster collaboration between hospitals and Medicare Advantage Plans, increase access to 4+ star rated Medicare Advantage plans in the State, and develop strategies that improve care coordination, quality, and lead to long term health improvement of Medicare Advantage Plan beneficiaries. Under this program, hospitals and their Medicare Advantage Plan partners collaborate to implement and expand strategies that will help improve the quality and sustainability of the Medicare Advantage Plans in Maryland.

The MAP Funding Program was designed to support, promote competition, and enhance access to Medicare Advantage benefits for Medicare beneficiaries in a defined period. This Funding Program helps to mitigate possible negative impacts to the State's total cost of care financial targets by helping to prevent Medicare Advantage Plans from exiting the market. The MAP Program was narrowly focused to support activities that lead to increased stability, expansion, more robust plan design, and improved quality of Medicare Advantage Plans. The intent of the Medicare Advantage Partnership Program was to achieve the following:

- Encourage partnerships and strategies that result in long term health improvement of Medicare Advantage Partnership beneficiaries

- Improve Medicare Advantage penetration and/or improve services to high-cost and high-risk populations
- Preserve and/or expand access to the number of 4+ star rated Medicare Advantage plans in the State to promote competition and access for seniors
- Develop strategies that improve care coordination and quality of services offered in Medicare Advantage Plans
- Extend healthcare transformation efforts to the Medicare Advantage market.

The MAP Funding Program released a Request for Proposals for two rounds of funding in the spring and fall of 2020. The first round of funding awarded $27.8 million to four recipients. The second round of funding provided $35.7 million to six recipients. Funding recipients focused efforts on expanding care coordination activities for Medicare beneficiaries, growing membership and market penetration, and developing new plans to support high-risk Medicaid-Medicare beneficiaries. The program concluded June 30, 2022. After reviewing final reports, the HSCRC determined that the significant investment did not result in expected outcomes. HSCRC decided not to make further investments in this program due to these results.

COVID-19 Community Vaccination Funding Program

In Spring 2021, the HSCRC launched a special funding program to support COVID-19 community vaccination efforts through June 30, 2022. This funding program provided hospitals with short-term funding through the all-payer rate setting system to allow for the creation, optimization, and/or expansion of community-based COVID-19 vaccine dissemination strategies. The Program aligns with the state's Vaccine Equity Task Force (VETF) and is intended to support efforts to increase vaccination rates in Maryland ZIP Codes identified as disadvantaged, vulnerable, underserved, and hard-to-reach. The Program was designed to achieve the following:

- Support statewide efforts to provide access to COVID-19 vaccines for all Marylanders in an equitable manner.
- Foster impactful, long-lasting partnerships between hospitals and community-based organizations
- Educate and schedule vaccine appointments for individuals in hard-to-reach areas.
- Address race, age, gender, and ZIP Code-based shortcomings in vaccine administration through multiple strategies suited best for the community, including a "come-to-you" approach.

The HSCRC awarded $12 million to 12 hospital systems in Maryland to expand hospitals' existing mobile and community-based vaccination programs and improve existing programs. Under this program, hospitals have worked with trusted community partners around the state -- including local health departments, non-

profits, faith-based organizations, and others-- to increase Marylanders' access to the COVID-19 vaccine, especially in vulnerable and hard-to-reach areas.

Hospitals and community partners hosted over 3,700 community events where they administered more than 118,000 vaccine doses through June 30, 2022. Beginning in December 2021, hospitals were also allowed to use funding to provide monoclonal antibody (mAb) treatment and administered 675 treatments through June 2022.

Table 9. Vaccination Counts, May 2021-June 2022

Vaccination Category	Count of Doses
1st & 2nd Doses (Moderna, Pfizer, and J&J)	67,245
Booster Doses	40,484
Pediatric Doses (Ages 5-11)	10,925
Total Doses	**118,654**

Source: Monthly Hospital Reporting

Hospitals submitted monthly reports to the HSCRC and participated in periodic calls to discuss shared challenges and exchange best practices. Given the evolving nature of the pandemic, hospitals had to develop their strategies to increase vaccination rates in their communities. Common challenges reported by hospitals included vaccine hesitancy, a dwindling demand for vaccines in the community, and language barriers. Hospitals worked to address these challenges through prioritizing one-on-one vaccine education with physicians and trusted community messengers, hosting vaccination events in strategic locations, and prioritizing hiring of bilingual workers. The program concluded June 30, 2022 and a final report can be found on the HSCRC website.[16]

Section VI: Stakeholder Engagement

HSCRC Workgroup Activities

The HSCRC continues to engage broadly with stakeholders in guiding policy and methodology development through various workgroup meetings throughout CY 2022. All workgroups are comprised of a wide range of healthcare industry stakeholders, including hospitals, clinicians, payers, consumer representatives, and community organizations. All workgroup meetings are conducted in public sessions, and comments are solicited from the public at each meeting. There are also several sub-workgroup meetings and task forces to discuss technical, data-driven matters related to specific policies, which report back to the larger workgroups. Input is also solicited in informal meetings with stakeholders. All proceedings

[16] HSCRC COVID-19 Community Vaccination Program Final Report. July 2022. https://hscrc.maryland.gov/Pages/COVID-19-Community-Vaccination-Funding-Program-.aspx

and reports of workgroup activities, as well as membership rosters, may be found on the Workgroups page on the HSCRC website.[17]

Payment Models Workgroup

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

Total Cost of Care Workgroup

The Total Cost of Care Workgroup is charged with providing feedback to the HSCRC on the development of specific methodologies for managing the Medicare Total Cost of Care, as required by the contract with CMS. The TCOC Workgroup met throughout 2022 to further refine methodologies related to Medicare TCOC policy. Additionally, the TCOC Workgroup discussed the source of cost drivers in Maryland and future benchmarking methodologies.

Performance Measurement Workgroup

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

Care Transformation Steering Committee

The Care Transformation Steering Committee is tasked with providing feedback on the CTI program policy and CRP. The committee met monthly through 2022 to prioritize, develop, and finalize proposed CTIs, provide feedback on CRP progress, and supply policy input as necessary. The committee members include healthcare industry representatives.

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

Model Progression Stakeholder Workgroups

HSCRC, in collaboration with MDH and the Maryland Health Care Commission (MHCC), is working with stakeholders to develop priorities and ideas for the future of the Maryland Model. HSCRC, MDH, and MHCC is using a mix of the standing workgroups described above and new, short-term, workgroups, to gather stakeholder feedback on the following priority topics:

- Cost-Containment & Financial Targets
- Population Health & Health Equity
- Multi-Payer Alignment
- Post-Acute and Long-Term Care
- Physician Engagement & Alignment

HSCRC also established a workgroup specifically for consumer advocates, which also discussed several priority topics.

Stakeholder feedback will be collected through the spring of 2023. This feedback will be used by State staff to develop a progression plan for the expansion of the TCOC Model (or a new Model) beyond 2026. The progression plan will be the basis for the State's negotiation with CMS, starting in 2023.

Population Health Management Group

In 2021, the State established a governance structure to guide SIHIS implementation and provide accountability through the Population Health Management Group (PHMG). The PHMG is composed of a diverse group of stakeholders across State agencies and includes hospital, physician, and payer representatives. The PHMG serves as the official oversight body for the Total Population Health domain under SIHIS. The PHMG meets every other month to review performance on the population health goals, receives reports on State-led initiatives for each priority area, and discusses broad strategies to impact SIHIS targets, including cross-sector strategies to address social determinants of health. The group will continue to meet throughout 2023.

Section VII: Methods of Rate Determination

Global Budget Overview

Under the TCOC Model, 95 percent of regulated hospital revenues must remain under global (or "population-based") budget structures. With 98 percent of regulated hospital revenues under global budget structures since CY 2016, Maryland currently exceeds this target level. The two percent of revenue not included in GBR accounts for drug costs, which are based on volume. All regulated acute-care Maryland

hospitals operate under Global Budget Revenue (GBR) agreements. The HSCRC continues to work with stakeholder workgroups (discussed in Section VI) to refine the GBR methodology and develop a number of policies discussed in this section.

Volume Methodologies

Market Shift Policy

The Market Shift Adjustment (MSA) provides criteria for increasing or decreasing the approved regulated revenue of Maryland hospitals operating under global revenue caps. Specifically, the MSA provides the criteria to reallocate funding to account for shifts in cases between regulated hospitals, with the objective of ensuring that funding follows the patient and that hospitals continue to have a competitive interest in serving patients efficiently and effectively. The MSA does not currently address all volume changes, only those the Commission can quantify as shifts between hospitals and only volume the Commission deems appropriate to evaluate, i.e., the Commission does not evaluate readmissions and preventable admissions in the MSA because doing so would incentivize competing for care that is potentially avoidable.[18]

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

Demographic Adjustment

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

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

Deregulation of Services

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

CDS-A Drug Funding

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

Integrated Efficiency Policy

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

The Integrated Efficiency Policy was approved in 2021 and was subsequently used to scale the FY 2022 Annual Update Factor. In effect, inefficient hospitals received a reduced inflation factor for FY 2022 and this funding was then redistributed to efficient hospitals. Staff also used the Integrated Efficiency Policy to assess budget enhancement requests from efficient hospitals that sought additional funding. The criteria hospitals submit must demonstrate that they have been financially disadvantaged by a Commission

methodology or will make population health investments that will further reduce TCOC. Future iterations of the Integrated Efficiency Policy are contingent on reliable volume data, which currently is not available due to ongoing effects of the pandemic.

Capital Policy

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

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

Full Rate Reviews

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

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

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

1. The total costs of all hospital services offered by or through a facility are reasonable;

2. The aggregate rates of the facility are related reasonably to the aggregate costs of the facility and;
3. The rates are set equitably among all purchasers or classes of purchasers without undue discrimination or preference.

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

Complexity and Innovation Policy

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

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

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

Section VIII: Reporting Requirements to CMS

Under the TCOC Model, the HSCRC is required to report to CMS on relevant policy and implementation developments. The HSCRC provides two annual monitoring reports to CMS on patient experience of care, population health and health care expenditures. The HSCRC submitted an annual report on CY 2021 healthcare expenditures to CMS in July 2022. The HSCRC submitted a second report on the State's CY 2021 performance on quality measures, inclusive of measures on patient experience of care and population health performance, in January 2023. As mentioned earlier in this report, the State also submitted an annual report to CMMI on 2022 progress under SIHIS. The following reports are included with this submission.

1. Annual Monitoring Report - Expenditures
2. Annual Monitoring Report - Quality
3. SIHIS Annual Report - 2022

Section IX: Adverse Consequences

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

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

As mentioned earlier in the report, one area of caution for our current contract is the fluctuation in trends of the total cost of care. Under the TCOC Contract, CMMI monitors the total cost of care in Maryland to ensure that reductions in hospital potentially avoidable utilization do not result in unreasonable increases in the total cost of care. More detail on total cost of care performance is provided in Section II.

Section X: Hospital Financial Performance

Hospital Profitability

The HSCRC monitors hospital financial performance of regulated hospitals through hospital financial data submissions. Specifically, the HSCRC conducts monthly monitoring of unaudited data and annual monitoring of audited data. The financial data provide a metric to monitor the efficiency and effectiveness of hospitals, pursuant to the HSCRC's statutory charge. While each hospital may adjust and correct its unaudited data throughout the year, the unaudited data provide a good indicator of the direction of trends in statewide hospital revenue, expenditures, utilization, and profitability. Below is a summary of key data regarding the profitability of hospitals on an audited basis in FY 2022 and on an unaudited basis for FY 2023 through January of 2023.

The HSCRC only regulates inpatient and outpatient hospital services located at the hospital. The HSCRC does not regulate the rates of physicians. It also does not regulate revenue-producing activities which, while

not related directly to the care of patients, are business-like activities commonly found in hospitals for the convenience of employees, physicians, patients, and/or visitors (e.g., parking garages and gift shops).

Audited Financial Data – FY 2022

Data for FY 2022 show a decline in profitability for both total operating and non-operating activities. Services regulated by the HSCRC also experienced a decline in profitability over the prior year. Decreases in non-operating profitability may be attributed, in large part, to losses on investments.

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

- The total combined audited regulated and unregulated operating margin was 0.67 percent (4.01 percent in FY 2021).
- The total margin, i.e., the combined operating and non-operating margins, was -2.73 percent (10.83 percent in FY 2021).
- The operating margin for services regulated by the HSCRC was 6.36 percent (9.7 percent in FY 2021).

Maryland's regulated hospital industry remained profitable despite experiencing a decline over FY 2021 and the continued disruption caused by the COVID-19 crisis. The decline is consistent with national trends and relates primarily to high-cost growth.

Unaudited Financial Data – FY2023

FY 2023 operating margins for both services regulated by the HSCRC and services not regulated by the HSCRC decreased over FY 2022, as shown by unaudited year-to-date financial data. Total profit margins increased by 1.84 percentage points versus unaudited results for the same period last year due to better non-operating returns so far in FY 2023. Hospital total margins are shown below. Final audited data, when available, may result in adjustments to these margins:

- The total combined unaudited regulated and unregulated operating margin was 0.51 percent (1.57 percent for the equivalent YTD FY 2022 unaudited results).
- The total margin, (the combined operating and non-operating margins), was 3.51 percent (1.67 percent for the equivalent YTD FY 2022 unaudited results).
- The operating margin for services regulated by the HSCRC was 3.15 percent (4.86 percent for the equivalent YTD FY 2022 unaudited results).

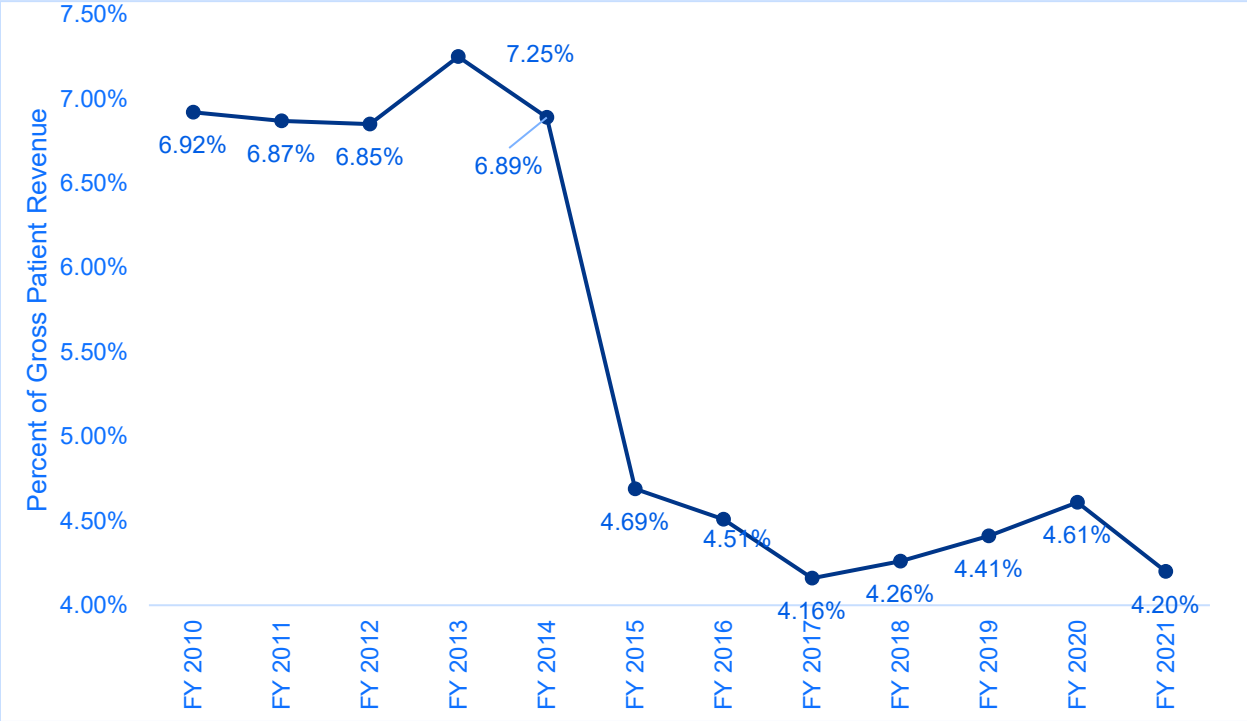
Uncompensated Care

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

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

Figure 16 below shows the actual total UCC rate for all regulated Maryland hospitals between FY 2010 and FY 2020. Uncompensated care steadily declined between FY 2010 and FY 2012; however, FY 2013 saw a 0.40 percent increase in uncompensated care. The HSCRC believes this can be partially explained by the increasing prevalence of commercial health insurance plans with high deductibles, coinsurance- and copayments,, which leave patients to pay a higher portion of a bill out-of-pocket. Additionally, outpatient hospital service utilization, for which commercially insured patients tend to be responsible for paying a higher portion of the bill out-of-pocket, has increased in recent years. Periods of low UCC rates occurred from FY 2014 and continued to FY 2017, driven by coverage expansions brought on with the implementation of the Affordable Care Act (ACA). From FY 2018 to FY 2020, there was a slight uptick in uncompensated care rates as the effects of the ACA appear to have mitigated. The probability of a patient subsequently deemed as having UCC is historically highest amongst commercial patients presenting though the ED. Thus, the significant declines in ED utilization by commercial patients having a write-off to UCC during the pandemic subsequently resulted in the decline in UCC experienced in FY 2021.

Figure 16. Uncompensated Care as a Percentage of Gross Patient Revenue, FY 2010-2020



Source: HSCRC Case-mix and Financial Data

Community Benefits

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

- Health services provided to vulnerable or underserved populations
- Financial or in-kind support of public health programs
- Donations of funds, property, or resources that contribute to a community priority
- Health education screening and prevention services

The most recently available report from hospitals reflects community benefits for FY 2021. In that year, Maryland hospitals expended just over $1.2 billion in community benefits, or 7.4 percent of total hospital

operating expenses, after offsetting expenditures related to amounts that are included in rates and not generated through hospital resources.

Since 2012, nonprofit hospitals have been required to conduct a community health needs assessment every three years, which they report to the federal government. The Commission obtains information annually on each hospital's community health needs assessments, related collaborations, how their community benefit functions are organized, and a summary of the top three or four primary community benefit initiatives. Additionally, the Commission has changed some reporting requirements for hospital community benefits to improve the consistency of reporting across hospitals, enhance the quality of data statewide and better incorporate local community health needs.

Section XI: Statutory and Regulatory Updates

2022 Legislative Updates

2022 Reports Required by the Joint Budget Committees' Report

HSCRC completed the following reports in 2022, required by the "Report on the Fiscal 2023 State Operating Budget (SB 290) And the State Capital Budget (SB 291) And Related Recommendations".

1. **Evaluation of the Maryland Primary Care Program:** This report evaluates the effectiveness of the Maryland Primary Care Program (MDPCP or Program) with a comparison between cost savings, utilization, and the additional payments provided to primary care practices, in addition to focusing on racial equity within the Program and primary care in general. The Joint Chairmen's Report (JCR) also asked HSCRC to describe the relationship between outcome-based credits and MDPCP. This report was submitted in October 2022.
2. **The Maryland Model and Hospital Responses to the COVID-19 Pandemic:** This report provides background information on the Maryland Health Model, an analysis of financial challenges faced by hospitals due to the COVID-19 pandemic, a description of State and Federal responses to these financial challenges, and a description of actions taken by the Maryland Health Care Commission and the Maryland Department of Health to increase hospital bed capacity during the COVID-19 pandemic. This report was submitted in October 2022.

2022 Reports Required by Legislation or Legislature Committees

The HSCRC completed the following legislatively-required reports during the 2022 legislative interim:

1. **Behavioral Health Emergency Department Wait Times and Service Improvements in Maryland**, requested by the House Health and Government Operations Committee;
2. **Annual Governors Report**, required by Health-General §19-207(b)(9);

3. **Guidelines for Hospital Payment Plans Report**, required by Ch. 770, 2021 Md. Laws (House Bill 565);
4. **Summary of UMMS Board of Directors Financial Disclosure**, required by Education Article §13-304(l)(4);
5. **Free Hospital Care Refund Process**, required by Health General §19-214.4; and
6. **Maryland Hospital Community Benefit Report: FY 2021**, required by Ch. 437, 2020.

2023 Statutory Updates

During the 2023 Legislative Session, the Legislature passed a number of bills with a direct impact on HSCRC operations.

HSCRC Rate Setting & the Total Cost of Care Model Bill (SB 234 / HB 420)

This bill was introduced at the request of HSCRC staff. The bill adds an additional reference to the Total Cost of Care Model to the 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 conforms with those other references to the model in law. This bill does not change how HSCRC staff review hospital rates, but rather ensures our statute aligns with the TCOC contractual requirements.

Budget Bill (SB 181 / HB 200) and Budget Reconciliation and Financing Act (BRFA) (SB 183 / HB 202)

The Budget Bill for Fiscal Year 2024 funds HSCRC's operations, including the uncompensated care fund. The Budget Bill and BRFA also include a one-year $50 million reduction in the Medicaid Deficit Assessment (special funding from hospitals to the State Medicaid Program) and an accompanying $50 million increase in general funds for Medicaid. This change to the Medicaid deficit assessment is a component of a four-part plan approved by the Commission to put the State back on track to meet the annual Medicare savings target under the Total Cost of Care agreement in 2023.

Hospital – Financial Assistance – Medical Bill Reimbursement Process (HB 333 / SB 404)

This bill makes changes to an existing law that requires that hospitals provide refunds to certain patients who paid bills but were eligible for financial assistance in 2017-2021 (this law passed in 2022). State data will be used to identify the patients that qualify for refunds. The 2023 legislation amends the 2022 law to provide necessary legal authority for hospitals and State agencies to share data to implement the law. HSCRC will work with the Maryland Hospital Association and several state agencies to create the process to provide refunds to patients under the law.

Health Services Cost Review Commission – Members – Appointment (SB 626)

This bill states that the Governor's appointments to the HSCRC must be confirmed by the Senate.

Regulatory Updates

Over the past fiscal year, the Commission proposed and adopted amendments to the following existing regulations:

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

On August 26, 2022, the Commission proposed to amend Regulation .26 under COMAR 10.37.10. The purpose of this action was to have the Commission's existing regulations on Patient and Obligations - Hospital Credit and Financial Assistance Policies conform to legislation enacted in the 2021 Maryland General Assembly legislative session. The Commission anticipates adoption of the proposed regulations in 2023.

COMAR 10.37.10.03, .05, Rate Application and Approval Procedures – Regular Rate Applications, Temporary Rate Applications

On December 2, 2022, notice was given in the Maryland Register of emergency amendments to Regulations .03 and .05 under COMAR 10.37.10 Rate Application and Approval Procedures. The purpose of the emergency action was to establish a moratorium on the filing of full rate applications until no later than June 30, 2023, and to update the standards for receiving temporary rate relief. The emergency status began on November 3, 2022, and expires May 2, 2023.

COMAR 10.37.01.02, Accounting System; Hospitals

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

COMAR 10.37.10.03.,04, .05, Regular Rate Applications, Commission Review of Established Rates, and Temporary Rate Applications

On February 10, 2023, the Commission proposed to amend Regulations .03, .04, .05 under COMAR 10.37.10 Rate Application and Approval Procedures. The purposes of these amendments are as follows:

- .03 establishes a moratorium on filing of full rate applications until the data used to evaluate a full rate application has no longer been substantially affected by the COVID pandemic;

- .04 clarifies that the Commission may examine the historical financial experience of a hospital since the advent of the All-Payer Model in February 2014 in conducting a full review of a hospital's rates rather than focusing exclusively on a smaller snapshot of the hospital's financial performance;
- .05 updates the standard for a temporarily approved rate to be used by the Commission.

The Commission adopted these proposals in April 2023.

Section XII: Commission Infrastructure

Commissioners

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

Table 10. Current HSCRC Commissioners

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

Staff

The State charges the HSCRC with regulatory authority over the rates and revenues of Maryland's 44 acute care hospitals, seven Freestanding Medical Facilities, three psychiatric hospitals (commercial rates only), and one pediatric specialty hospital (commercial rates only), an industry with annual revenues in excess of $20 billion. This responsibility is accomplished by a relatively small and highly skilled staff of 48 full-time equivalents and several contractual employees. To meet the demands of the TCOC Model, the Commission organized its staff structure under five centers:

1. Medical Economics and Data Analytics
2. Hospital Rate Revenue and Regulations

3. Quality and Population-Based Methodologies
4. Healthcare Data Management and Integrity
5. Administration and Operations

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

Budget

A small user fee assessed on hospital rates in Maryland supports Commission staff salaries and operations. Due to the technical nature of the work of the Commission, expenses are driven primarily by personnel costs and contracts. The total user fee assessment in FY 2022 was $16.0 million and the fund balance at the end of the fiscal year was $4.5 million.

Section XIII: Future Outlook

As HSCRC begins calendar year 2023, the Commission is focused on continuing to support and expand Maryland's unique Health Model. The TCOC agreement with CMS, combined with HSCRC's hospital rate setting authority, continues to support private and public efforts to improve the health and lives of Marylanders through innovative healthcare reforms. Maryland is increasing accountability for hospitals on health equity. Hospitals and the State are using the Maryland Health Model to invest in population health (including investments in diabetes prevention, crisis support for behavioral health, and maternal health and childhood asthma). The goal is to invest "upstream" from traditional hospital care to further limit growth in future health care expenditures as people live healthier lives. HSCRC continues to work to develop and implement policies that enhance the quality of healthcare and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders. The HSCRC will continue to lead efforts to meet the ambitious goals of the TCOC Model. Achieving these goals is a collaborative effort between the State, hospitals, non-hospital providers, payers, and a broad spectrum of community partners, all working together to create long-term health improvements and cost savings for Marylanders.

Maryland faced some headwinds in these efforts over the past few years. This hospital global budget revenue payment system provided Maryland hospitals with financial stability during the pandemic, which preserved important access to health care services. However, hospitals were not able to focus on many broader reform and population health initiatives during 2020 and 2021. That work resumed in earnest in 2022. However, in 2022, hospitals were, for the first time in a number of years, under financial stress as a result of staffing shortages and inflation in workforce and other costs. At the same time, Maryland, for the first time since the Model agreements with CMMI began in 2014, missed the Medicare savings target under that contract. In 2023, HSCRC is focused on ensuring that the State meets the 2023 Medicare total cost of

care savings target under the TCOC agreement with CMMI, while responding to hospital requests for funding support and balancing the interests of consumers, employers, and insurers to control hospital costs.

At the same time, HSCRC and other State agencies and stakeholders are planning for future negotiations with CMMI to determine what happens when the TCOC Model agreement ends. HSCRC is guiding efforts in 2023 to develop a "progression plan" document which will provide a high-level framework to guide State negotiations with CMMI. HSCRC plans to work with the Governor's Office, MDH, Stakeholders, and CMMI to finalize the plans for after the TCOC Model ends in the next few years, well before the end of the current model in 2026.

Appendices