maryland
health services
cost review commission

Annual Report

Fiscal Year 2020 Activities and
Calendar Year 2020 Total Cost of Care Model Performance

May 2021

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Introduction

The State of Maryland is leading a transformative effort to improve care and lower healthcare spending growth through the Maryland Total Cost of Care (TCOC) Model with the federal Centers for Medicare and Medicaid Services (CMS). The TCOC Model, which began in January 2019, aims to enhance the quality of health care and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders. The Health Services Cost Review Commission (HSCRC) leads State efforts under the Model and aligns its statutory rate setting authority with the goals of the Model. The 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. Maryland's unique 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 has been particularly important in the pandemic;
- Uses savings generated from reduced hospital utilization to fund investments in social determinates of health and population health; and
- Provides support for state healthcare infrastructure.

Achieving the goals of this 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.

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.

Response to COVID-19

Maryland's hospitals are at the center of the State's efforts to prepare for the COVID-19 pandemic. The TCOC Model provides essential protections to Maryland hospitals that are not available in states with fee-for-service reimbursement systems for hospitals. In 2020, the HSCRC acted quickly to ensure hospitals have adequate funding to provide care to COVID-19 patients. HSCRC's actions in response to the public health emergency include the following:

1. **Aligning with federal partners.** HSCRC staff worked closely with federal partners in Congress and the Centers for Medicare and Medicaid Services (CMS) to ensure that Maryland's unique hospital payment model did not limit the amount of federal relief aid available to Maryland hospitals and to ensure that aid did not impact CMS's evaluation of Maryland's compliance with the TCOC Contract.
2. **Addressing regulatory and policy barriers**. HSCRC staff modified and suspended pre-pandemic policies and established new policies to remove regulatory barriers for hospitals as they provided care for patients affected by COVID-19.
3. **Ensuring hospital financial stability**. Maryland's population-based global-budget revenue system provides hospitals with financial stability, as the system provides guaranteed revenue even if patient volumes change within a year. This system was particularly helpful has hospitals faced declining volumes of patients due to COVID-19. Building on this foundation, HSCRC modified rate setting methodologies and identified available funding to support hospitals during the COVID-19 pandemic.
4. **Supporting State capacity planning**. HSCRC staff have played an active role in the State Surge Activation Planning Team by modeling hospital patient volumes, providing rate setting support for alternative settings of care, interpreting federal relief packages, and identifying additional funding sources.
5. **Communicating broadly.** HSCRC staff have issued frequent communications to hospitals to ensure immediate COVID-19 policy questions are addressed. Additionally, staff proactively sent information to State legislators, the Department of Legislative Services, and partner agencies about HSCRC's actions to address COVID-19.

Under the TCOC Model and global budgets, our hospital payment structure has given Maryland hospitals a unique advantage in responding to this emergency, avoiding the financial instability that many hospitals in other states experienced during the pandemic. More information on HSCRC policy actions to respond to COVID-19 can be found on the HSCRC website: https://hscrc.maryland.gov/Pages/COVID-19.aspx.

Section I: Overview of TCOC Model and Key Requirements

Healthcare Spending under TCOC Model

The TCOC Model continues the per capita all-payer hospital growth limit requirement from the All-Payer Model (APM), which began in 2014 and ended in 2018, and sets new, more ambitious TCOC savings targets. The two key spending requirements under the Model are:

- Average annual hospital cost growth per capita must stay at or below 3.58 percent.
- The State must build up to $300 million in savings for Medicare total cost of care spending on Medicare Part A and Part B (hospital and non-hospital) annually by the end of CY 2023 and maintain those annual savings through the end of the Model (CY 2028).
- The total cost of care growth for Maryland Medicare beneficiaries may not exceed the national growth rate by more than one percent in any given year and may not exceed the national growth for two consecutive years.

Quality Measures and Population Health under TCOC Model

The State must make reductions in healthcare cost growth without "backtracking" on hospital quality measures for the remainder of the Model (through 2028). Additionally, Maryland must identify population health priorities and develop health improvement goals by establishing robust methodologies in at least three population health priority areas and propose the approach to CMS for approval. If the State performs positively in these population health efforts, the State is eligible to receive credit towards the Model's financial targets through an Outcomes Based Credit (OBC), discussed in Section IV. These areas of focus should align with the Statewide Integrated Health Improvement Strategy, also discussed in Section IV.

Section II: Total Cost of Care Performance (Calendar Year 2020)

Total Hospital Per Capita Cost Growth

The Maryland TCOC Model agreement requires the State to limit its 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. The State continued its favorable performance under the APM with a minimal per capita revenue growth rate of 0.21 percent in CY 2020. This low growth rate is due in part to the COVID-19 Pandemic and the mandate that elective hospital procedures be

cancelled. The State also continued its favorable performance for 2020 Medicare fee-for-service (FFS) per capita with a decline of 3.37 percent per capita in CY 2020 over CY 2019.

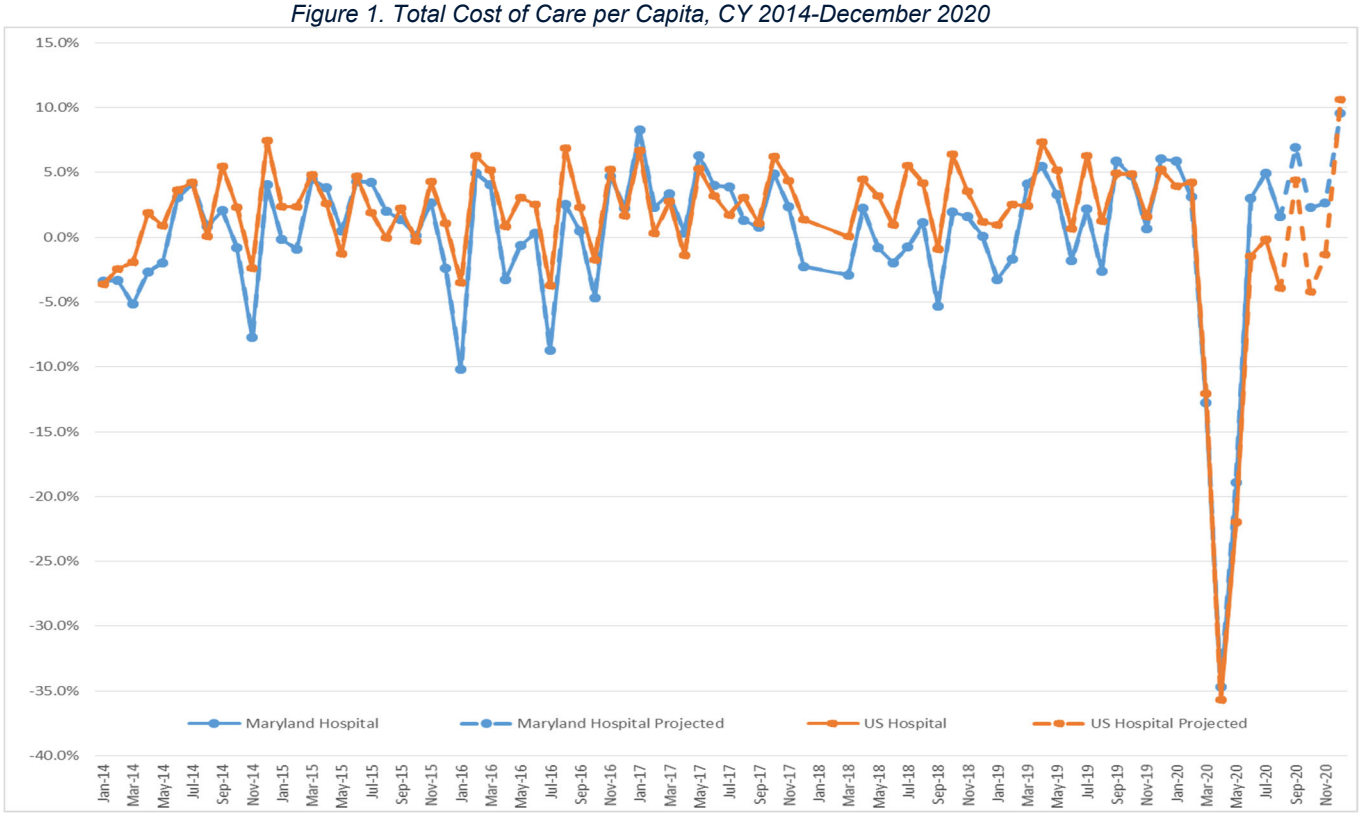
Medicare Savings and Total Cost of Care Performance

Under the TCOC Model, the total cost of care growth for Maryland Medicare beneficiaries may not exceed the national growth rate by more than one percent in any given year and may not exceed the national growth for two consecutive years. Additionally, Maryland must build to an annual $300 million in TCOC savings by the fifth year of the Model (CY 2023).

In CY 2020, the trend in both hospital and total cost of care spending per capita was mixed with Maryland trending both favorably and unfavorably compared to the Nation. Non-hospital spending per capita was favorable compared to the nation during CY 2020. This is in large part due to changes in utilization during the COVID-19 pandemic. These trends continue to be monitored on a monthly basis. Data through December of 2020 shows Maryland achieved TCOC savings of approximately $343 million. This estimate is preliminary and not final until certified by CMS.

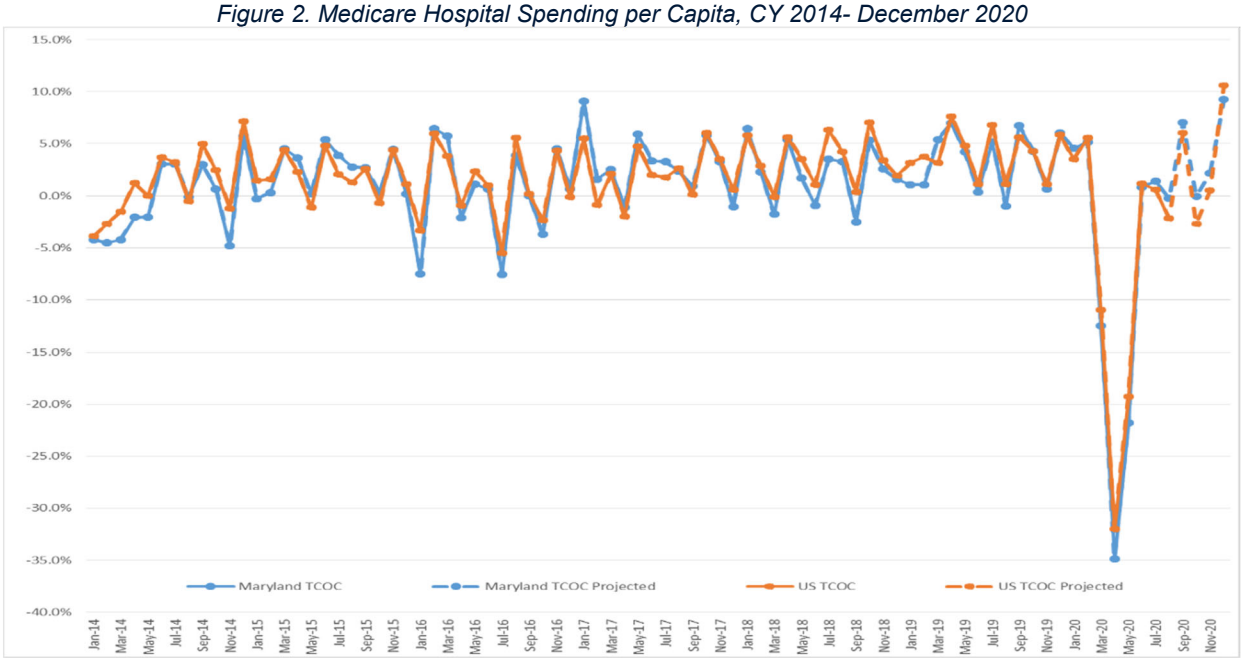
The following figures represent actual growth trends from CY 2014 through CY 2020. The trend measures growth for the current calendar year month versus the prior calendar year month.

Figure 1. Total Cost of Care per Capita, CY 2014-December 2020



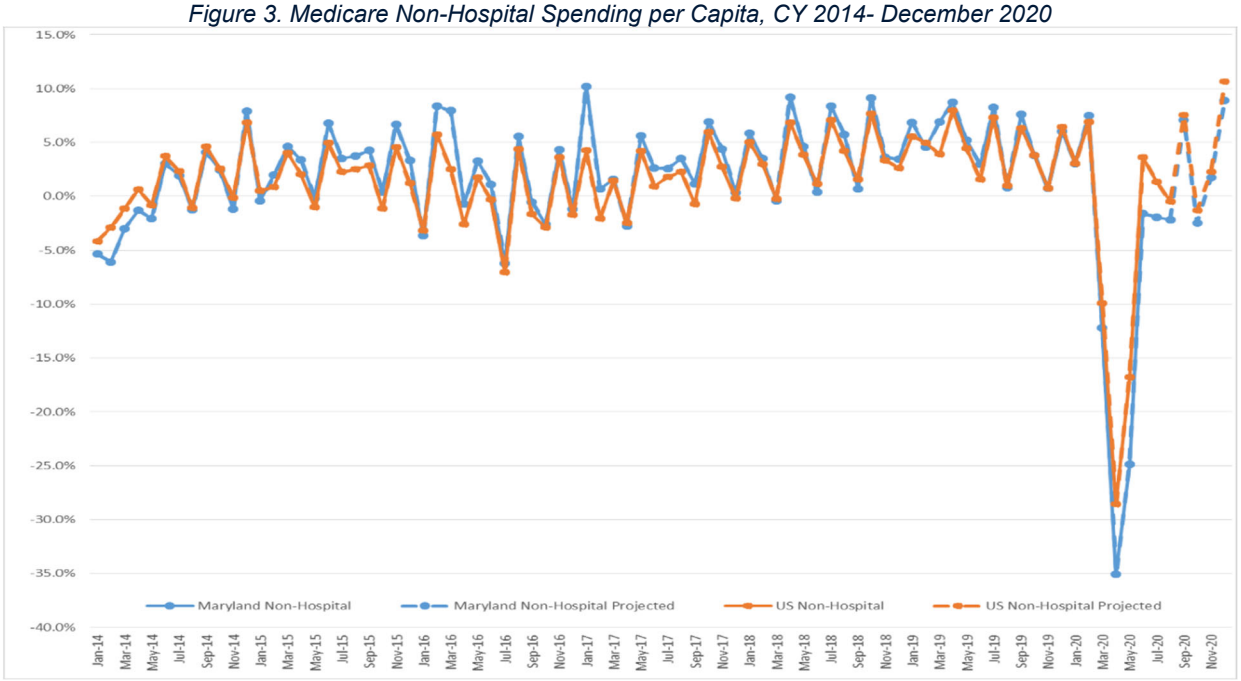
Source: CMMI Monthly Data Reports to HSCRC

Figure 2. Medicare Hospital Spending per Capita, CY 2014- December 2020



Source: CMMI Monthly Data Reports to HSCRC

Figure 3. Medicare Non-Hospital Spending per Capita, CY 2014- December 2020



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 controlling both hospital and non-hospital costs under the TCOC Model. The MPA adjusts hospital Medicare payments based on Medicare total cost of care performance. Commissioners voted on the initial policy in November 2017 to allow for a January 2018 implementation date, with payment adjustments that began in July 2019 (Rate Year 2020). A slightly modified policy was approved by Commissioners to continue through RY 2021 (July 2020-June 2021). Based on CY 2019 to-date performance data, the HSCRC expects that the RY 2021 adjustment will result in net positive payments to hospitals. The TCOC Workgroup, described in Section VI of this report, recommended continuing RY2021 policies for RY 2022 (July 2021 – June 2022) and Commissioners approved this approach in November 2019.

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; providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes; 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 incorporating quality performance programs (discussed in Section III). The FY 2021 Update Factor was implemented on July 1, 2020 and included the following policy recommendations:[1]

- Provide an overall increase of 3.52 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.35 percent per capita revenue increase for hospitals under Global Budgets.
- Provide an overall increase of 2.77 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).
- Continue to work with all stakeholders to address specific COVID-19 issues such as anticipated hospital undercharges, the challenge of maintaining affordability in a time of economic crisis and the need to ensure sufficient ongoing health system liquidity.

HSCRC staff is currently developing the FY 2022 Update Factor, which HSCRC Commissioners will vote on in June 2021 for a July 1, 2021 implementation date. The Commission will continue to closely monitor performance targets for Medicare, including Medicare's growth in TCOC and Hospital Cost of Care per beneficiary during the performance year. As always, the Commission has the authority to adjust rates as it deems necessary.

Section III: Hospital Quality Programs & Performance (Calendar Year 2019 Only)

Due to the ongoing COVID-19 Public Health Emergency, the HSCRC is not presenting aggregated quality of care trends for Maryland hospitals in CY 2020 at this time. With the consent of CMMI, we are re-presenting CY 2019 quality of care performance metrics to be used as a proxy for CY 2020 performance. Maryland hospitals continue to monitor all quality measures throughout the COVID-19 pandemic to ensure maintenance of high standards of MD Hospital Quality. We continue to work with subject matter experts through our stakeholder work group to ensure that hospital quality of care standards are maintained and upheld throughout these years. Below is information on each of the Hospital Quality Programs and 2019 performance.

[1] Additional recommendations approved in the FY 2021 Update Factor did not move forward as staff addressed pressing policy issues related to the ongoing COVID-19 pandemic.

Quality-Based Reimbursement (QBR) Program

Established in FY 2010, the QBR program adjusts hospital payments based on their performance on a number of quality-of-care measures. These include clinical care measures, patient experience of care measures, and safety measures. Each domain is then weighted to determine hospitals' final scores on the program (Table 1).

Table 1. QBR Measure Domain Weights for FY 2020-FY 2023

Measure Domain	Weight
Clinical Care	0.15
Patient Experience of Care (HCAHPS)	0.50
Safety	0.35

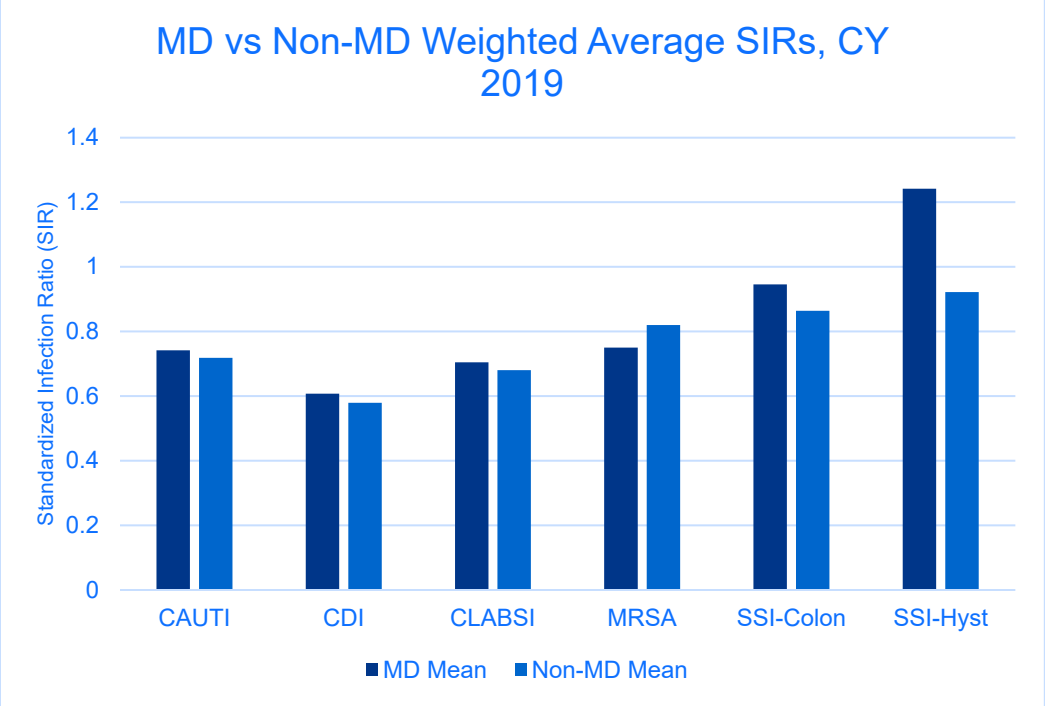
In the FY 2022 policy update, the HSCRC maintained the measurement domains and weights from the policy approved for FYs 2020 and 2021 to be as consistent as possible with the CMS Value-Based Purchasing (VBP) Program, while also targeting areas of needed improvement. In FY 2022, the amount of total hospital revenue at-risk for scaling was held to a two percent maximum penalty. Since the scaling of rewards and penalties was expanded, the maximum reward was correspondingly maintained at two percent. Maryland does not include an efficiency measure as part of the QBR Program, but it does apply a Potentially Avoidable Utilization (PAU) savings adjustment to hospital global budgets, and evaluates Medicare payments based on hospitals' TCOC performance under the MPA.

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

Maryland's QBR program is similar in design and detail to the federal Medicare Value-Based Purchasing Program. Data trends for the most recently available 12 month performance period which includes CY 2019:

- For the healthcare-associated infection measures in the Safety domain, Maryland is performing better (lower rate is better) than the national Standardized Infection Ratios (SIR) of 1 established for the nation in 2015 for all measures except Surgical Site Infection (SSI) after hysterectomy surgery. However, the nation currently performs slightly better than Maryland on all measures, with exception of the MRSA measure where Maryland performs slightly better, as illustrated in Figure 4 below.

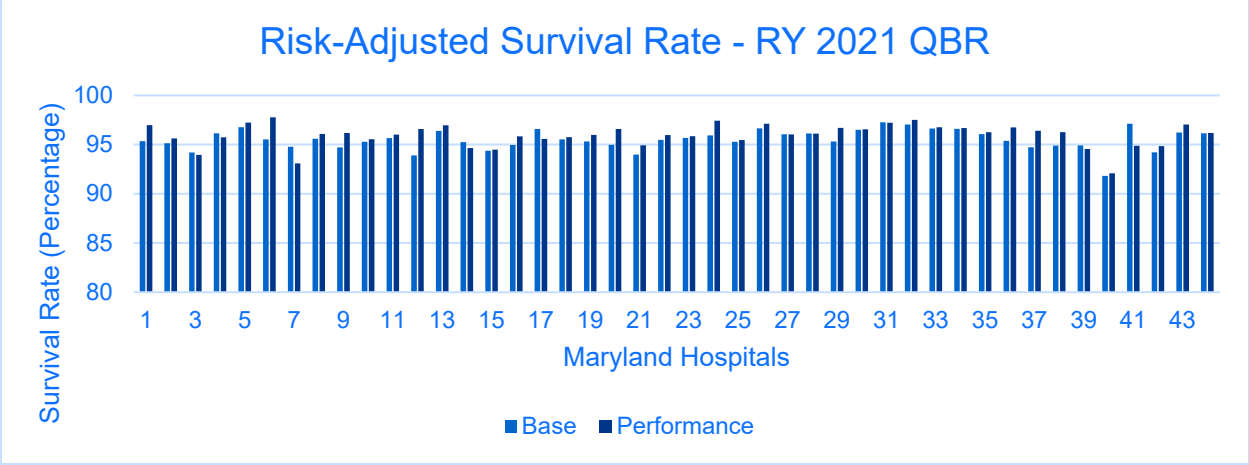
Figure 4. Maryland-Nation NHSN HAI Weighted Average SIRs (CY 2019)



Source: Mathematica Policy Research analysis of CMS Hospital Compare Data

- Maryland is trending favorably in inpatient mortality, as CY 2019 performance is compared to FY 2018 (Jul 2017 – Jun 2018) performance – over two-thirds of Maryland hospitals improved during the RY 2021 timeframe specified above.

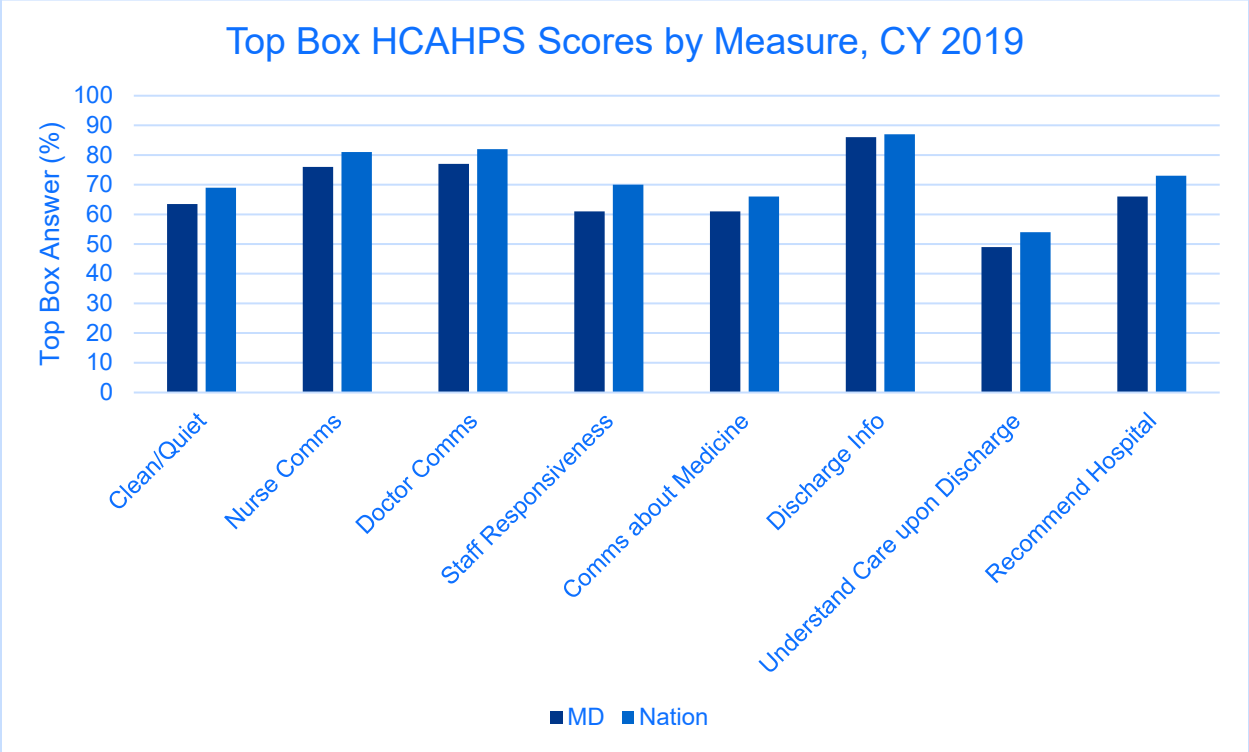
Figure 5. . RY 2021 QBR Risk-Adjusted Survival Rate



Source: HSCRC Case-mix Data

- Maryland continues to lag behind the nation in performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience measures (Figure 6). HSCRC staff remain concerned about Maryland HCAHPS performance. In the FY 2018 QBR policy, the HSCRC increased the weighting of the HCAHPS measures in determining hospitals' overall scores in order to incentivize improvement in patient satisfaction, and has kept this domain weighting through the following several QBR policy iterations. Currently, Maryland is also exploring additional correlation analyses and conducting a literature review to strategize additional ways to improve in this critical area of patient experience.

Figure 6. HCAHPS – Maryland and Nation HCAHPS Scores, CY 2019



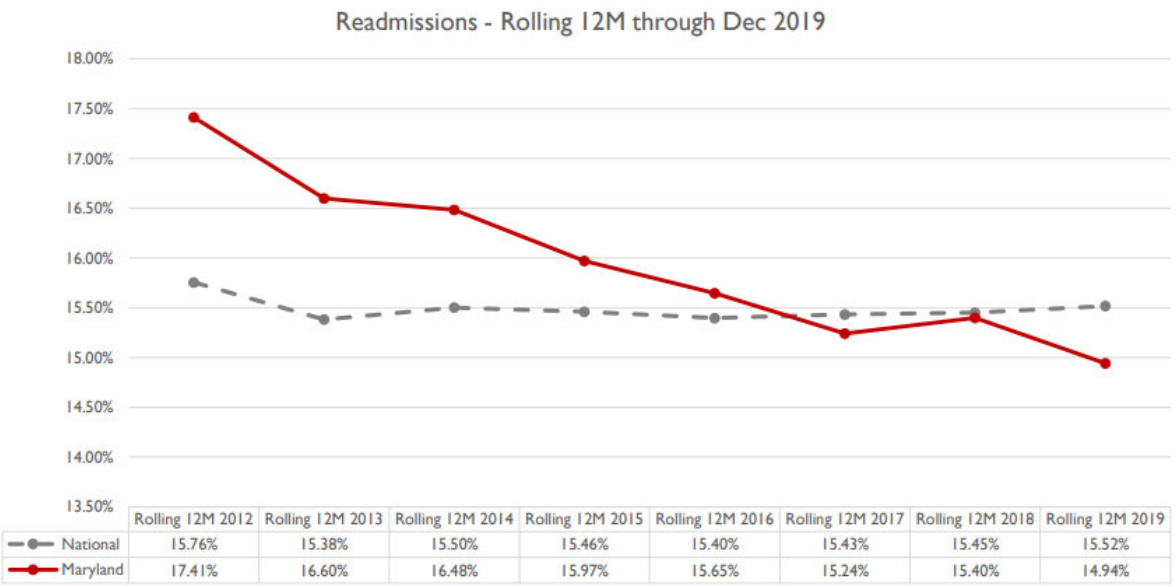
Source: CMS Hospital Compare Data

Readmission Reduction Incentive Program (RRIP)

The APM Agreement required Maryland's hospital readmission rate for Medicare FFS beneficiaries to be at or below the national readmission rate by the end of 2018, which Maryland successfully achieved. When the APM concluded in December 2018, the Maryland Medicare FFS Readmission Rate was 0.05 percentage points lower than the National Medicare FFS Readmission Rate (Maryland: 15.40 percent;

Nation: 15.45 percent). In 2019, Maryland maintained the State's achievements under the APM. Data through CY 2019 showed that Maryland maintained its improvement relative to the Nation, with Maryland readmissions at 15.09 percent compared to the national rate of 15.47 percent (Figure 7).

Figure 7. Medicare Readmissions - Rolling 12 Months Trend, Data through CY 2019

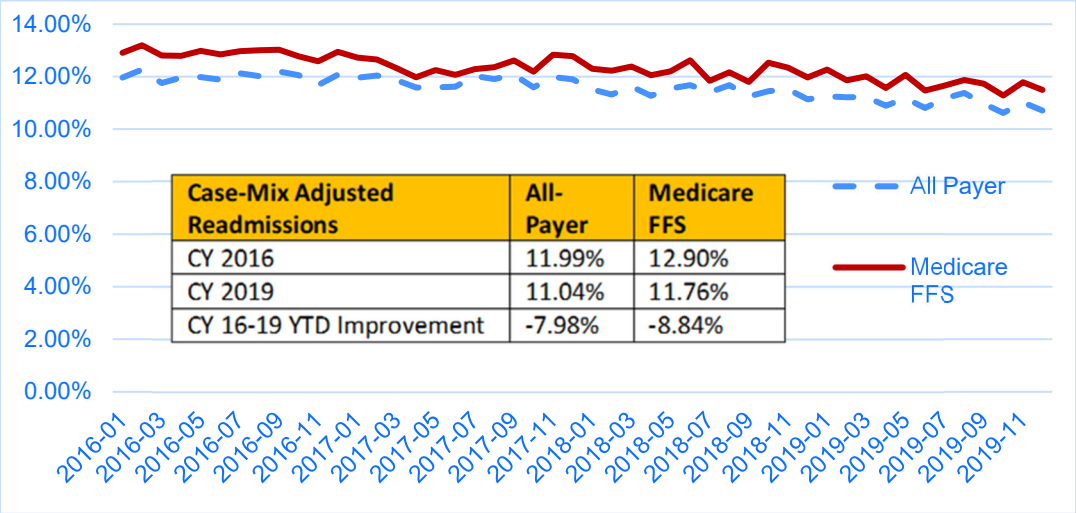


	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017	Rolling 12M 2018	Rolling 12M 2019
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%

Source: CMS Monthly Data File

Additionally, HSCRC's hospital data show that the monthly case-mix adjusted readmission rate through December 2019 continued to improve when compared to CY 2016 (Figure 8). 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 2019 was 11.04 percent, compared to 11.99 percent in CY 2016--a 7.98 percent reduction. The corresponding readmission reduction for Medicare FFS beneficiaries was slightly higher at 8.84 percent. This reduction is notable given the difficulty and time involved in reducing readmissions, as it requires sustained effort, investment, and coordination across providers.

Figure 8. Case-Mix Adjusted Readmissions in Maryland, CY 2016- CY2019



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
CY 2016	11.99%	12.90%
CY 2019	11.04%	11.76%
CY 16-19 YTD Improvement	-7.98%	-8.84%

Source: HSCRC Case-Mix Data

In the RY 2021 policy, hospitals continued 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 Health Information Exchange (HIE) and providing timely, monthly, and patient-specific data to hospitals. During CY 2019, the State worked with hospital quality experts and other measurement subject-matter experts to update the readmission policy and monitor for unintended consequences in order to sustain hospital readmissions improvements.

Maryland Hospital Acquired Conditions (MHAC) Program

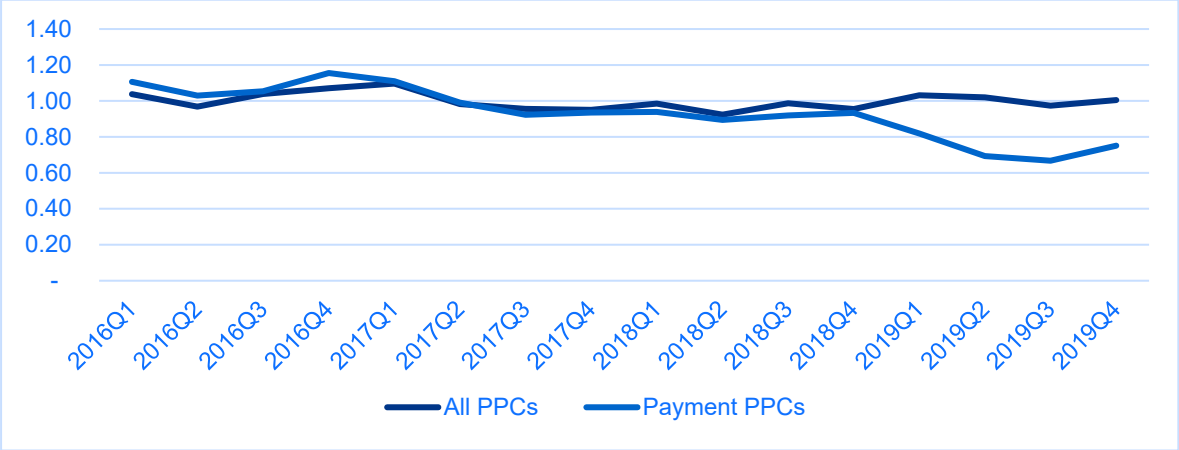
Maryland measures Hospital Acquired Conditions (HACs) using a list of potentially preventable complications (PPCs). PPCs are defined as post-admission harmful events (e.g. accidental laceration during a procedure) or negative outcomes (e.g. hospital-acquired pneumonia) that may result from the process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

By the end of the APM, Maryland achieved a 51.50 percent reduction in all-payer, case-mix adjusted PPC rates, far exceeding the required 30 percent reduction requirement. The HSCRC worked with hospitals to build on the State's commendable work under the APM to incentivize further reductions in PPCs under the TCOC Model in the updated RY 2021 MHAC Policy. During CY 2019, the overhauled MHAC policy focuses on a narrower list of clinically recommended PPCs that in general have higher statewide rates and variation across hospitals. The updated RY 2021 policy also rewards hospitals for achieving low PPC rates rather than rewarding them for improving PPC rates over time. The approved RY 2022 policy maintains the

methodology updates of the RY 2021 policy and extends the performance period to two years for small hospitals.

Based on CY 2019 YTD data applicable to RY 2021 hospital rates, there has been a 20 percent reduction in the observed to expected ratio of MHAC Payment PPCs as compared to CY 2018 (a ratio lower than one means that fewer PPCs than expected were experienced). Staff will continue to monitor the impacts of the revised MHAC policy as more data becomes available.

Figure 9. Observed-to-Expected Ratios in Maryland, CY 2016 – CY 2019



Source: HSCRC Case-Mix Data

Potentially Avoidable Utilization (PAU) Savings Program

The HSCRC adopted a final PAU Savings policy for FY 2021 as part of the FY 2021 Update Factor at its June 2020 Commission meeting. The PAU Savings policy includes savings realized from readmissions reductions as well as savings that should be realized from reducing per capita avoidable admissions as defined under the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI) logic. For FY 2021, the Commission implemented an incremental prospective savings requirement of 0.28 percent of total hospital revenue, which is distributed based on a hospital's share of revenue deemed to be potentially avoidable.

Staff are currently developing the PAU Savings policy for FY 2022 as part of the FY 2022 Update Factor which will be considered at the June 2021 Commission meeting.

Section IV: Population Health

Statewide Integrated Health Improvement Strategy

Under the TCOC Model, in addition to controlling hospital-based Medicare costs, Maryland is responsible for addressing population health priorities. To outline a statewide plan to achieve substantive improvements in identified population health areas, the HSCRC, in partnership with the Maryland Department of Health (MDH), developed a Statewide Integrated Health Improvement Strategy (SIHIS). The SIHIS aims to align stakeholders across the State to address top population health goals through achieving consensus on priorities and developing a shared action plan to tackle these challenges. In 2019, the State collaborated with CMMI to establish the broad domains for goals that the State would impact under the Total Cost of Care Model. The collaboration also included an agreed-upon process and timeline by which the State would submit proposed goals, measures, milestones, and targets to CMMI. As a result of the collaboration with CMMI, the State entered into an MOU that required Maryland to provide a proposal for the SIHIS to CMMI by December 31, 2020. The State submitted its proposal to CMMI on December 14, 2020 which CMMI approved on March 17, 2020.

The SIHIS aligns statewide efforts across three domains that are interrelated and, if addressed successfully, have the potential to make significant improvement in not just Maryland's healthcare system, but in the health outcomes of Marylanders. In addition, the State identified three key priority health areas to address as part of the Total Population Health domain.

- Domain 1: Hospital Quality
- Domain 2: Care Transformation Across the System
- Domain 3: Total Population Health
    - Priority Area 1: Diabetes
    - Priority Area 2: Opioid Deaths
    - Priority Area 3: Maternal and Child Health

To establish the goals, measures, milestones, and targets for the SIHIS proposal, the State undertook a broad stakeholder engagement process, involving workgroups led by the Maryland Department of Health (MDH), Maryland Opioid Operational Command Center (OOCC), and the Health Services Cost Review Commission (HSCRC). These workgroups obtained stakeholder input as the State developed its SIHIS proposal. In particular, the groups identified goals, measures, milestones, and targets that could be achievable in the SIHIS performance period established by CMMI. The workgroups were specifically designed to solicit input from diverse health system stakeholders including hospitals, consumer advocates, health policy experts, payers, physicians, State agencies, and other community-based healthcare resources. Agency staff from MDH, OOCC, and HSCRC guided detailed discussions with workgroups between July-October 2020 to evaluate options for the SIHIS proposal. Additionally, MDH, OOCC, and

HSCRC provided clinical, epidemiological, and statistical expertise to assist the groups in discussions to evaluate the feasibility of the proposed improvements across the domains throughout the SIHIS performance period.

Based on the expertise of agency staff and stakeholders, the following goals, as shown Table 2. SIHIS Goals below, were selected for each domain.

Table 2. SIHIS Goals

Domain Area	Goal(s)
Domain 1 – Hospital Quality	Reduce avoidable admissions and readmissions
Domain 2 – Care Transformation Across the System	Increase the amount of Medicare TCOC or number of Medicare beneficiaries under Care Transformation Initiatives (CTIs), Care Redesign Program, or successor payment model Improve care coordination for patients with chronic conditions
Domain 3 – Total Population Health "Diabetes"	Reduce the mean Body Mass Index (BMI) for adult Maryland residents
Domain 3 - Total Population Health "Opioid Use Disorder"	Improve overdose mortality
Domain 3 - Total Population Health "Maternal and Child Health"	Reduce severe maternal morbidity rate Decrease asthma-related emergency department visit rates for ages 2-17

The initiative was designed to engage State agencies and private-sector partners to collaborate and invest in improving health, addressing disparities, and reducing costs for Marylanders. The State is working with the Stakeholder Innovation Group (SIG), discussed in Section VI of this report, to identify collaboration opportunities for public-private partnerships and leverage private-sector resources to improve population health.

The full SIHIS proposal, as well as the approval memo from CMMI, can be read at: https://hscrc.maryland.gov/Pages/tcocmodel.aspx.

Outcomes Based Credits

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[2] [3] and Maryland is projected to spend $11.1 billion annually by 2025. [4]

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 fewer Marylanders than expected are newly diagnosed with diabetes in a given year, the State will be eligible to receive a financial credit that will help the State meet its TCOC savings targets. In 2020, the HSCRC completed its evaluation of 2019 diabetes performance under the diabetes OBC. Diabetes incidence in Maryland fell in Maryland in 2019. However, incidence in the control group dropped more quickly. Thus, Maryland was not entitled to a 2019 credit under the terms of the Total Cost of Care Model.

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 has retained Advanta Government Services to develop the cost methodology, and is currently reviewing the draft methodology submitted

[2] 2017 Maryland Behavioral Risk Factor Surveillance System. Maryland Department of Health Dataset Query System. https://ibis.health.maryland.gov/query/selection/brfss/BRFSSSelection.html
[3] 2013-2017 American Community Survey. Department of Planning Maryland State Data Center. https://planning.maryland.gov/MSDC/Pages/american_community_survey/2013-2017ACS.aspx
[4] "Maryland Diabetes Data & Forecasts." *Diabetes 2030.* Institute for Alternative Futures, 2015, http://www.altfutures.org/pubs/diabetes2030/MARYLANDDataSheet.pdf

under that contract. The HSCRC has retained Mathematica to develop the performance methodology and anticipates receipt of a draft methodology during the second quarter of 2021, with submission of the full methodology to CMS later in 2021.

Section V: Care Transformation and Partnerships Across the System

While the APM focused primarily on improving care and controlling costs within hospitals, the new 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 tools that incentivize providers to achieve savings and quality improvements for the system by implementing best practices.

Provider Alignment Programs

Partnerships across the care continuum and inclusion of community partners are key to the success of the TCOC Model. 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.).

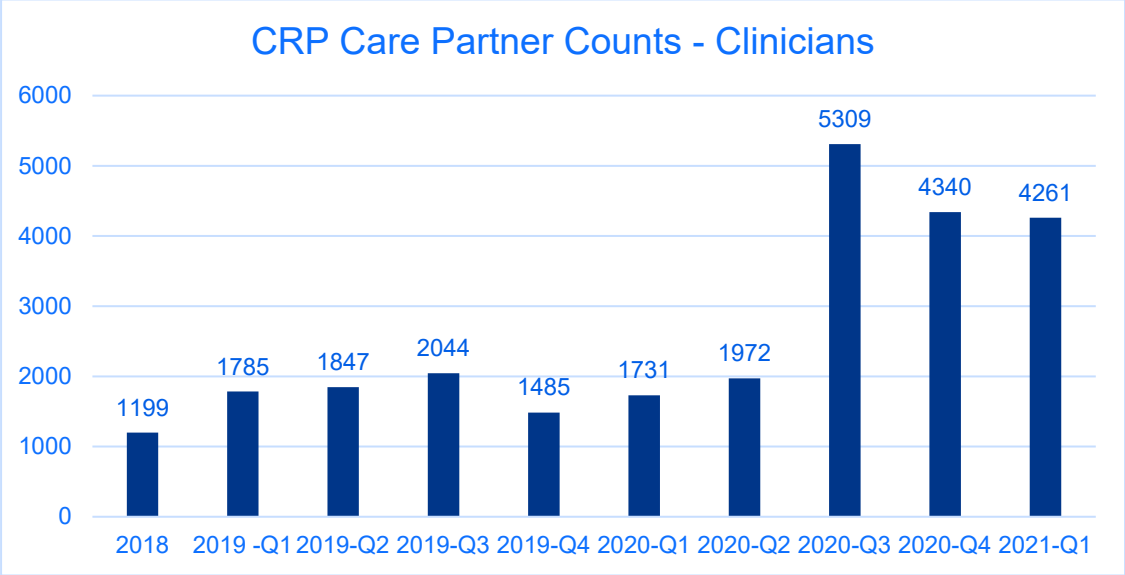
Care Redesign Program (CRP)

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 2020, the State operated two care redesign tracks: the Episode Care Improvement Program (ECIP) and the Hospital Care Improvement Program (HCIP). 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. Care Partner

engagement has grown significantly since the beginning of the program. As of the first quarter of CY 2021, hospitals engaged 4,261 clinicians and 31 facilities as care partners in CRP. Clinicians participating 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 program may be eligible for an additional 5 percent bonus on all Medicare payments, as authorized by the Medicare Access and CHIP Reauthorization Act (MACRA). More information on the QPP program can be found here: https://qpp.cms.gov/

Figure 10. CRP Care Partner Counts - Clinicians, 2018 - 2021 (Q1)



ECIP allows hospitals to link payments to providers across certain clinical episodes of care. The track is modeled off of CMS' Bundled Payments for Care Improvement Advanced (BPCI-Advanced) program. This episode payment approach aligns incentives across hospitals, physicians, and post-acute care facilities to generate savings and improve quality by enhancing care management during episodes, eliminating unnecessary care, and reducing post-discharge emergency department visits and hospital readmissions. ECIP began in 2019 and hospitals continue to build and expand implementation of ECIP both inside and outside of hospital walls.

Hospitals elected to engage a variety of provider types as care partners in 2021. 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 2021.

Table 3. ECIP Hospital Care Partner Selections, CY 2020

Care Partner Type	# of Hospitals
Physician	21
Home Health Agency	13
Nurse	18
Physician Assistant	17
Skilled Nursing Facility	11
Physical Therapist	7
In-Patient Rehabilitation Facility	0

HCIP is designed to facilitate care improvement and efficiency within hospitals. The main goals of the track are to improve inpatient medical and surgical care delivery, incentivize effective transitions of care, reduce potentially avoidable utilization, and encourage efficient management of inpatient resources. HCIP engages physicians, such as hospitalists, as care partners.

During 2020, there was a total of 24 unique hospital participants across all tracks, with seven hospitals participating in HCIP and twenty-two hospitals participating in ECIP. A new performance period began January 1, 2021 with a total of 22 unique hospital participants across HCIP and ECIP. Twenty-one hospitals are participating in ECIP and four hospitals are participating in HCIP.

While the program had its highest participation in 2019 with 42 hospital participants, the drop in participation since 2019 is primarily attributed to the following:

- Care Transformation Initiatives (CTIs), discussed below, have been developed and many hospitals have chosen to redirect their resources to this program. CTIs, which have similar goals to CRP, can be customized to interventions hospitals are already conducting, while ECIP has set episodes and interventions that hospitals must select.
- The HSCRC decided to release detailed patient-level claims data to all Maryland hospitals beginning in CY 2020. This data was previously only available to hospitals participating in CRP, which was a key motivator for some hospitals to participate.

Hospitals remaining in HCIP and 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, such as the Episode Quality Improvement Program (EQIP), discussed below, to support provider alignment based on stakeholder interest and policy needs.

Episode Quality Improvement Program (EQIP)

The HSCRC is currently developing a new CRP track called the Episode Quality Improvement Program (EQIP). This program will engage specialist physicians in an episode-based payment program for Medicare beneficiaries, custom to Maryland. EQIP will offer 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 will 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. EQIP will leverage 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 are in agreement that this alignment will create stronger incentive to participate and behavioral change among providers, strengthening outcomes for Marylanders with both Medicare and CareFirst health coverage.

The Stakeholder Innovation Group (SIG), discussed in Section VI of this report, convened an EQIP subgroup that met throughout 2020 and continued into 2021, to discuss technical details of the program, including policy design. The subgroup is led by MedChi and supported by HSCRC staff and includes membership spanning from hospitals, specialist physicians, health policy leaders and industry representatives.

EQIP has a targeted program start for January 2022. Throughout 2021, the HSCRC plans to disseminate information on EQIP, solicit stakeholder feedback, recruit provider participants and develop the program's methodologies.

Maryland Primary Care Program (MDPCP)

Maryland is also continuing efforts to implement the Maryland Primary Care Program, which is voluntary to all qualifying Maryland primary care providers (PCPs) 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 Program Management Office (PMO), which operates under MDH. The PMO works closely with CMMI on policy and operations, while providing a wealth of resources to practices including data analytics, coaching, and integration with the State's public health priorities including opioids and COVID-19. The HSCRC provides support as needed.

As of January 2021, there are 525 participating practices (562 sites) participating in the program with 392,241 attributed Medicare FFS beneficiaries. In 2021, MDPCP welcomed seven Federally Qualified Health Centers (FQHCs) representing 44 sites from across the state. These practices employ over 2,000 providers including physicians, clinical nurse specialists, nurse practitioners, and physician assistants across all 24 Maryland counties. Since 2020, the PMO began working closely with CareFirst 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, approximately seven per county, 16 of which are hospital-based.

The MDH PMO has been working closely with practices to respond to the COVID-19 pandemic. Since early 2020, the PMO has conducted over 90 COVID-19 update webinars for MDPCP practices. Content has included guidance and resources on testing, treatment, and vaccination as well as telehealth setup for virtual care. The PMO has also provided the practices with a beneficiary level Covid-19 vulnerability Index to assist with prioritizing their patient outreach and care. Most recently, the PMO established a vaccine program for MDPCP practices to vaccinate their patients with a focus on health equity.

Moreover, the MDPCP practices continue to focus on reducing avoidable hospital utilization that can be treated in primary care. Practices are provided with monthly claims-based reports that track their attributed beneficiaries' avoidable hospital events. In addition, practices are given a monthly report with the predictive probability of individual beneficiary having an avoidable hospital event in the next 30-60 days, a model the State built with The Hilltop Institute at UMBC.

Special Funding Programs[5]

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

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

for numerous initiatives and enable hospitals and their partners to collaborate on statewide delivery system transformation activities.

Regional Partnership Catalyst Program

The HSCRC Regional Partnership Transformation Program[6] was created in 2016 to enable diverse hospitals and community stakeholders to work together on interventions designed to reduce avoidable utilization for Medicare enrollees. To further the State's success under the TCOC Model, the HSCRC aims to build upon the prior Regional Partnership structure to achieve the population health goals of the TCOC Model and SIHIS (discussed in Section IV). In November 2019, Commissioners voted to approve a new version of the program called the Regional Partnership Catalyst Program. Commissioners voted to allocate up to approximately $45 million per year for five years to support the population health priority areas under SIHIS. The program will begin January 1, 2021 and is scheduled to end December 31, 2026.

HSCRC staff released a Request for Proposals in January 2020 outlining the framework for the program. To receive funding under the Regional Partnership Catalyst Program, applicants were required to identify a broad coalition of community partners and describe how the partners will collaborate to implement these programs. The program includes two separate funding streams to support infrastructure investments in diabetes and behavioral health services. Funding for diabetes prevention and management programs supports the implementation of the National Diabetes Prevention Program (National DPP), approved by the Centers for Disease Control (CDC), and the Diabetes Self-Management Training (DSMT), recommended by the American Diabetes Association (ADA). Funding for behavioral health crisis programs supports the implementation and expansion of behavioral health crisis management models that improve access to crisis intervention, stabilization, and treatment referral programs. Maternal and child health, the third population health priority area under SIHIS, will receive funding through a separate program.

In November 2020, the Commission approved awards for the top-ranking diabetes and behavioral health crisis services proposals received for the Regional Partnership Catalyst Program. This included the approval of nine proposals valued at $165.4 Million in five-year cumulative funding. Thirty-six geographically diverse hospitals are participating in at least one of the two funding streams.

Six Regional Partnerships received awards under the diabetes funding stream, receiving a five year cumulative total of $86.3 million to fund diabetes prevention and management activities.

[6] In previous reports submitted by the HSCRC, this program was referenced as Transformation Implementation Awards.

Table 4. Diabetes Funding Recipients

Regional Partnership	# Hospitals	Region
Baltimore Metropolitan Diabetes Regional Partnership	6	Baltimore City
Full Circle Wellness for Diabetes in Charles County (FCW4D)	1	Charles County
Nexus Montgomery	4	Montgomery County
Saint Agnes and Life Bridge Diabetes Health Collaborative	3	Baltimore City/County
Trivergent Health Alliance (Western Regional Partnership)	3	Allegany, Frederick, Washington Counties
Totally Linking Care in Maryland (TLC-MD)	6	Prince George's, Charles, St. Mary's Counties

Three Regional Partnerships received awards under the behavioral health funding stream, receiving a five-year cumulative total of $79.1 million to fund behavioral health crisis services.

Table 5. Behavioral Health Funding Recipients

Regional Partnership Name	# of Hospitals	Region
Greater Baltimore Regional Integrated Crisis System (G-BRICS)	17	Baltimore City/County, Howard, Carroll Counties
Totally Linking Care (TLC)	4	Prince George's County
Tri-County Behavioral Health Engagement (TRIBE)	2	Lower Eastern Shore

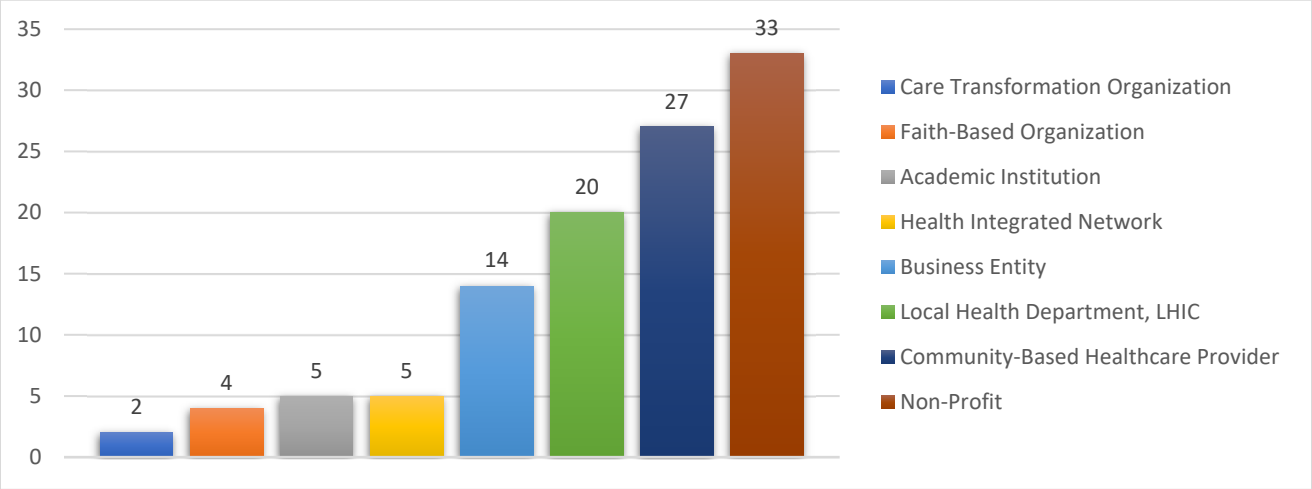
Hospital and Community Partnerships

A core goal of the Regional Partnership Catalyst Program is to foster widespread collaboration between hospitals and community partners. Under this program, hospitals are partnering with neighboring hospitals and diverse community organizations including local health departments, provider organizations, and non-profits to implement diabetes interventions and expand behavioral health crisis services infrastructure that are intended to aid in improving population health. In total, Regional Partnerships identified a total of 159 community partners to support their efforts to address diabetes and behavioral health needs in the State.

Collaboration - Diabetes

The six diabetes funding recipients identified 110 partners to support their work under the Regional Partnership Catalyst Program. Partners include, but are not limited to, community-based non-profits, local health departments and local health improvement coalitions, and faith-based organizations.

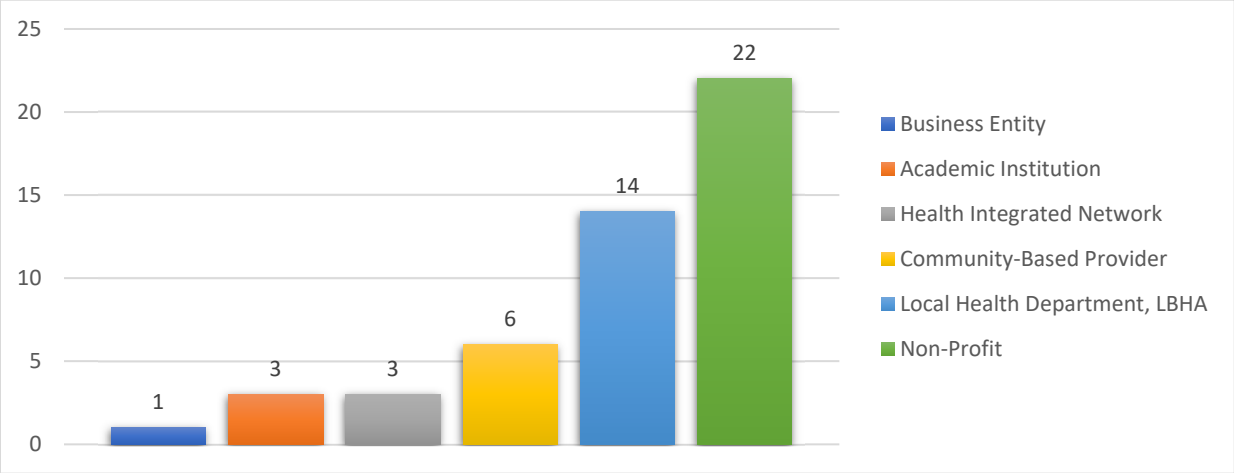
Figure 11. Diabetes Funding Community Partner Counts



Collaboration – Behavioral Health

The three behavioral health funding recipients identified nearly 50 community collaborators, including , but is not limited to, non-profit organizations, community-based healthcare providers, local health departments and local behavioral health authorities, and local businesses.

Figure 12. Behavioral Health Community Partner Counts



More information, including program summaries and full program proposals, can be found here: https://hscrc.maryland.gov/Pages/regional-partnerships.aspx.

Medicare Advantage Partnership Program

The Medicare Advantage Partnership (MAP) Funding Program is intended to foster collaboration between hospitals and Medicare Advantage Plans, increase access to 4+ Star Rating 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 Program is designed to support, promote competition, and enhance access to Medicare Advantage benefits for Medicare beneficiaries in a defined period. This Funding Program will help to ensure access to Medicare Advantage services for populations and will 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 is 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 Funding Program is 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 Rating 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 totaling $100 million. The first round of funding provided four awards and the second provided six awards. Recipients plan to expand care coordination activities for Medicare beneficiaries, grow membership and market penetration, and develop new plans to support high-risk Medicaid-Medicare beneficiaries.

More information on the MAP Program can be found on the HSCRC website: https://hscrc.maryland.gov/Pages/MedicareAdvantagePartnershipGrantProgram.aspx.

Long-Term Care Partnership Program

The COVID-19 Long-term Care grant ("LTC") program is intended to foster collaboration between hospitals and long-term care facilities and other congregate living facilities that serve vulnerable populations during the COVID-19 crisis. Under the LTC Grant Program, hospitals and their long-term care/congregate living

partners will collaborate on data sharing, infection prevention and control, resource sharing, and patient management strategies to reduce the spread of COVID-19 in these settings. The intent of the LTC Grant Program is to assist long-term care and other congregate living facilities that serve vulnerable populations with patient management, infection prevention, and infection control strategies during the COVID-19 pandemic. Further, the program is designed to achieve the following:

- Foster partnerships between hospitals and long-term care/congregate living facilities
- Support statewide efforts to combat COVID-19 in long-term care/congregate living facilities
- Prevent the introduction of COVID-19 into a facility through entry screening and entry restrictions
- Rapidly identify persons with respiratory illness that may be COVID-19 positive
- Prevent the spread of COVID-19 within and among facilities
- Strengthen environmental cleaning and disinfection procedures
- Manage, isolate, and accommodate persons with suspected or confirmed COVID-19

This program awarded $8.2 million in funding to 10 hospital partnerships to support activities associated with COVID-19 patient management, infection prevention and infection control. These hospital partnerships have collaborated with 121 skilled nursing facilities, rehabilitation centers, and other community based organizations to serve vulnerable populations during the COVID-19 crisis. Programs are funding interventions to support resource sharing, quality improvement and consultation and data analytics.

More information on the program can be found on the HSCRC website at: https://hscrc.maryland.gov/Pages/Long-Term-Care-Partnership-Grants.aspx.

COVID-19 Community Vaccination Funding Program

The HSCRC launched a special funding program to support COVID-19 community vaccination efforts. This funding program provides hospitals with short-term funding through the all-payer rate setting system in order 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 is 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 has 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 will work 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. The funding will enable these hospitals to implement community-based vaccination activities through June 30, 2022.More information on the program can be found on the HSCRC website at: https://hscrc.maryland.gov/Pages/COVID-19-Community-Vaccination-Funding-Program-.aspx

Care Transformation Initiatives (CTIs)

Under the TCOC Model, HSCRC staff are evaluating hospital efforts to address specific patient population needs, defined as Care Transformation Initiatives (CTIs). CTIs develop 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. Hospitals will be rewarded for improving the population health of their population. HSCRC staff solicit feedback from the Care Transformation Steering Committee, who prioritize, develop, and finalize each CTI proposed by hospitals. To date, the Steering Committee has approved five CTIs: (1) Transitions of Care, (2) Palliative Care, (3) Primary Care Transformation, (4) Community-Based Care, and (5) Emergency Care. The program will begin July 1, 2021.

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 2020. All workgroups are comprised of a wide range of healthcare industry stakeholders, including hospital, 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 a number of sub-workgroup meetings and task forces to discuss technical, data-driven matters related to specific policies, which report back to the larger workgroups. Input is also solicited in informal meetings with stakeholders. All proceedings and reports of workgroup activities, as well as membership rosters, may be found on the Workgroups page on the HSCRC website. https://hscrc.maryland.gov/Pages/Workgroups-Home.aspx

Payment Models Workgroup

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

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 2020 to further refine methodologies related 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 develops recommendations for HSCRC consideration on measures that are important, reliable, informative, and feasible for assessing a number of important quality and efficiency issues. Throughout the fall of 2020 and into the spring of 2021, the Workgroup reviewed and updated RY 2023 policies, including the Maryland Hospital Acquired Conditions (MHAC) Program, the Quality-Based Reimbursement (QBR) Program, and the Readmissions Reduction Incentive Program (RRIP). Because of the serious challenges posed by the COVID-19 public health emergency during CY 2020, the Workgroup also considered alternative options for data used in the quality measurement programs. For the RY 2022 programs, the Workgroup retrospectively recommended using CY 2019 data and revenue adjustments again rather than using CY 2020 data. The Workgroup also prospectively made recommendations for the RY 2023 programs that entail considerations specifically for measuring quality on COVID-19 patients separately.

Care Transformation Steering Committee

The Care Transformation Steering Committee is tasked with providing feedback on the Care Transformation Initiative (CTI) policy and Care Redesign Program (CRP). The Committee is comprised of healthcare industry representatives who meet monthly to prioritize, develop, and finalize proposed CTIs, provide feedback on CRP progress, and supply policy input as necessary.

Consumer Standing Advisory Committee

In addition to having consumers embedded in all standing HSCRC workgroups, the HSCRC convenes a Consumer Standing Advisory Committee (CSAC). This Committee builds on existing consumer engagement and involvement across various HSCRC efforts to bring together a diverse group of consumers, consumer advocates, relevant subject matter experts, and other stakeholders. Throughout 2021, the CSAC will narrow their focus to consider the benefit that Maryland hospitals operating under the TCOC Model create within their communities. This will include the amount of community benefit dollars that hospitals are spending in their communities. The HSCRC's goal is to ensure that a community and consumer perspective is included in understanding community health needs and assessing the extent to which community benefit spending addresses those community health needs and population health. The Commission will use this expertise to make informed, impactful changes to its community benefits regulations and guidelines for both FY 2021 and FY 2022.

Stakeholder Innovation Group

Maryland's Secretary of Health directed Maryland stakeholders to convene an advisory group to discuss ongoing health care delivery and payment innovations that may be leveraged or scaled, as well as to identify and develop any additional tools or programs needed to achieve the goals of the TCOC Model. The group, known as the Stakeholder Innovation Group (SIG), is a broad group of health care industry representatives that includes hospitals, physicians, skilled nursing and long term care facilities, payers, and consumer representatives. The group is staffed by the Maryland Hospital Association and attended by several State agencies including the HSCRC, the Maryland Health Care Commission (MHCC), and Maryland Department of Health (MDH). The group met throughout 2020, though the frequency was reduced from prior years due to the COVID-19 pandemic. The group plans to continue to collaborate on the development of new tools and make recommendations to MDH that may be incorporated into the implementation strategy of the TCOC Model in 2021 and beyond. Additionally, the SIG will take an active role in contributing to the success of SIHIS through identifying opportunities for community based alignment and innovative interventions, as well as promoting SIHIS activities statewide. More information on the SIG can be found here: https://www.mhaonline.org/transforming-health-care/tracking-our-all-payer-experiment/stakeholder-innovation-group.

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. [7]

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.

With the advent of COVID-19, the CY 2020 market shift policy has been suspended. The commission recognizes that hospitals have had to suspend certain service lines, most notably elective surgeries, and that the public has been reluctant to use hospital services during the pandemic; therefore, assessing market shifts that are not truly indicative of actual, permanent changes in volumes is inappropriate. Staff is currently evaluating the possibility of reinstating the market shift policy for Calendar Year 2021.

[7] 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.

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 APM and TCOC Model parameters.

Deregulation of Services

Deregulation is the movement of a hospital service from a HSCRC regulated space to an unregulated space. 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 hospital setting. If services are shifted to an unregulated setting, global budgets generally must be reduced to prevent excess billing. HSCRC staff has worked with hospitals make necessary adjustments to their global budgets when necessary.

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 four 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 portion of the annual update factor which provides hospitals with the ability 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 2022 Update Factor is still being developed, a portion of it has been earmarked to continue funding of these high cost drugs.

Integrated Efficiency Policy

Due to requests from HSCRC Commissioners to evaluate and scale global budgets based on efficiency, staff has developed an integrated efficiency policy. The policy evaluates hospital cost per case and TCOC 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 to reduce TCOC.

The final policy on the Integrated Efficiency Policy will be released in 2021 and may be used to scale the FY 2022 Annual Update Factor for certain affected hospitals (depending on the term of the COVID-19 response), using an equal weighting of hospital cost-per-case and TCOC efficiency. In effect, inefficient hospitals will receive a reduced inflation factor for FY 2021 and this funding will be redistributed to efficient hospitals. Staff will also use this Integrated Efficiency policy to assess budget enhancement requests from efficient hospitals that seek 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.

Capital Policy

Over the course of the HSCRC's 40 year history of rate setting, 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, TCOC 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, funding is capped at 100 percent of depreciation, 70 percent of interest to ensure that hospitals expend funding from its capital reserves when implementing large scale capital projects.

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 hospitals' revenue base compared to average peer group cost per case with profit removed PLUS a productivity adjustment. 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, and yet still adhere to its statutory mandate, per 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
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 TCOC performance relative to attainment and growth standards that then modifies a hospital's ICC result, but the extent of this modification is limited to the responsibility or influence hospitals have on TCOC on a statewide basis.

Complexity and Innovation Policy

Under the APM and TCOC Model, the cornerstone methodology 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. In order 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 innovation. Complexity and Innovation is determined by evaluating all inpatient procedure codes and removing procedures from the GBR system when Johns Hopkins and University of Maryland Medical Center perform a preponderance of these activities (95 percent) and the cases are deemed high acuity (1.5 times the average case mix index). In effect, the two academic medical centers will have a partial cost-based reimbursement system for select higher level acuity cases that are indicative of healthcare complexity and innovation.

Funding for Complexity and Innovation, which is provided prospectively in rates through the Annual Update Factor, is established by the historical average growth rate of these services, which will reflect increases

due to emerging technologies and declines due to dissemination of these services 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 on patient experience of care, population health and health care expenditures. The HSCRC submitted an annual report on CY 2019 healthcare expenditures to CMS in July 2020. The HSCRC submitted a second report on the State's CY 2019 performance on quality measures, inclusive of measures on patient experience of care and population health performance, in January 2021. These reports are included with this submission.

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 were developed over the course of the APM 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 for implementation of the global budgets contain consumer protection clauses. In addition, the HSCRC, in conjunction with the Payment Models Workgroup, developed the Transfer Adjustment Policy and a Market Shift Policy (discussed in Section VII) 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 (AMCs).

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 TCOC in Maryland to ensure that reductions in hospital potentially avoidable utilization do not result in unreasonable increases in the total cost of care. Maryland is currently performing within the established guardrails of the Model. More detail on TCOC 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 2020 and on an unaudited basis for FY 2021 through February of 2021.

The HSCRC 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 2020

Data for FY 2020 show a slight decrease in profitability for total operating activities, as well as non-operating activities, compared with the prior year. There was also decrease in profitability for services regulated by the HSCRC over the prior year. The decreases in non-operating profitability may be attributed, in large part, to unrealized 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 1.93 percent.
- The total margin, i.e., the combined operating and non-operating margins, was 1.67 percent.
- The operating margin for services regulated by the HSCRC was 7.61 percent.

Despite the tremendous disruption caused by the COVID-19 crisis in the 2nd half of FY2020, Maryland's hospital industry remained profitable.

Unaudited Financial Data – FY 2021

Based on unaudited year-to-date financial data for FY 2021 operating margins for both services regulated by the HSCRC and services not regulated by the HSCRC increased over FY 2020. Total profit margins increased by 9.50 percentage points versus unaudited results for the same period last year. This is, in large part, due to increases in investment income. Hospital total margins are shown below. Please note that final audited data, when available, may result in adjustments to these margins:

- The total combined unaudited regulated and unregulated operating margin was 4.67 percent.
- The total margin, (the combined operating and non-operating margins), was 12.01 percent.
- The operating margin for services regulated by the HSCRC was 7.58 percent.

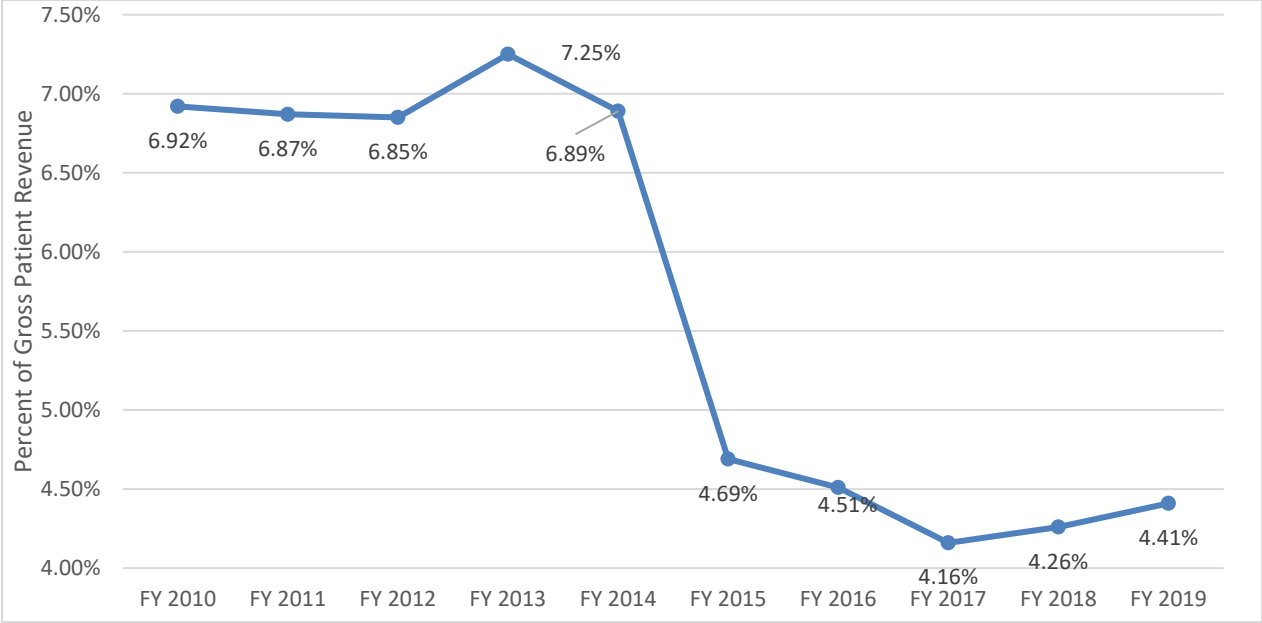
Uncompensated Care

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 cannot readily pay for them. 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 in the State for those patients who cannot readily pay for them 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 uncompensated care provisions were previously 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.

The graph below shows the actual total uncompensated care rate for all regulated Maryland hospitals between FY 2010 and FY 2019. 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 high deductible-, coinsurance-, and copayment-commercial health insurance plans, which leave patients to pay a higher portion of a bill out-of-pocket. This phenomenon is furthered by the fact that 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 uncompensated care 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). As of FY 2018 there is a slight uptick in uncompensated care rates as the effects of the ACA appear to have mitigated.

Figure 13. Uncompensated Care as a Percentage of Gross Patient Revenue, FY 2010-2018



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 2019. In that year, Maryland hospitals expended just over $1.24 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, each nonprofit hospital has 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. Those reports may be found on the Commission's Community Benefits Program website page under Reports, 2019, Individual Hospitals' Narrative Reports: FY 2019, at http://hscrc.maryland.gov/Pages/init_cb.aspx.

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

2020 Statutory Updates

The legislature passed several bills that impact HSCRC during the 2020 legislative session. The bills are described below with descriptions of the actions that HSCRC has taken to implement the bills.

Budget Bill and BRFA

The annual budget bill (SB 190 – Chapter 19) and Budget Reconciliation and Financing Act (BRFA) (SB 192 – Chapter 538) reduced the Medicaid Deficit Assessment from $309,825,000 in FY 2020 to $294,825,000 in FY 2021; a $15,000,000 decrease. This reduction will lower hospital rates and produce savings to all payers in the system, including Medicare, Medicaid, and commercial health insurance.
The Joint Chairmen's Report on the FY 2021 budget, which accompanies the budget bill and the BRFA, required HSCRC to complete the following reports:

1. **HSCRC Policy on and Management of Hospital Profits:** The report explains the Commission's policy for managing hospital operating profits, the tools available to regulate hospital profits, and the Commission's future plans to contain regulated profits. The HSCRC submitted this report in October 2020.
2. **Evaluation of the Maryland Primary Care Program:** This report evaluates the effectiveness of the Maryland Primary Care Program (MDPCP) in transforming care in the State under the Total Cost of Care Model, with particular focus on cost-savings from reduced unnecessary utilization of health care services for patients participating in MDPCP compared to the cost of provider incentives paid through MDPCP. This report was submitted in October 2020.
3. **Analysis of HSCRC Programs on dual Medicare/Medicaid Beneficiaries:** This report analyzes utilization of HSCRC-led programs by individuals who are eligible both for Medicare and Medicaid

(dual-eligible beneficiaries) and the benefits accruing to Medicaid from those programs. This report was submitted in January 2021.

4. **Independent actuarial analysis of the State's hospital medical liability market:** HSCRC studied the hospital medical liability malpractice market in Maryland and compared the market to other States. HSCRC also analyzed the likely impact of certain proposed policies on the market. The HSCRC was granted an extension for the medical liability analysis through June 30, 2021.

Revisions to HSCRC Duties and Reports (SB 42 – Chapter 505)

This departmental legislation gives the State flexibility to develop provider- and payer- led care transformation programs and support healthcare innovation in the State. The legislation also aligns the HSCRC's statutorily required reports with the requirements of the Total Cost of Care Model Agreement with the Centers for Medicare and Medicaid Services (CMS), which began in 2019. The legislation combined multiple reports into a single annual report. These changes align state and federal reporting requirement and will reduce staff time needed to produce required reports.

Facility Fee Right to Know Act (HB 915 – Chapter 365 and SB 632 – Chapter 366)

This legislation focused on improving the transparency of hospital billing practices and required hospitals to provide an estimate of facility fees and alternative, lower cost, locations for services to patients scheduled to receive outpatient services. HSCRC is required to manage facility fee complaints through a formalized process, report annually on hospital-based rate-regulated outpatient services and ensure hospital compliance with the statute. HSCRC has formalized a complaint management process and, in 2021, will update guidance for hospitals on reporting the required list of hospital-based, rate-regulated outpatient services provided by the hospital.

Hospital Employee Retraining Fund (SB 938 – Chapter 489 and HB 1571 – Chapter 490)

This legislation requires that all facilities subject to HSCRC rate setting pay a fee to the existing Hospital Employees Retraining Fund. The purpose of the fund, maintained by the Department of Labor, is to re-train workers displaced at a regulated facility. HSCRC retains rate setting authority for funding worker retraining in the case of full closures of any type. Hospitals must pay a direct remittance to the Department of Labor for partial closures. The HSCRC oversees direct payments from hospitals, collects workforce reports from hospitals, and assists the Department in calculating the assessment and compiling an annual report to legislators. The HSCRC is helping the Department of Labor administer the Hospital Employees Retraining Fund, with payments into the fund expected to start in FY 2022.

Hospital Financial Assistance Policies (HB 1420 – Chapter 470)

This legislation provides HSCRC with statutory authority related to presumptive eligibility requirements for hospital free and reduced care. The legislation increased the income threshold for eligibility for free care (which resulted in a increased minimum income threshold for eligibility for reduced-cost hospital care. The legislation also standardizes hospital procedures for determining patient eligibility for financial assistance and increasing transparency about hospital free and reduced care programs so that consumers have more awareness of the availability of that assistance. HSCRC is required to develop a complaint management process for financial assistance-related concerns and submit an annual financial assistance report to the legislature. HSCRC was also required to model and evaluate the impact of potential changes to financial assistance thresholds. This report was submitted to the legislature in February 2021. The HSCRC also developed reporting guidelines for hospitals, which are required to submit annual financial assistance reports to HSCRC.

Hospital Community Benefits Reporting (HB 1169 – Chapter 436 – SB 774 – Chapter 437)

This legislation the definition of "community benefit" and "community health needs assessment" under State law, requires HSCRC to establish a community benefit reporting workgroup, and adopt regulations that implement the recommendations of the workgroup. HSCRC convened the Commission's Consumer Standing Advisory Committee to do the work required under this legislation. The report from this workgroup was submitted in and submitted a report with its findings from the workgroup in December 2020.

Maryland Loan Repayment Assistance Repayment Program (HB 998 – Chapter 402 and SB 501 – Chapter 403)

This legislation transfers oversight of the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants from the Office of Student Financial Assistance within the Maryland Higher Education Commission to the Maryland Department of Health. HSCRC is required to participate in a workgroup, led by MDH, to identify long-term sources of funding for the LRAP. HSCRC is participating in MDH's workgroup. HSCRC also asked CMS for input on the potential for using hospital rates to fund the program. This request was denied.

Other 2020 Legislative Activities

Unregulated Operating Room Space Pilot Study

In 2019 the Chair of the House Health and Government Operations Committee asked HSCRC to study the feasibility of a pilot program for unregulated space in hospital operating suites, including how such a

program would interaction with Commission policies. HSCRC convened a workgroup, developed an Unregulated Operating Room Space Pilot, and submitted a report on the issue in 2020.

2021 Statutory Updates

During the 2021 Legislative Session, the Legislature was passed several bills with a direct impact on HSCRC operations. HSCRC is prepared to implement these bills if they become law.

Budget Bill and BRFA

The annual budget bill (HB 588) and Budget Reconciliation and Financing Act (BRFA) (HB 589) made no changes to the Medicaid Deficit Assessment.

The Joint Chairmen's Report on the FY 2021 budget, which accompanies the budget bill and the BRFA, will require HSCRC to complete the following reports:

1. **Evaluation of the Maryland Primary Care Program:** HSCRC is required to conduct another evaluation of the effectiveness of the Maryland Primary Care Program (MDPCP) (a similar report was completed in 2020). This report is due on October 1, 2021.
2. **Hospital at Home**: HSCRC and MHCC are required to report on the efficacy of the Hospital at Home model, including how this model fits into the TCOC model, barriers in existing law and regulations to implementing the model, impacts on public and private payers, and recommendations. This report is due on December 1, 2021.

Preserve Telehealth Access Act of 2021 (HB 123 – Chapter 70 and SB 3 – Chapter 71)

This bill requires Medicaid to cover medically necessary somatic, dental, or behavioral health services via telehealth. From July 1, 2021 through June 30, 2023, both Medicaid and private insurers must also cover audio-only visits and must reimburse for telehealth at the same rate as in-person care. Clinic fees are not permitted for telehealth services unless the health care professional cannot bill directly. HSCRC retains the authority to set rates for regulated services. MHCC, in consultation with HSCRC, MDH, and MIA, must study the use of telehealth services in Maryland and submit a report with findings and recommendations by December 1, 2022.

Medical Debt Protection (HB 565/SB 514)

Under this bill, HSCRC will develop guidelines for hospital income-based payment plan policies with input from stakeholders. HSCRC must report on the guidelines by January 1, 2022. Hospitals are prohibited from pursuing debt through legal action until they implement a payment plan policy that aligns with HSCRC's guidelines. The bill also requires hospitals to submit data on debt collection procedures to HSCRC.

HSCRC will use this data to compile an annual report for the legislature. The bill also requires HSCRC to study and report on the impact on UCC of certain specified hospital actions by January 1, 2022.

Regulatory Updates

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

COMAR 10.37.01.02

This regulation concerns the Commission's Accounting and Budget Manual for Fiscal and Operating Management (Manual). At its September 2020 meeting, the Commission proposed an amendment to COMAR 10.37.01.02. This amendment updated the Manual (August, 1987), which is incorporated by reference, including the addition of Supplement 26. The Commission approved final action on this amendment at its January 2021 meeting.

COMAR 10.37.10.26

This regulation concerns the Commission's Rate Application and Approval Procedures. At its November 2020 meeting, the Commission proposed an amendment to COMAR 10.37.10.26. This regulation concerns the Credit and Collection and Financial Assistance Policies of Maryland hospitals. These proposed changes will bring the regulation into conformance with the Commission's statute, which was amended during the 2020 General Assembly session by House Bill 1420 (subsequently enacted at Chapter 470). As required by statute, these changes to the regulation enhance patient accessibility to financial assistance, provide an avenue for patients or their representatives to file a formal complaint with the HSCRC or jointly with the Health Education Advocacy Unit of the Maryland Attorney General's Office for alleged violations of the hospital's financial assistance policy, and hold hospitals more accountable for the financial assistance given or denied. The Commission approved final action on this amendment at its March 2021 meeting.

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 6. Current HSCRC Commissioners

Commissioner	Term Start Date	Term End Date
Adam Kane, Chairman	July 1, 2017	June 30, 2021

Joseph Antos, Ph.D.	July 1, 2016	July 30, 2024
John M. Colmers	July 1, 2017	June 30, 2021
Victoria W. Bayless	July 1, 2019	June 30, 2023
Sam Malhotra	July 1, 2020	June 30, 2022
James N. Elliott, M.D.	July 1, 2018	June 30, 2022
Stacia Cohen	July 1, 2019	June 30, 2023

Staff

The State charges the HSCRC with regulatory authority over the rates and revenues of Maryland's 46 acute care hospitals and four specialty hospitals, an industry with annual revenues in excess of $19 billion. This responsibility is accomplished by a relatively small and highly skilled staff of 47 full-time equivalents and several contractual employees. To meet the demands of the TCOC Model, the Commission organized its staff structure under four centers:

1. Payment Reform and Provider Alignment
2. Medical Economics and Data Analytics
3. Revenue and Compliance
4. Population Based Methodologies

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 2020 was $15.0 million and the fund balance at the end of the fiscal year was $6.2 million. The HSCRC is taking on additional tasks related to the implementation of TCOC Model that will require additional resources. This balance will be utilized in conjunction with the FY 2021 user fee assessment in order to implement the critical new tasks required by the TCOC Model and will bring the fund balance to a reasonable level at the end of FY 2021.

Section XIII: Future Outlook

Maryland's unique Health Model, which began in 2014 and was expanded in 2019, presents the State with an opportunity to improve the health and lives of Marylanders through innovative healthcare reforms. Hospitals and the State are using savings estimates and flexibilities granted by CMS under the Model to invest in social determinants of health (such as housing) and population health (including investments in diabetes prevention, crisis support for behavioral health, and maternal and child health). By focusing the system on upstream investments, the State plans to further limit health care expenditures over time as people live healthier lives and avoid unnecessary acute healthcare. Global budget revenue systems provide Maryland hospitals with financial stability and an incentive to reduce unnecessary utilization. During the COVID-19 pandemic, this system has been especially valuable to Maryland hospitals that have not experienced revenue declines and instability common among hospitals nationwide. Once the pandemic subsides, Maryland hospitals will be better prepared to re-focus their work on innovative delivery system reforms while continuing work to keep people healthy, rather than increasing hospital visits.

Looking forward, 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. In 2024, CMS will decide whether to expand the model long-term for Maryland, affording the State and stakeholders the stability necessary to make significant investments in reform. In the intervening years, HSCRC is focused on developing and implementing policies that enhance the quality of health care and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders.