Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Maryland Department of Health
Fiscal Year 2021 Operating Budget
Response to the Department of Legislative Services
Health Regulatory Commissions Budget Analysis

House Appropriations Committee
Health and Social Services Subcommittee
Chair Kirill Reznik
February 13, 2020

Senate Budget and Taxation Committee
Health and Human Services Subcommittee
Chair Melony Griffith
February 17, 2020

Policy Questions

The Department of Legislative Services (DLS) recommends adopting committee narrative asking HSCRC to detail its policies on what is considered an appropriate level of profit and tools and strategies available to constrain excessive hospital profits under the regulated rate structure.

Under the Total Cost of Care Model, the HSCRC has multiple value-based payment policies that it uses to monitor hospital global budgets in order to ensure costs are reasonable and charges are reasonably related to costs as is dictated in Maryland statute (Health-General Article §19-212 and §19-219). By ensuring charges are related to costs, this ensures profit levels of hospitals are not excessive. The following four payment policies are regularly used as part of the HSCRC strategy to monitor hospitals:

- **Unit Rate Corridors** – Under the global budget system, hospitals are able to increase or decrease their HSCRC approved unit rates in line with changes in volume in order to achieve the overall approved global revenue target for the hospital. To ensure hospitals continue to provide a reasonable level of services and to ensure charges for services are not excessively high, hospitals may only vary their approved unit rates within a "rate corridor." The rate corridor prohibits hospitals from increasing or decreasing unit rates by more than 5% without receiving permission from the HSCRC – 10% is the maximum a hospital may adjust its charges with HSCRC permission. Thus, the rate corridors prevent hospitals from raising prices too high and mitigates the possibility of excessive profit levels.

- **Integrated Efficiency Policy** – HSCRC compares volume-adjusted cost per case data and Medicare Total Cost of Care growth to determine the cost efficiency of hospitals. Outlier hospitals with high costs and/or excessive retained revenue and profits do not perform well on this measure and are flagged for revenue reduction. This is either implemented in the form of negotiated spend downs of a hospital's budget or through automatic reductions in a hospital's annual inflation.
- **Potentially Avoidable Utilization (PAU) Shared Savings Program** – PAU is defined as hospital care that is unplanned and may be prevented through improved care, care coordination, or effective community based care. With the introduction of the Total Cost of Care Model and global budgets, reducing PAU through improved care coordination and enhanced community-based care became a central focus. To this end, the HSCRC does not provide inflation into hospital global revenue for PAU visits. This inflationary cut to hospital revenue ultimately results in lower profits for hospitals for visits that are preventable or better suited for community care.
- **Medicare Performance Adjustment (MPA) Analysis -** This analysis assesses the total cost of care compared to hospital spending for Medicare beneficiaries attributed to hospitals. Hospitals with excess retained revenue but no corresponding reduction in the total cost of care for attributed patients are flagged for revenue reduction.

HSCRC should also comment on why it sets rates to offset unregulated hospital losses and the degree to which the regulated system should be responsible for mitigating losses on unregulated activities. (pgs. 2, 7, 21)

The HSCRC does not set rates to offset unregulated hospital losses. While hospitals may choose to offset losses in unregulated space against profits in regulated space in order to offer much needed services to communities, including physician coverage at a hospital, this does not factor into the hospital rate setting process. The HSCRC is required to ensure regulated hospital costs are reasonable and charges are reasonably related to costs as is dictated in Maryland statute (Health-General Article §19-212 and §19-219). This premise is used as the basis for setting hospital rates. The system is not designed to account for unregulated losses in the rate setting process for regulated space.

DLS recommends adopting narrative requesting the evaluation of the MDPCP. This evaluation should include comparisons of the MDPCP additional FFS payments and costs savings attributed to avoidable hospital or emergency department utilization by individuals receiving primary care services through the MDPCP. (pgs. 2, 7, 21)

The MDPCP Program Management Office (PMO) strongly supports the need to evaluate the effect of non visit based payments within the MDPCP program on the costs and outcomes of the health of the population served by the program. The PMO notes that there is abundant evidence that making strategic investments in Primary Care can reduce the overall costs of care and improve health outcomes and longevity. The Maryland TCOC and MDPCP model provides an opportunity to further evaluate the relationship between the relative percent of spending in primary care, health outcomes and overall costs of care. In Maryland approximately 5% of the total health care spending goes to Primary Care, with 36-38% in hospitals. Other States (Colorado,Connecticut, Delaware, Rhode Island, Massachusetts, Vermont, Oregon) have either

set targets at much higher levels (12%) or are in process of setting such targets by regulation and/or statute.

The payments that are made to MDPCP practices are made in the form of risk stratified Care Management Fees (CMF) and Performance Bonuses. The CMFs are utilized by the practices to add care management staff, integrate behavioral health, expand access, focus on issues related to the Social Determinants of Health, and other patient related activities important to improving the health of the population served and not typically paid under Fee for Service(FFS) payments. These payments are called non-visit based payments. We do not anticipate any significant increase in visit-based FFS payments to the practices.

Performance bonuses paid to the practices are 100% at risk, best performers keep all of the bonus and poor performers revert some or all of the bonus to CMS.

It will be challenging to measure cost savings associated with reductions in avoidable hospital and ED due to complexities in the Global budgeting process. It may be more realistic to focus on reduction in rates of utilization for these events.

Budget Questions

To ensure continued support for [Local Health Improvement Coalitions] LHICs and to replace general funds deleted in the MDH Administration budget, DLS recommends restricting $1,000,000 special funds from the MCHRC budget for the funding of LHICs. (pgs. 2, 13, 21)

The Community Health Resources Commission has been working with MDH over the last few months to develop the parameters to support LHICs and (prior to the DLS recommendation) had been planning on supporting LHICs.