**The Maryland Department of Health's**
**Responses to the DLS FY 2022 Budget Analyses**
**February 15, 2021**

**Maryland Department of Health - Health Regulatory Commissions**

The Department thanks the Governor, the Department of Budget and Management, and the Budget Committees for their support in 2020 and in 2021 with COVID-19 response efforts. We thank the Department of Legislative Services for its insightful budget analysis.

Key Observations

1. Hospital Profits and Additional Assistance during COVID-19 Pandemic:

**HSCRC should comment on progress made within the hospital financial data submissions to better align unregulated hospital losses with the TCOC model performance.**

**HSCRC Response**

HSCRC has been working with hospitals to update the submission of financial data in order to capture and evaluate the level of spend on unregulated investments. This was an initiative that was taken before COVID, but is even more important now. In order to move towards enhanced reporting of unregulated expenses, HSCRC included a prototype of the revised financial data submissions with the HSCRC's Annual Filing instructions for Fiscal Year 2020. Staff plans to use this prototype version to refine the reporting requirements and formalize the requirements in the FY2021 Annual Filing. Due to the public health emergency, hospitals asked for, and were granted, a delay in submitting the new information. This information is now due 3/31/2021. Staff believe this delay should not impact our ability to assess the information gathered and issue final reporting requirements with the FY2021 Annual Filing, as originally intended.

Operating Budget Recommended Actions

1. Adopt the following narrative:

**Health Services Cost Review Commission Evaluation of the Maryland Primary Care Program:** Given the role of the Maryland Primary Care Program (MDPCP) in transforming care in the State under the total cost of care model and the prior findings that the MDPCP has yet to produce cost savings, the budget committees request information on the effectiveness of the program. In particular, this evaluation should focus on cost-savings from the MDPCP reducing unnecessary utilization or hospitalization for patients participating in the MDPCP over the increased expenditures from provider incentives.

**HSCRC Response:**

HSCRC concurs with this recommendation and will produce the suggested report to evaluate the effectiveness of the Maryland Primary Care Program (MDPCP), specifically cost savings and reduced utilization for patients in the program.

**MDPCP Response:**

MDPCP is demonstrating lower hospital and emergency department (ED) utilization than non MDPCP practices. Under the hospital global budget system in Maryland, lower utilization does not translate to lower hospital costs. However MDPCP practices demonstrate lower overall costs compared to non MDPCP practices. MDPCP will continue to monitor and report on these parameters.

The MDH Program Management Office (PMO) is currently working with HSCRC staff and independent data contractors on conducting a regular analysis to assess the status of MDPCP. The analysis will show MDPCP Medicare fee-for-services (FFS) costs against a comparison group. The analysis will also focus on utilization, given the hospital global budget system in Maryland in which reductions in utilization do not directly translate into lower hospital costs. The analysis will also reflect the caveat that the MDPCP was not expected to deliver savings after just one year. No primary care program in the country has ever done that. Instead, the program is designed under the Maryland Medicare Model Total Cost of Care (TCOC) contract to broadly transform the delivery of primary health care to meet the goals of advanced primary care while shifting to population based payments. MDPCP is achieving the goals.

The MDH will continue to work closely with the HSCRC to monitor the progress of the MDPCP. The program is entering Year 3 of operations, having added another 50 practices in 2021 for a total of 525 official participants. The statewide program is one of the largest advanced primary care initiatives in the country. Moreover, MDPCP is critical and indispensable to meeting the Statewide Integrated Health Improvement Strategy (SIHIS) goals and benchmarks under the TCOC contract. MDPCP is inextricably linked to success in diabetes prevention and management, identifying substance use disorders and linking individuals to treatment, coordination of care, and reduction of avoidable utilization For example, as of January 2021, 154 MDPCP practices have implemented the evidence-based protocol known as Screening Brief Intervention Referral to Treatment (SBIRT) to address substance use disorder needs in the

community including opioids; MDPCP has also added a quality measure on weight management to MDPCP's pay for performance system that is integral to diabetes incidence reduction.

**Role of MDPCP**

MDPCP is one of the foundational elements of the TCOC contract. It was well understood by the authors of the TCOC that in order for the state to be successful in achieving the goals of the TCOC, it was necessary to have a foundation of statewide advanced primary care including care management, behavioral health integration, and attention to the social determinants of health. The authors also recognized the need to provide funding for this program in the form of population-based, risk-stratified Care Management Fees and performance incentives. The voluntary MDPCP, now beginning its third program year, has proven to be one of the largest advanced primary care programs in any state, by number of practices and patients served and proportion of the primary healthcare delivery system that has been transformed. As of January 2021, there were approximately 392,250 Medicare beneficiaries attributed to the MDPCP program. The program has effectively transformed the care for Marylanders in a positive and measurable manner. Beginning in 2021, MDPCP will have approximately 525 practice participants. This represents 562 primary care sites across the state, including 44 FQHC locations providing primary care for approximately two-thirds of Marylanders every day.

**Performance**

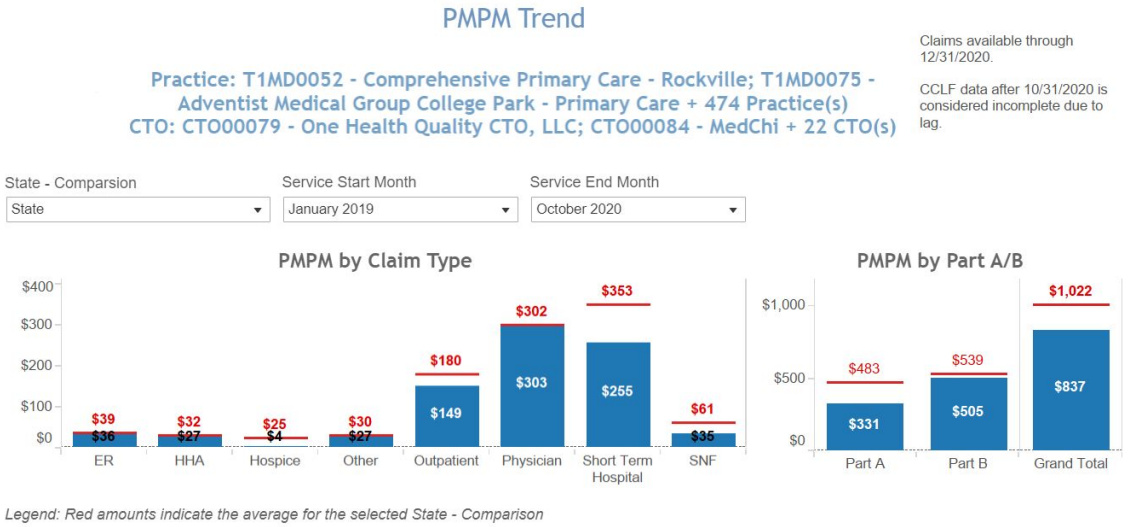
As documented in the MDPCP 2019 Annual Report, the care transformation has been broad and meaningful. The report shows that over the course of 2019 (2020 data is not available yet):

- **Enhanced access** – Patient access to practices improved, with increasing percentages of practices offering same or next-day appointments (increased from 59.6% of practices to 68.6%), and telephone advice outside of regular work hours (increased from 66.5% of practices to 78.7%).
- **Alternatives to office-based visits** – Practices offered patients an increasingly wide range of medical treatment settings, including telehealth (the percentage of practices offering video-based teleconferencing increased from 38.6% to 47.6%, and the percentage of practices offering medical visits over an electronic exchange increased from 47.3% to 54.3%).
- **Care management** – Practices' use of care management increased (the percentage of patients under longitudinal care management grew from 7.2% in the first quarter to 10.0% in the fourth quarter).
- **Behavioral health integration** – Nearly all practices (95%) integrated behavioral health into the delivery of primary care by the end of the fourth quarter, ushering in a new era of statewide behavioral health integration.

Recent performance of MDPCP has shown promise. As can be seen in the figure below (Practices vs State), since starting in the program in 2019, compared against Maryland Medicare overall, utilization for MDPCP beneficiaries has shown lower rates of inpatient admissions per 1,000, readmission rate, and ER visits per 1,000.

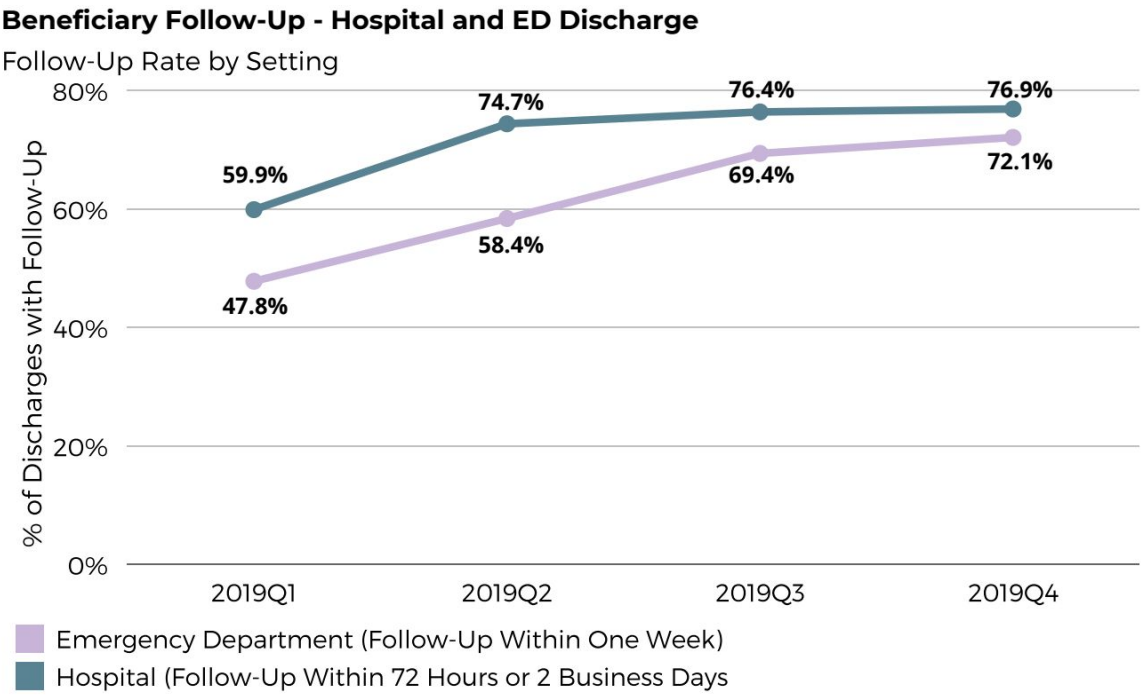

Source: CRISP MDPCP Medicare claims reports

In addition, MDPCP practices remain lower on Part A and B Medicare FFS costs. Compared to all Medicare Part A and B beneficiaries in Maryland, MDPCP beneficiaries have lower total Medicare expenditures by $185 per beneficiary per month.




Source: CRISP MDPCP Medicare claims reports

The illustration below shows the growth in follow-up for all patients from the first quarter of MDPCP Program Year 1 (PY1), through the fourth quarter of the year. The 2019 follow-up rate for Medicare beneficiaries is already exceeding the 2021 SIHIS milestone of 72.43%.




Source: MDPCP practice reporting for 2019

**COVID-19**

Since 2020, the MDPCP has been supporting the State's response to COVID-19. The PMO helped transition practices from in-person office visits to telehealth in just a few months. By April 2020, 99% of MDPCP practices reported the establishment of telehealth to support patients. The PMO has also been providing COVID updates and technical assistance in the form of workflows, guidance documents, and webinars. As of December 2020, the PMO had conducted 74 COVID-19 webinars with over 17,800 attendees.

**COVID-19 Outcomes**

In our analysis of COVID-19 outcomes across the two groups, MDPCP participation was associated with lower incidence of COVID-19 diagnosis (2.04% of patients vs. 2.26%, P<.0001), a lower fraction of inpatient admissions admitted to the intensive care unit or ICU (30.91% of COVID-19 admissions vs. 35.86%, P=.005), and a lower proportion of total patients who died of COVID-19 (0.21% vs. 0.25%, P=.005).

There was no between group difference in COVID-19 related admission counts, COVID-19 admission length of stay, the number of COVID-related emergency room visits, or COVID-19 deaths as a proportion of total COVID-19 diagnoses.

**COVID-19 outcomes in the MDPCP Group and Non-Participating Group, and statistical test p-values.**

| | MDPCP Group (n=287,867) | | Non-Participating Group (n= 172,168) | | |
|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | **p-value** |
| **COVID Diagnosis** | 5,866 | 2.04 | 3,898 | 2.26 | <0.0001 |
| **Inpatient** | | | | | |
| **COVID IP Member Count** | 1,650 | 28.13 | 1,056 | 27.09 | 0.262 |
| **Proportion of COVID IP Count among All Beneficiaries** | | 0.57 | | 0.61 | 0.085 |
| **COVID IP Admission Count (% of total IP claims)** | 1,799 | 3.81 | 1,174 | 3.96 | 0.314 |
| **COVID IP ICU Admission Count** | 556 | 30.91 | 421 | 35.86 | 0.005 |
| **COVID IP Non-ICU Admission Count** | 1,243 | 69.09 | 753 | 64.14 | |
| **Avg. COVID IP Admissions Length of Stay** | 10.08 | | 10.41 | | 0.346 |
| **COVID ER Member Count** | 663 | 11.3 | 410 | 10.52 | 0.225 |
| **Proportion of COVID ER Count to All Beneficiaries** | | 0.23 | | 0.24 | 0.594 |
| **COVID ER Count (% of total ER claims)** | 737 | 0.96 | 450 | 0.9 | 0.296 |
| **COVID members with neither IP or ER** | 3,710 | 63.25 | 2,534 | 65.01 | 0.076 |
| **COVID Death Count** | 609 | 10.38 | 435 | 11.16 | 0.223 |
| **COVID IP Mortality Count** | 375 | 22.73 | 256 | 24.24 | 0.363 |
| **COVID ER Mortality Count** | 13 | 1.96 | 12 | 2.93 | 0.308 |
| **Proportion of COVID Death Count among All Beneficiaries** | | 0.21 | | 0.25 | 0.005 |

Source: 2021 Program Management Analysis using a matched cohort of Medicare FFS beneficiaries