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625th Meeting of the Health Services Cost Review Commission

November 13, 2024

(The Commission will begin in public session at 11:30 am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

CLOSED SESSION
11:30 am

1. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on October 9, 2024

Specific Matters

There will be no specific matters discussed during this meeting. For the purpose of public notice, here is the docket status.

Docket Status – Cases Closed

2658A Johns Hopkins Health System
2659A University of Maryland Medical Center

Docket Status – Cases Open

2660A Johns Hopkins Health System
2661A Johns Hopkins Health System

Subjects of General Applicability

2. External Presenters: Totally Linking Care – Crisis Services Expansion in Prince George's County under the Regional Partnership Catalyst Program

3. Report from the Executive Director

    a. Model Monitoring
    b. ED Wait Time Activities

4. ED-Hospital Throughput Best Practices Incentive Policy Update

5. Draft Recommendation: High-Cost Drug Funding Approach

6. Final Recommendation: MPA and Set Aside Policy Updates

7. Draft Recommendation: 2025 Funding for AHEAD Preparation

8. Hearing and Meeting Schedule

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

November 13, 2024

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IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2470
BALTIMORE, MARYLAND	*	PROCEEDING:	2660A

I. INTRODUCTION

On September 30, 2024, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins Howard County Medical Center and Suburban Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospitals are requesting approval to continue to participate in a revised global price arrangement with the Priority Partners Managed Care Organization, Inc., the Johns Hopkins Employer Health Programs, Inc., and the Johns Hopkins Uniformed Services Family Health Plan for spine and bariatric surgery services. The Hospitals request that the Commission approve the arrangement for one year beginning November 1, 2024.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the new global rates for solid organ transplants was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement

among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that experience under this arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for bariatric and spine surgery services with the Priority Partners Managed Care Organization, Inc., the Johns Hopkins Employer Health Programs, Inc., and the Johns Hopkins Uniformed Services Family Health Plan for the period beginning November 1, 2024. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

November 13, 2024

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IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2471
BALTIMORE, MARYLAND	*	PROCEEDING:	2661A

I. INTRODUCTION

On September 30, 2024, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospitals are requesting approval to continue to participate in a revised global price arrangement with Quality Health Management for cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning November 1, 2024.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the new global rates for solid organ transplants was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in

payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that there was no activity under this arrangement for the prior year. However, staff believes that the Hospitals can achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services with Quality Health Management for the period beginning November 1, 2024. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Proposed Revisions to Outpatient High-Cost Drug Funding Policy

Draft Recommendation

November 13th, 2024

This is a draft recommendation for consideration by the Commission. Public comments must be received by November 27th, 2024, to william.henderson@maryland.gov

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List of Abbreviations

340B	340B Drug Pricing Program[1]
AHEAD	States Advancing All-Payer Health Equity Approaches and Development Model
ASP	Average Sales Price[2]
Casemix	Patient-level discharge data submitted by hospitals to the HSCRC
CDS-A Drugs	Cost of Drugs Sold - Audit[3]
CMS	Centers for Medicare & Medicaid Services
GBR	Global Budget Revenue
NDCs	National Drug Codes
TCOC	Total Cost of Care Model

[1] The 340B Program requires pharmaceutical companies participating in Medicaid to provide outpatient drugs to clinics that serve certain low-income patients at significantly reduced prices.
[2] Medicare pays for certain Part B drugs through Average Sales Price (ASP) methodology. Most separately payable drugs and biologics are paid at a rate of ASP plus 6% according to CMS
[3] CDS-A stands for Costs of Drugs Sold – Audit and refers to the statewide list of high-cost physician-administered outpatient drugs meeting certain defined inclusion criteria, these criteria are listed in Appendix A. These drugs are subject to an annual audit to validate reported amounts and ensure appropriate funding.

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
Simplify the current policy to ensure high-cost drugs are adequately funded by making the policy more directly volume variable and reducing complexity in the decision-making process	Adjust volume funding to 100% of measured cost change from the audit and introduce a new annual evaluation report and penalties to maintain hospital incentives for cost efficiency	Hospitals would be 100% reimbursed for changes in high-cost drug volumes. Hospitals would be subject to an annual report to monitor the use of Part B drugs and potential penalties for inefficient cost management.	Annual report would allow HSCRC to monitor hospitals and ensure Part B drugs are efficiently managed to maximize value to payers and consumers	Shifting to 100% volume-based funding will help ensure the availability of life saving treatments regardless of insurance status, location or other demographic characteristics

Summary of the Recommendation

Currently, certain high-cost physician-administered drugs, known as “CDS-A drugs”, are financed via a special funding provision outside of the Global Budget Revenue (GBR) process that is 50% inflation-based and 50% volume-based. HSCRC Staff propose shifting the current CDS-A drug funding policy to 100% volume-based funding in order to simplify the policy and make funding more representative of actual costs at a hospital level. A new report would be instituted to monitor the impact of the changes on the cost of these drugs in Maryland.

Background

In HSCRC’s rate setting process, certain high-cost drugs paid under the medical benefit, also known as Medicare Part B drugs, are subject to special funding provisions outside of the Global Budget Revenue process. These drugs are referred to as “CDS-A drugs” and include high cost, physician-administered, outpatient, oncology and infusion drugs as well as biologics. CDS-A drugs are determined annually based on a set of criteria established by staff in consultation with industry stakeholders. The current criteria can be found in Appendix A. Currently hospitals are funded for CDS-A Drug cost changes

via two pathways: 50% of funding comes from volume adjustments and the other 50% comes from the prospective price inflation factor, which is applied to CDS-A Drugs during the update factor. The current CDS-A approach was implemented in 2016 to recognize high Part B drug trends. The high-cost drug trends decreased later in the decade but began to accelerate again in Fiscal Year 2023 - the Staff expects this acceleration will continue into Fiscal Year 2024. Implementing this policy was necessary as these disproportionate trends were not being addressed by standard GBR policies. The policy was intended to provide extra funding for hospitals experiencing high-cost drug trends while still controlling spending on these drugs. In addition to clinical benefits for patients, high-cost drugs should reduce the need for acute hospitalization and other expensive services and therefore their adoption is strongly aligned with the goals of the Maryland Model.

Current Policy

Overview

Hospitals currently receive funding for CDS-A drugs via a 50/50 blend of specific volume-based funding and across the board inflation funding. Volume-based funding is provided either at Medicare's "Average Sales Price" (ASP) or 340B pricing, depending on whether a hospital qualifies for the 340B program. Volume adjustments are based on Casemix reporting and validated by staff via an audit process to ensure hospitals' volumes are appropriately reported.

Inflation funding is included in the annual Update Factor. Amounts are estimated by staff based on historical data and applied to each hospital's CDS-A drug spending. Since the inflation factor is prospective, it is estimated using data from two years prior, so funding tends to lag behind the actual inflation trends under the current policy.

The intention behind this two-lever policy was to incentivize hospitals to manage the high cost of administering these drugs:

- Hospitals that move to lower cost drugs benefit by retaining 50% of the drug cost in their GBR.

- Hospitals can also benefit by "beating" the average prospective inflation by negotiating prices with suppliers. However, 340B prices generally start lower and these participating hospitals may have less opportunity to negotiate.
- Hospitals absorb 50% of volume increases; therefore, a hospital that fails under the prior bullets will lose money under the policy.

The current approach operates under the assumptions that every hospital will have an equal opportunity of success under this policy and that the impact of new high-cost drugs would be evenly distributed because the inflation factor is set on a statewide basis. Even though HSCRC has provided different inflation factors for academic hospitals[4], it would not be operationally feasible to accurately estimate hospital specific inflation factors for every hospital; therefore, differential inflation experience will never be fully captured under the current policy.

The funding described in this section pertains only to the direct costs of acquiring the covered drugs. It does not impact the funding provided for the administration of drugs or hospital overhead (i.e. a $10,000 increase in funding under this policy increases total funding by only $10,000, there are no additional overhead loads). An important component of current policy is that hospitals are expected to "tier" their charges so that the loads applied to high-cost drugs are less than those applied to lower cost drugs, in percentage terms, as the cost of administration and overhead does not increase proportionally with the drug cost. Staff intend to continue this expectation and increase oversight to ensure it is applied.

Policy Impact

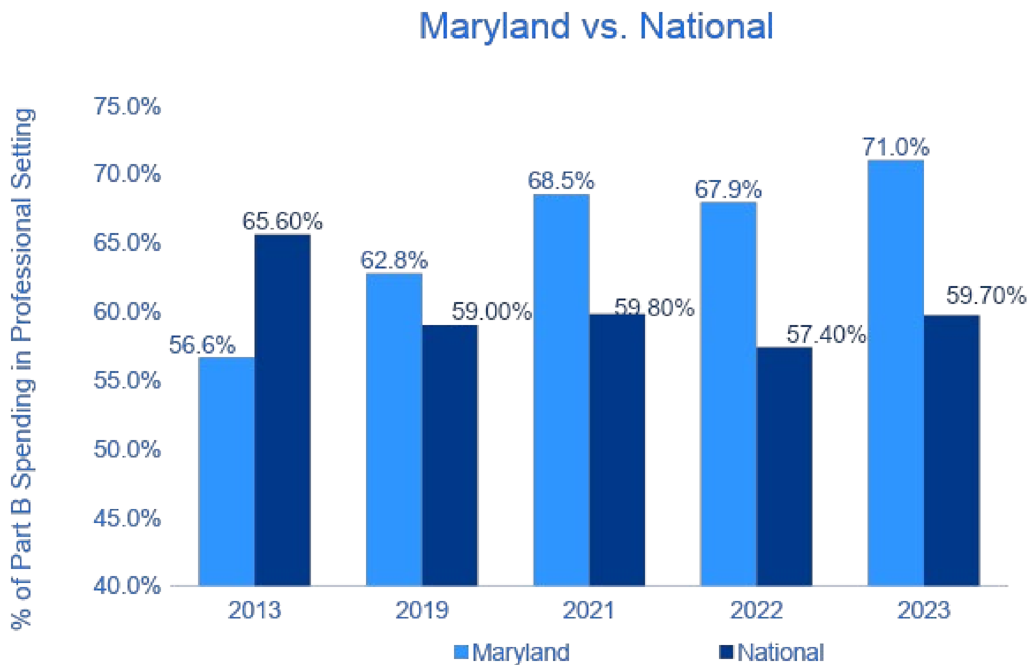
In FY23, HSCRC estimated that the average hospital was overfunded by 0.4% of total GBR based on the two-pathway drug funding approach, with the median hospital being overfunded by an estimated 0.24%.

Maryland has been successful in shifting administration of Part-B drugs to the

[4] In 2024, HSCRC provided a separate inflation factor for academic hospitals due to differing inflation trends. This had not been done previously

professional setting rather than the hospital. In 2023, 71.0% of Part-B spending was in the non-hospital setting (that is drugs were billed as professional rather than facility claims), compared to 59.7% for the nation as a whole, which effectively reversed the site of care shares that existed prior to global budgets in 2013 (see Figure 1). Staff estimate that the Part B place of service changes generated Medicare run rate savings of ~$180 million dollars since 2013 under the Total Cost of Care Model (TCOC Model)[5].

Figure 1: Maryland Model Impact on Part B Drugs



Issues with current funding approach

Both the inflation and the volume lever cause challenges for providing accurate funding. While the current approach does vary based on volume, the combination of

[5] *CDS-A Drugs are billed under Medicare Part B and therefore are part of the model savings test. See July 2025 TCOC workgroup materials for further information on model savings. (https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx)*

prospective inflation and 50% volume funding do not reliably match the actual hospital experience. Even if funding is accurate at the statewide level, variation in cost and volume at the hospital level will result in over/underfunding for individual hospitals. Hospitals facing the highest cost pressures are the most likely to be underfunded.

The prospective inflation factor is unlikely to be accurate given the rapidly changing nature of the CDS-A drug market and the two-year data lag. This volatility in the market creates a funding stream at the statewide level that lags the actual needs of hospitals, causing overfunding in times of slow drug cost growth, and under funding in times of high drug cost growth.

Additionally, changes in drug mix receive overlapping funding, as they are considered in both the volume and inflation adjustments. The complexity of this two-track funding policy creates confusion and results in suboptimal decision making, and shifting to a one-track approach would give stakeholders a clearer understanding of the funding approach.

Case for Changes to Cost Reimbursement

Staff believe that now is an appropriate time to change this policy. Currently, hospitals are appropriately funded for CDS-A drugs through FY2023, which means that this policy can be modified without requiring adjustment to current funding levels. The current two-tiered structure makes it difficult to project how these two funding streams will interact in any given situation. This complexity makes it difficult for the HSCRC to administer, hospitals to operationalize, and also risks creating confusion at hospitals about how drug costs will be reimbursed which could adversely impact appropriate adoption of new drugs. Additionally, there are indications that cost growth is shifting primarily towards a small volume of high-cost drugs administered at select hospitals, which the current approach is poorly equipped to handle.

The CDS-A approach is already a volume variable component in GBRs as scored under the TCOC Model[6]. Therefore, making changes to it does not impact that test. However, the current policy has been effective in generating total cost of care savings, which HSCRC should strive to maintain under any proposed policy change.

Staff Recommendation

To simplify the CDS-A policy, HSCRC Staff propose to make it more directly volume variable. This policy will consist of the following components:

1. Continue to identify high-cost drugs for volume-based funding based on criteria set by Staff in consultation with industry stakeholders (see Appendix A for current criteria)
2. Continue to conduct an audit of reported volumes to ensure volume-based reimbursement is fairly stated
3. Change volume funding to 100% of measured cost change, per the annual audit, effective 1/1 each year.
4. Implement a provisional adjustment period for each year, at the end of the year based on the first 6 months of data to smooth the impact of increased adjustment size.
    a. Provisional adjustment period will be directly calculated by staff using Casemix data, excluding drugs with outlier dosage counts. No manual adjustments will be made.
    b. Provisional adjustment will be temporary only, final adjustment derived from the audit will supersede the provisional adjustment and all amounts will be trued up to the final audit.

[6] Under the TCOC Model Maryland is required to “ensure that 95 percent of all 17 Regulated Revenue for Maryland residents is paid according to a Population-Based Payment methodology”. The CDS-A drug funding policy does not meet this standard and is therefore scored against the 5% exception under this provision.. It accounts for approximately 2% of total charges.

5. Set the drug component of inflation in the update factor to only reflect any price inflation not captured during the volume adjustment;[7] inflation on drugs will primarily be provided through the volume adjustment
6. Implement a new annual report, produced by a consultant, to identify hospital efficiency in controlling CDS-A drug costs and assess penalties, up to 20% of drug cost, to hospitals that are not meeting target goals. Further details are outlined below.
7. Hospitals will continue to be expected to "tier" charges for drugs. Staff will periodically evaluate hospital tiering of drug prices to ensure high-cost drugs are not being loaded with proportionate overhead, resulting in unfair costs to consumers.
8. Continue to audit data reported in Casemix to validate amounts reported and gather appropriate ASP and 340B price data.

Staff recommend Implementing the revised policy retrospectively for FY2024, effective 1/1/2025. As volume adjustments under this policy were always implemented retrospectively, HSCRC Staff believe it is appropriate to implement in FY25 for FY24. Policy timelines can be found in Appendix B.

New Reporting Requirements

In order to maintain incentives to control cost growth of CDS-A drugs under this new policy, HSCRC proposed additional reporting requirements via an annual report. 100% volume-based cost reimbursement does not provide the same incentives to manage costs effectively as the current policy. Under the proposed policy, HSCRC will contract for an annual report to monitor the State's use of Part B drugs. If this report finds an erosion in the efficiency of Maryland spending from 2023 levels, GBR reductions equal to 20% of CDS-A spending will be assessed on a statewide, regional, or hospital basis,

[7] If the price of a drug changes and there is no volume change, the volume adjustment will not capture that inflation; therefore, a small allowance is needed in the Update Factor for this impact.

depending on the extent of the erosion. This annual report would become the basis for future policy changes.

The annual report will be compiled by a consultant with a background in Pharmaeconomics and other relevant topics. HSCRC has enlisted the Prescription Drug Affordability Board (PDAB) to aid us by managing this report. The report will focus on the following factors regarding high-cost drugs:

- Place of service use rates
- Generic and biosimilar use rates
- Adoption of new drugs
- Acquisition pricing

This report will allow the HSCRC to effectively evaluate whether the policy change is impacting the efficiency of high-cost drug utilization in Maryland and examine additional opportunities for improved utilization efficiency. It will also evaluate the rate at which the State is adopting new drugs relative to the rest of the nation. In the new report, Staff will require NDCs to be collected as part of Casemix data. HSCRC expects that the first report will be released in late CY2025 based on FY25 data to assess the baseline metrics and initial impacts of this policy change. The report would be released annually thereafter.

Appendix A: Criteria for Drugs to be Treated under CDS-A Policy

The state-wide list is composed of Billed High-Cost Physician-Administered Outpatient Infusion, Chemotherapy, & Biological Oncology Drugs meeting all the following criteria:

- 3M's EAPG Class Code of VII or higher in either of the past two fiscal years (to reference relatively high cost per patient visit), and
- State-wide case-mix charges in either of the past two fiscal years of $2 million or greater (to reference relatively high-cost utilization), and
- Market share by point of service of less than 90% at physicians' offices (to minimize inclusion of drugs best served outside of a hospital setting), and
- An Ambulatory Payment Classification - OPPS Payment Status Indicator of G or K, Paid under OPPS/Separate APC payment (to preclude drugs packaged under other charge codes), and
- Inclusion of alternate codes for same listed drug (so to capture brand, generic, biologic, biosimilar, replacement, discontinued and temporary codes)

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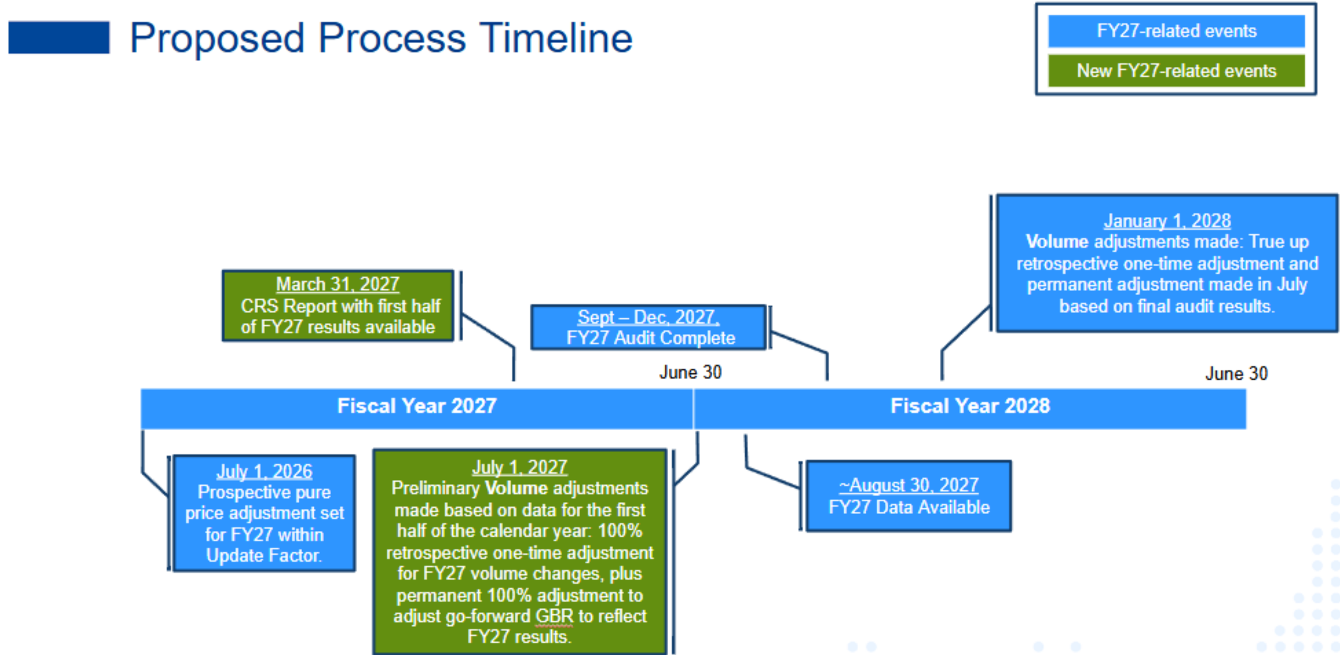
Appendix B: Proposed Process Timeline, FY27 Focused Example



MPA and Set Aside Policy Updates

Final Recommendation

November 13th, 2024

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List of Abbreviations

AHEAD	States Advancing All-Payer Health Equity Approaches and Development Model
CMS	Centers for Medicare & Medicaid Services
GBR	Global Budget Revenue
MPA	Medicare Performance Adjustment
NCBP	Non-Claim-Based Payment
TCOC	Total Cost of Care
TCOC Model	Total Cost of Care Model

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
Adjust the existing MPA and Update Factor Policies for specific purposes.	Two separate adjustments will be made: (1) an increase in the set aside provided in the Fiscal Year 2024 Update Factor Recommendation from 0.15% to 0.30% (2) a retroactive correction to the Traditional MPA savings target for calendar years 2020 to 2024 to reflect newly available information on non-claims-based payments resulting in a one-time increase to hospital rewards under this policy of approximately $22.0 M through 2023.	Hospitals would have more available funding based on need documented in the set aside process and/or the correction to the MPA calculation.	Set aside change will increase hospital costs for all payers in Fiscal Year 2025. MPA correction only impacts Medicare payments and does not impact other payers or Medicare or non-Medicare consumers.	No Impact

Summary of the Recommendation

Staff recommend the Commission adjust two existing policies as follows:

(1) increase the set aside provided in the Fiscal Year 2024 (FY24) Update Factor Recommendation from 0.15% to 0.30% (approximately $30 million on an all-payer basis, bringing the total set aside to $60 million).

(2) retroactively correct the Medicare Performance Adjustment (MPA) savings target for Calendar Years 2020 to 2024 (CY2020 to CY2024) to reflect newly available information on non-claims-based payments resulting in a one-time increase to hospital rewards under this policy (Currently estimated at approximately $22.0 M from Medicare only, through Calendar Year 2023, the final amount is contingent on review of the calculations by industry and CMS and policy requires CMS approval).

Both adjustments would be largely one-time[1] in nature and Staff will work with industry and CMS to implement them in CY24, but if that is not operationally feasible, they will be implemented in 2025 instead. These adjustments are possible due to Maryland's strong position in the Total Cost of Care Model savings test.

Background

Set Aside

In June 2024 the Commission approved the FY25 Update Factor. This included a Set Aside of 0.15% (estimated at $31.7 million). The Set Aside is routinely created during the update factor process to allow the HSCRC to meet unanticipated, documented funding needs of specific hospitals. The cost of the set aside is shared across all payers. In the FY25 Update Factor the Commission also directed staff to "create a process where the set aside will be distributed through a competitive exercise and require a corrective action plan for improved financial operations."[2] Since June Staff have been working to gather information on hospital needs in accordance with that recommendation. To date staff have received requests totaling $181 million of which Staff believe approximately $81million may merit funding, review is ongoing on this amount and staff believe the revised amount of approximately $60 million will be adequate. The delta between $81 million and $181 million is due to hospitals that did not meet the eligibility thresholds for funding and for items that cannot be funded by the Commission (i.e. Physicians).

Traditional Medicare Performance Adjustment

The traditional MPA is a program established under the TCOC Model whereby hospitals are at risk for up to 2% of Medicare revenue based on their performance managing TCOC risk for a set of attributed beneficiaries. This approach will continue under the new Advancing All-Payer Equity Approaches and Delivery Challenges Model

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[1]Hospitals can submit an application for set aside funding for financial hardship or efficiency. Hospitals that submit an application for efficiency receive permanent funding. Two hospitals submitted applications in FY25 under the efficiency criteria.

[2] See FY25 Update Factor Final Recommendation page 3 (pdf page 73) at June 2024 Commission Pre-Meeting Materials

(AHEAD). The specific provisions of this program can be found in the annual MPA recommendation to the Commission[3]. Changes to the MPA only impacts Medicare Trust Fund payments to hospitals and does not impact other payers or Medicare or non-Medicare consumers. The MPA policy is subject to annual approval by CMS and any changes to the policy require CMS approval.

Under the Traditional MPA the target for measuring hospitals' performance is based on national Medicare per beneficiary growth consistent with the TCOC Model savings target. However, since 2020, the TCOC Model savings target has gradually been adjusted to reflect the cost of certain national programs that are not paid via the standard claims reimbursement process. Known as non-claims-based payments (NCPBs), these payments typically relate to value-based programs. Because there are multiple programs, with varying levels of data available and significant data time lag these programs have only recently been fully reflected in the TCOC Model Savings Test.

Because of these same limitations not all of these payments have been included in measuring performance under the Traditional MPA even as they were added to the TCOC Model savings test. The excluded payments add more to national costs than to Maryland costs, which means their exclusion results in harder growth targets under the Traditional MPA than the State faces under the TCOC Model test. Table 1 shows the Staff's estimate of the difference between the MPA targets used and the targets reflecting NCBP.

[3] The most recent MPA Recommendation can be found on pdf page 8 at March 2024 HSCRC Public Pre-Meeting Materials

Table 1: Impact of NCBP on Traditional MPA Per Beneficiary TCOC Growth Targets[4]

Calendar Year	Target Used	Revised Target[5]	$ Impact
2020	-3.38%	-2.99%	$3.7 M
2021	8.96%	9.18%	$5.5 M
2022	2.84%	3.25%	$3.2 M
2023	5.36%	5.53%	$9.7M
2024[6]	TBD	TBD	TBD
Total through 2023	14.1%	15.4%	$22.2 M

Model Savings Position

The funds for this spending are available because we are exceeding savings targets. For Calendar Year 2023 (CY23) CMS certified that under the TCOC Model Maryland achieved savings of $509 Million versus a target of $300 Million. During the Update Factor Staff estimated savings remaining approximately flat into 2024. However, through July 2024[7] (YTD CY24) Maryland's savings have increased to approximately $600 million. This increase results from per beneficiary total cost of care growth of 4.3% in Maryland versus 6.3% nationally. This variance is driven primarily by accelerations in

[4] are estimates and are currently being reviewed by industry.
[5] For the purposes of this calculation the HSCRC is netting Maryland NCBPs against National and then adjusting the National trend. The TCOC Model savings test adjusts both Maryland and the Nation separately, Staff are proposing to use the alternative approach in the MPA to simplify they impact as the Maryland amounts are de minimis.
[6] The impact for Calendar Year 2024 is not yet known as the year is not yet complete and impact can vary with hospital performance. Staff anticipates an amount in the $5 to $10 million range, consistent with prior years.
[7] All CY24 amounts include 2 months run out and completion. All prior periods include 3 months run out. This approach is consistent with ongoing TCOC reporting methods.

national hospital spending and a slowing in Maryland non-hospital spending in comparison to the nation. Specifically:

- An increase in the national hospital per beneficiary growth to 6.7% in YTD CY24 compared to 3.7% for the same period in CY23 and average annual growth from 2013 to 2023 of 2.5%
- A reduction in Maryland non-hospital per beneficiary growth to 4.3% in YTD CY24 compared to 5.3% for the same period in CY23. For the same time period national non-hospital growth has gone up from 5.1% to 5.9%.

The $100 M extra savings accumulated year-to-date is split approximately 50:50 between hospital and non-hospital drivers. These adjustments have been identified for implementation in 2024 as it should be possible to implement them rapidly without significant disruption to the rate setting system. Making larger adjustments within 2024 would result in undesirably large variations in hospital rates and would be hard to operationalize.

Staff Recommendation

Staff recommend the Commission adjust two existing policies as follows:

(1) increase the set aside provided in the Fiscal Year 2024 (FY24) Update Factor Recommendation from 0.15% to 0.30% (approximately $30 million on an all-payer basis).

(2) retroactively correct the Medicare Performance Adjustment (MPA) savings target for Calendar Years 2020 to 2024 (CY2020 to CY2024) to reflect newly available information on non-claims-based payments resulting in a one-time increase to hospital rewards under this policy.

Both adjustments would be principally one-time in nature[8]. The Update Factor increase would only be effective for Fiscal Year 2025 (FY25) and would have to be renewed by the Commission beyond July 1, 2025.

[8] See footnote 1.

The MPA correction is a catch-up for a change in prior year rewards and is therefore one-time in nature. The cost of this change is borne only by Medicare. The impact as shown in Table 1 is an estimate and subject to review by industry and CMS. The impact of this recommendation is to include NCBP in the calculation of the MPA target rather than any specific dollar amount. This change is also contingent on approval by CMS, as with all MPA policy changes. This recommendation only addresses periods through CY24. Staff intend to include a similar recommendation in the CY25 MPA Recommendation covering future periods.

Staff should work with industry and CMS to effect both these changes in CY24 to avoid creating disproportionate headwinds to CY25 savings. However, given their one-time nature, the changes should be pursued even if they can’t be fully implemented in CY24 due to operational limitations.

2025 Funding for AHEAD Preparation

Draft Recommendation

November 13th, 2024

This is a draft recommendation for consideration by the Commission. Public comments must be received by November 27th, 2024, to hscrc.payment@maryland.gov

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List of Abbreviations

AHEAD	States Advancing All-Payer Health Equity Approaches and Development Model
CMS	Centers for Medicare & Medicaid Services
TCOC	Total Cost of Care
TCOC Model	Total Cost of Care Model

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
To prepare for successful implementation of the AHEAD model.	An increase of 1.6% will be implemented in hospital rates for 2025 to be collected by hospitals throughout 2025 and held to be redirected to various purposes to prepare for the AHEAD model as outlined in this recommendation. The rate increase would sunset December 31, 2025, without further action from the Commission.	Hospitals would gain directly when eligible for the additional funding and indirectly from strengthening of the Maryland model for AHEAD.	The rate increase will add to the costs for payers and consumers however payers and consumers will also benefit from the impact as the held funds are allocated to health improvement efforts and a successful launch of the AHEAD model	As one of the fundamental goals of AHEAD is increasing health equity, preparing for successful implementation will advance this goal.

Summary of the Recommendation

Staff recommend the Commission increase rates as of January 1, 2025, for Calendar Year 2025 by 1.6 percent, on an all-payer basis, and that hospitals hold the revenues collected under this provision until directed to specific purposes by the Commission to prepare for successful performance under the new Advancing All-Payer Equity Approaches and Development Model (AHEAD). Twenty percent of the funds held will be directed to the Population Health Trust the State agreed to establish under the AHEAD agreement and the remaining eighty percent will be used for new efforts related to AHEAD implementation as described in this recommendation.

The Commission will provide specific directions for the use of funds contingent on the establishment of necessary funding vehicles by the Maryland General Assembly. Additionally, an increase in the Maryland State Deficit Assessment will be necessary to offset the budgetary impact to Medicaid. The rate increase is only for calendar year 2025 and will sunset at the end of the year if the Commission takes no further action. Staff

believe there is sufficient room under the Total Cost of Care Model (TCOC Model) savings target to fund these efforts.

Background

AHEAD

The States Advancing All-Payer Health Equity Approaches and Development Model (AHEAD) is an 11-year multi-state total cost of care (TCOC) model administered by the Centers for Medicare and Medicaid Services (CMS). The Model seeks to drive state and regional healthcare transformation and multi-payer alignment to curb healthcare cost growth, improve population health, and advance health equity by reducing disparities in health outcomes across all payers including Medicare, Medicaid, and private coverage.

Maryland will begin its AHEAD implementation period on January 1, 2026. To ensure successful implementation, significant investment is necessary to accelerate healthcare transformation, bolster access to necessary services, and develop and launch an equity-centered population health strategy.

Population Health Trust

Under the AHEAD agreement the State committed to establishing a Population Health Trust comprised of public and private sources to support statewide population health improvement initiatives in alignment with the Statewide Health Equity Plan (HEP) and State Health Improvement Plan (SHIP). The Statewide HEP will be developed by the State and Maryland Commission on Health Equity (MCHE) and will serve as the foundation for all actions and investments under AHEAD. The plan is set to be finalized by July 2025 and will include quality and equity measures, along with performance targets for the State under the Model. It will address key areas such as chronic disease, behavioral health, healthcare access and utilization, population health, and the promotion of prevention and wellness. Maryland's SHIP has already established priorities, strategies, and targets aimed at improving health, based on needs identified in the State Health Assessment (SHA), which provides a comprehensive overview of the state's current health status.

Availability of Funds - Model Savings Position

For Calendar Year 2023 (CY23), CMS certified Maryland saving under the TCOC Model of $509 Million versus a target of $300 Million. During the Update Factor, Staff estimated savings remaining approximately flat into 2024. However, through July 2024[1] (YTD CY24) Maryland's savings have increased to approximately $600 million. This increase results from per beneficiary total cost of care growth of 4.3% in Maryland versus 6.3% nationally. This variance is driven primarily by accelerations in national hospital spending and a slowing in Maryland non-hospital spending in comparison to the nation. Specifically:

- An increase in the national hospital per beneficiary growth to 6.7% in YTD CY24 compared to 3.7% for the same period in CY23 and average annual growth from 2013 to 2023 of 2.5%
- A reduction in Maryland non-hospital per beneficiary growth to 4.3% in YTD CY24 compared to 5.3% for the same period in CY23. For the same time period, national non-hospital growth has gone up from 5.1% to 5.9%.

The $100 M extra savings accumulated year-to-date is split approximately 50:50 between hospital and non-hospital drivers. As long as national trends remain high and Maryland non-hospital trends remain low, Staff expect the positive savings to continue into 2025 accumulating to as much as $650 or $700 million.

While Staff believe Maryland will end Calendar Year 2025 well above the TCOC Model target of $372 million and, therefore, some actions to utilize savings above target are appropriate, Staff also note that there are several contextual factors to consider, and these informed the recommendation of a 1.6% increase.

- The $509 million savings in 2023 will become the baseline for AHEAD starting in 2026 and should savings go below that level in the intervening years, they will have to be recovered to achieve 2026 targets.

[1] All CY24 amounts include 2 months run out and completion. All prior periods include 3 months run out. This approach is consistent with ongoing TCOC reporting methods.

- Savings are driven by high national hospital spending and low Marland non-hospital spending. Both factors lie largely beyond the control of the Commission.
- As noted in the bullet above, YTD CY24 national hospital growth is very high compared to historical averages, and data reflects only 7 months of experience
- YTD CY24 Maryland hospital growth of 4.3% is in line with projections made during the Update Factor and reflects both significant catch-up inflation adjustments made during that process and significant demographic catch-up adjustments made during the prior Update Factor.
- CY23 savings of $509 million represented a considerable acceleration from 2022 levels of $269 million, but when compared to pre-pandemic 2019 savings of $364 million are generally in line with the rate of savings accumulation ($60 M per year 2014 to 2019 versus $51 M per year 2014 to 2023). Therefore, 2023 savings levels when compared to 2022 should not be considered unusual within the longer-term view of the model but rather a correction from disruption triggered by the pandemic. Continued savings into 2025 would still be within the longer-term model trajectory.
- The performance on the TCOC Model savings test described above reflects only Medicare Fee-for-Service performance; to justify an all-payer rate increase, the Commission must assume other payers are seeing a similar benefit. Staff analysis has previously shown that TCOC Model has resulted in hospital cost growth below Gross State Product, so the correlation of Medicare performance with all-payer performance has a historical basis. However, due to data lags, Staff cannot demonstrate the same is true of the current savings over target.

New Programs to Address Health Cost and Delivery Challenges

In addition to providing funding for the Population Health Trust, Staff support investments in various health cost and delivery improvement programs to prepare for successful performance under AHEAD. Staff believe creating an access and transformation fund that leverages the capabilities of hospitals as well as other participants in the system, such as independent physician practices and not-for-profit community health organizations, is the most productive way to use savings in excess of target. Staff have identified 7 areas of potential investment:

1. An all-payer value-based program, similar to the current Medicare Care Transformation Initiatives program, to support clinical innovation and transformation to achieve better and more equitable health outcomes while maintaining affordability.
2. Common platforms and efforts for the hospital system to improve efficiency and effectiveness of care.
3. Access expansions to meet latent demand for high-value clinical services across the healthcare system.
4. Global payment arrangements with hospitals that are working to improve health and lower costs in their geographic areas.
5. Workforce investments, including but not limited to updates to the GME program.
6. Greater understanding of patient financial burdens with seed funding for new approaches to assistance.
7. Additional pay-for-performance programs with transformation or access impact.

Staff will work with stakeholders and the legislature to refine and prioritize this list before recommending final funding allocations to the Commission.

Staff Recommendation

Staff recommend the Commission increase rates as of January 1, 2025, for Calendar Year 2025 by 1.6 percent, on an all-payer basis, and that hospitals hold the revenues collected under this provision until directed to specific purposes by the Commission. Twenty percent of the funds held will be directed to the Population Health Trust, which the State agreed to establish under the AHEAD agreement, while the remaining eighty percent will be used for newly established programs as described in the prior section.

The Commission will provide specific directions for the use of funds after consultation with the Maryland State Legislature and the creation of the necessary funding vehicles.

To allow additional assessment of the State's savings position as the AHEAD model begins in 2026 and to provide time to work with stakeholders to clarify the use of funds, Staff recommend sunsetting this rate increase on December 31, 2025, unless the Commission acts to extend it.

To avoid increasing the cost to Medicaid under this proposal, Staff recommend an increase to the deficit assessment paid to Medicaid to offset the cost of this rate increase to the Maryland Medicaid program. Hospitals would pay this assessment out of a portion of the funds they are holding under this rate increase; this will avert any added costs to Medicaid without impacting hospitals or further increasing the cost of the rate increase to non-Medicaid payers.

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Director
Healthcare Data Management & Integrity

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: November 13, 2024

RE: Hearing and Meeting Schedule

December 11, 2024 In person at HSCRC office and Zoom webinar

January 8, 2025 In person at HSCRC office and Zoom webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.