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HSCRC Planning Retreat

December 19, 2024

Agenda

- Closed Session
- Public Session: Staff Projects Update
  - Access Measurement
  - Annual Filing Modernization
  - Facility Fee
- Breakout Sessions
  - Access Measurement and Volume
  - Quality Overview and Strategic Priorities
  - Clinical and Population Health Programs
- Closing Remarks

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HSCRC Planning Retreat

HSCRC FRA: Access Project

December 19, 2024

Today, we want to discuss a plan to understand healthcare access barriers on a deeper level

Background and Overarching Objective

Barriers to healthcare access can directly impact patient outcomes and a hospital's ability to perform under the Maryland TCOC model. Today, there is **no singular method to measure Maryland's healthcare access** need or performance.

As such, there is a need to create an **Access Framework** that can identify the potential for latent demand, **support execution of the AHEAD model** and help with informed decision-making, resulting in **better care access** for patients.

What we plan to cover today

Level set on role of volume policies

Understand potential indicators of Maryland statewide healthcare access barriers

Discuss the potential direct impacts of access barriers on individuals through a patient lens

Understand the need for Access Framework, and the potential next steps for modifying volume policies

Intent of Volume Policies

The overarching incentive of the Model is to minimize and replace unnecessary hospital utilization with essential hospital services and/or investments that tackle population health/social determinants of health.

The current and proposed volume policies aim to provide financial adjustments for key utilization shifts for hospitals like population growth, market shifts, innovation, etc.

Current volume policies identify **micro-level changes that are necessary for making precise adjustments** at the hospital-level.

There is also a need to more **proactively diagnose** and **understand utilization at a broader, more macro-level** which can help further inform policies and measure additional access components (e.g., an Access Framework).

Global Budget Volume Policy Suite and Incentives

Volume Adjustment	Intended Purpose	Action and Associated High-Level Incentive
Demographic Adjustment	Annual population funding for Maryland resident use rate growth	**Maintain hospital growth at a reasonable rate**, receive +25% of projected age-adjusted population change
Market Shift	Semi-annual adjustments for regulated market shifts (e.g. from other MD hospitals) (zero sum)	**Compete for market share**, receive incentive based on +50% variable cost factor
Out-of-State	Annual adjustments for material changes to out-of-state volumes	**Attract non-Marylanders to use Maryland facilities**, receive positive adjustment to GBR
Deregulation	As needed reductions for observed shifts to unregulated settings, with a balance for inappropriate hospital dissipation	**Encourage use of lower-cost settings through unregulated** settings, increasing capacity for higher acuity cases with ability to retain 50% of fixed costs
Repatriation	As needed adjustments for cross state border hospital shifts	**Deliver care for Marylanders who previously received out-of-state care**, receive positive adjustments to GBR
Complexity and Innovation	Annual funding to Academic Medical Centers for growth in unique quaternary services	**Invest in innovation** and receive standard transfer payment for receiving complex, quaternary services without downside risk
CDS-A	Annual funding for changes in volume for select drugs	**Provide innovative, specialty drugs to patients who need it**, receive 0.19% carve-out of inflation update without downside risk

**Potentially Avoidable Utilization is a categorization of volume that is carved out of volume policies and further incentivized by scaling inflation*

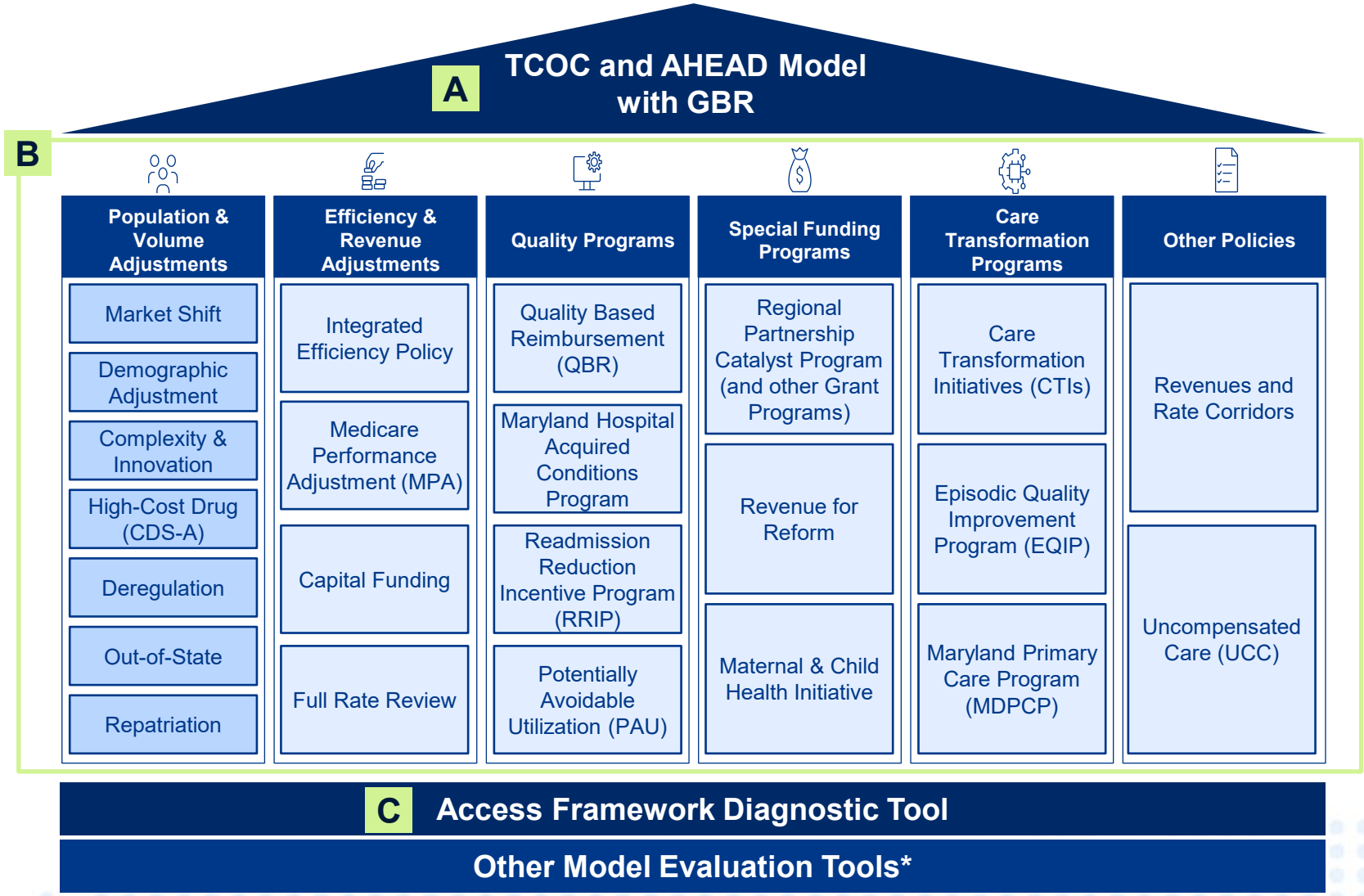
Global Budget Volume Policy Suite and Incentives

Current Volume Policies
Questions about current volume policies? What analyses would be helpful for informing future discussions of current volume policies?

Current Analytic Gap
No comprehensive method to examine volume and utilization to understand where access is not adequate to meet the needs of a region.

Access Framework
The Access Framework in development would provide a new way to think about volume and assess gaps in access…

HSCRC policies could benefit from a diagnostic monitoring tool



Current and Future Components of the Policy Landscape:

A Outcomes aligned to AHEAD model and TCOC target overall care improvement and cost reduction in Maryland

B Existing policies help to incentivize outcomes and meet performance targets set within the CMS agreements (May consider short term edits to these)

C An Access Framework can be utilized as a foundational diagnostic tool to proactively **inform refinement of Maryland's policies, identify areas for funding, and understand care delivery and access performance**
(Focus for long term development)

*Additional existing or potential evaluation tools may include benchmarks, volume scorecard, financial conditions assessment, etc.

Indicators HSCRC should look for in terms of understanding access barriers

Potential Indicators of Healthcare Access Barriers:

- **Provider[1] shortages across Primary Care, Surgery, Behavioral Health Support Staff (e.g., Techs and Aides)**
- **Distance to care setting and wait time to treatment (e.g., ED wait time, time to next available primary care or specialty appointment, etc.)**
- **Utilization by care type and inpatient length of stay and excess days**
- **Capacity and availability across care types (e.g., beds per capita)**
- **Adoption of alternative care types for appropriate populations such as telehealth for behavioral health**

These barriers point to the need for Maryland to have a better understanding of the factors and drivers that could be hindering access to cost effective, high-quality care

1. Should be inclusive of Nurse Practitioners and Physician Assistants

Access barriers can directly impact patient experience and health outcomes

Name: Dave

Age: 67

Condition: Diabetes, Poorly Managed

Insurance: Commercial

Illustrative of a Typical Patient Journey

Cannot get a Specialty visit

Dave is diagnosed with Type 2 Diabetes by his PCP and referred to a **specialist two counties away due to limited availability** of specialists in his area. He is on **~4-month wait** list.

Condition worsens, experiences numbness

Dave's blood sugar is poorly managed, and he also **begins to feel tingling and numbness** in his feet.

Arrives at ED unaware of other settings

Dave **goes to the emergency room**, unaware that symptoms could be handled in a lower-cost setting (*e.g., urgent care, etc.*). He **waits ~20 hours to be seen** and treated.

No follow up, leading to future admissions with bed constraints

Dave is **sent home with pain mgmt.** treatment and a rec. to see his Specialty provider.

He delays visits due to wait times and **condition worsens. He ends up back in ED and awaits admission due to limited bed availability.**

No step-down access leads to readmission

There are barriers to receiving step-down care (e.*g., facility-based rehab, home care, etc.*)

Instead, **Dave's LOS increases** until he is discharged (*impacting bed availability for other patients*) and future readmissions continue.

Drivers impacting Dave's journey that would be helpful to understand through an Access Framework

Physician Demand, Supply and Availability

Capacity across services and broader care continuum

Quality of Services and Follow-Up

SDoH, Disparities, Social Factors, etc.

The Need for an Access Framework | Maryland needs a tool to comprehensively view and measure access

Today…

There is no comprehensive, formal method to measure healthcare access in Maryland, as such the current view of access is:

- **Siloed** by individual care setting, often only focusing on inpatient domains
- **Limited in understanding** preventative and condition-specific **access needs**
- **Reactive** as barriers and situations of concern arise
- Limited tools to understand the **balance of cost of care efforts with quality and health equity impacts**

Tomorrow…

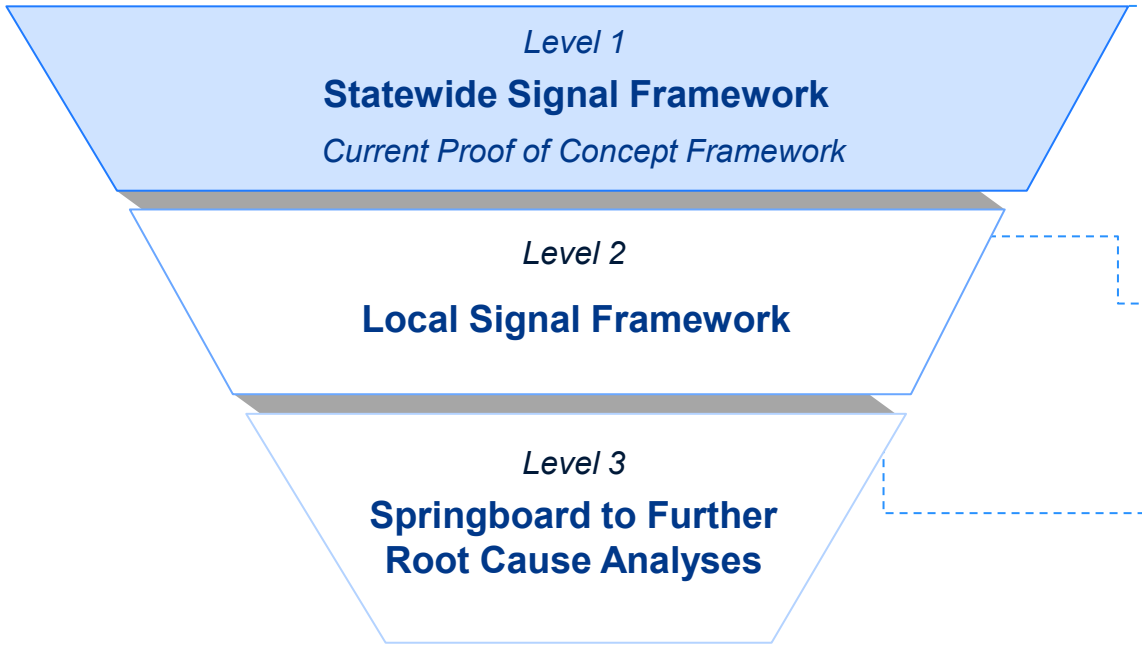
The goal will be to develop a framework that highlights access needs and measures performance to:

- **Create a systemic, end-to-end view** of healthcare access across the state
- **Bolster the AHEAD model** through a better understanding of outpatient settings
- Proactively **identify latent demand** based on a subset of KPIs across the care continuum
- **Align health equity and outcomes** measures based on geographic, demographic factors, etc.
- **Inform future policy development** and Commission determinations.

The current framework provides preliminary insights to statewide access barriers but presents opportunity for refinement

Framework Goal: To develop a comprehensive tool that identifies healthcare access needs across care settings, geographies and care types, thus delivering targeted and improved health outcomes

Access Framework Tiers



Objectives for each level will involve…

September – Q1 2025 | Evaluating access on a statewide level and compare against national averages to better inform where to target future iterations and elicit stakeholder feedback

January – Q2 2025 | Level 2" understanding of access needs based on county jurisdiction, along with refined data sources and targeted hypotheses to explore further

Q2 2025 – Beyond | Optional "Level 3" analysis to identify causes for the barriers identified in local framework and/or to test the associated impact of future policy decisions

Topics for Q&A Session

Future Use Cases for the Access Framework
(e.g., how might an Access Framework be utilized in the future to inform decision-making or policy?)

Local and County-Level Assumptions or Adjustments to Consider
(e.g., as the Access Framework is refined from a statewide to a more local view, are there filters or county/regional-level nuances that should be factored in?)

Access Components, Care Settings, or Metrics to Include or Consider
(e.g., the Access Framework will look across the care continuum to meet statewide population health goals, are there particular care settings that should be included or excluded?)

Access Framework Executive Summary

Challenge Today: A focus strictly on cost versus access could lead to unintended consequences by potentially incentivizing limitations of needed services to manage costs at the expense of quality and patient outcomes

HSCRC Access Framework Purpose: Develop a tool to give us a better understanding of healthcare access across Maryland by various care settings, care types, and geographies to ensure needs can be met with quality services to drive health outcomes from a delivery system perspective.

Current Access Framework Scope:

- This project focuses on defining access parameters and identifying factors impacting access and/or quality which drives increased acute care need. Recommendations were created by combining Maryland-specific perspective with empirical examples of global frameworks and case studies.
- To create an initial, proof-of-concept Access Framework by December ’24 for the aggregated and diabetes populations and scale it to other populations through for future policy development in mid-to-late 2025.

Limitations

- Building a defined Access Framework has not been done before for the same type of system and population characteristics as Maryland
- Data availability narrows the scope of metrics that can be measured in the framework in the near term
- There is not a single, “one-size-fits-all” definition for access
- Macro view does not provide immediate funding determinations but a springboard to additional analyses

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Annual Filing Modernization

Update to Commissioners

December 19, 2024

Agenda

- Overall Project Status
- Clinician Supplement Schedule Updates

Overall Project – Annual Filing Modernization (AFM)

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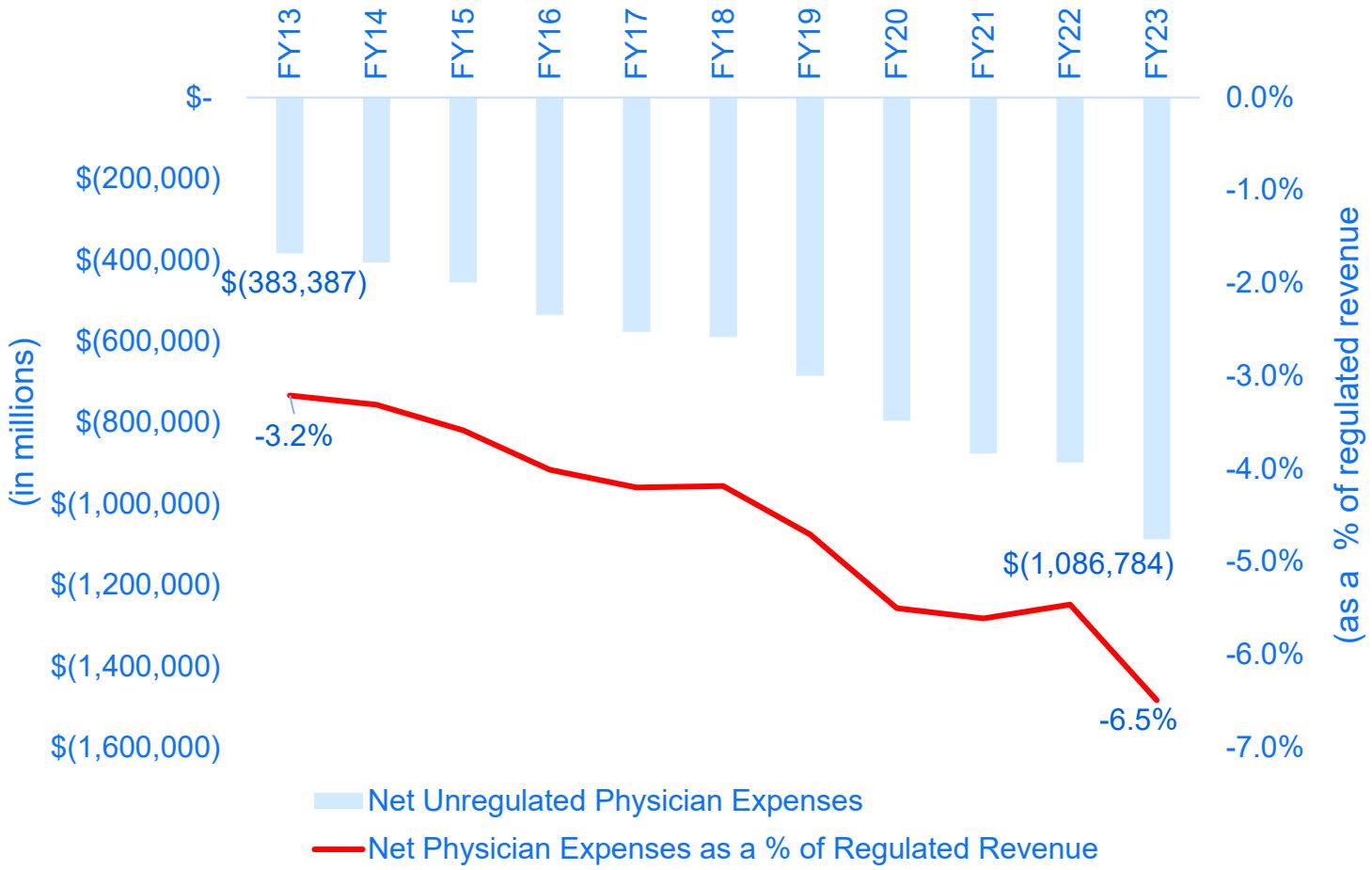
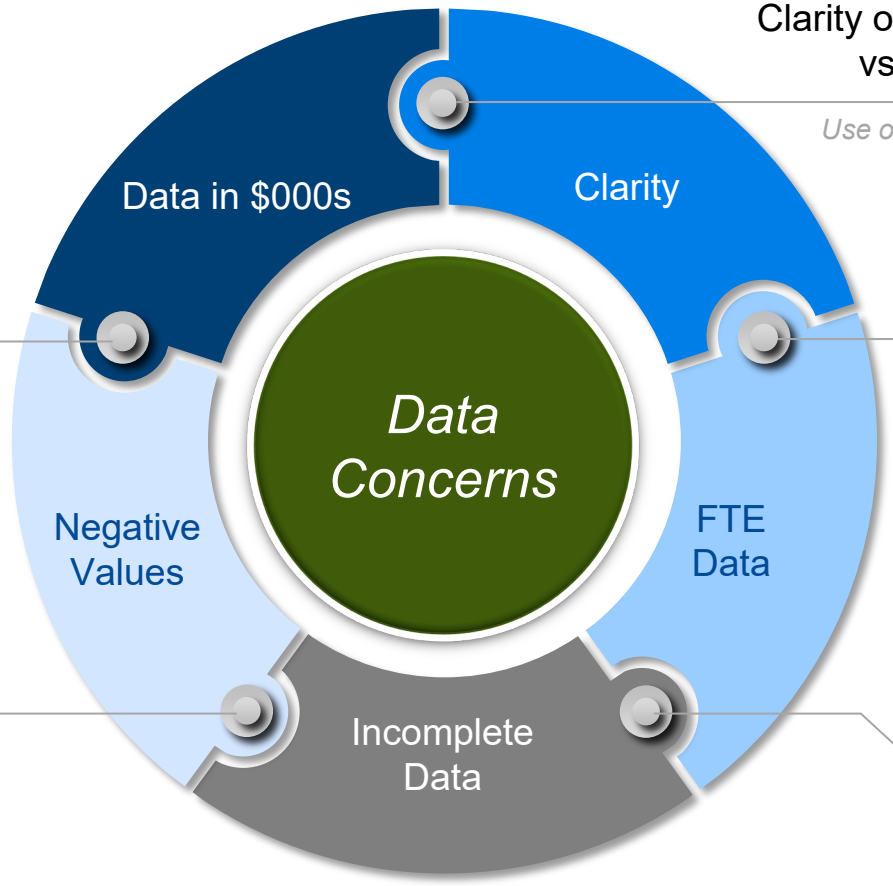
Task	Status	Workflow
1, 2, 3		**Information Gathering**: Determine pain points and information gaps; Identify primary goals and priorities → **Initial Field Testing**: Using HSCRC-approved data collection tool & instructions, complete initial field testing with selected hospital respondents → **Refinements**: Update data collection tool and instructions based on respondent feedback → **Secondary Field Testing**: Using HSCRC-approved revised data collection tool and instructions → **MHA Workgroup**: Solicit feedback from MHA Workgroup → **Dec 2024 Release**: Supplemental Schedule release for physician spending (Fiscal 2024) → **Allocation Modelling**: Modelling of overhead allocation methodology → **E-Filing Release**: Capture of policy revisions (physician spending, cost centers, overhead allocation methodology)
4, 6, 7		**Existing internal tool?**: Investigation resulted in no existing tool found that meets the needs → **Vendor Selection**: RFP process planned for Oct '23 to Apr' 24 → **Changes to the current modeling process**: No substantial changes other than change to the method in which data is collected. → **Changes based on outcome of Tasks 1, 2, and 3**: What changes are required resulting from tasks 1, 2 and 3 in addition to physician costs supplemental schedule? → **Partner with select hospitals for QA**: Will we partner with one or two hospitals to assist with QA? If so, what is selection criteria and who are potential partners?
5		**Create Workable Documents**: Download and/or create shareable, workable documents; Post to shared project team folder → **Prioritize**: Assess work by Section and prioritize sections to be updated → **Define Review Steps**: Confirm adds, deletes, revisions and updates needed, and sub-sections impacted by future policy changes → **Conduct Preliminary Review**: Complete first pass review with HSCRC experts; Create strategy by section to complete updates → Steps repeat for each Section: **Validate Strategy**: Review strategy with Project Sponsors by section to verify desired direction → **Make Changes**: Write, revise, review, quality review; Submit to HSCRC Project Sponsor to approve for feedback → **Submit for Feedback**: Level 1: HSCRC; Level 2: Industry stakeholders; Level 3: QA → **Maryland State Legislative Approval** → **Publish Online**: Follow directives from Key Workflow #2 to publish new section(s) online

Impact of Physician Losses on Hospital Financials



- The pressure on regulated margins from unregulated physician expenses has grown throughout the life of the model.
- In 2013, physician expenses, net of related revenue, were 3.2% of regulated revenue by 2023 that had doubled to 6.5%, adding a 3.3-point drain on regulated margins.
- The current annual filing contains little detail beyond the total amounts which limits the Commission's ability to understand drivers of this change.
- The increase likely reflects some combination of:
  - Increased need to compensate hospital-based physicians and provide physician coverage
  - Expansion of primary care networks
  - Expansion of specialty networks
  - Premium compensation amounts demanded by physician entities
- Subsidizing physician salaries via regulated hospital rates likely distorts the both markets.

Concerns with Submitted Data in First Test Version of Clinician Supplemental Schedule



Misinterpretation of data in $000's

Inconsistency dramatically changes summary at the State level

Clarity of subsidy payments vs. offsetting revenue

Use of this data is limited without further clarification

Payments to physicians without associated FTE count

Missing FTE information makes comparison data impossible

Use of Negative Values

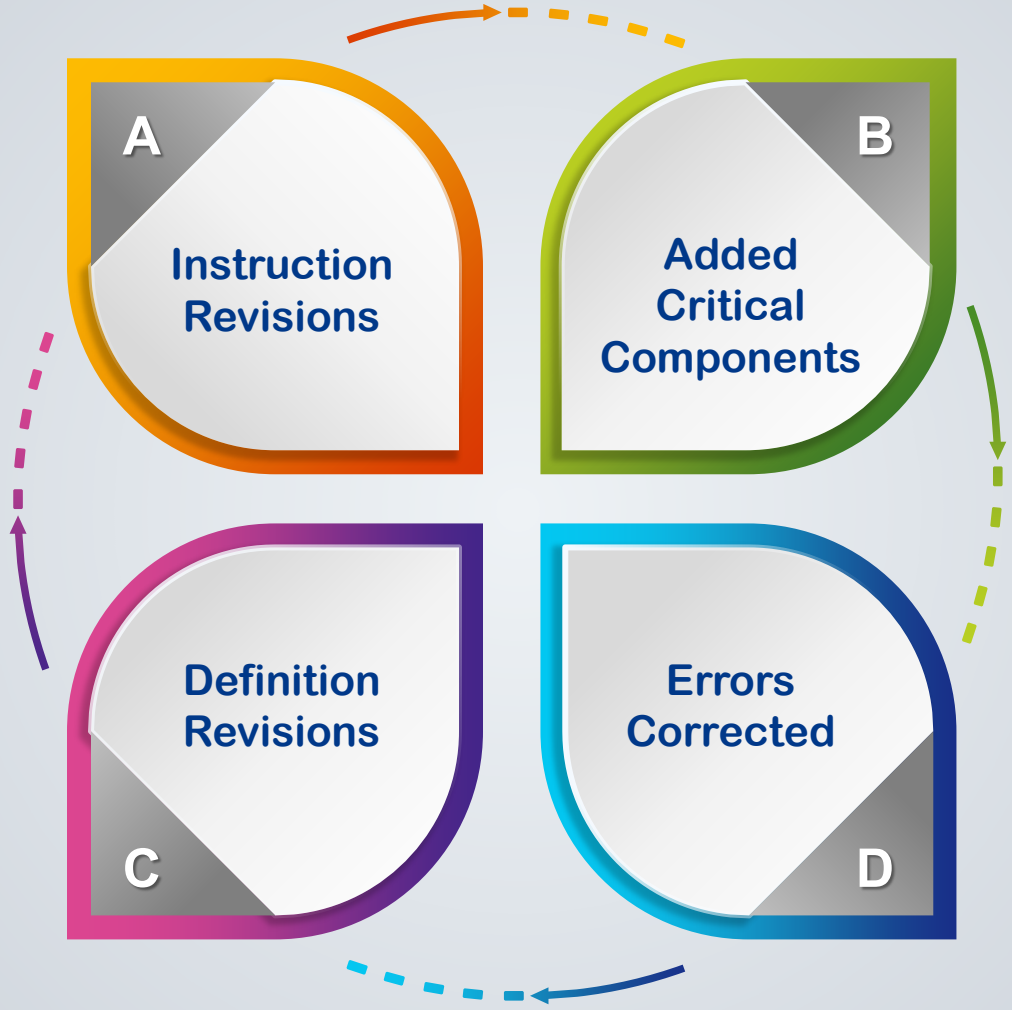
Use of negative values invalidates summary totals based upon specific calculations

Incomplete Data

While all requested hospitals submitted data, some were incomplete

Summary of Changes Made

- Updated data period
- Defined numeric format



- Specialties:
  - Hyperbaric & Wound (NS)
  - Neonatology (NS)
  - Pediatric Surgery (SS)
- Clinician Support Services Net Costs
- Other Offsetting Revenues & Awards
- Employee Health Services
- Benefit Types

- Employed by Hospital
- APP definition
- Paid FTEs

- Summary columns
- Calculations on Summary sheet
- Payor mix proofs

Outcomes To Date and Future Expectations

Outcomes & Expectations

- Understand and quantify financial burden hospitals absorb for deployment of Clinicians (Physicians and APPs)
- Net Regulated and Unregulated Costs are clearly significant. Complete data and proper reporting are expected to provide you with a much better tool to evaluate future options.

Clinician Schedule Collection

Sep ’24	Test Hospital ability to produce data
Mar ‘25	Baseline data and trend
May ’25	Share state level preliminary baseline info
Jul ’25	Incorporate into standard e-filing template
Jan ‘26	Use data to support policy decisions / actions

- Future revisions to the schedule will likely be necessary as operational changes occur and we learn from future hospital submissions.
- All hospitals will be asked to participate in all future data collection and submission (vs. only acute hospitals)

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Commissioner Retreat - Facility Fee Update

William Henderson, Principal Deputy Director

Medical Economics and Data Analytics

December 19th, 2024

Overview: Facility Fee Law & Regulation

1970's

- HSCRC sets hospital charges (e.g. facility fees) for all payers for outpatient hospital services that are at the hospital (e.g. on-campus)

2020

- **Facility Fee Notice Law -** Hospitals must provide notices of facility fees to patients in HSCRC-regulated outpatient clinic rate centers.*
- HSCRC redistributed rates, so that charges in the clinic rate center were lower (making charges in other rate centers higher).

2024**

- Legislature changed the text of the notice.
- HSCRC is required to conduct a study and submit reports, with stakeholder input.

*Health General 19-349.2 **Ch 142, 2024

2024: Required Report and Status Update

- Requirement: Report containing recommendations related to expanding the outpatient facility fee notice to all outpatient services.
- Status: The 2024 report will be submitted this month; Workgroup meet 3 times and had an opportunity to provide written comment on an early draft of the report and recommendations.
- Key Issues & Recommendations:
  - Expand Notices: Because notices are limited to the HSCRC-regulated outpatient clinic, many consumers do not receive notices. The report recommends expanding the notice requirements to most hospital outpatient services, but delaying expansion until after the 2026 legislative session, so legislators can respond to the 2025 study findings on the effectiveness of facility fee notices.
  - Medicaid Patients: The current notice includes the estimated full hospital charge (not the patient's out-of-pocket cost), is written at a 12th grade reading level, and requires health insurance literacy. Some patients, including Medicaid patients may cancel their appointments due to sticker shock. The report recommends amending the law to clarify that hospitals do not need to provide notices to Medicaid beneficiaries.

2025: Required Report and Status Update

- **Requirement:** Report on-
  - Evaluation of the effectiveness of facility fee notices.
  - The impact of facility fees on patients, payers, and hospitals.
  - Recommendations related to alternative approaches to facility fees, such as to reducing or eliminating facility fees.
- **Status:**
  - Hilltop is assisting w/ workgroup and reports, two other procurements in process.
  - Research started. Financial analytics will start once the analytics procurement is complete (est. spring).
  - Workgroup membership changed to reflect 2025 scope. Meetings start in January.