Maryland
Hospital Association

July 17, 2023

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Steffen:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on primary care spending investment target considerations presented at the June 21 Maryland Health Care Commission (MHCC) Primary Care Workgroup meeting.

Before providing feedback on the four investment target considerations, MHA would like to note that Senate Bill 734, passed during the 2022 legislative session, directs MHCC to develop a *plan* to analyze primary care spend in 2023 and to suggest ways to enhance health equity and quality in the primary care setting. To date, the work group has opined on the definition of primary care spending. Projections for the current level of spending in Maryland have been shared, but only for the individual and small group markets.

MHA recommends MHCC focus additional time on recommendations to measure and monitor primary care spend among all payers before contemplating a specific investment target.

We also encourage MHCC to consider accountability for a primary care investment target. Medicare increased primary care spending through additional care management fees as part of the Maryland Primary Care Program (MDPCP). However, the state is held accountable for any increase in total cost of care growth, with financial penalties and rewards imposed on hospitals. If a primary care investment target is added, MHCC should clarify the expectations for payers beyond Medicare.

MHA acknowledges increases in primary care spend may improve access and health outcomes. Existing initiatives and the conditions of our Total Cost of Care Model should be examined before suggesting any voluntary or required increase. We offer more detailed feedback under each of the four considerations below.

Consideration 1: Voluntary Target or Required Increase
Any statewide primary care spending investment target must be considered in conjunction with the Model objectives and targets. Maryland cannot exceed certain Medicare total cost of care growth limits, including physician costs. Prior to considering a target, MHCC may want to explore adding contract provisions, so the guardrail is not tripped.

The state will submit a Model progression plan to the Center for Medicare and Medicaid Innovation (CMS Innovation Center) in the fall. The plan will set overarching aims for Maryland, but any specific changes to Medicare and all-payer savings targets, as well as MDPCP will be determined by the state and CMS Innovation Center after 2023. It is premature to set an investment target until it can be evaluated in the context of new Model discussions.

At the June 21 work group meeting, MHCC compared state investment policies. Some states require certain quality, cost, and infrastructure goals in their primary care definitions. If certain care transformation requirements are suggested as part of the spending recommendation, they should align with those captured by MDPCP and align across payers. MHCC should also consider the design of MDPCP, which includes multi-disciplinary team expenditures as part of primary care and align the definition of primary care spend accordingly.

It should be noted that social determinants of health and specific population health needs drive spending. Health care providers and payers need to have flexibility to offer services and innovate care delivery given their unique population needs.

MHCC should examine state regulatory authority before implementing any required increase. As mentioned during the work group meeting, most states use a designated state commission or similar entity to enforce accountability. Hospitals are the only entity in Maryland subject to rate regulation and financial incentives *so as not to increase* total health care spending. While the Maryland Insurance Agency (MIA) has the authority to approve rates among non-public payers, it is unclear if broader authority is needed to enforce primary care spending. MHCC should work with Maryland Medicaid, the Health Services Cost Review Commission, MIA, and other state agencies as appropriate, to determine the regulatory structure needed to enforce a required target.

Consideration 2: Single Target or Target for Each Payer Type
A single target implies each payer is starting at the same level of investment. It also assumes similar benefit plan offerings among payers, which vary.

Premiums may rise to account for higher spending. MHCC should explore whether provisions may be added to limit the unintended impact to beneficiaries.

This exercise should focus on primary care service coverage and services critical to meet primary care needs.

Consideration 3: Absolute or Relative Improvement
An absolute target assumes an appropriate spending level is known to improve primary care and associated health outcomes. In conjunction with setting any spending target, MHCC should consider evaluating the target in relation to key quality or access metrics.

The literature shows most states targeted an investment level of 10-12% of overall health care spend, but health care spend may vary across states due to socioeconomic factors, like median household income. States also measure primary care spending differently. MHCC may want to consider a combination of absolute and relative improvement for these reasons.

Consideration 4: Measuring Percent of Total Cost of Care or Per Member Per Month Amount
Per member per month (PMPM) is commonly used by payers to report spend. A limitation to using this approach is PMPM amounts will vary based on disease burden and population characteristics. Spending should be targeted to reduce future cost growth – bending the cost curve – and to improve overall quality results.

Given the Model agreement, it will be imperative to know the percentage of primary care spend contributing to overall total cost of care and whether dollars are being reallocated to produce savings. MHA recommends monitoring spend as a percent of total cost of care but also reporting a PMPM amount.

Thank you again for the opportunity to comment. Please contact me if you would like to discuss any of our recommendations.

Sincerely,

Brett McCone, Senior Vice President, Health Care Payment