maryland
health services
cost review commission

594th Meeting of the Health Services Cost Review Commission
April 13, 2022

(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)

EXECUTIVE SESSION
11:30 am

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104

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

3. Update on Commission Response to COVID-19 Pandemic - 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 March 9, 2022

2. Docket Status – Cases Closed

   Johns Hopkins Hospital - 2582R
   Brook Lane Health Services - 2584N
   Johns Hopkins Medical System - 2586A
   Johns Hopkins Medical System - 2583A
   Johns Hopkins Medical System - 2585A

3. Docket Status – Cases Open

   Tidal Health Peninsula Regional Medical Center - 2587R
   Shady Grove Adventist Medical Center - 2589R
   Johns Hopkins Medical System - 2591A
   Carroll Hospital - 2588R
   Johns Hopkins Medical System - 2590A
   Johns Hopkins Medical System - 2592A

4. Report on Readmissions Reduction Incentive Program (RRIP) for RY 2024

5. Draft Guidelines for Hospital Payment Plans

6. Policy Update and Discussion

   a. Model Monitoring
   b. Legislative Update
   c. Workgroup Update

7. Hearing and Meeting Schedule

MINUTES OF THE
593rd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
March 9, 2022

Chairman Adam Kane called the public meeting to order at 11:31 a.m. Commissioners Joseph Antos, PhD, Victoria Bayless, Stacia Cohen, James Elliott, M.D., Maulik Joshi, DrPH, and Sam Malhotra were also in attendance. Upon motion made by Commissioner Antos and seconded by Commissioner Elliot the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:20 p.m.

STACIA COHEN HONORED

Chairman Kane congratulated Commissioner Cohen on being named amongst Modern Healthcare Top Women of the Year.

STAFF UPDATE

Ms. Katie Wunderlich, Executive Director, announced that Andi Zumbrum, Chief, Quality Analysis and Reporting, will be leaving the Commission. Ms. Wunderlich thanked Ms. Zumbrum for all her dedicated work on behalf of the citizens of Maryland.

REPORT OF MARCH 9, 2022 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the March 9, 2022, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE FEBRUARY 9, 2022, CLOSED SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the February 9, 2022, Public meeting and Closed Session.

ITEM II
CASES CLOSED

2580R- Brooks Lane Hospital

2581A- Johns Hopkins Health System

ITEM III
OPEN CASES

2582R- Johns Hopkins Hospital

On January 31, 2022, Johns Hopkins Hospital ("the Hospital") submitted a partial rate application to the Commission requesting its Oncology Clinic (OCL) rate center be combined with the Clinic (CL) rate center effective April 1, 2022.

This request is revenue neutral and will not result in any additional revenue for the Hospital. The consolidation of these clinics will bring the Hospital in line with all other hospitals. The Hospital's currently approved rates and the new proposed rate are as follows:

	Budgeted Volumes	Approved Revenue	Approved Unit Rate
Oncology (OCL)	1,151,433	$37,935,156	$32.9460
Clinic (CL)	1,623,811	$89,045,408	$54.8373
Combined Rate	2,775,344	$126,980,564	$45.7547

After reviewing the Hospital's application, the staff recommends as follows:

1. That the Hospital be allowed to collapse its OCL rate center into its CL rate center;
2. That a CL rate of $45.7547 per RVU be approved effective April 1, 2022; and
3. That no change be made to the Hospital's Global Budget Revenue for CL services.

Commissioners voted unanimously in favor of Staff's recommendation.

Brook Lane Health Services

On February 22, 2022, Brook Lane Health Services ("the Hospital") submitted a partial rate application to establish a new Transcranial Magnetic Stimulation (TMS) service. The Hospital is a nonprofit provider of mental health services. TMS is a noninvasive treatment that uses magnetic resonance pulsed fields to induce an electric current in the brain for the treatment of major depressive disorder in patients. The Hospital requests a rate for TMS to be approved effective April 1, 2022.

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. The Hospital provided projected costs associated with the TMS

expansion and requested a rate of $343.49 per treatment, while the statewide median rate for TMS is $341.3937 per treatment.

Service	Service Unit	Unit Rate	Projected Volumes	Approved Revenue
TMS	Treatments	$341.3937	720	$245,803.46

After reviewing the Hospital's application, the staff recommends:

1. That the TMS rate of $341.3937 per treatment be approved effective April 1, 2022;
2. That the TMS rate center not be rate realigned until a full year of cost data has been reported to the Commission; and
3. That the TMS service be subject to the application of the Approved Revenue and Unit Rate Policies.

Commissioners voted unanimously in favor of Staff's recommendation.

ITEM IV
PRESENTATION BY TRI-COUNTY BEHAVIORAL HEALTH ENGAGEMENT (TRIBE) ON REGIONAL PARTNERSHIP CATALYST PROGRAM

Mr. Tina Simmons, Director of Population Health, Atlantic General Hospital, provided an update of the Tri-County Behavioral Health Engagement catalyst grant program (see "Tri-Country Behavioral Health Engagement (TRIBE)" available on the HSCRC website).

Ms. Simmons stated that TRIBE is made up of TidalHealth Peninsula Regional Hospital (TPR) and Atlantic General Hospital (AGH) and along with 16 community partners. Total grant funding for TRIBE is $11,316,322 with TPR and AGH receiving 75% and 25% respectively of the grant funding. Ms. Simmons reported that the primary service areas are Worchester, Wicomico, and Somerset counties. TRIBE has built a crisis stabilization center and centralized the three counties' responses to individuals in behavioral health crises. The joint crisis stabilization program serves as a Behavioral Health Urgent Care Center that provides 12-hour crisis stabilization as an alternative to emergency department and psychiatric hospitalization. Included in these services provided are crisis respite, observation, and intervention in a community setting.

The Tidal Health Crisis Center, the Primary site, located at TPR, is a crisis stabilization center and is targeted to open in May 2022. Initially, the crisis center will be open seven days a week for 12 hours a day (8am to 8pm). The Primary Site is modeled after a safe, home like environment.

A Secondary Site, Atlantic Health Center is located on the campus of AGH. The Crisis Center opened on January 31, 2022. The hours of operation will initially be Monday to Friday 8am to 4:30pm.

TRIBE seeks to relieve immediate crisis symptoms, provide observation, determine level of care, and reduce unnecessary higher levels of care. Law enforcement and EMS can transport patients to the centers, if allowable by state regulations. Individuals are triaged, linked with peer support, crisis counseling, and medication management services to include psychiatric and substance abuse as appropriate. Follow-up care and services with community providers are available to all the next day or the same day. Due to the ongoing pandemic, part of the service offering is completed via telehealth, as needed, to share resources between sites.

TRIBE's 5 Year Plan is as follows:

> **Year 1** – Build infrastructure, renovate designated buildings, recruit, hire & train staff, develop policies and procedures, secure necessary equipment, and create and deploy marketing strategy & community education campaign.
>
> **Year 2** – Open both the primary and secondary crisis centers. Primary site to be open 7 days a week 12 hours a day. Secondary site will be open initially 5 days a week 8 hours a day with a plan to expand to 6 days based on patient volume.
>
> **Year 3** – Primary site to extend hours based on data obtained in Year 2. Secondary site to extend hours based on data obtained in Year 2. Continued targeted marketing and community education.
>
> **Year 4** – Focus on increasing community collaboration and service line expansion.
>
> **Year 5** – Continued focus on increasing community collaboration, service line expansion, and sustainability of the program.

Commissioner Antos asked whether the delivery model collaborates with local law enforcement since first responders to behavioral health crises are typically directed by 911.

Ms. Simmons stated that Eastern Shore law enforcement is an integral partner in their efforts. Law enforcement members actively participate in the TRIBE subcommittees and offer input and security assessments for patient treatment spaces.

Commissioner Elliott asked if the hours of operation are limited to patient intake.

Ms. Simmons elaborated that the hours are primarily applicable to patient intake since the crisis centers will remain open to finish patient care until they are ready to leave or be transferred to a

higher level of treatment. Limited hours of operation are due to staffing shortages; otherwise, the primary crisis center would be open 24/7.

ITEM V
RY 2023 QUALITY PROGRAMS: COVID UPDATE

Dr. Alyson Schuster, Deputy Director, Quality Methodologies, presented an update on the effect of COVID on quality programs for RY 2023 (see "Quality COVID Analytics" available on the HSCRC website).

Historically, quality-based rate adjustments have focused on the use of norms for MHAC program PPC's, readmissions, and QBR inpatient mortality. These statistics were projected using performance period data to generate statewide norms that are directly used to calculate hospital expected rates for the programs. For RY 2023, concurrent norms from CY 2021 are applied to the base period to calculate improvement.

Staff ran multiple models accounting for COVID and non-COVID scenarios for each quality measure. Staff found that most assessments suggest little difference in level of performance with and without COVID patients included. Generally, staff prefer to include COVID cases to align with the principle of inclusivity. Additional analyses included adding a COVID variable to the mortality regression model and testing relative ranking for MHAC revenue adjustments similar to CMS quality programs.

Staff presented proposed adjustments for the Quality Programs that they believe are most inclusive of patients, provide the best picture of quality of care within the programs during the performance period, and are the fairest to hospitals. Staff noted that the MHAC and RRIP measures and the QBR Mortality and PSI measures rely on case-mix data submitted to the HSCRC directly. For the case-mix derived measures except for the all-payer PSI measure, staff is proposing to re-calculate norms using the performance period, meaning the performance and performance standards will be based on the same time period. In effect, staff is proposing a scoring method that relatively ranks hospitals because there is no time period prior to COVID that can adequately account for the impact of the public health emergency.

Staff also presented a proposal for re-evaluating the scale of scores where rewards and penalties are assigned and where a hospital is held harmless in the middle of the scale for the MHAC program. This adjustment would be done to better align with the range of Maryland scores after the norms are re-calculated using the performance period data. This could also be considered for the QBR program.

ITEM VI
POLICY UPDATE AND DISCUSSION

Model Monitoring

Ms. Caitlin Cooksey, Deputy Director of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 11 months ending November 2021. Maryland's Medicare Hospital spending per capita growth was trending close to the nation, with the past several months being favorable. Ms. Cooksey noted that Medicare Nonhospital spending per-capita was trending unfavorably for both Part A and Part B when compared to the nation. Ms. Cooksey noted that Medicare Total Cost of Care (TCOC) spending per-capita was unfavorable when compared to the nation. Ms. Cooksey noted that the Medicare TCOC guardrail position is .83% above the nation through November. Ms. Cooksey noted that Maryland Medicare hospital and non-hospital growth through November shows a run rate erosion of $89,529,000.

Legislative Update

Ms. Megan Renfrew, Associate Director of External Affairs presented the Legislative Update (see "Legislative Update" available on the HSCRC website).

Ms. Renfrew noted that Staff is monitoring the following bills:

- HB 300/ SB 290 - Budget Bill for FY 2023 (The Governor's Budget)
- HB 510/SB 917 - Health Care Facilities- Health Services Cost Review Commission- User Fee Assessment

- HB 694/SB 944- Hospital- Financial Assistance – Medical Bill Reimbursement

    a) Seeks to require hospitals to provide refunds to patients who were eligible for free care but paid a bill in 2017-2021.

- HB 1148/SB 836- Health Insurance- Two-Sided Incentive Arrangements and Capitated Payments-Authorization

    a) Permits insurers and certain non-hospital providers to enter certain value-based payment arrangements.

- HB 669/SB 503 Maryland Medical Assistance Program- Doula Services Coverage
- HB 765/SB 166 Maryland Medical Assistance Program- Doula Program

a) Seeks to codify Medicaid regulations re: funding doulas

- HB 1048/SB 840 COVID-19 Response Act of 2022

  a) Provides for the establishment of unregulated hospital-adjacent urgent care centers.
  b) HSCRC amendment focuses on the definition of hospital-adjacent urgent care center.

Workgroup Update

Ms. Katie Wunderlich, Executive Director, presented a workgroup update on the activities of the standing workgroups.

- Payment Models Workgroup
  a) RY 2023 Update Factor
  b) Draft recommendation May
  c) Final recommendation June

- Total Cost of Care Workgroup
  a) Revenue for Reform
  b) Market Shift

- Performance Measurement Workgroup
  a) Evaluate appropriate COVID related changes for FY 2023.
  b) RY 2024 Readmission Reduction Incentive Program.
  c) Expanding Potential Avoidable Utilization quality programs into the ER.

ITEM VII
HEARING AND MEETING SCHEDULE

April 13, 2022 Times to be determined - Go to Webinar

May 11, 2022 Times to be determined - Go to Webinar

There being no further business, the meeting was adjourned at 2:37 pm.

Closed Session Minutes
of the
Health Services Cost Review Commission

March 9, 2022

Upon motion made in public session, Chairman Kane called for adjournment into closed session to discuss the following items:

1. Discussion on Planning for Model Progression– Authority General Provisions Article, §3-103 and §3-104

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

3. Update on Commission Response to the COVID-19 Pandemic – Authority General Provisions Article, §3-103 and §3-104

The Closed Session was called to order at 11:31 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance via conference call in addition to Chairman Kane were Commissioners Antos, Bayless, Cohen, Elliott, Joshi, and Malhotra.

In attendance via conference call representing Staff were Katie Wunderlich, Allan Pack, William Henderson, Geoff Daugherty, Will Daniel, Alyson Schuster, Claudine Williams, Megan Renfrew, Amanda Vaughn, Cait Cooksey, Bob Gallion, Erin Schurmann, and Dennis Phelps.

Also attending via conference call were Eric Lindemann, Commission Consultant and Stan Lustman, Commission Counsel.

Item One

Eric Lindemann, Commission Consultant, updated the Commission on Maryland Medicare Fee-For-Service TCOC versus the nation.

In addition, Mr. Lindemann updated the Commission on Medicare Advantage penetration in Maryland.

Item Two

William Henderson, Director-Medical Economics & Data Analytics, updated the Commission on the year-to-date hospital profit margins and volumes through January 2022.

Item Three

Ms. Wunderlich updated the Commission, and the Commission discussed the activities and upcoming topic areas of the various standing workgroups.

Item Four

Ms. Wunderlich updated the Commission on the magnitude and utilization of Set-Aside funds.

The Closed Session was adjourned at 1:06 p.m.

Cases Closed

The closed cases from last month are listed in the agenda

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF April 5, 2022

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2587R	Tidal Health Pennisula Regional	2/25/2022	7/25/2022	FULL	JS/AP	OPEN
2588R	Carroll Hospital	3/14/2022	8/11/2022	DEF/MSG	WN	OPEN
2589R	Shady Grove Adventist Medical Center	3/16/2022	8/13/2022	CAPITAL	JS/AP	OPEN
2590A	Johns Hopkins Health System	3/28/2022	N/A	ARM	DNP	OPEN
2591A	Johns Hopkins Health System	3/28/2022	N/A	ARM	DNP	OPEN
2592A	Johns Hopkins Health System	3/30/2022	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

RE: THE FULL RATE	* BEFORE THE HEALTH SERVICES
APPLICATION OF	COST REVIEW COMMISSION
TIDALHEALTH	* DOCKET: 2022
PENINSULA REGIONAL	* FOLIO: 2397
SALISBURY, MARYLAND.	* PROCEEDING: 2587R

* * * * * * * * * * * * *

STAFF RECOMMENDATION

April 13, 2022

List of Abbreviations

APR-DRG	All-Patient Refined Diagnosis-Related Group
CON	Certificate of Need
DRG	Diagnosis-Related Group
ECMAD	Equivalent Case Mix Adjusted Discharge
GBR	Global Budget Revenue
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commissions
ICC	Interhospital Cost Comparison
ICD-10	International Classification of Disease, 10th Edition
JHHS	Johns Hopkins Health System
MHCC	Maryland Health Care Commission
PAU	Potentially Avoidable Utilization
PPC	Potentially Preventable Complication
PSA	Primary Service Area
PSAP	Primary Service Area Plus
PQI	Prevention Quality Indicator
QBR	Quality-Based Reimbursement
SNF	Skilled Nursing Facility
TCOC	Total Cost of Care

Key Methodology Concepts and Definitions

Diagnosis-Related Group (DRG): A system to classify hospital cases into categories that are similar clinically and in expected resource use. DRGs are based on a patient's primary diagnosis and the presence of other conditions.

All Patient Refined Diagnosis Related Groups (APR-DRG): Specific type of DRG assigned using 3M software that groups all diagnosis and procedure codes into one of 328 groupings.

Certificate of Need (CON): With certain exceptions, a CON is required to build, develop, or establish a new healthcare facility; move an existing facility to another site; change the bed capacity of a healthcare facility; change the type or scope of any health care service offered by a healthcare facility; or make a healthcare facility capital expenditure that exceeds a threshold established in Maryland statue. The Maryland CON program is intended to ensure that new healthcare facilities and services are developed in Maryland only as needed and that, if determined to be needed, that they are: the most cost-effective approach to meeting identified needs; of high quality; geographically and financially accessible; financially viable; and will not have a significant negative impact on the cost, quality, or viability of other health care facilities and services.

Equivalent Casemix Adjusted Discharges (ECMADS): ECMADS are a hospital volume statistic that account for the relative costliness of different services and treatments, as not all admissions or visits require the same level of care and resources.

Interhospital Cost Comparison (ICC) Standard: Each hospital's ICC revenue base is built up from a peer group standard cost, with adjustments for various social goods (e.g., trauma costs, residency costs, uncompensated care mark-up) and costs beyond a hospital's control (e.g., differential labor market costs) that are not included in the peer group standard. The revenue base calculated through the ICC does not include profits. Average costs are reduced by a productivity factor ranging from 0 percent to 4.5 percent depending on the peer group. The term "Relative efficiency" is the difference between a hospital's actual revenue base and the ICC calculated cost base.

Payer Differential: The HSCRC has employed a differential, whereby public payers (Medicare and Medicaid) pay 7.7 percent (previously 6 percent, prior to July 1, 2019) less than other payers. Commercial payers also pay approximately 2 percent less than billed charges for prompt pay practices.

Potentially Avoidable Utilization (PAU): PAU is the measurement of hospital care that is unplanned and may be prevented through improved care, care coordination, or effective community based care. PAU includes readmissions and hospital admissions for ambulatory-care-sensitive conditions as defined by the Agency for Healthcare Research and Quality's Prevention Quality Indicators (PQIs) measurement approach. PAU may be expressed as a percent of hospital

revenue received from PAU events at that hospital or the rate of PAU events for a hospital's attributed population.

Potentially Preventable Complications (PPCs): 3M originally developed 65 PPC measures, which are defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. PPCs, like national claims-based hospital-acquired condition measures, rely on present-on-admission codes to identify these post-admission complications. The HSCRC uses a subset of PPCs in its quality pay-for-performance programs.

Primary Service Area (PSA): The Primary Service Area (PSA) was identified by the hospital in their original GBR agreement and is described by a list of zip codes.

Primary Service Area Plus (PSAP): The PSAP is assigned to hospitals based on geography, following the algorithm described below and is modified from the PSA below to allow for attribution of 100% of Maryland residents. This methodology assigns zip codes to hospitals through three steps:

1. Zip codes making up the PSA are assigned to the corresponding hospitals. Costs in zip codes claimed by more than one hospital are allocated according to the hospital's share of ECMADs for inpatient and outpatient discharges among hospitals claiming that zip code. ECMAD, for this purpose, is calculated from Medicare Fee for Service (FFS) claims for the two Federal Fiscal Years 2014 and 2015.

2. Zip codes not claimed by any hospital are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed 30 minutes' drive-time from the hospital's PSA. Plurality is identified by the ECMAD of the hospital's inpatient and outpatient discharges during the attribution period for all beneficiaries in that zip code.

3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.

Quality Based Reimbursement (QBR): Maryland's QBR program is similar to the federal Medicare Value-Based Purchasing program and incentivizes quality improvement across a wide variety of quality measurement domains, including person and community engagement, clinical care, and patient safety.

Total Cost of Care (TCOC) Model: The agreement between the State of Maryland and the federal government, which obligates the State to obtain certain levels of health care savings to the federal Medicare program (along with other requirements) through State flexibility provided through the agreement. For example, Medicare participates in the State's system for all-payer hospital global budgets.

Overview

TidalHealth Peninsula Regional Medical Center ("PRMC," or "the Hospital") submitted a full rate application on September 9, 2021, requesting an increase to its permanent Global Budget Revenue (GBR) totaling $56.8 million, an 11.24 percent increase over PRMC's approved GBR that was effective for the one-year period from July 1, 2021 through June 30, 2022. HSCRC staff calculations indicate the request totals to $57.5 million and itemization of this request henceforth will be based off of that value. The requested increase is a general revenue adjustment, with a requested effective date of September 15, 2021. The requested revenue increase is in addition to HSCRC-approved adjustments, including: the update factor, market shift adjustments, demographic adjustments, quality adjustments, population health, and other routine adjustments.

Following the submission of additional required information not included with its original submission, HSCRC staff accepted PRMC's full rate application and considered it complete on March 9, 2022.

Request for General Revenue Increase

PRMC justifies the requested $57.5 million in additional operating revenue based on its objective to increase its profit margin and to make investments in the successful operations of the hospital and delivery of care, most notably as a regional referral center that operates a Level III trauma center under the Maryland Institute of Emergency Medicine Services System (MIEMSS) requirements. The Hospital states that in addition to a revenue enhancement for a 5 percent margin ($23 million), several costs and anticipated outlays contribute to the need for additional revenue[1]:

1. Funding of existing Trauma program expenses --$25.8 million
2. Market adjustment to wages --$16 million
3. Future Medical Education Program (Year 1) --$2.4 million
4. New Adolescent Behavioral Health Program (Year 1) - $3.2 million

[1] Itemized revenue enhancement exceeds total revenue request of $57.5 million because PRMC's initial efficiency evaluation deems the Hospital inefficient relative to the full rate application standard.

Background

Peninsula Regional Medical Center (PRMC)

PRMC is an acute care hospital in Salisbury, Maryland with 266 licensed acute beds that provides the only trauma center coverage on the Eastern Shore, pediatric services, an open heart surgery program that has the seventh highest number of cardiovascular surgeries in the State (301 in Fiscal Year 2019), a labor and delivery program that produces over 1,900 births annually, and an oncology program, among others things. The Hospital's total approved revenue cap for Fiscal Year 2022 was $516,427,928. Approximately 49 percent of its revenues came from Wicomico County residents in 2019, 20 percent came from out-of-state residents (most notably Delaware - 13 percent), 16 percent came from Worcester County, 11 percent came from Somerset County, 2 percent from Dorchester County, and the remaining 2 percent was derived from all other counties in Maryland.[2]

PRMC is part of the TidalHealth Inc., which also includes: TidalHealth Nanticoke, a 139 bed hospital in Seaford, Delaware that was acquired in January 2020; TidalHealth McCready Foundation, an acute facility that was converted to a free-standing medical facility once it merged with Peninsula Regional Health System in March 2020; TidalHealth Medical Partners, a not-for-profit physician network of primary and specialty services that includes physicians from Nanticoke Physicians Network that were acquired in the aforementioned acquisition; TidalHealth Surgery Center, a not-for-profit Ambulatory Surgery Center that provides Women's Health Services in Salisbury, MD; and Peninsula Health Ventures, which is a for-profit organization that includes a home healthcare provider with expertise in Chronic Obstructive Pulmonary Disease and Obstructive Sleep Apnea (American HomePatient of Delmarva), a full service imaging center (Peninsula Imaging, LLC), and a 50 percent ownership in post-acute facility located two miles from PRMC (Salisbury Rehabilitation and Nursing Center).

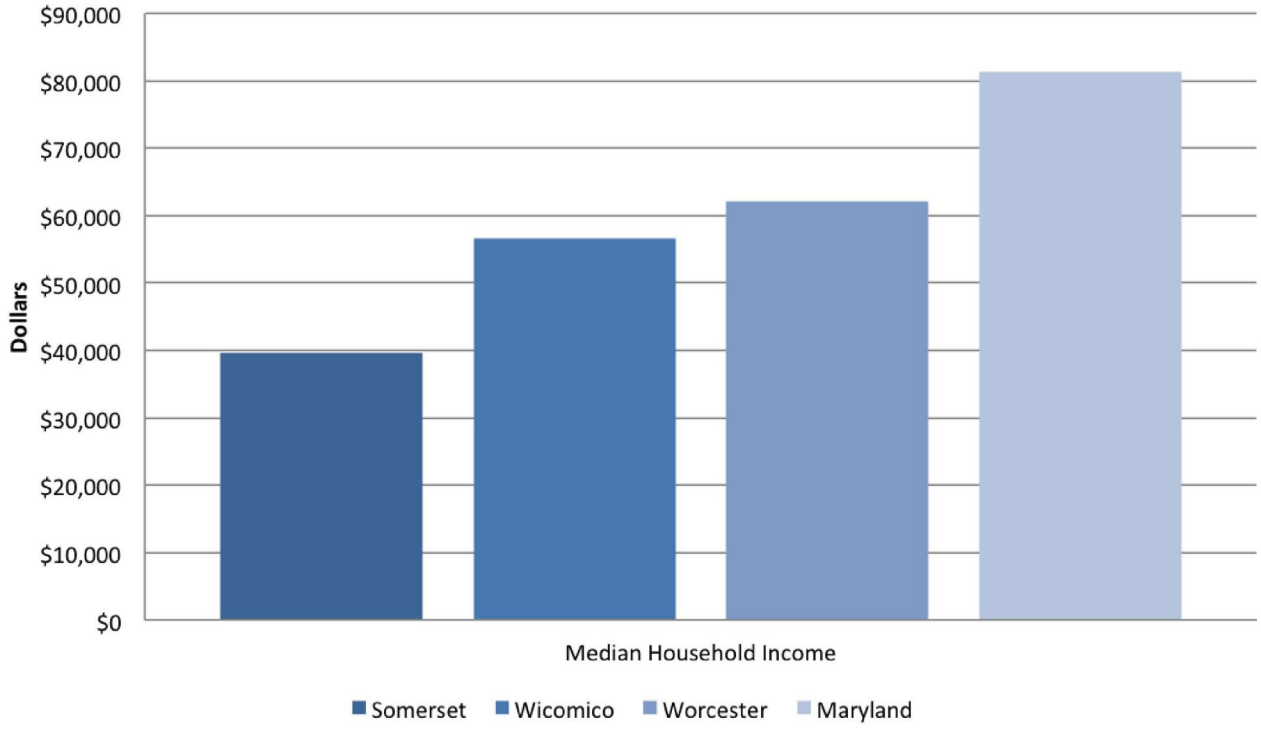
From Fiscal Years 2014 through 2019, PRMC had an average regulated operating margin of 11.0 percent based on its annual filing Schedule RE reporting. Average total operating margin for the same period, inclusive of unregulated losses, most notably physician subsidies, was 0.6 percent. The overall performance for 2014 through 2019 was reduced by regulated margin deterioration in 2017 when operating margin fell to -5.0 percent (5.4 percent regulated). If 2017 is excluded, the average regulated margin for Fiscal Years 2014, 2015, 2016, 2018 and 2019 was 12.1 percent; total operating margin was 1.7 percent. Fiscal Year 2017 similarly affected PRMC's operating cash flow margin, which removes depreciation and amortization and better represents the ongoing cash generation of the organization's operation. From 2014 through 2019, the operating cash flow margin was 6.8 percent, yielding cash generation of $168.1 million; removing 2017, the pro-forma operating cash flow margin would increase to 7.9 percent, yielding a pro-forma cash generation of $195.6 million.

PRMC Service Area and Affordability Implications

The total population estimate for the Tri-County Service Maryland Service Area identified in PRMC's 2019 Community Health Needs Assessment [3] was 180,778. The majority of the population lives in Wicomico County, which had an estimated 103,378 residents. Worcester and Somerset counties had estimated populations of 51,455 and 25,945, respectively.

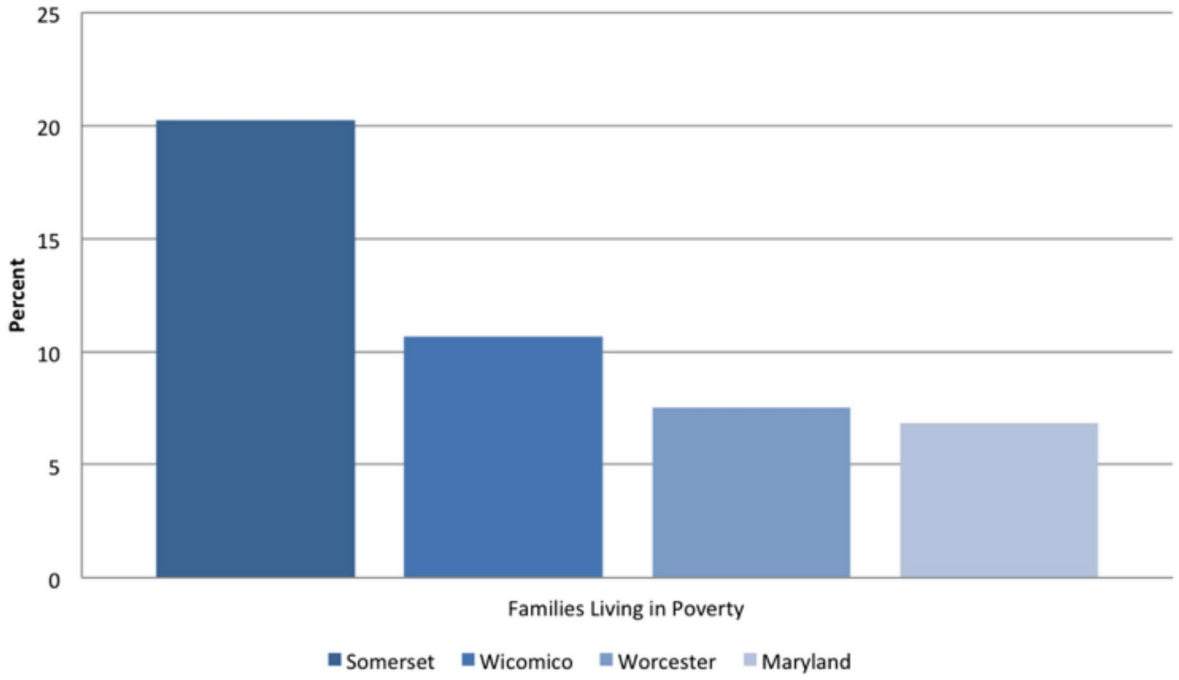
The median household income values in all three counties in the Tri-County Service Area are lower than that of the state of Maryland. In comparison to the state of Maryland overall, all three counties in the Tri-County Service Area have higher percentages of families living in poverty.[4]

Exhibit 1a. Tri-county Service Area Median Household Income



[2] Source: HSCRC hospital discharge data , Fiscal Year 2019
[3] Source: https://www.wicomicohealth.org/wp-content/uploads/2019/06/chna-2019.pdf
[4] Source: IBID

Exhibit 1b. Tri-county Service Families Living Below the Poverty Line



One of the most serious health care problems faced by most Americans is affordability. Increases in hospital charges, such as those requested by PRMC have a direct impact on affordability. As discussed above, income levels in PRMC's service area are lower and poverty levels are higher. In this report, HSCRC staff evaluates the impact of the requested revenue increases on affordability for the residents in PRMC's service area.

Full Rate Applications

In January 2018, the Commission updated its regulations for full rate applications to incorporate new requirements for efficiency. In January of 2021, the Commission, following public comment, approved a policy to evaluate full rate applications. The revised methodology utilizes updated but historical evaluations of hospital cost-per-case efficiency and incorporates new measures of efficiency based on the move from volume-based payments under the charge-per-case system, employed prior to 2014, to a per-capita system with value-based requirements.

Similar to the evaluations of the Garrett Regional Medical Center application in 2018, Suburban Hospital application in 2019, and Bayview Hospital in 2020, HSCRC staff has evaluated the performance of PRMC by reviewing its total cost of care performance, measures of avoidable utilization and quality using the latest data available, and evaluating cost per case under the HSCRC's Interhospital Cost Comparison (ICC) methodology.

As indicated above, HSCRC staff has also evaluated the impact of the requested revenue increases on affordability for the residents in PRMC's service area.

Staff Analyses

HSCRC staff has reviewed costs, financial trends, system financial statements, unregulated losses, volume trends, quality performance, cost-per-case efficiency through the ICC and Medicare and Commercial per capita cost trends in the Hospital's primary service area, among other considerations. Summaries of several of these analyses follow.

Hospital Rate History

PRMC entered into a GBR agreement with the HSCRC for Fiscal Year 2014. Under the GBR agreement, PRMC has received the following adjustments over the subsequent six years:

Exhibit 2. PRMC's GBR Adjustments, RY 2014-2019

Component:	2014	2015	2016	2017	2018	2019
Update Factor	1.65%	2.41%	2.40%	2.64%	2.91%	2.46%
Mark Up Change	0.00%	-0.77%	-0.89%	-0.43%	-0.17%	-0.28%
Demographic Adjustment	0.00%	0.40%	0.18%	0.23%	0.44%	0.52%
Market Shift & other volume adjustments	0.00%	0.00%	-0.01%	-0.60%	-0.12%	0.20%
Net Quality Adjustments	0.00%	-0.08%	0.14%	0.03%	0.33%	-0.60%
PAU	-0.19%	-0.23%	-0.12%	-0.82%	-0.29%	-0.16%
Infrastructure	0.33%	0.33%	0.40%	0.00%	0.00%	0.00%
Oncology Adjustments	0.00%	0.00%	0.00%	0.01%	-0.07%	0.00%
Other	0.00%	0.00%	0.36%	0.00%	0.00%	0.37%
Total	**1.79%**	**2.06%**	**2.46%**	**1.06%**	**3.03%**	**2.51%**

Source: HSCRC final rate files for fiscal years 2014 -2019. Table above shown in percentages.

As reflected in Exhibit 2, annual adjustments to PRMC's GBR averaged 2.15 percent. Excluding one-time adjustments associated with Quality pay-for-performance programs and changes related to markup, annual adjustments averaged 2.61 percent. The mark up reductions resulted from reductions in uncompensated care that occurred primarily as a result of Medicaid expansion under the Affordable Care Act (ACA). As more residents gained healthcare coverage, uncompensated care declined and the HSCRC reduced the amount of uncompensated care from hospitals' rates. Also, the State eliminated an assessment for a high risk individual insurance product referred to as MHIP, over 2014 and 2015, as high risk persons were able to access subsidized coverage through coverage provided under the ACA. These mark up adjustments generally reduce hospital rates, but actual uncompensated care expenses declined at the same time.

Revenue Growth and Financial Condition

PRMC's HSCRC approved regulated revenues have increased by $39.5 million or 9.5 percent since Fiscal Year 2014.

Exhibit 3. Change in PRMC's Approved GBR -For the 5 years Ended June 30, 2019

Year Ended June 30	Approved GBR (in 000's)	Percent Change from Prior Year
2014	$416,053	
2015	$421,601	1.33%
2016	$430,193	2.04%
2017	$437,765	1.76%
2018	$451,199	3.07%
2019	$455,585	0.97%
Change 2014 to 2019	$39,532	9.50%

Source: Peninsula Regional Medical Center Final Rate Order Revenues FY 2014 - FY 2019

As reflected in Exhibit 3, The approved GBR for PRMC grew from $416.1 million in Fiscal Year 2014 to $455.6 million in Fiscal Year 2019, an increase of $39.5 million or 9.5 percent over the span of five years.

According to its annual filings with the HSCRC, PRMC has averaged an operating profit margin of 11 percent or $40.8 million per year on regulated services over the six years ending FY 2019. For all services combined (regulated and unregulated), PRMC has averaged an operating profit margin of 0.6 percent or $2.2 million per year over the six years studied. During this six-year study period, the combined cash flow operating margin, which removes depreciation and amortization and better represents the ongoing cash generation of the organization's operation, averaged $28.0 million per year. In addition to referencing the annual filing, the staff reviewed the audited financial statements for the same six-year period, and noted consistency in the reporting.

Exhibit 4. PRMC Regulated and Unregulated Annual Profit Margins
For the 8 Fiscal Years Ended June 30, 2021

	PRMC Regulated and Unregulated Annual Profit Margins ($ 000's), Under GBRs								PRMC GBR Averages		State wide
Metric	2014	2015	2016	2017	2018	2019	2020	2021	Average 2014 to 2021	Average Excluding 2017	Avg 2014 to 2021
Regulated Operating Margin $	$36,420	$48,495	$38,429	$20,072	$47,317	$53,820	$46,282	$88,631	$47,433	$51,342	
Regulated Operating Margin %	10.4%	13.4%	10.4%	5.4%	12.3%	13.8%	11.5%	19.6%	12.1%	13.1%	8.4%
Unregulated Operating Margin $	($28,729)	($33,051)	($39,247)	($40,578)	($40,419)	($49,078)	($52,699)	($24,852)	($38,582)	($38,296)	
Unregulated Operating Margin %	-107.0%	-104.2%	-107.1%	-99.1%	-79.5%	-74.1%	-65.6%	-70.3%	-88.4%	-86.8%	-43.7%
Total Operating Margin $	$7,691	$15,444	($818)	($20,506)	$6,897	$4,742	($6,417)	$63,779	$8,852	$13,045	
Total Operating Margin %	2.0%	3.9%	-0.2%	-5.0%	1.6%	1.0%	-1.3%	13.1%	1.9%	2.9%	3.0%
Total Cash Flow Operating Margin $	$31,217	$38,802	$21,782	$5,913	$35,840	$34,505	$23,374	$91,143	$35,322	$39,523	
Total Cash Flow Operating Margin %	8.3%	9.9%	5.4%	1.4%	8.3%	7.6%	4.8%	18.7%	8.0%	9.0%	8.5%

Source: PRMC HSCRC Annual Filings - Schedule R

In reviewing Exhibit 4, it is notable that the regulated net operating margin in 2017 is materially lower than that of the other fiscal periods in this comparative study. PRMC management indicated that the hospital installed and began using the EPIC interfacing software for patient electronic medical records during 2017, which resulted in approximately $18.5 million in incremental operating expenses related to the initial EPIC installation and the resulting profit erosion.

The approximate cash on hand at the end of Fiscal Year 2019 was $46.6 million, which was the fourth highest in the State, as measured by system level cash per hospital. When cash and

investments are accounted for, in 2019 TidalHealth the system had $398.6 million, which equated to 338 days cash on hand; this represents the second highest days of cash on hand in the State and well above the statewide average of 192.

Exhibit 5. Cash on Hand For the Fiscal Years Ended June 30, 2019

Rank	System	2019 Cash and Investments (1)	Days Cash On hand (2)
1	Calvert Health System, Inc.	127,015,447	372
2	Tidal Health, Inc.	398,611,000	338
3	Johns Hopkins Health System Corporation	4,364,733,000	247
4	Lifebridge Health, Inc.	984,178,000	245
5	Meritus Medical Center, Inc.	250,752,000	242
6	GBMC healthcare, Inc.	362,182,000	239
7	Holy Cross Health, Inc., Maryland	320,885,000	237
8	Garrett Regional Medical Center	33,801,657	226
9	Anne Arundel Health System, Inc.	416,417,000	211
10	Western Maryland Health System Corporation	174,002,000	209
11	Frederick Regional Health System, Inc.	216,187,000	197
12	Mercy Health Services, Inc.	336,321,000	173
13	Medstar Health, Inc.	2,128,100,000	146
14	University of Maryland Medical System Corporation	1,386,647,000	129
15	Adventist HealthCare, Inc. (1)	238,552,825	114
16	The Union Hospital of Cecil County	47,175,983	114
17	Doctors Community Hospital	57,047,544	90
18	Atlantic General Hospital Corporation	21,089,196	60

.

Looking beyond the six-year period under study, PRMC continues to perform in a positive fashion, notwithstanding the financial effects of the COVID-19 pandemic. The Schedule RE reflects a cumulative operating margin on regulated operations of $134.9 million and a cumulative net cash flow margin on regulated operations of $191.5 million for the two years ended FY 2021. The balance sheet at June 30, 2021 reflects cash and investments, net of advances from third parties of $485.5 million, and the leverage and debt service ratios are very healthy

One potential concern for TidalHealth's financial outlook is its recent acquisitions. Following the acquisition of Nanticoke Memorial Hospital and Nanticoke Physician Network in January 2020, the Peninsula Regional Health System recorded losses from operations for the year ended June 30, 2020 associated with these acquisitions of $2.4 million and $6.2 million, respectively. Following the renaming of these entities in fiscal 2021, TidalHealth Nanticoke Hospital recorded a loss on operations of $11.0 million for the year ended June 30, 2021, and TidalHealth Physician Network recorded a loss of $1.7 million for fiscal 2021 prior to being dissolved into a

newly formed TidalHealth Medical Partners ("Partners"). Partners was constructed by combining the operations of the physicians practices formerly organized under PRMC and under Nanticoke, and which recorded an operating loss of $52.2 million for the stub period ending June 30, 2021. As per reference to a pro-forma presentation prepared by TidalHealth, for the fiscal years ended 2020 and 2021, the combined operating losses of the Medical Partners services are approximately $59.0 million annually of which the former Nanticoke Physicians network accounts for approximately $10.5 million annually. As per reference to a pro-forma budget presentation by TidalHealth, the former Nanticoke Hospital and Nanticoke Physician Network are expected to incur operating losses of $16.5 million and $10.7 million respectively for fiscal 2022. With the acquisition of Nanticoke Hospital and its Physician Network, staff is concerned that PRMC's rate application is in part motivated by the projected ongoing financial deterioration of these entities, totaling $27.2 million initiated through this acquisition. Staff wants to guard against charging Maryland residents and payers for TidalHealth's losses in Delaware.

Staff researched the values of cash and unrestricted investments at June 30, 2021 for the hospital systems in Maryland as per reference to their audited financial statements, so as to gain an understanding of relative available liquid resources, and made note that the state's health systems include those both larger and smaller than TidalHealth. TidalHealth reflects a value of $702.3 million in gross unrestricted liquid resources at June 30, 2021, and $590.5 million net of potential pay backs for advances. The average value of such unrestricted liquid resources available to hospital systems (excluding academic medical centers) in Maryland (exclusive of TidalHealth) as of June 30, 2021 was approximately $629 million gross , and approximately $521 million net of potential paybacks. This comparison implies that TidalHealth has a strong liquid position of available assets on which to draw relative to Maryland's other hospital systems.

Volume Funding

This section of the staff's report addresses historical volumes measured at PRMC.

The HSCRC uses ECMADs to calculate volume changes when possible, because ECMADs include volumes of both inpatient and outpatient services with recognition of expected relative costs of services on a consistent scale. From Calendar Year 2013 through Calendar Year 2019, PRMC has experienced volume declines. Volumes as measured by ECMADs were 36,191 in 2014 and 35,210 in 2019, an implied decrease of 2.7 percent over 5 years. However, this volume growth calculation is not entirely reliable due to the move to ICD-10, which is used for coding diagnoses on hospital bills. The move to ICD-10 made the use of consistent inpatient DRG groupers and weights, for all years, unavailable. Thus, staff have also assessed volume growth through equivalent inpatient days and equivalent inpatient admissions as well as: a) the year over year volume funding relative to funding a 50 percent variable cost factor for growth in in-state

ECMADs; b) the funding of drug costs through the CDS-A methodology; and c) a six year assessment of out-of-state volume funding using billed relative value units.

The volume of patient traffic declined 2.4 percent between 2014 and 2019 as measured by equivalent inpatient days (EIPDs) (127,129 EIPDs in 2014 compared to 124,083 EIPDs in 2019). The approximate average length of stay was fairly stable over the 6-year period of study. This is further supported by analysis of inpatient casemix index (CMI), which measures acuity across all inpatient services, which was relatively stable from 2014 through 2019. Moreover, it appears that the relative acuity of PRMC inpatient services has actually declined slightly, as the CMI was 1.06 and 1.05 in Fiscal Years 2014 and 1.01 and 1.02 in Fiscal Years 2018 and 2019, respectively. An index of 1.0 represents an average index. The reduction in patient volumes and relatively consistent acuity is notable, since regulated employee staffing has remained fairly consistent; regulated FTE's have declined 1.19 percent from 2012 to 2019

Finally, staff also have assembled an analysis that compares expected funding, i.e., growth in in-state ECMADS at a 50 percent variable cost factor, growth in drug costs at average sales price, and out-of-state relative value units at a 50 percent variable cost factor, relative to all volume funding methodologies. Please note there is no underlying population based methodology for out-of-state volume changes, as it is not required under the TCOC contract; staff adjusts global budget revenues when there is material change in out-of-state volumes. Exhibit 6 below summarizes the analyses and shows that PRMC was overfunded for volume changes by $7.4 million annually as of the end of Calendar Year 2019.

Exhibit 6. Volume Funding Provided to PRMC for Six Calendar Years 2014 through 2019 (current dollars, in millions)

	Funding	Expected Funding (50% Variable Cost Factor or Average Sales Price for CDS-A Drugs)	Net Over (Under) Funding
Market Shift (through RY 2021 adjustments)	-$0.2 million		
Demographic Adjustment (through RY 2020 adjustment)	$8.8 million		
Medicaid Expansion	$1.5 million		
Total In-State Volume (excl CDS-A eligible drugs)	$10.1 million	$3.5 million	$6.6 million
Out-of-State Adjustment (excl Drug Rate Center)	$0	$.5 million	-$.5 million
CDS-A Adjustment*	$4.2 million	$2.8 million	$1.3 million
Total Volume**	$14.3 million	$6.9 million	$7.4 million

*The CDS-A assessment does not account for savings related to PRMC converting to a 340b hospital, as all Maryland hospitals have been allowed to retain revenue associated with the conversion. If the savings are accounted for, PRMC has been overfunded for CDS-A drug costs by $10.9 million.

**Volume assessment does not account for inflationary reductions to potentially avoidable utilization, which through Calendar Year 2019, Fiscal Year 2020 amount to $8.4 million, nor does it account for additional revenue provided through infrastructure funding, which in Fiscal Year 2020 dollars amounted to $4.9 million.

Retained Revenue

The most significant incentive for a hospital under the All-Payer and TCOC Model is to reduce avoidable utilization while charging a prospectively determined global budget. To operationalize this incentive, hospitals are allowed to increase charges up to 5 percent over the course of the year as volumes decline by a corresponding amount (10 percent if special permission is granted by HSCRC staff). PRMC has been successful in this endeavor over the course of the Model, especially in recent years.

In Fiscal Year 2019, PRMC increased its charges by 4.2 percent, i.e. volumes were 4.2 percent less than budgeted and the Hospital charged the remaining volume base 4.2 percent more to ensure it collected its entire global budget. This allowed PRMC to retain $18.9 million more in revenue than it otherwise would in a traditional fee-for-service system. The Commission memorialized this additional charging capacity in Fiscal Year 2022 by allowing hospitals to reestablish budgeted volumes equivalent to hospital's experience in calendar year 2019 when it increased charges by 3.2 percent. In effect, PRMC is expected to retain approximately $16.3 million in retained revenue (current year dollars) as long as volumes remain below calendar year

2019 experience. Given the ongoing volume suppression that has occurred due to the COVID-19 pandemic, HSCRC staff believes this retained revenue will be sustained and likely increase.

Affordability

In addition to retained revenue, another central benefit of the State's waiver from Medicare's Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) is that Maryland hospitals do not receive reduced reimbursements from governmental payers. Conversely, private payers, employers, and consumers in other states pay higher hospital rates to cover the losses associated with reduced payment from governmental payers.

In the case of PRMC, which has a disproportionate share of volume attributable to governmental payers (49% is Medicare FFS, 17% is Medicaid, and 4% is Medicare Advantage), this has resulted in more generous reimbursement for PRMC, even after considering potentially higher reimbursement from private payers, employers, and consumers. HSCRC staff have benchmarked payment levels for PRMC versus similar geographic areas for Medicare and private payers. The HSCRC has not benchmarked Medicaid costs but published research shows Medicaid payments range from 70% to 100% of Medicare - for the purpose of this estimate Staff assumed 90%. If all payers are considered, staff estimates the PRMC revenue would be reduced by $15.0 M[5] absent the model:

Medicare reduction:	($57.2)
Medicaid reduction:	($27.4)
Private Payer increases:	$69.6
Total reduction:	($15.0)

HSCRC's full rate application policy (see Full Rate Application Methodology below) calls for a reduction of PRMC's revenue of $10.6 million. So, both under HSCRC's approved Maryland policy and in comparison to similar national geographies PRMC's current reimbursement is generally comparable to a reasonable standard and any increase would make them inefficient versus these standards.

PRMC has requested a regulated revenue increase of $57.5 million (a 11% increase), even though it has consistently generated high profits from regulated hospital operations, has generated an average cash flow margin of $28 million per year,[6] has earned an average of $30 million[7] in investment income over the past 10 years, and has substantial cash reserves relative to other hospitals and health systems in Maryland.

[5] The estimated net loss in revenue to PRMC is estimated based on the level of hospital spending for commercial and Medicare payers in comparable national regions to PRMC's service area as identified in the HSCRC's benchmarking process.

[6] Statistic removes depreciation and amortization and better represents the ongoing cash generation of the organization's operation

[7] Since investments are reported at a system level this reflects results of the applicable system parent for all years.

This calls into question affordability for the residents of PRMC's service area. Increased rates would reduce affordability without efficiency justification. Medicare patients would have to pay for part of these increases through higher co-insurances payments, competing with their ability to pay for housing, food, medications, transportation and other essentials. Likewise, private paying patients and local employers would also have to pay more for services. These higher costs for employers would ultimately be passed on to workers through higher premium contributions, higher co-payments and deductibles. They would also be passed on to workers in the form of lower wage increases, a well-documented fact documented in numerous scholarly articles and studies.[8]

An additional, highly significant threat to local affordability occurs if PRMC's request for additional revenue puts the Maryland waiver at risk by establishing unsustainable statewide precedents. In the event the waiver was lost the PRMC community would lose the additional funding from Medicaid and Medicare noted above, a loss of ~$85 million of external funding. while local business would bear additional costs of ~$70 million. This would be a triple blow to the local residents and businesses resulting in a more financially challenged hospital, significant loss of outside investment and higher local commercial healthcare costs.

Potentially Avoidable Utilization

Staff evaluated the levels of potentially avoidable utilization at PRMC compared to levels of potentially avoidable utilization at all other Maryland hospitals, and PRMC's experience in reducing these volumes. As outlined below, PRMC had lower rates of potentially avoidable utilization relative to the state average. This favorable performance is driven by the Hospital's readmissions, as PRMC has slightly higher avoidable admissions per capita relative to State average but has lower readmissions relative to the state average; it has also reduced readmissions faster than the state average. Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions" for which outpatient care can potentially prevent the need to be admitted to the hospital, or for which early intervention can prevent complications or more serious conditions. While PRMC's unfavorable performance in PQI's may be partially attributable to a lower rate of primary care physicians in the Eastern Shore and southern Delaware, as evidenced by Health Professional Shortage Area (HPSA) designations and HPSA scores ranging from 15-19 for PRMC's primary and secondary service areas,[9] it should also be noted that the Hospital's PQI per capita statistics

[8] Increases in health care costs are coming out of workers' pockets one way or another: The tradeoff between employer premium contributions and wages - UC Berkeley Labor Center, Rising health care costs mean lower wages | News | Harvard T.H. Chan School of Public Health

[9] HPSA Primary Care Scores are based on a 25 point scale and include a Population-to-Provider Ratio [10 points max], Percent of population below 100% Federal Poverty Level (FPL) [5 points max],Infant Health Index (based on Infant Mortality Rate (IMR) or Low Birth Weight (LBW) Rate) [5 points max], and Travel time to Nearest Source of Care (NSC) outside the HPSA designation area [5 points max]. https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring

are likely understated because the metric does not account for Maryland residents that seek care outside the State.

Exhibit 7. Potentially Avoidable Utilization Performance

Metric	Hospital Performance	State Quintile	Unweighted State Average
PAU Revenue as a Percent of Eligible Revenue CY19	16.59%	2	17.17%
Readmission Percent Change (CY16-CY19)	-12.32%	2	-4.59%
Readmission Case-Mix Adjusted Rate CY19 w Out-of-State Adj.	10.18%	1	11.22%
PQI rate per 1000 adults for Hospital's Geography	15.61	4	14.45
PQI rate per 1000 adults for Hospital's Geography Percent Change (CY13-CY19)*	-1.1%	3	-0.03%

* The weighted average reduction in PQI's over the course of the All-Payer and TCOC Model (2013-2019) was -13.2 percent.

Quality Performance

Staff reviewed PRMC's performance on Fiscal Year 2021 quality measures for readmissions, potentially preventable complications (PPCs), and the Quality Based Reimbursement (QBR) domains.

Under the HSCRC's Readmissions Reduction Improvement Program (RRIP), PRMC reduced its risk-adjusted readmissions by 12.32 percent between Calendar Year 2016 and Calendar Year 2018, which places PRMC in the 2nd quintile of statewide improvement. When this improvement is compounded with Calendar Year 2013 to Calendar Year 2016 improvement, the total Fiscal Year 2020 improvement is 16.93 percent. Further, PRMC's readmission rate is 10.18 percent, which is in the first or top quintile of statewide performance.

Under the HSCRC's Maryland Hospital Acquired Conditions program, PRMC had a 48 percent improvement in its case-mix adjusted PPCs rate for Fiscal Year 2021, putting it in the 1st quintile of state performance. Furthermore, PRMC's case-mix adjusted PPCs rate for Calendar Year 2019 of 0.97 per one thousand discharges is in the 2nd quintile of statewide performance.

Under the HSCRC's QBR program, PRMC had a Fiscal Year 2021 total QBR score of 24.3 percent, which is in the 5th quintile of statewide performance. Specifically for patient experience, PRMC scored 25 percent, which makes up half of the total QBR score and places them in the 2nd quintile of statewide performance. The Fiscal Year 2021 performance data shows that for the eight HCAHPS measures, PRMC performed better than the national average on 5 measures and improved slightly on all measures except "Discharge Info" and "Care Transitions" measures. On the Mortality measure, PRMC scored 10 percent, which places them in the lowest (5th quintile) of statewide performance. For the safety measures, PRMC scored 16 percent, which also places them in the 5th quintile of statewide performance.

Exhibit 8. Summary of Quality Performance

Quality Program	Metric	Hospital Performance	State Quintile	State Average
MHAC	PPC Percent Change (FY18-CY19)	-48.32%	1	-29.87%
	PPC Case-Mix Adjusted Rate CY19	0.45	5	0.93
RRIP	Readmission Percent Change (CY16-CY19)	-12.32%	2	-4.59%
	Readmission Case-Mix Adjusted Rate CY19 w Out-of-State Adj.	10.18%	1	11.22%
QBR	Patient Experience Domain	25.45%	2	23.00%
	Mortality Domain	10.00%	5	49.07%
	Safety Domain	16.00%	5	38.70%
	Total Score	24.33%	5	33.27%

Full Rate Application Methodology

The Commission approved its full rate application methodology that utilizes the Interhospital Cost Comparison (ICC) and TCOC assessments in January 2021. In the ICC, each hospital's cost-per-case is utilized to develop a peer group adjusted cost-per-case standard, and each hospital's approved ICC revenue is then calculated from the peer group adjusted cost-per-case standard as well as any hospital specific costs that are purposefully passed through without

qualification, e.g., direct and indirect medical education, trauma standby costs. Per Maryland statute, there is no allotment for profit for a non-profit hospital, and, the Commission must assure each purchaser of hospital services that "total costs of all hospital services offered by or through a facility are reasonable; [and] that the aggregate rates of the facility are related reasonably to the aggregate costs of the facility."[10] Furthermore, any costs not evaluated in the ICC due to an insufficient casemix adjustment, most notably oncology drugs, are provided to the hospital without efficiency qualification.[11] The TCOC assessment accounts for both Medicare and Commercial performance relative to national "benchmark" peers as well as TCOC growth relative to Maryland performance; positive or negative performance in TCOC is used to scale the full rate determination made by the ICC.

PRMC's ICC peer group includes all acute care hospitals with the exception of the State's two academic medical centers. The 2020 ICC results show that PRMC's costs per ECMAD were 12 percent lower than the peer group average. However, PRMC had the ninth highest regulated margin in Fiscal Year 2019 among ICC evaluated facilities (13.81 percent vs an average of 9.88 percent),[12] which is the basis for profit removed in the 2020 ICC. Due to the Hospital's above average margin, which means charges that purchasers and consumers pay are well above cost, the 2020 ICC methodology results in a revenue reduction of 3.87 percent. After accounting for the oncology drug costs removed from the ICC evaluation ($14.1 million), total approved revenue for PRMC is $451 million, which is an unfavorable revenue write-down of $17.6 million or -3.75 percent. Finally, because PRMC's 2018 TCOC exceeds that of its benchmark peers (21.47 percent unfavorable; 6th worst in the State) and because PRMC has had TCOC growth in excess of the statewide average (8.48 percent vs 7.31 percent), an additional negative adjustment of $2.2 million is applied to the full rate determination to claw back excess TCOC growth attributable to PRMC. This yields a net unfavorable revenue write-down of $19.8 million or -4.22 percent as described in the "baseline" full rate determination in Exhibit 9. There was no adjustment for Commercial TCOC performance, as the Hospital was 21.99 percent better than its benchmark (21st best in the State), but it cannot obtain a revenue adjustment for this performance due to its Medicare TCOC performance. The calculations performed are in accordance with the central tenet of our statute that charges must reasonably related to costs and the publicly approved policy that governs full rate applications.

[10] Maryland HEALTH-GENERAL Article, An. Code Ann. § 19-219(a)

[11] Statewide there is less than 7 percent of revenue not evaluated by the ICC. PRMC has approximately 5% excluded from the ICC evaluation.

[12] Among the State's seven non-academic trauma centers, PRMC had the second highest regulated margin (13.81 percent vs an average of 9.34 percent).

Exhibit 9. Summary of Components of Baseline ICC and TCOC Recommended Revenue for Peninsula Regional Medical Center*

FRA Methodology	Hospital Revenue Assessed	Revenue Change	FRA Recommend Revenue
ICC Efficiency Tool	$454.5 million	-$17.6 million	$436.9 million
Oncology Drugs	$14.1 million	-$0	$14.1 million
TCOC Assessment	NA	-$2.2 million	-$2.2 million
Total	$468.6 million	-$19.8 million	$448.8 million

***Total may not add due to rounding, Values are Denoted in Fiscal Year 2020 Dollars**

PRMC identified several methodology and revenue enhancement considerations in its rate application that moved the full rate determination from an unfavorable revenue write-down of $19.8 million to a favorable revenue enhancement of $57.5 million. They are as follows:

1) ***Methodology Consideration*** - PRMC noted that the revenue evaluated in the ICC was in excess of the actual revenue provided to the Hospital to support ongoing operations. Staff originally removed $6.7 million from the ICC in recognition of the combined PRMC and McCready Memorial Hospital rate orders, which occurred due to the merger between the two institutions; $6.7 million represents the ongoing revenue that will support operations at the McCready freestanding medical facility. However, PRMC noted that the full amount of revenue attributable to McCready Memorial Hospital should be removed from the ICC, as RY 2019 volumes at PRMC did not yet reflect any transition of services and thus the charge/cost per case was overstated. PRMC's rate application reflects a revenue adjustment to the ICC of $16.7 million, reflecting the revenue that the Commission had approved for McCready Memorial Hospital.

2) ***Methodology Consideration -*** PRMC notes the ICC accounts for the regulated and "...incremental costs associated with the [trauma] program by allowing a "direct strip" of allowed trauma costs. These incremental costs only account for on-call costs and limited administrative costs associated with maintaining trauma program requirements. However, the on-call costs are a relatively small component of the cost of meeting the stringent requirements for maintaining a Level III trauma center in the State. These costs are eclipsed by the need to hire physicians to be available for care, along with the premium required to attract the appropriate professionals to a rural market[13]." In recognition of "...the social costs of meeting the state's requirements for providing Level III Trauma care,"[14] PRMC requests that a direct cost strip of $25.9 million ($25.5 million attributable

[13] PRMC Full Rate Application (Page 51)
[14] IBID (Page 51)

to unregulated physician subsidies and on-call pay) be removed from PRMC's cost per case assessment and then passed through the ICC without qualification. The Hospital also recognizes that a similar cost strip should be provided to the state's other trauma centers, but in the absence of physician contracts for each trauma center, it suggests the cost strip should be equal to the percentage of the PRMC cost strip relative to its total permanent revenue (6 percent).[15]

3) ***Methodology Consideration -*** PRMC suggests that: the benchmarking methodology for Medicare may not be representative of actual TCOC, because it is based on a 5 percent sample of National Medicare beneficiaries; the benchmarking methodology for Commercial has potential data inconsistencies because in the Maryland All Payer Claims Database (APCD) - the source for the Commercial TCOC assessment - CareFirst data are 28 percent lower than reported in the National Association of Insurance Commissioners (NAIC), and there is inconsistent membership identification for United HealthCare; neither the Medicare nor the Commercial benchmarking methodologies directly account for differences in wages levels; and the regression model used for both the Medicare and Commercial TCOC assessments yields higher coefficients for median income than deep poverty, thus "increasing disparities for populations in counties with higher levels of poverty."[16] Due to these concerns, PRMC requests that negative TCOC adjustment be removed from the full rate determination.

4) ***Revenue Enhancement Consideration:*** PRMC requests $3.2 million to fund year 1 expenses for a new psychiatric service line that provides services to children and adolescents. This request is reflective of a 100 percent variable cost factor for an estimated 100 admissions (926 inpatient days) and 2,433 outpatient visits. PRMC further requests that the 100 percent variable cost factor be applied until the program reaches full maturity in Fiscal Year 2025: 373 admissions (3,458 patient days) and 3,650 outpatient visits, which will equate to $9.5 million in additional revenue.[17]

5) ***Revenue Enhancement Consideration:*** PRMC intends to establish a graduate medical education (GME) program and seeks direct and indirect medical education ($244 thousand per resident per year) for 10 residents in year 1 ($2.4 million). PRMC also notes that it anticipates to expand its GME program to a forecasted resident population of 65 over a five year period and would ask that it receive the same direct and indirect medical education credit of $244 thousand per resident per year ($15.9 million) in line

[15] PRMC's Responses to Second Round of Completeness Questions 12.14.21 (Page 9)
[16] PRMC Full Rate Application (Page 59)
[17] Certificate of Need application approved by MHCC on May 16, 2019

with the national Medicare policy on funding new GME programs.[18] The current rate request only reflects the initial 10 residents.

6) ***Revenue Enhancement Consideration:*** PRMC requests $16 million to provide market adjustments to maintain competitive wages.

7) ***Revenue Enhancement Consideration:*** PRMC requests $23 million to generate a 5 percent total operating margin in order to support population health initiatives.

For a complete summary of PRMC's rate application requests see Exhibit 10 below:

Exhibit 10. Summary of Components of ICC and TCOC Proposed Revenue for Peninsula Regional Medical Center Per PRMC Rate Application*

FRA Methodology	Hospital Revenue Assessed	Revenue Change	FRA Recommend Revenue
ICC Efficiency Tool (Reflective of All PRMC Methodology Considerations)	$444.4 million	$12.8 million	$457.2 million
Oncology Drugs	$14.1 million	-$0	$14.1 million
TCOC Assessment	NA	-$0	-$0
Year 1 GME for 10 Residents	NA	$2.5 million	$2.5 million
Year 1 Child & Adolescent Behavioral Health Program	NA	$3.3 million	$3.3 million
Market Adjustment to Wages	NA	$16 million	$16 million
Improved Operating Margin	NA	$23.1million	$23.1million
Total	$458.5 million	$57.5 million	$515.9 million

***Total may not add due to rounding, Values are Denoted in Fiscal Year 2020 Dollars**

[18] Per CMS policy, "if a hospital did not train any allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins to participate in training residents in a new medical residency training program (allopathic or osteopathic) on or after January 1, 1995, the hospital's unweighted FTE resident cap (which would otherwise be zero) may be adjusted based on the sum of the product of the highest number of FTE residents in any program year during the fifth year of the first new program's existence at all of the hospitals to which the residents rotate, the minimum accredited length for each type of program, and the ratio of the number FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents in the program that trained at all hospitals over the entire 5-year period" - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10240.pdf

In the following sections, HSCRC staff will respond to all of PRMC's methodology considerations and to two of the four revenue enhancement considerations in greater detail. **The remaining two revenue enhancement considerations ($16 million for competitive wages and $23 million to generate a 5 percent operating margin) are not reasonable requests, as they are not based on an efficiency assessment or an associated methodology consideration, nor do they constitute the establishment of a new, regulated service, which could warrant a revenue enhancement. Moreover, the Commission does not guarantee margins or wage levels and to do so for one hospital on an isolated basis would be inconsistent with general policies. Thus, staff will not dedicate additional research to these topics and recommend rejecting the request for revenue enhancements related to these items.**

Full Rate Application Methodology - McCready Hospital Revenue Adjustment (Methodology Consideration)

HSCRC staff concur with the proposed technical adjustment to increase the McCready Hospital revenue removed from the RY 2020 ICC (currently $6.7 million). Given the merger of the facilities and the combined Fiscal Year 2020 rate orders that prospectively moved revenue from McCready to PRMC in anticipation of inpatient services transitioning to PRMC, it is methodologically unsound to assess this revenue with RY 2019 volumes that had not yet reflected the change in utilization patterns. Staff does not concur, however, that all $16.7 million of McCready's permanent revenue should be removed from the ICC because $4.9 million will be permanently charged at PRMC to support community investments, including capital, and to stabilize McCready's financial performance. These revenues are not associated with volumes that have not yet materialized at PRMC, but rather constitute something akin to the safe harbors in the proposed Revenue for Reform policy, which is not applicable to a full rate application determination. **Thus, staff recommends removing $11.9 million of McCready Memorial Hospital associated revenue from the PRMC Fiscal Year 2020 ICC evaluation. This modification reduces the baseline revenue write-down, as outlined in Exhibit 9, from $19.8 million to $14.7 million.**

Full Rate Application Methodology - Trauma Cost Strip (Methodology Consideration)

HSCRC staff agree that there are inherent, incremental costs to supporting a trauma center. This is why the Commission has historically removed regulated standby costs from the ICC peer group standard. In the case of PRMC, $1.9 million in standby costs is passed through the 2020 ICC without qualification. Additionally, the State has recognized that trauma facilities should be supported for uncompensated care, on-call and standby expenses for physician services, as well as equipment purchases, which is why the Maryland General Assembly in the 2003 legislative session created the Maryland Trauma Physician Services Fund (Trauma Fund). In the case of PRMC, $1.4 million was provided to the Hospital in Fiscal Year 2020 through the Trauma Fund.

PRMC notes that these two supports are insufficient to cover the fixed costs of operating a Level III trauma center. Exhibit 11 below outlines the costs for which PRMC seeks consideration in the ICC:

Exhibit 11. Trauma Fixed Costs

Physician Subsidies and On-Call Pay	$25,473,440	A	Unregulated
Fiscal Year 2020 Trauma Cost per HSCRC Annual Filing Schedule	$1,840,604	B	Regulated
Trauma Fixed Costs	$27,314,044	A+B=C	
Less Trauma Fund	$1,431,736	D	Unregulated
Net Trauma Fund Fixed Costs	**$25,882,302**	E=A-D	
ICC Evaluated Permanent Revenue (Adjusted for McCready)	$435,298,364	F	
% Trauma Strip	6%	G=E/F	

Source: PRMC Responses to Completeness Questions 12.14.21 (Page 9)

PRMC is requesting that $25.8 million ($25.5 million of which is attributable to unregulated physician costs) be stripped out of the ICC evaluation and similarly a 6% cost strip be applied to all trauma centers because the Hospital cannot ascertain the actual trauma fixed costs without access to physician contracts for each trauma facility. HSCRC staff have numerous concerns about the proposed methodology consideration. They are as follows:

1) HSCRC does not have jurisdiction over physician services per statute,[19] and since 93 percent of costs put forward by PRMC as "Trauma Fixed Costs" are unregulated physician subsidies, the proposed cost strip would extend HSCRC's regulatory jurisdiction beyond its statutory authority. The remaining 7 percent of costs put forward by PRMC is already covered by the existing regulated standby cost strip in the ICC.
2) In response to the completeness question: "If these [physician] subsidies will continue in the event that PRMC ceases trauma services, please outline the extent of the subsidies," the Hospital noted the following: "TidalHealth Peninsula Regional has evaluated existing physician subsidies including on-call pay to determine the amount if any that would remain if TidalHealth Peninsula Regional eliminated trauma services. Based on projected volumes and required physician coverage, it is estimated that the $25,473,440

[19] a) In general. – (1) Except for a facility that is operated or is listed and certified by the First Church of Christ Scientist, Boston, Massachusetts, the Commission has jurisdiction over hospital services offered by or through all facilities. (2) The jurisdiction of the Commission over any identified physician service shall terminate for a facility on the request of the facility. (3) The rate approved for an identified physician service may not exceed the rate on June 30, 1985, adjusted by an appropriate index of inflation. Md. HEALTH-GENERAL Code Ann. § 19-211

in physician costs would be reduced to $8,424,224." In effect, PRMC is noting that approximately one third of the proposed cost strip that is needed to support trauma fixed costs would continue if trauma services were discontinued, and thus the proposed cost strip, if allowed, would need to be reduced to $17,458,078 or 4 percent of revenue.

3) The Commission is unable to determine if the subsidies provided to trauma physicians are reasonable, nor does it know whether the assumption that all other trauma facilities have a similar level of costs for trauma coverage is sound; therefore, the Commission would have no basis on which to adjust other Trauma centers should such an allowance be made for PRMC. PRMC has not provided sufficient evidence to assuage these concerns.
4) During the course of the development of the full rate application policy, staff demonstrated that there was no statistically significant relationship between various hospital characteristics and ICC performance. In effect, there were no variables, such as number of medical residents, that had an alarming explanatory power on the outcome of a hospital's ICC assessment. One particular characteristic that was assessed was the presence of a trauma program, both as a categorical and continuous variable, and in both instances there was not a statistically significant relationship, indicating that the Commission's assessment of a hospital's performance under the ICC is not negatively affected by having a trauma program.
5) Unregulated costs are purposefully not reflected in HSCRC efficiency methodologies, and the consideration to include one particular type of unregulated cost due to the argument that it is a social good fails to recognize that similar arguments could be made for other service lines, e.g., labor and delivery, open heart surgery, pediatric oncology, etc. Thus, unless all unregulated costs deemed a social good are allowed in an HSCRC efficiency methodology, contingent on expanded regulatory authority, the handpicking of a select few would disadvantage all other hospitals with a different service array.

In light of these concerns, HSCRC staff do not recommend approving the trauma methodology consideration put forward by PRMC.

Full Rate Application Methodology - Precision of TCOC Benchmarking (Methodology Consideration)

The Commission approved the use of TCOC assessments in its full rate application methodology in January 2020, because historical evaluations based solely on hospital cost per case efficiency do not align with the aims of the TCOC Model.

HSCRC staff understand stakeholder concerns about the precision of the TCOC benchmarking, but staff would note that benchmarking is a complex but necessary process with many reasonable options on how to proceed. From these options, HSCRC staff must select the one they regard as best, balancing competing considerations in an unbiased and justifiable way. Moreover, any perceived imprecision in the underlying benchmarking methodology can be addressed by careful

application of the benchmarking results in HSCRC policies, which is why staff have created a two step algorithm for receiving a TCOC penalty in a full rate application determination. Namely, in order for a hospital to be penalized, it must first be determined to be higher cost than its TCOC benchmark, and it must be growing faster than the statewide average. In the case of PRMC, the Hospital's attributed Medicare population under the existing benchmarking methodology is 21.47 percent more expensive than its benchmark (6th worst in the State), and it has grown 1.17 percent faster than the statewide average.

PRMC has agreed that the growth statistic is not inaccurate but noted that given its concerns with the benchmarking methodology, "...it is unclear whether the rest of the [TCOC] algorithm would remain as currently constructed."[20] HSCRC staff believe this theory is begging the question and thus continue to support the two step TCOC algorithm. In terms of the specific benchmarking concerns put forward by PRMC, staff would note the following:

1) Medicare Data Completeness - The 5 percent sample of Medicare claims is provided by Medicare for research purposes within the Chronic Conditions Warehouse (CCW), which is the same environment and data standard under which Maryland's performance under the TCOC model is evaluated. Therefore, by using the 5 percent data for the nation, HSCRC staff are using a data set that is comparable to the data used in Maryland's performance assessment. The 5 percent sample is widely used by researchers and, more importantly, by qualified entities to develop national benchmarks, indicating staff's use of the 5 percent sample is appropriate (see https://www.qemedicaredata.org/apex/Data_Availability_and_Cost).
2) Commercial Data Validity - The benchmarking relies on Maryland's Medical Claims Database (MCDB, often referred to as APCD), which is compiled by the Maryland Health Care Commission based on data from insurers in the State and national commercial claims data acquired from a highly experienced national vendor (Abt, Inc., and its subcontractor Milliman using Milliman's Consolidated Health Cost Guidelines Sources Database). Moreover, Milliman compared the MCDB data to the Maryland data from their national data set (which undergoes substantial vetting) and determined that data were comparable. Staff also notes that the commercial TCOC assessment is not germane to the PRMC rate application, as it has no scaling effect on the Hospital's full rate determination.
3) Absence of a Wage Adjustment - In lieu of a wage adjustment, staff elected to utilize median income, because a hospital wage index adjustment is circular: only hospital wages in a market are considered in the wage index, which then feeds back into hospitals' ability to pay those wages. The circularity is particularly acute in Maryland, where the TCOC Model has undoubtedly affected the wages paid by Maryland hospitals. There is also widespread concern about the Centers for Medicare & Medicaid Services' (CMS's) wage index that was recommended by PRMC. The Institute of Medicine's report summarized the issues as problems with inconsistencies in the definitions of payment areas and labor markets, concerns about the relevance and accuracy of the source data

[20] PRMC Responses to Completeness Questions 9.23.21 (Page 8)

used to determine area wages and other input prices, questions about the occupational mix used to create the hospital wage and physician practice expense adjustments, and lack of transparency in the index construction. Finally, HSCRC staff also believe that median income and wage factors are collinear, and that one cannot be wholly inappropriate but the other wholly appropriate. In testing, HSCRC staff found that substituting broader wage indices (to avoid the circularity of hospital wage indices) for Median Income did not significantly alter the benchmarking results.

4) Regression Coefficients are more Significant for Median Income than Deep Poverty - HSCRC staff believe this argument overlooks the fact that the regression is the second step in a two-step TCOC benchmarking process. The first step is selecting peer jurisdictions that are similar to the Maryland jurisdictions. The selected peer counties are, therefore, already comparable to the Maryland counties, and the second regression step then adjusts for any *remaining* differences. Thus, any perceived differences in scale are actually due to the initial peer group selection, not an underlying flaw in the selected independent variables in the regression that may lead to inequitable treatment of hospitals and their surrounding service areas.

Finally, in an effort to be responsive to industry concerns on the benchmarking methodology, HSCRC staff worked with its contractor to develop an approach to look at variation in TCOC outcomes across 20 different iterations of the benchmarking analysis. Specifically, the different models used alternative metric sets for peer selection and regression, including three different wage measures to both replace and supplement median income. The alternatives all yielded very similar results to the selected approach, especially in terms of rankings.[21] Moreover, in no model did PRMC's attributed TCOC perform better than its benchmark peers, suggesting that in all cases the Hospital would incur a TCOC penalty under the TCOC algorithm that first tests if a hospital is worse than its benchmark before clawing back excess growth.[22] **Thus, staff does not recommend approving PRMC's request to not consider its TCOC performance under the existing TCOC algorithm.**

Full Rate Application Methodology - Adolescent Behavioral Health Program (Revenue Enhancement Consideration)

Staff is supportive of the request to provide additional funding for child and adolescent psychiatric services in Salisbury, MD, as there are no pediatric inpatient services available on the Eastern Shore. Moreover, this request was approved by MHCC through the CON process in

[21] The lowest Spearman correlation between the rankings under the selected approach and the rankings among the 20 alternatives was 0.87, yielding an average absolute change in rank of 2.8 (which was driven by variations in the smallest counties). The Spearman correlation for most alternatives was well over 0.90. In addition, staff did not find any biases against types of counties (such as rural counties or counties in the Baltimore area) when using the selected approach versus the alternative approaches.

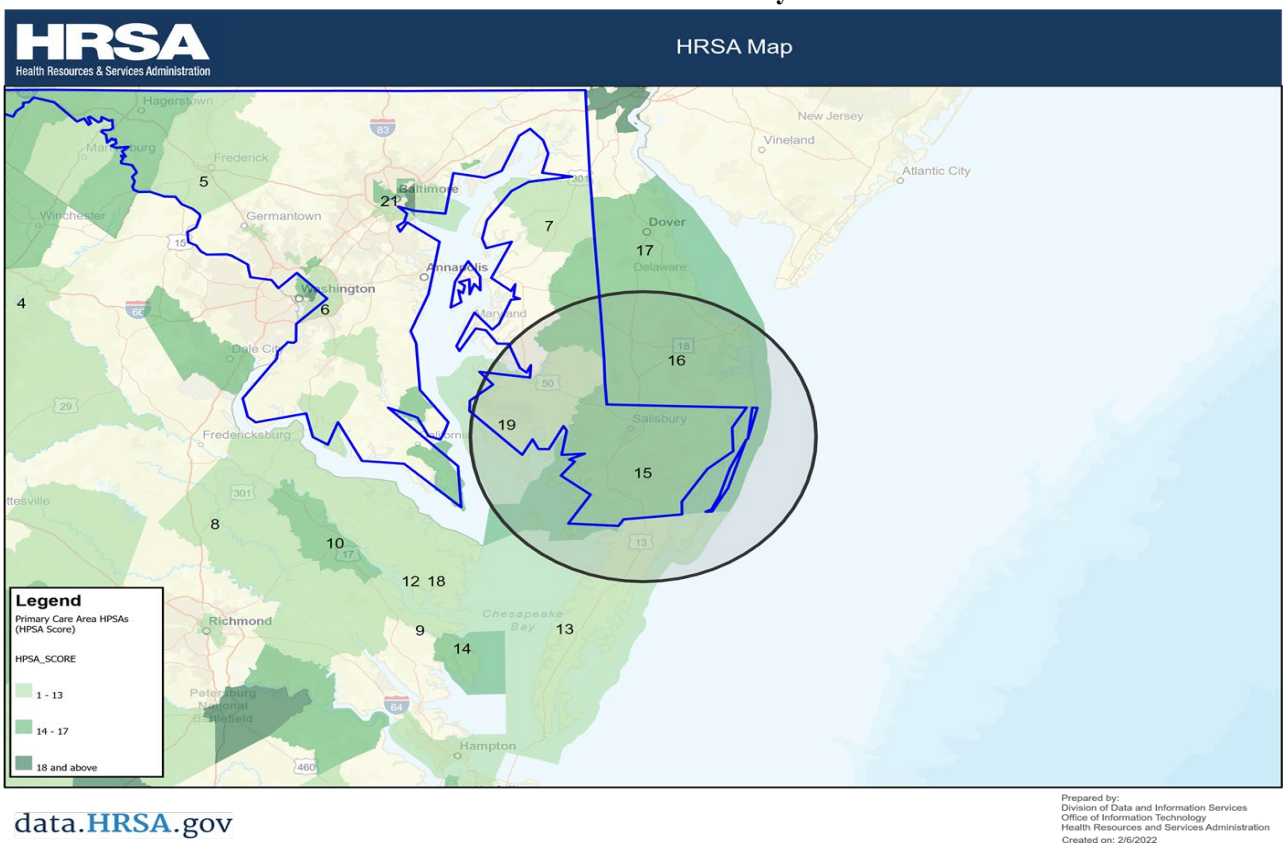
[22] For more information on the HSCRC's validation of its benchmarking methodology, please see: https://hscrc.maryland.gov/Documents/Memo%20on%20Additional%20Benchmarking%20Considerations-2-4-22%20FINAL.pdf

May 2019.[23] Staff would note, however, that in keeping with prior volume policies for new regulated services (e.g., open heart surgery program at Anne Arundel Medical Center), the funding should be limited to a 50 percent variable cost factor. **Thus, staff recommends reducing PRMC's request from $3,249,853 to $1,624,927. The 50 percent variable cost factor will be applied to growth in the adolescent behavioral health program until it reaches maturity in Fiscal Year 2025. All prospective adjustments for volume will be subject to retrospective review and settlement, including an accounting of volume funding received from the market shift methodology. In tandem with the McCready methodology consideration, this modification reduces the baseline revenue write down, as outlined in Exhibit 12, from $19.8 million to $13 million.**

Full Rate Application Methodology - Graduate Medical Education Program (Revenue Enhancement Consideration)

PRMC provides the vast majority of its services in a portion of the State that is considered a primary care health professional shortage area (HPSA), and its out-of-state volume is similarly from a designated HPSA.

Exhibit 12: PRMC Service Area and Primary Care HPSA Scores



[23] https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/2019_decisions/con_peninsula_2417_decision_20190516.pdf

Thus, a priori, it is logical that PRMC would start a residency program to increase its physician supply, especially for primary care physicians (PCP). The specialty mix for the intended residency program, however, is not exclusive to PCP's, as evidenced by Exhibit 13 below, which shows the projected resident count through the first five years of the program and will serve, per PRMC, as the basis for the resident cap in future ICC analyses:

Exhibit 13: Specialty Mix for Intended Residency Program

Specialty	Academic Year 2022 -2023	Academic Year 2023 -2024	Academic Year 2024 - 2025	Academic Year 2025 - 2026	Academic Year 2026 - 2027
Internal Medicine	10	20	30	30	30
General Surgery		3	6	9	12
OBGYN			4	8	12
Psychiatry				4	8
Anesthesiology					3
Total	10	23	40	51	65

Source: PRMC Full Rate Application (Page 56)

Because the specialties identified by PRMC are not exclusive to primary care, HSCRC staff utilized a physician supply analysis that it contracted with Mathematica Policy Research (MPR) to author. The study uses groupings based on literature (Grasreiner 2018, Weiss 2017) that consolidate over 60 medical specialties (and 100 subspecialities) into five medical specialty groups. Following this consolidation, the study then assessed the physician supply of each consolidated specialty by metropolitan statistical area (MSA) in the State versus 20 comparable regions outside of Maryland, as derived from the TCOC benchmarking assessment. The results of that assessment are identified in Exhibit 14 below.

Exhibit 14:Eastern Shore MSA Physicians Per Capita Relative to National Peers

	Total	Primary medical	Nonprimary medical	Surgical	Diagnostic	Psychiatric
Eastern Shore						
Number	880	382	213	173	43	69
Rate per 100,000	148	64	36	29	7	12
Peer MSA ranking	12	11	12	14	14	7

Source: National Plan and Provider Enumeration System, November 2020; U.S. Census, June 2019.; Note: Each region has a total of 20 peer MSAs and the populations of these MSA's are adjusted for differences in health status based on average Medicare HCC scores and HHS platinum risk scores at the MSA level. MSA rankings indicate that region's physician density relative to its 20 peer MSAs; 1 indicates the MSA has the highest density and 21 indicates that the MSA has the lowest density. HCC and HHS platinum risk scores were calculated in the HSCRCs benchmarking process and can be found in the benchmarking materials available on this page: https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx

The Eastern Shore, across all consolidated specialties, does not appear to have a high number of physicians per capita relative to national peers, as in only one case does the Eastern Shore exceed the median of its peers for physician supply (psychiatric physicians ranks 7th). Additional analyses in the study that account for physician productivity and age, among other things, also indicate that the supply in the Eastern Shore is potentially inadequate to address the current level of visits provided in the region, both in the near term and the long term. Thus, HSCRC staff believe that addressing physician supply in the Eastern Shore is important to maintaining access in the region. However, HSCRC staff contend that doing so with a residency program is potentially an inefficient approach that utilizes scarce resources in a fixed revenue system, i.e., the TCOC Model, and GME in Maryland is already heavily invested relative to the rest of the nation.

Staff note that GME is potentially an inefficient approach to addressing physician supply, because residents that complete training do not necessarily stay in the area. AAMC's 2019 State Physician Workforce Data Report notes that only 37 percent of physicians that completed GME in Maryland stayed in Maryland.[24] Moreover, staff's own analysis yields an even lower

[24] https://store.aamc.org/downloadable/download/sample/sample_id/305/ (page 78)

retention rate of 11.9 percent. Staff used data from the Healthcare Cost Reporting Information System (HCRIS) and the Maryland Board of Physicians to assess patterns of medical resident retention in Maryland and across regions within the State. Staff first used the HCRIS data to calculate the average annual number of medical residents who graduated from each of the 19 teaching hospitals in Maryland from 2016 through 2018. Staff then used information from the state's licensure data on where recent medical graduates in Maryland were trained, and where they established their primary medical practice after graduation to determine the number of medical graduates who stay and practice medicine in Maryland each year, and in which regions of the State they practice. Exhibit 15 below shows the findings of this analysis:

Exhibit 15: Average annual number and rate of newly graduating physicians entering workforce in Maryland, by region and specialty

Hospital	MSA cohort	Average number of medical residents in Maryland	Number of residents graduating in Maryland each year	Number of graduating residents practicing in Maryland	In-state retention rate (%)
The Johns Hopkins Hospital	Baltimore Area	911	228	27.7	12.2
University of Maryland Medical System	Baltimore Area	622	155	24.7	15.9
Johns Hopkins Bayview Medical Center	Baltimore Area	164	41	1.7	4.1
Sinai Hospital of Baltimore	Baltimore Area	133	33	2.7	8.0
Medstar Union Memorial Hospital	Baltimore Area	89	22	3.0	13.4
St. Agnes Hospital	Baltimore Area	73	18	1.0	5.5
Medstar Franklin Square Medical Center	Baltimore Area	69	17	2.7	15.4
Greater Baltimore Medical Center	Baltimore Area	58	14	1.7	11.6
Mercy Medical Center	Baltimore Area	50	13	1.3	10.6

UM Prince Georges Hospital Center	Southern Maryland	47	12	1.3	11.3
Maryland General Hospital	Baltimore Area	46	12	0.0	0.0
Medstar Harbor Hospital	Baltimore Area	41	10	1.7	16.4
Good Samaritan Hospital	Baltimore Area	37	9	1.0	10.8
Holy Cross Hospital	Northern DC Suburbs	24	6	0.0	0.0
Kennedy Krieger	Baltimore Area	21	5	1.0	19.2
Sheppard & Enoch Pratt Hospital	Baltimore Area	20	5	1.0	20.1
James Lawrence Kernan Hospital	Baltimore Area	7	2	0.0	0.0
Suburban Hospital	Northern DC Suburbs	6	2	0	0.0
Anne Arundel Medical Center	Eastern Shore	6	2	0	0.0
Total		**2,425**	**606**	**72**	**11.9**

Source: Hospital Cost Reporting Information System, 2016–2018, Maryland Board of Physicians data, accessed in November 2020.

Note: The number of graduated residents practicing in Maryland was defined as the number of physicians who were licensed as of the November 2020 Maryland Board of Physicians roster file who reported graduating from a medical residency program in Maryland from 2015 through 2017. If physicians completed more than one residency, internship, or fellowship, they were counted as Maryland-trained if any of these trainings were in a Maryland-based program.

In response to these statistics, PRMC noted that "...the long-term trends in the retention of graduates appears to be larger than the numbers in recent years. According to the AAMC, Maryland retention rates from 2008-2017 averaged 47.3 percent -- still lower than the nation but substantially higher than the recent-year averages."[25]

[25] PRMC Responses to Completeness Question (Page 12)

While there is merit to PRMC's argument, any policy that aims to address physician supply, especially in a fixed revenue system, should be weighed against other options, most notably loan assistance repayment programs. Staff could not assess the efficacy of the Maryland loan assistance repayment program because the State does not track retention at this time, but staff did find in a 2019 Delaware Health Care Workforce Study that from 2012 to 2019, Delaware made 59 loan repayment awards, of which 34 were provided to physicians, for a total of $2,529,000 ($57 thousand per provider), and 40 of the 43 providers are still working in Delaware, which is a retention rate of 93 percent.[26] Given the performance of the Delaware loan assistance repayment programs and the fact that the retention rate of the state's GME programs ranges from 11.9 percent to 47.3 percent at a cost of $244 thousand per resident (per PRMC's filing), there is a question of whether or not residency programs are the most efficient way to address physician supply.

Finally, staff notes that Maryland has already invested significantly in GME. Based on staff analyses (see exhibit 16 below), Maryland's GME spending per Medicare and Medicare Advantage beneficiary is $35.9 million more than the national experience. Moreover, for the nation to have a similar level of investment in GME, it would need to add 13,508 residents at its current rate of funding for direct and indirect medical education. While Congress is considering a proposal that would provide 14,000 GME slots over seven years,[27] approved legislation in 2020 only approved 1,000 slots over 5 years.[28] **Given Maryland's existing level of GME funding relative to the nation and the State's required savings per the TCOC contract, HSCRC staff recommend Commissioners consider a standard by which additional GME slots could be funded in the State. Specifically, until national funding of GME per Medicare and Medicare Advantage beneficiaries reach levels equivalent to Maryland, no additional funding for new GME slots, including PRMC's request, should be provided in hospital rates.**

[26] https://dhss.delaware.gov/dhss/dhcc/files/hlthcrewrkfrcestudy2019.pdf

[27] https://www.aamc.org/advocacy-policy/washington-highlights/bill-expand-graduate-medical-education-introduced

[28] https://www.cms.gov/newsroom/press-releases/cms-funding-1000-new-residency-slots-hospitals-serving-rural-underserved-communities

Exhibit 16: Maryland GME Funding per Medicare and Medicare Advantage Beneficiary Compared to National Funding

Spend Inputs	Maryland	Algebra	National	Algebra	Source	Link
MD Total and National IME Spending	$515,277,248	A	$10,100,000,000	A	ICC, MedPac June 2021 Report	http://www.medpac.gov/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf
MD Total and National Medicare DME Spending	$250,208,869	B	$3,800,000,000	B	ICC, MedPac June 2021 Report	http://www.medpac.gov/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf
Shares						
MC Share (incl. duals)	31.98%	C		C	Based on RY 2019 Data for Hospitals with Approved Residency Programs	
MA Share	3.60%	D		D		
CO Share	39.93%	E		E		
Medicaid	23.47%	F		F		
Total Including MA	98.98%	G=C+D+E+F		G=C+D+E+F		
Beneficiary Counts						
Medicare (including duals)	909,418	H	37,898,471	H	All from MC National Enrollment Report	https://www.cms.gov/files/document/2019cpsmdcrenrollab2.pdf
Medicare Advantage	127,535	I	22,344,144	I	All from MC National Enrollment Report	https://www.cms.gov/files/document/2019cpsmdcrenrollab2.pdf
Commercial	3,533,400	J		J		
Medicaid	951,400	K		K		
Total	**5,521,753**	L=H+I+J+K	**60,242,615**	L=H+I+J+K		
Spend Calculation						
Medicare	$ 247,325,824	M=(A+B)*C/G	$ 8,744,453,522	M=H/L*(A+B)		
Medicare Advantage	$ 27,844,133	N=(A+B)*D/G	$ 5,155,546,478	N=I/L*(A+B)		
Commericial	$ 308,826,927	O=(A+B)*E/G				
Medicaid	$ 181,489,232	P=(A+B)*F/G				
Total	**$ 765,486,117**	Q=M+N+O+P	**$13,900,000,000**	Q=M+N		
Check	$ -		$ -			
Per Resident 2019						
Residents	2,166	R	90,000	R	Maryland lesser of Schedule P and the Cap (by facility), National from MedPac Report	
Medicare FFS &MA Annual per Resident	$127,041	S=(M+N)/R	$154,444	S=(M+N)/R		
MD as a % of National	82.3%	T=R MD/R Nat'l				
Per Beneficiary						
Medicare FFS & Medicare Advantage	$265	U=(M+N)/(H+I)	$231	U=(M+N)/(H+I)		
MD Medicare & MA as % of National	115%	V=U MD/U Nat'l				
Total MD Excess Spending: Medicare FFS & Medicare Advantage	$35,909,980	W= (U MD - U Natl) * (H+I)				
Resident Projection if National Matched Maryland						
National Medicare Spending at MD Per Bene Rates			$15,986,219,033	X=U MD*L		
Number of Residents Funded at National Rate			103,508	Y=S/X		
Number of Additional National Residents Required to Equal MD's Per Ben Spending			13,508	Z=Y-R		

Summary of Findings

HSCRC staff has reviewed the quality, financial performance, and efficiency of PRMC over the last several years. The Hospital's quality performance is commendable in readmissions, hospital complications, and potentially avoidable utilization with the lone exception that avoidable admissions are in the fourth quintile of State performance. The Hospital has significant room for improvement in the Quality Based Reimbursement program, as it performs in the worst quintile for all assessments with the exception of patient experience, for which it performs in the second quintile. Average total operating margin from Fiscal Years 2014 through 2019, inclusive of unregulated losses, most notably physician subsidies, was 0.6 percent, which is the below the statewide average of 3.03 percent. Staff have determined that this is not a function of volume funding, as volume growth through CY 2019 (Fiscal Year 2019 for CDS-A eligible drugs) was overfunded by $7.4 million. This is also not a function of underfunding of regulated services generally, as regulated margins for Fiscal Year 2014 through 2019 was 11.0 percent, which is above the statewide average 8.23 percent. While the Hospital's total operating profit level is lower than the profits achieved by some other hospitals, the HSCRC evaluates cost efficiency of hospitals, and it does not guarantee hospital profit levels.

As outlined above, PRMC does not qualify for a rate increase under the ICC standard and the Hospital's assessment is further negatively scaled due to poor TCOC performance. In fact, it would receive a revenue decrease under the full rate application standard. See Exhibit 17 for the final full rate determination inclusive of all methodology and revenue enhancement considerations; staff have provided the rate determination with and without the approval of the first year of a residency program due to PRMC's genuine physician supply concerns and because there currently is not a standard or method by which to evaluate additional GME slots.

Exhibit 17: Summary of Components of Final ICC and TCOC Recommended Revenue for Peninsula Regional Medical Center*

FRA Methodology	Current Hospital Revenue Assessed	Revenue Change	FRA Recommend Revenue
ICC Efficiency Tool (Reflective of HSCRC Recommended Methodology Considerations)	$449.3 million	-$12.5 million	$436.8 million
Oncology Drugs	$14.1 million	$0	$14.1 million
TCOC Assessment	NA	-$2.2 million	-$2.2 million
Year 1 Child & Adolescent Behavioral Health Program	NA	$1.6 million	$1.6 million
Total	**$463.3 million**	**- $13 million**	**$450.3 million**
Year 1 GME for 10 Residents**	NA	$2.5 million	$2.5 million
Total with Approved Year 1 GME for 10 Residents	**$463.3 million**	**-$10.6 million**	**$452.7 million**

*Total may not add due to rounding, Values are denoted in Fiscal Year 2020 Dollars

** Approved amount would increase each year until program reached full maturity, which is estimated to be $15.9 million (65 residents X $244 thousand per resident)

Because PRMC has filed a full rate application, staff needs to make a recommendation on the Hospital's approved revenues. **As such, staff recommends adjusting the hospital's rate structure for a $13,043,455 revenue write-down or -2.82 percent, contingent on the Commission's determination that no additional funding should be provided to PRMC for a graduate medical education program. If the Commission elects to approve new residency slots at PRMC, staff recommend implementing a revenue write-down of $10,597,952 million or -2.29 percent to recognize the intended resident count (10) for the first year of the GME program and potentially restore that reduction after 5 years once the program has reached maturity in order to fund an additional 43 residents. In effect, this would allow PRMC to fund 53 residents or 82 percent of its projected program. Should the Commission determine that a new residency program at PRMC be funded through hospital rates, staff recommend that mandatory reviews occur. Specifically, the Hospital must attest to providing the same residency specialty mix as outlined in the full rate application and must provide data on the retention of trained residents within the State of Maryland. If the specialty mix changes by more than 50 percent for any one category or if the retention rate falls below 50 percent, staff would recommend that the Hospital forfeit any funding provided in rates for the GME program.**

Recommendation

HSCRC staff recommends that the Commission:

1) Consider adopting a statewide standard for funding additional residency slots in hospital rates. Specifically, until national funding of graduate medical education per Medicare and Medicare Advantage beneficiaries reach levels equivalent to Maryland, no additional funding for new residency slots should be provided in hospital rates.

2) Staff Recommendation for PRMC Full Rate Application - Implement a revenue write-down of $13,043,455 or -2.82 percent to reflect approval of:

a. PRMC's technical consideration to reduce McCready Hospital's revenue from its ICC evaluation
b. A 50 percent variable cost factor for growth in the adolescent behavioral health program until it reaches maturity in Fiscal Year 2025.
    i. All prospective adjustments for volume will be subject to retrospective review and settlement, including an accounting of volume funding received from the market shift methodology.
c. Establish a standard until national funding of GME per Medicare and Medicare Advantage beneficiaries reach levels equivalent to Maryland; no additional funding for new GME slots, including PRMC's request, should be provided in hospital rates.

Alternative

1) Staff Recommendation for PRMC Full Rate Application with GME **Alternative** - Implement a revenue write-down of $10,597,952 or -2.29 percent to reflect approval of:

a. PRMC's technical consideration to reduce McCready Hospital's revenue from its ICC evaluation
b. A 50 percent variable cost factor for growth in the adolescent behavioral health program until it reaches maturity in Fiscal Year 2025.
    i. All prospective adjustments for volume will be subject to retrospective review and settlement, including an accounting of volume funding received from the market shift methodology.
c. The establishment of a graduate medical education program for which 10 residents will receive credit for direct and indirect medical education in the current ICC evaluation
    i. The Hospital must attest to providing the same residency specialty mix as outlined in the full rate application and must provide data on the retention of trained residents within the State of Maryland. If the

specialty mix changes by more than 50 percent for any one category or if the retention rate falls below 50 percent, staff would recommend that the Hospital forfeit any funding provided in rates for the GME program.

ii. The hospital may be allowed to apply for funding of the GME program each year and finally when the program reaches maturity after the 5th year. The Hospital must attest to providing the same residency specialty mix as outlined in the full rate application and must provide data on the retention of trained residents within the State of Maryland. If the specialty mix changes by more than 50 percent for any one category or if the retention rate falls below 50 percent, staff would recommend that the Hospital not qualify for restoration of any rate support for the GME program.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2400**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2590A**

Staff Recommendation

April 13, 2022

I. INTRODUCTION

On December 17, 2020, the 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") requesting approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular surgery with Quality Health Management. The Hospitals request that the Commission approve the arrangement for one year effective May 1, 2022.

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 System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates 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 payment, 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 the 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 outcome under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular surgery for one year beginning May 1, 2022. The Hospitals must file a renew 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 will formalize the understanding between the Commission and the Hospitals, and will 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, and 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.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2401**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2591A**

Staff Recommendation

April 13, 2022

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on March 28, 2022, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital ("the Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement for Executive Health Services with Under Armor, Inc. for a period of one year beginning May 1, 2022.

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 manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates 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.

IV. IDENTIFICATION ANDASSESSMENT 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 the experience under this arrangement was positive for the last year. Staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Executive Health Services for a one-year period commencing May 1, 2022. The Hospitals will need to file a renewal application for review to be considered 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.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2402**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2592A**

Staff Recommendation

April 13, 2022

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on March 30, 2022 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a revised global rate 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 System requests approval of the arrangement for a period of one year beginning May 1, 2022.

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 manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates 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 ANDASSESSMENT 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 the experience under this arrangement for the last year has been slightly unfavorable. The Hospitals have adjusted the prices in their current arrangement to eliminate the losses. Staff believes that with the revised arrangement the Hospitals can achieve a favorable outcome.

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 Procedures for a one year period commencing May 1, 2022. The Hospitals will need to file a renewal application for review to be considered 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.

TidalHealth Peninsula Regional Full Rate Application – 4.13.2022 Remarks in Response to Staff Recommendation

Steven Leonard, PhD, MBA, FACHE
President/CEO

Overview of TidalHealth Peninsula Regional

- **The most advanced hospital in Delmarva providing tertiary and trauma services in a rural and medically underserved area**
  - Highly Medicare/Medicaid dependent population (70%)
  - Statewide resource for trauma services
  - Regional referral center for tertiary services
    - *Designated primary stroke center*
    - *Open Heart Surgery*
    - *Neurosurgery*
    - *Advanced cancer services*
- **Serves as primary resource for access to physicians in the community by employing more than 300 providers**
  - Key to Total Cost of Care/Population Health Efforts

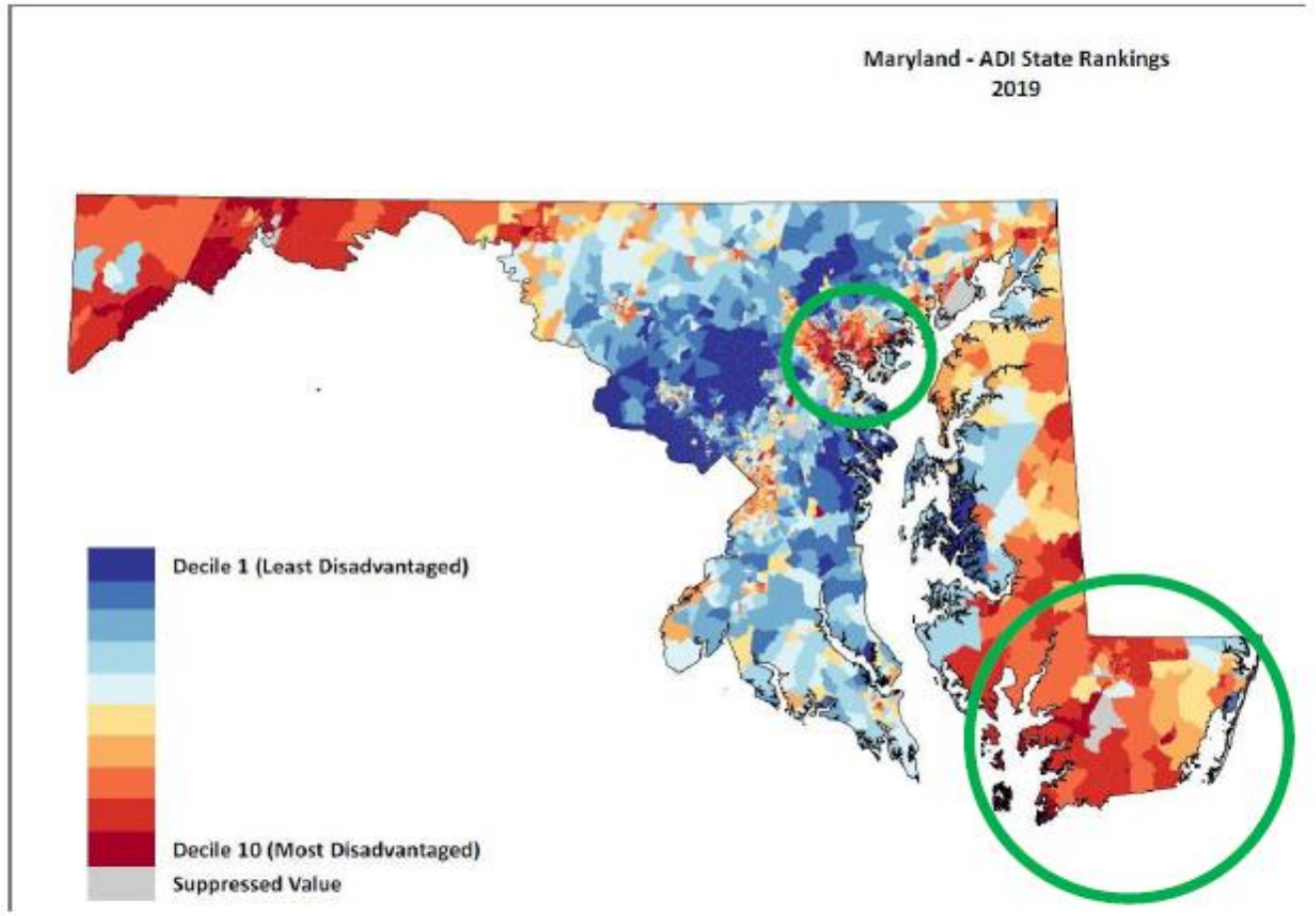
Provides these services at a rate structure that is the 5th lowest in the State.

TidalHealth

TidalHealth Peninsula Regional Serves a Population with Socioeconomic Challenges that Impact Health Outcomes

- Area Deprivation Index (“ADI”) = a multidimensional evaluation of a region's socioeconomic conditions that impact health outcomes

- TidalHealth Peninsula Regional’s ADI is comparable to Baltimore City
  - ***Key Difference*** – Our patients are spread over a broader and rural geographic area, which results in unique challenges

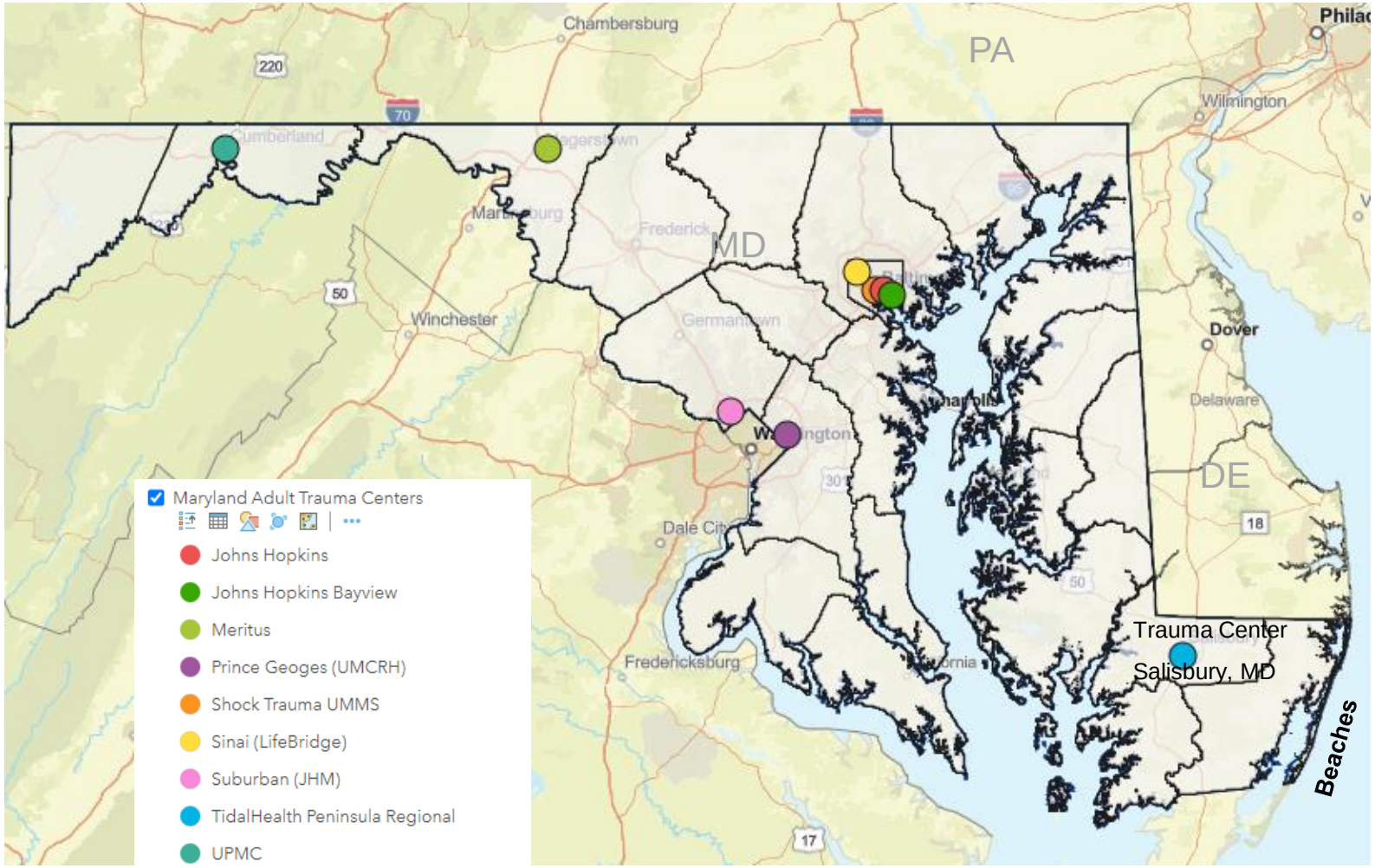


Neighborhood Atlas - Mapping (wisc.edu)

TidalHealth

TidalHealth Peninsula Regional is the only MIEMSS Adult Trauma Center on the Eastern Shore

- Serves the Eastern Shore of Maryland (Region IV)
  - Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester Counties
- Also provides trauma services to Sussex County, DE and Accomack County, VA residents ***and tourists from all over the state of Maryland***

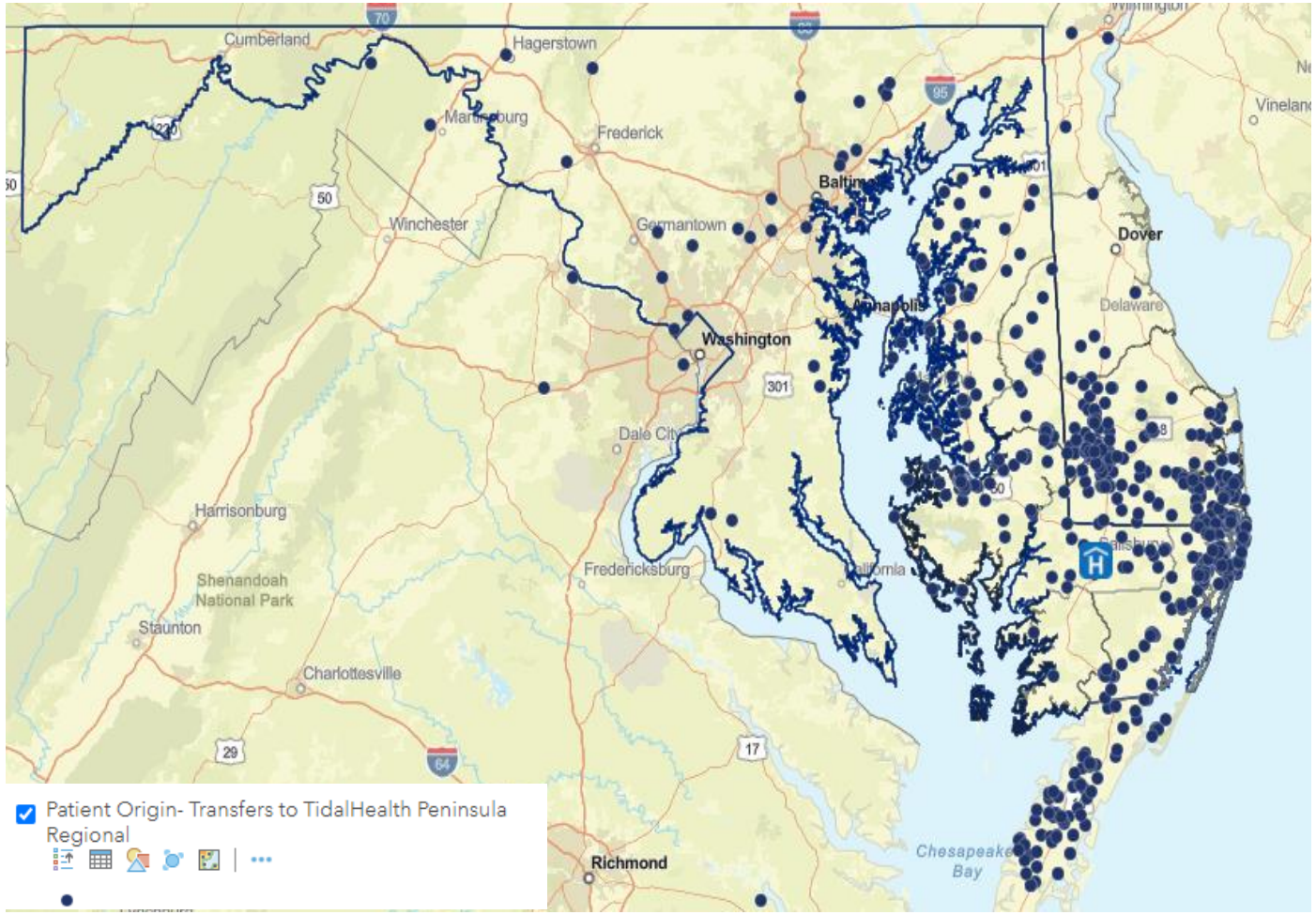


Source: MIEMMS website, ArcGIS Online

TidalHealth

TidalHealth Peninsula Regional also serves as the Regional Referral Center on the Eastern Shore

- Receives over 800 transfers annually from other acute care facilities
  - FY2021 - 839
  - FY2020 - 897
- Inpatient transfers come from Atlantic General, Easton, Dorchester, Shore Memorial, Nanticoke, and other facilities
- Reasons for transfers include:
  - Access to specialized cardiac and stroke care
  - Lack of capability or capacity at other facilities
  - Trauma services
  - Extremes of age and weight
  - Other specialized care



Source: TidalHealth Peninsula Regional BICA report "Thtransfer Center In", Finance

TidalHealth

TidalHealth Peninsula Regional Began Discussions with the HSCRC related to Financial Pressures in 2017

- 1998: Last full rate application
- May 2017: Opened a dialogue with the HSCRC regarding potential rate relief consistent with those raised in the current full rate application
  - ***Rising cost of physicians, trauma and tertiary services coupled with inadequate inflation updates has resulted in financial pressures***
  - Prior to COVID, TidalHealth Peninsula Regional constrained expenses, including market adjustments, to maintain historical margins

TidalHealth Peninsula Regional's Rate Request is not Intended to Address TidalHealth Nanticoke

- January 2020: Nanticoke Acquisition
  - Nanticoke – Financially close to breakeven
  - Expectation – Reduction of cost/improved margins through economies of scale
- Pandemic Impact: Financial challenges for TidalHealth Nanticoke similar to other rural hospitals in the country

Key point: TidalHealth Peninsula Regional's rate application is intended

✓ **to address financial pressures related to TidalHealth Peninsula Regional AND**

X **not to address short-term losses of Nanticoke related to the pandemic**

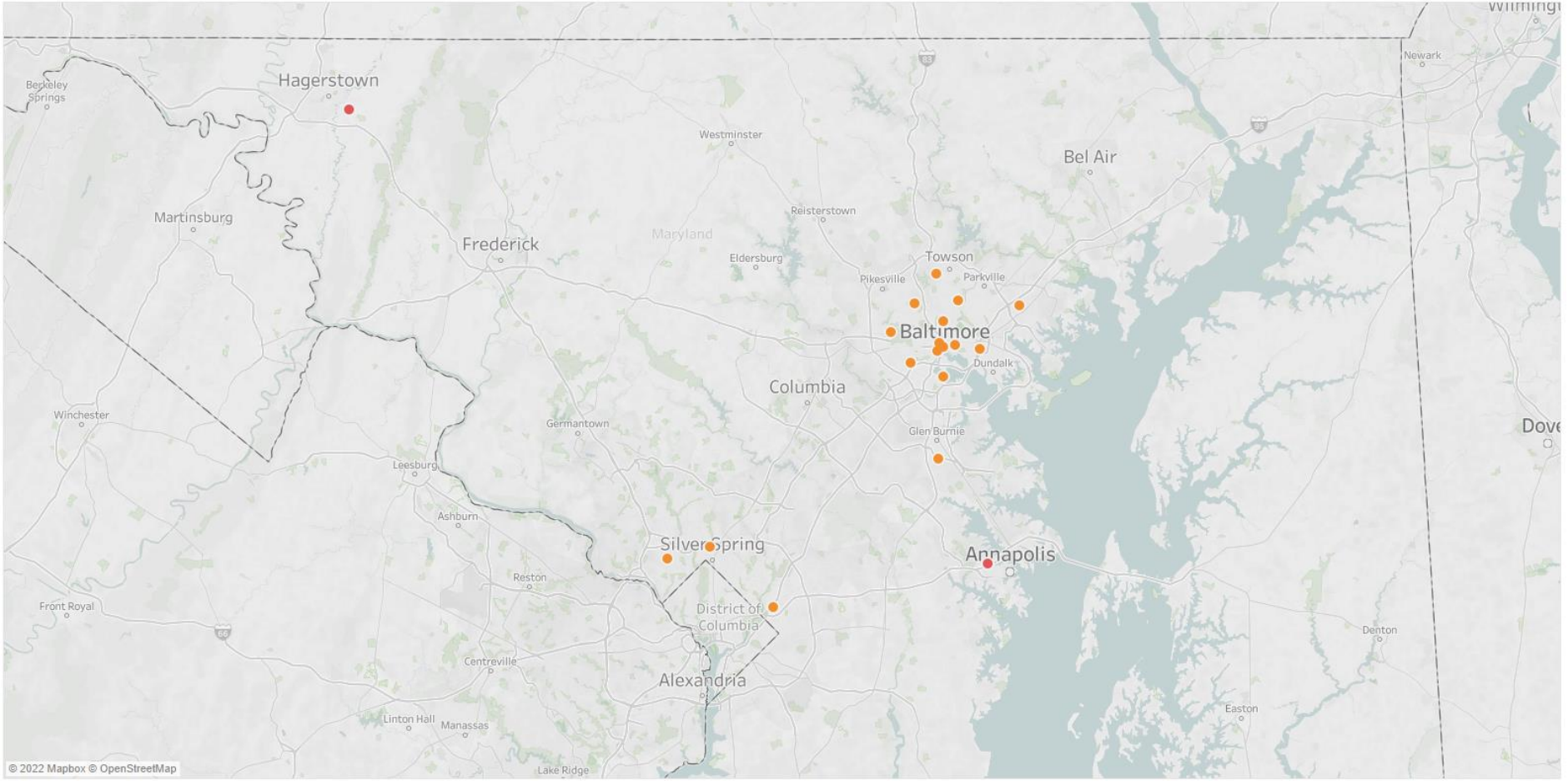
TidalHealth Peninsula Regional's Financial Pressures Remain and are Worsening

- Projecting a significant operating loss in FY2022 and beyond…Why?
  - Cost pressures related to COVID
  - Overdue market adjustments
  - Elimination of COVID-related funding (*e.g.*, CARES Act)
- Margin pressures + decline in days cash on hand = negative outlook on our bond rating
- System operating loss attributable to TidalHealth Peninsula Regional should be considered
  - Important for Population Health/Total Cost of Care initiatives
  - Important for Trauma Program

Existing Residency Programs are Concentrated in the Baltimore Metro Area

- The Eastern Shore ***does not have any*** residency programs
- Benefit to being trained at a hospital that provides trauma and tertiary services in a rural medically underserved area
- Long-term availability of physicians on the Eastern Shore
- Focus on population health/total cost of care

Maryland Hospitals with Residents

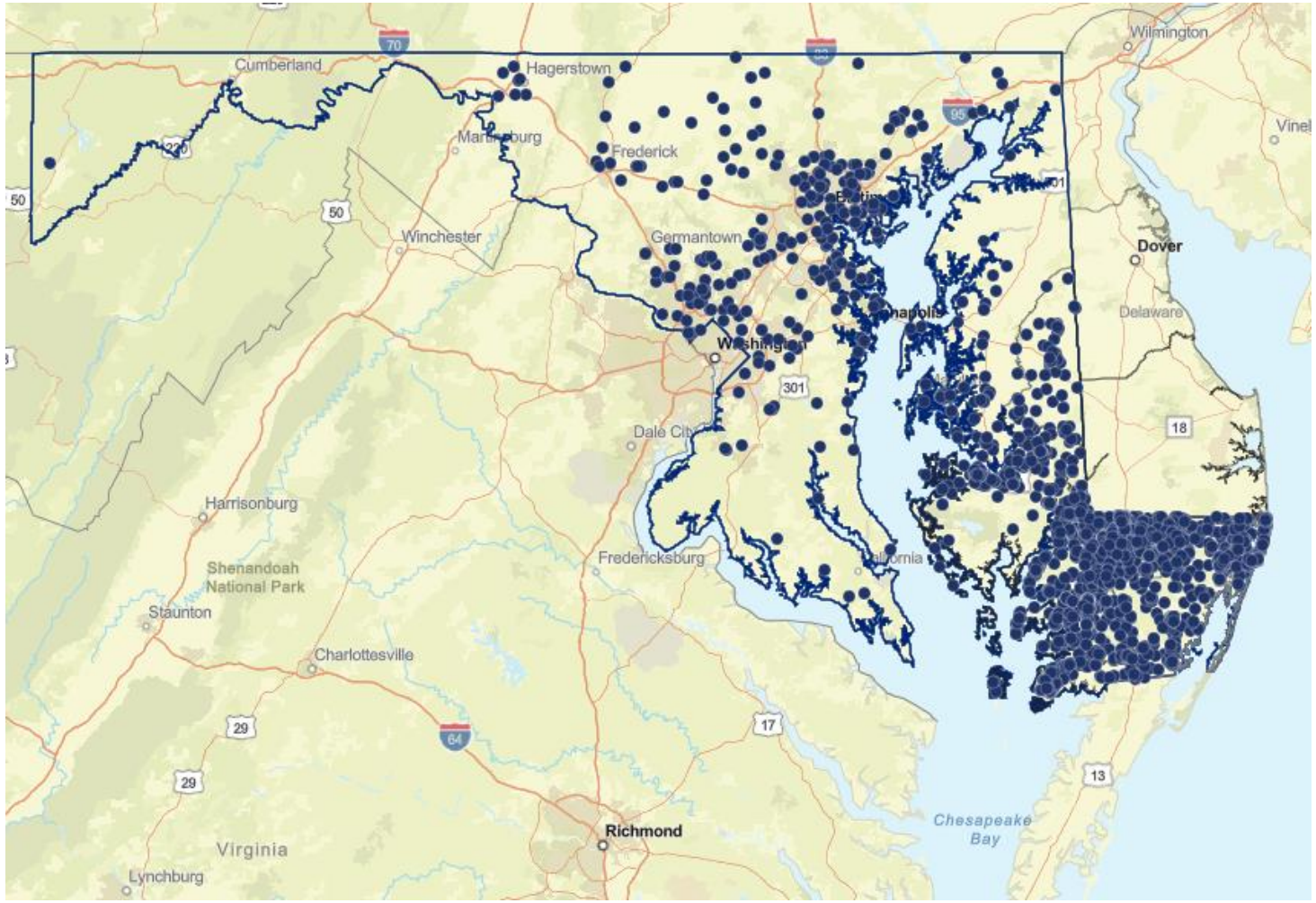


Note: Meritus Medical Center and Luminis Anne Arundel Medical Center (colored in red) have residents but do not receive adjustment in ICC.

TidalHealth

TidalHealth Peninsula Regional's Level III Trauma Center Serves Patients from Across the Entire State

- Second busiest trauma center in Maryland (according to activations)
- Serves ~ 500,000 people year round
- Safety net for 8 million summer visitors
- Like Shock Trauma, we serve the ***entire state of Maryland***
  - Map shows Maryland residents using our Trauma Center
    - ALL counties included over last 4 years



Source: 2018, 2019, 2020 & 2021 Maryland residents utilizing Salisbury Trauma Center

TidalHealth

When time is critical, TidalHealth Peninsula Regional plays a vital role in treating trauma and ER cases on the Eastern Shore

- Air support is not always available (wind, rain, fog, snow, other emergencies, etc.)
- Drive times do not consider traffic, which is high during the summer months
  - **Increases the drive time to possibly > 3 hours from Ocean City, Salisbury, and Crisfield to Baltimore**
- Driving to TidalHealth Peninsula Regional is within the “golden hour,” but Baltimore is not.

	Shock Trauma Baltimore		TidalHealth Peninsula Regional	
Location	Distance	Time	Distance	Time
Ocean City, MD	143 miles	2 hr. 34 min.	30.1 miles	40 min.
Salisbury, MD	115 miles	2 hr. 8 min.	.5 miles	2 min.
Crisfield, MD	152 miles	2 hr. 43 min.	31.7 miles	42 min.
Cambridge, MD	83.7 miles	1 hr. 34 min.	32.3 miles	37 min.
Bethany Beach, DE	126 miles	2 hr. 29 min.	37.5 miles	54 min.

Source: Google Maps

Conclusion

- We are open to continuing to work with the HSCRC staff to develop a resolution but cannot accept the staff recommendation.

- As a **low cost**, **rural**, **tertiary**, **regional referral center** and **trauma center**, the recommended $15 million rate reduction does not address the unique needs of our facility and the Eastern Shore community we serve.

- Thank you for your time.

TidalHealth Peninsula Regional Medical Center Rate Application Recommendation

Hospital Overview

- TidalHealth PRMC is an acute care hospital in Salisbury, Maryland with 266 licensed acute beds and a total approved revenue cap for Fiscal Year 2022 of $516,427,928
  - The only trauma center coverage on the Eastern Shore
  - Pediatric services
  - Open heart surgery program that has the seventh highest number of cardiovascular surgeries in the State (301 in Fiscal Year 2019)
  - A labor and delivery program that produces over 1,900 births annually, and
  - An oncology program, among other specialty programs.

TidalHealth FY19 Payer Mix[1]	
Charity/Self Pay	1%
Commercial/Other	29%
Medicaid	17%
Medicare FFS	49%
Medicare MA	4%

70% Governmental

TidalHealth FY19 Revenue Sources[1]	
Wicomico	49%
Worcester	16%
Somerset	11%
Other in State	4%
Out of State (Del = 13%)	20%

Tri-County Service Area

1. As a % of revenue

Request Overview

- TidalHealth requested an increase to its permanent Global Budget Revenue (GBR) totaling $57.5 million on September 9, 2021 with a requested effective date of September 15, 2021.
- The request consisted of the following:
  - Funding of existing Trauma program expenses --$25.8 million
  - Market adjustment to wages --$16 million
  - Future Medical Education Program (Year 1) --$2.4 million
  - New Adolescent Behavioral Health Program (Year 1) -- $3.2 million
  - 5 percent margin -- $23 million

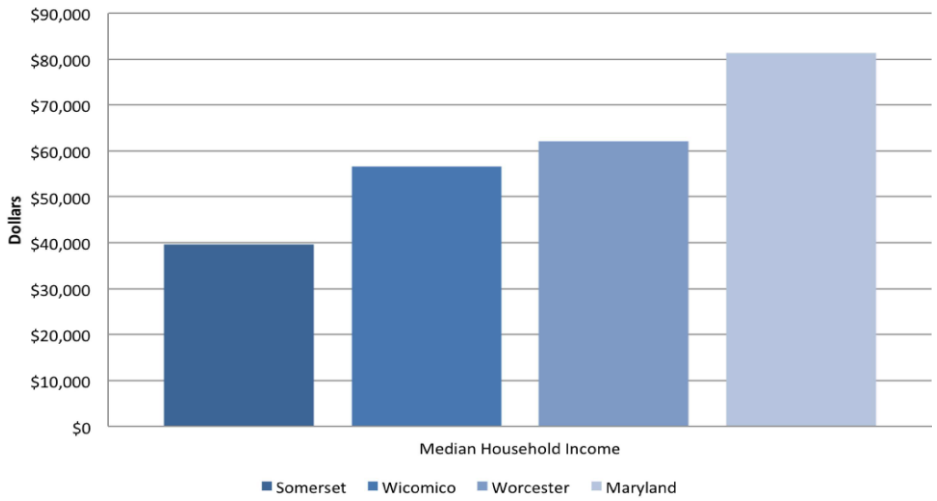
Request increases over time by $13.4 million for expanded GME program and $6.3 million for ramp up of the Behavioral Health Program

- Itemization of costs exceeds the $57.5 million requested because the Hospital started with a revenue write down of $19.8 million in the Full Rate Application Methodology.

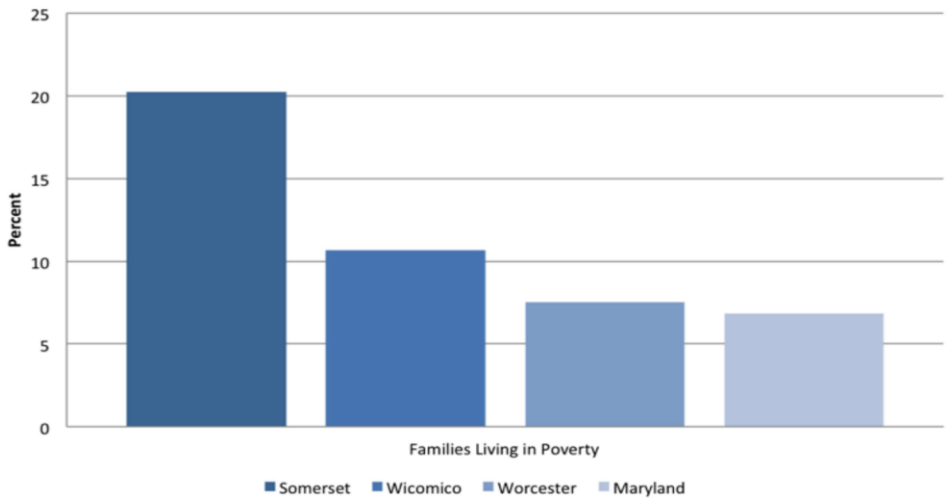
Hospital Service Area Overview

- The magnitude of the rate request and the relatively low incomes statistics in TidalHealth's tri-county area has significant implications on affordability

Tri-county Service Area Median Household Income



Tri-county Service Families Living Below the Poverty Line

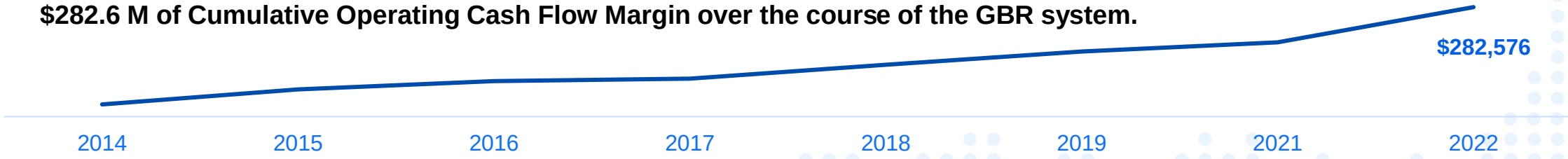


Financial Assessment: Margin Statistics

	Pre-Pandemic 2014 to 2019			2014 to 2021		
Metric $ and %	PRMC	Average Excluding 2017[2]	Statewide	PRMC	Average Excluding 2017[2]	Statewide
Regulated Operating Margin	$40,759	$44,896		$47,433	$51,342	
	11.0%	12.1%	8.2%	12.1%	13.1%	8.4%
Unregulated Operating Margin	($38,517)	($38,105)		($38,582)	($38,296)	
	-95.2%	-94.4%	-45.0%	-88.4%	-86.8%	-43.7%
Total Operating Margin	$2,242	$6,791		$8,852	$13,045	
	0.6%	1.7%	3.0%	1.9%	2.9%	3.0%
Total Operating Cashflow Margin[1]	$28,010	$32,429		$35,322	$39,523	
	6.8%	7.9%	8.6%	8.0%	9.0%	8.5%

- PRMC's regulated margin is well above state average while their Total Operating Margin and Total Operating Cash Flow Margin are very similar to State average. TidalHealth PRMC receives significantly greater than average subsidies for their unregulated businesses.
- All statistics reflect operating margins; TidalHealth PRMC also earned substantial **income from their investment portfolio, which equated to an average of $30 million per year** over the last ten years, which is not included above.
- Additionally, not included is TidalHealth's recent acquisition of Delaware's Nanticoke Memorial Hospital and Nanticoke Physician Network in January 2020; per reference to a pro-forma budget presentation by TidalHealth, these entities will incur a $27.2 million loss in RY 2022

$282.6 M of Cumulative Operating Cash Flow Margin over the course of the GBR system.



1. Total cash flow operating margin equals Total Operating Margin plus Depreciation and Amortization
2. Fiscal Year 2017 was anomalous due to the installation of EPIC (approximately $18.5 million in incremental operating expenses)

Financial Assessment: Fiscal Year 2019 Statewide Cash Balance

Rank	System	2019 Cash and Investments (1)	Days Cash On hand (2)
1	Calvert Health System, Inc.	127,015,447	372
2	Tidal Health, Inc.	398,611,000	338
3	Johns Hopkins Health System Corporation	4,364,733,000	247
4	Lifebridge Health, Inc.	984,178,000	245
5	Meritus Medical Center, Inc.	250,752,000	242
6	GBMC healthcare, Inc.	362,182,000	239
7	Holy Cross Health, Inc., Maryland	320,885,000	237
8	Garrett Regional Medical Center	33,801,657	226
9	Anne Arundel Health System, Inc.	416,417,000	211
10	Western Maryland Health System Corporation	174,002,000	209
11	Frederick Regional Health System, Inc.	216,187,000	197
12	Mercy Health Services, Inc.	336,321,000	173
13	Medstar Health, Inc.	2,128,100,000	146
14	University of Maryland Medical System Corporation	1,386,647,000	129
15	Adventist HealthCare, Inc. (1)	238,552,825	114
16	The Union Hospital of Cecil County	47,175,983	114
17	Doctors Community Hospital	57,047,544	90
18	Atlantic General Hospital Corporation	21,089,196	60

Reflects 2019 balances consistent with most data used in assessing PRMC rate application. Cash and investments are evaluated at a hospital system level (Tidal Health for PRMC) as they are typically held by the system rather than the regulated hospital.

Statewide cash balances have increased since FY 2019 by approximately $2.5 B (excluding Medicare advances), PRMC cash and investments increased to $590 million as of 6/30/2021

(1) Reflects unrestricted and board restricted cash and investments held as of June 30, 2019, except for Adventist which is as 12/31/2018. Excludes hospitals owned by systems whose primary operations were outside Maryland in FY19

(2) Days cash on hand is a measure of how long an institution could pay its expenses, at historic levels, if it did not receive a single dollar of revenue.

Baseline Full Rate Application Methodology

- TidalHealth PRMC's baseline full rate application results in a $19.8 million write-down because, while the costs per ECMAD are 12 percent lower than the peer group average, the hospital had the ninth highest regulated margin in Fiscal Year 2019 among ICC evaluated facilities (13.81 percent vs an average of 9.88 percent).

Baseline Full Rate Application Methodology

FRA Methodology	Hospital Revenue Assessed	Revenue Change	FRA Recommend Revenue
ICC Efficiency Tool	$454.5 million	-$17.6 million	$436.9 million
Oncology Drugs	$14.1 million	-$0	$14.1 million
TCOC Assessment	NA	-$2.2 million	-$2.2 million
Total	$468.6 million	-$19.8 million	$448.8 million

TidalHealth Proposed Phase II Methodology and Revenue Enhancements

	Methodology Considerations		Revenue Enhancements		
TidalHealth Request	Remove $16.7M of McCready associated revenue from ICC	Remove TCOC Assessment from Full Rate Application because of concerns over benchmarking	Provide $3.2M to fund year 1 expenses for a new psychiatric service line	Provide $16M to provide market adjustments to maintain competitive wages.	Provide $23M to generate a 5% total operating margin in order to support population health initiatives
Staff Recommendation	**Staff recommends removing $11.9M**	**Staff recommends denying this request**	**Staff recommends funding $1.6M**	**Staff recommends denying this request**	**Staff recommends denying this request**

Additional Phase II Consideration: Trauma Allowance

- In recognition of "...the social costs of meeting the state's requirements for providing Level III Trauma care," PRMC requests that a direct cost strip of $25.8 million ($25.5 million attributable to unregulated physician subsidies and on-call pay) be removed from PRMC's cost per case assessment and then passed through the ICC without qualification[1].
  - HSCRC does not have jurisdiction over physician services per statute; 93 percent of costs put forward by PRMC as "Trauma Fixed Costs" are unregulated physician subsidies
  - Per PRMC completeness responses, not all of the $25.8 M is specific to Trauma and in fact covers subsidies for physicians separate from Trauma Services
  - Staff has no basis for determining if subsidies are reasonable or similar to those at other facilities
  - Staff have previously demonstrated that there was no statistically significant relationship between ICC performance and trauma coverage
  - Similar arguments could be made for many service lines' unregulated costs to be considered a social good, e.g., labor and delivery, open heart surgery, pediatric oncology, etc.

HSCRC staff do not recommend approving the trauma methodology consideration put forward by PRMC.

1. The Hospital also recognizes that a similar cost strip should be provided to the state's other trauma centers, but in the absence of physician contracts for each trauma center, it suggests the cost strip should be equal to the percentage of the PRMC cost strip relative to its total permanent revenue (6 percent)

Additional Phase II Consideration: GME Allowance

- PRMC is establishing a graduate medical education (GME) program and seeks direct and indirect medical education ($244 thousand per resident per year) for 10 residents in year 1 ($2.4 million).
  - PRMC also notes that it anticipates to expand its GME program to a forecasted resident population of 65 and would ask that it receive the same credit of $244 thousand per resident per year ($15.9 million) in line with the national Medicare policy on funding new GME programs
  - 30 of the residents would be primary care with the remainder in general surgery, OBGYN, anesthesiology, psychiatry (see appendix D for detail).

- Staff acknowledge that the Eastern Shore has physician supply issues, as evidenced by its HPSA designation and comparison to national peer regions, but there are concerns about funding GME to resolve physician deficits.

Additional Phase II Consideration: GME Allowance cont.

- GME is potentially an inefficient approach to addressing physician supply, because residents that complete training do not necessarily stay in the area.
- Other alternatives to address physician supply are potentially more cost efficient and effective (e.g. loan repayment).
- Maryland already heavily invests in GME, compared to Medicare nationally, and future investments will generate TCOC dissavings. Staff analyses indicate that for the nation to have a similar level of investment in GME, it would need to add 13,508 residents at its current rate of funding for direct and indirect medical education.

Staff recommend Commissioners consider a standard whereby there be no additional funding for GME slots, including PRMC, in the State only until national funding of GME per Medicare and Medicare Advantage beneficiaries reach levels equivalent to Maryland.

Staff Recommended Full Rate Application Methodology

FRA Methodology	Current Hospital Revenue Assessed	Revenue Change	FRA Recommend Revenue
ICC Efficiency Tool (Reflective of HSCRC Recommended Methodology Considerations)	$449.3 million	-$12.5 million	$436.8 million
Oncology Drugs	$14.1 million	$0	$14.1 million
TCOC Assessment	NA	-$2.2 million	-$2.2 million
Year 1 Child & Adolescent Behavioral Health Program	NA	$1.6 million	$1.6 million
Total	**$463.3 million**	**- $13 million**	**$450.3 million**
Year 1 GME for 10 Residents**	NA	$2.5 million	$2.5 million
Total with Approved Year 1 GME for 10 Residents	**$463.3 million**	**-$10.6 million**	**$452.7 million**

The final staff recommendation for TidalHealth PRMC is a revenue write down of $13 million

- Staff also modelled approval of the first year GME program, which would result in a revenue write down of $10.6 million

**Funding of GME is contingent upon Commission approval in recommendation

Staff Recommendation

Staff Recommendation

1) Consider adopting a statewide standard for funding additional residency slots in hospital rates. Specifically, until national funding of graduate medical education per Medicare and Medicare Advantage beneficiaries reach levels equivalent to Maryland, no additional funding for new residency slots should be provided in hospital rates.

2) Staff Recommendation for PRMC Full Rate Application - Implement a revenue write-down of $13,043,455 or -2.82 percent to reflect approval of:

A. PRMC's technical consideration to reduce McCready Hospital's revenue from its ICC evaluation

B. 50 percent variable cost factor for growth in the adolescent behavioral health program until it reaches maturity in Fiscal Year 2025.

i. All prospective adjustments for volume will be subject to retrospective review and settlement, including an accounting of volume funding received from the market shift methodology.

C. Establish a standard until national funding of GME per Medicare and Medicare Advantage beneficiaries reach levels equivalent to Maryland; no additional funding for new GME slots including PRMC's request, should be provided in hospital rates.

Alternate Staff Recommendation

1) Staff Recommendation for PRMC Full Rate Application with GME Alternative - Implement a revenue write-down of $10,597,952 or -2.29 percent to reflect approval of: (Same as staff recommendation except:)

C. The establishment of a graduate medical education program for which 10 residents will receive credit for direct and indirect medical education in the current ICC evaluation

i. The Hospital must attest to providing the same residency specialty mix as outlined in the full rate application and must provide data on the retention of trained residents within the State of Maryland. If the specialty mix changes by more than 50 percent for any one category or if the retention rate falls below 50 percent, staff would recommend that the Hospital forfeit any funding provided in rates for the GME program.

ii. The Hospital may be allowed to apply for funding of the GME program each year and finally when the program reaches maturity after the 5th year. The Hospital must attest to providing the same residency specialty mix as outlined in the full rate application and must provide data on the retention of trained residents within the State of Maryland. If the specialty mix changes by more than 50 percent for any one category or if the retention rate falls below 50 percent, staff would recommend that the Hospital not qualify for restoration of any rate support for the GME program.

Appendix: Additional Exhibits

A: Volume Funding Efficiency
B: Quality Performance
C: Potentially Avoidable Utilization Performance
D: PRMC Proposed Resident Slots

Appendix A: Volume Funding Efficacy

	Funding	Expected Funding[1]	Net Over (Under) Funding
Market Shift (through RY 2021 adjustments)	-$0.2 million		
Demographic Adjustment (through RY 2020 adjustment)	$8.8 million		
Medicaid Expansion	$1.5 million		
Total In-State Volume (excl CDS-A eligible drugs)	$10.1 million	$3.5 million	$6.6 million
Out-of-State Adjustment (excl Drug Rate Center)	$0	$.5 million	-$.5 million
CDS-A Adjustment[2]	$4.2 million	$2.8 million	$1.3 million
Total Volume[3]	$14.3 million	$6.9 million	$7.4 million

1. 50% Variable Cost Factor or Average Sales Price for CDS-A Drugs
2. The CDS-A assessment does not account for savings related to PRMC converting to a 340b hospital, as all Maryland hospitals have been allowed to retain revenue associated with the conversion. If the savings are accounted for, PRMC has been overfunded for CDS-A drug costs by $10.9 million.
3. Volume assessment does not account for inflationary reductions to potentially avoidable utilization, which through Calendar Year 2019, Fiscal Year 2020 amount to $8.4 million, nor does it account for additional revenue provided through infrastructure funding, which in Fiscal Year 2020 dollars amounted to $4.9 million.

Appendix B: Qualify Performance

Quality Program	Metric	Hospital Performance	State Quintile	State Average
MHAC	PPC Percent Change (FY18-CY19)	-48.32%	1	-29.87%
	PPC Case-Mix Adjusted Rate CY19	0.45	5	0.93
RRIP	Readmission Percent Change (CY16-CY19)	-12.32%	2	-4.59%
	Readmission Case-Mix Adjusted Rate CY19 w Out-of-State Adj.	10.18%	1	11.22%
QBR	Patient Experience Domain	25.45%	2	23.00%
	Mortality Domain	10.00%	5	49.07%
	Safety Domain	16.00%	5	38.70%
	Total Score	24.33%	5	33.27%

Appendix C: Potentially Avoidable Utilization Performance

Metric	Hospital Performance	State Quintile	Unweighted State Average
PAU Revenue as a Percent of Eligible Revenue CY19	16.59%	2	17.17%
Readmission Percent Change (CY16-CY19)	-12.32%	2	-4.59%
Readmission Case-Mix Adjusted Rate CY19 w Out-of-State Adj.	10.18%	1	11.22%
PQI rate per 1000 adults for Hospital's Geography	15.61	4	14.45
PQI rate per 1000 adults for Hospital's Geography Percent Change (CY13-CY19)*	-1.1%	3	-0.03%

Appendix D: PRMC Proposed Resident Slots

Specialty	Academic Year 2022 -2023	Academic Year 2023 -2024	Academic Year 2024 -2025	Academic Year 2025 -2026	Academic Year 2026 -2027
Internal Medicine	10	20	30	30	30
General Surgery		3	6	9	12
OBGYN			4	8	12
Psychiatry				4	8
Anesthesiology					3
Total	10	23	40	51	65

maryland
health services
cost review commission

Report Extending the Readmission Reduction Incentive Program for Rate Year 2024

April 13, 2022

Final RY 2023 & 2024 RRIP Recommendations

1. Maintain the 30-day, all-cause readmission measure.
2. **Improvement Target** - Maintain the RY 2022 statewide 5-year improvement target of -7.5 percent from 2018
3. **Attainment Target -** Maintain the attainment target whereby hospitals at or better than the 65th percentile statewide performance receive scaled rewards for low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in **within-hospital readmission disparities**. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years, capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
6. Continue development of an all-payer **Excess Days in Acute Care** measure in order to account for readmission, emergency department, and observation revisits post-discharge.
7. Adjust the RRIP pay-for-performance program methodology as needed due to **COVID-19 Public Health Emergency** and report to Commissioners.

maryland
health services
cost review commission

Draft Hospital Payment Plan Guidelines

4/13/22

Draft Hospital Payment Plan Guidelines

- **Legal Requirement:** A 2021 law to increase hospital-based medical debt consumer protections required HSCRC to develop guidelines for income-based payment plans offered by hospitals.
- **Process for guidelines development**
  - Staff from HSCRC and the Office of the Commissioner of Financial Regulation (OCFR) worked together to develop a first draft of the guidelines.
  - HSCRC convened a workgroup, in accordance with the law, that met three times to review and discuss the guidelines.
  - HSCRC staff incorporated feedback received from stakeholders into the draft presented today.

Draft Hospital Payment Plan Guidelines (continued)

- **Content:** These guidelines address a number of topics related to hospital payment plans, including:
  - notice requirements,
  - monthly payment amounts may not exceed 5% of a patient's income;
  - duration of payment plans,
  - a cap on interest rates,
  - treatment of prepayments, missed payments, and late payments, and
  - modifications of payment plans.
- **Other Medical Debt bill documents:** Staff plan to present updates to regulations to Commissioners in May, develop an FAQ document with OCFR, and update Special Audit Procedures to align with the law.

maryland
health services
cost review commission

Update on Medicare FFS Data & Analysis

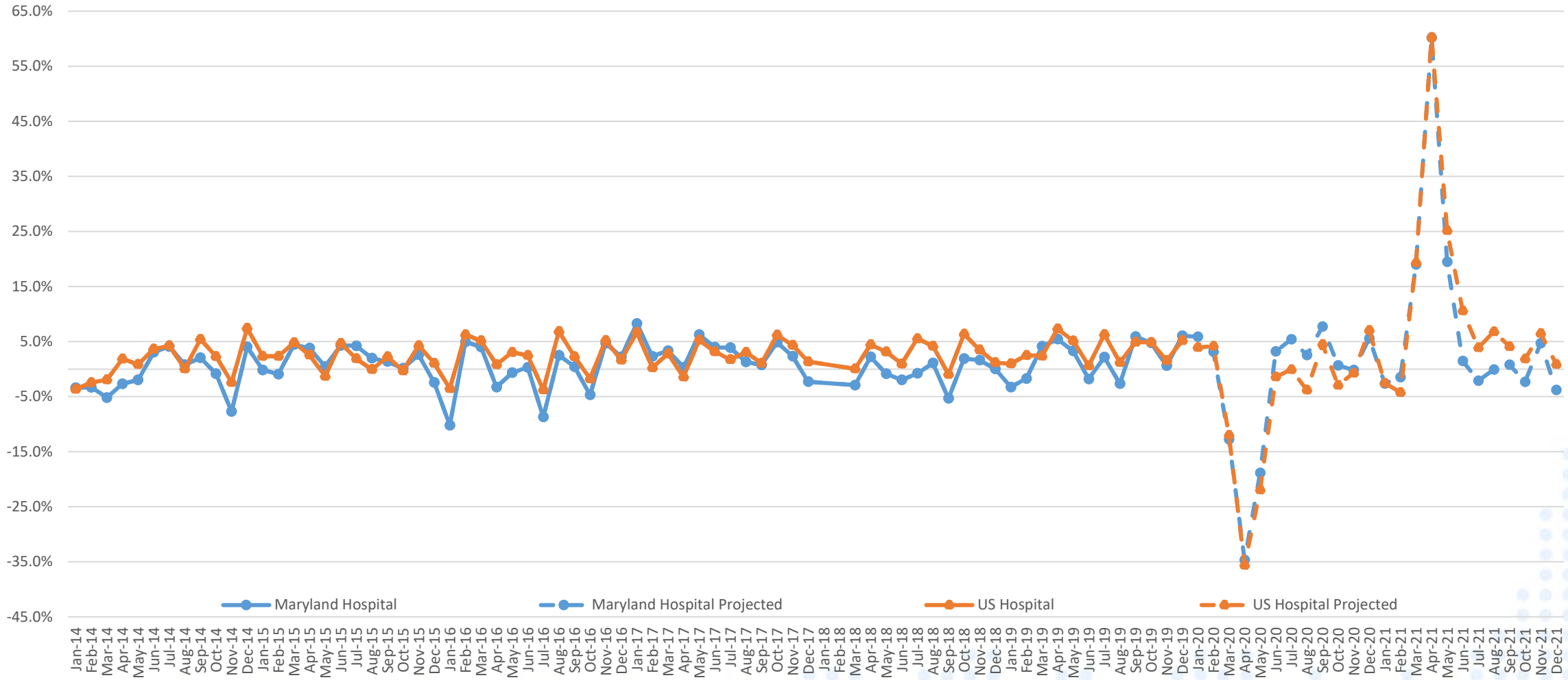
March 2022 Update

Data through December 2021, Claims paid through February 22

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital Spending per Capita

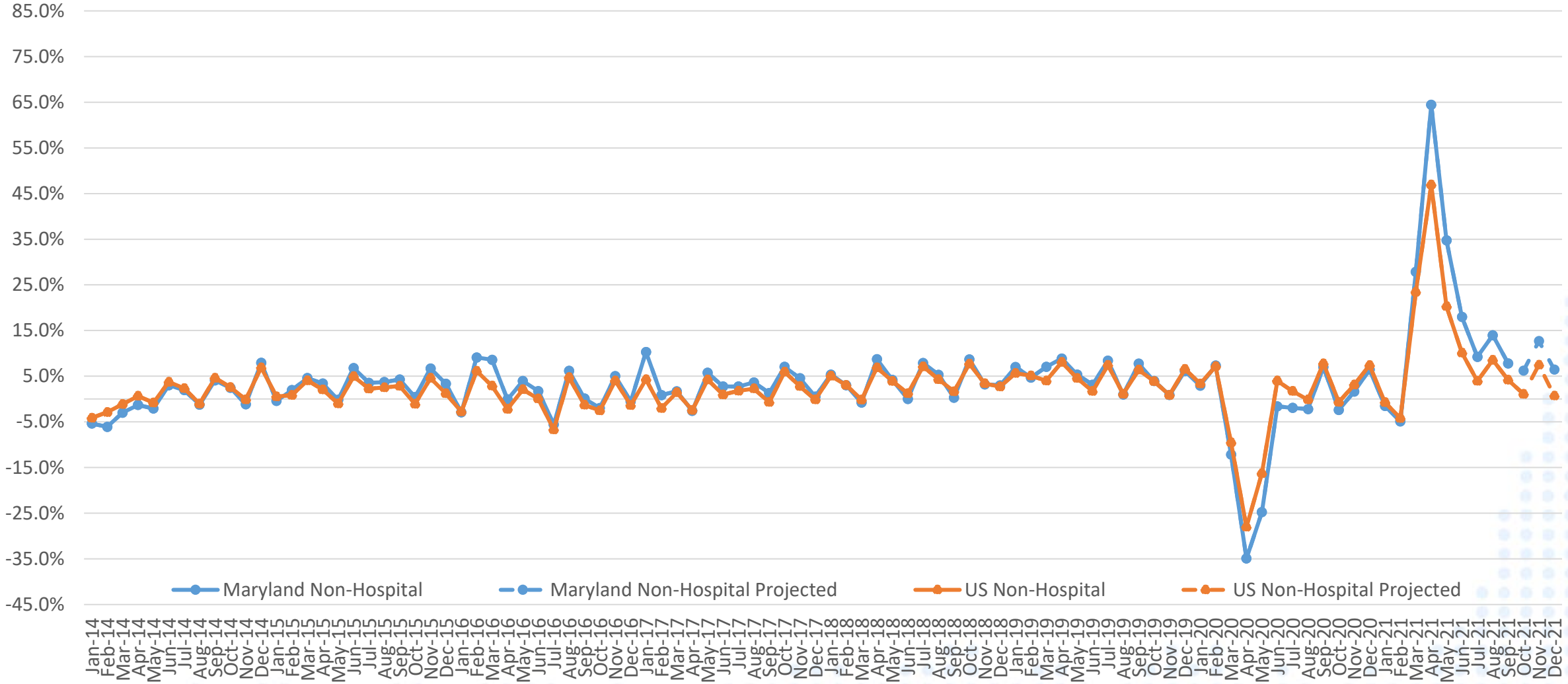
Actual Growth Trend (CY month vs. Prior CY month)



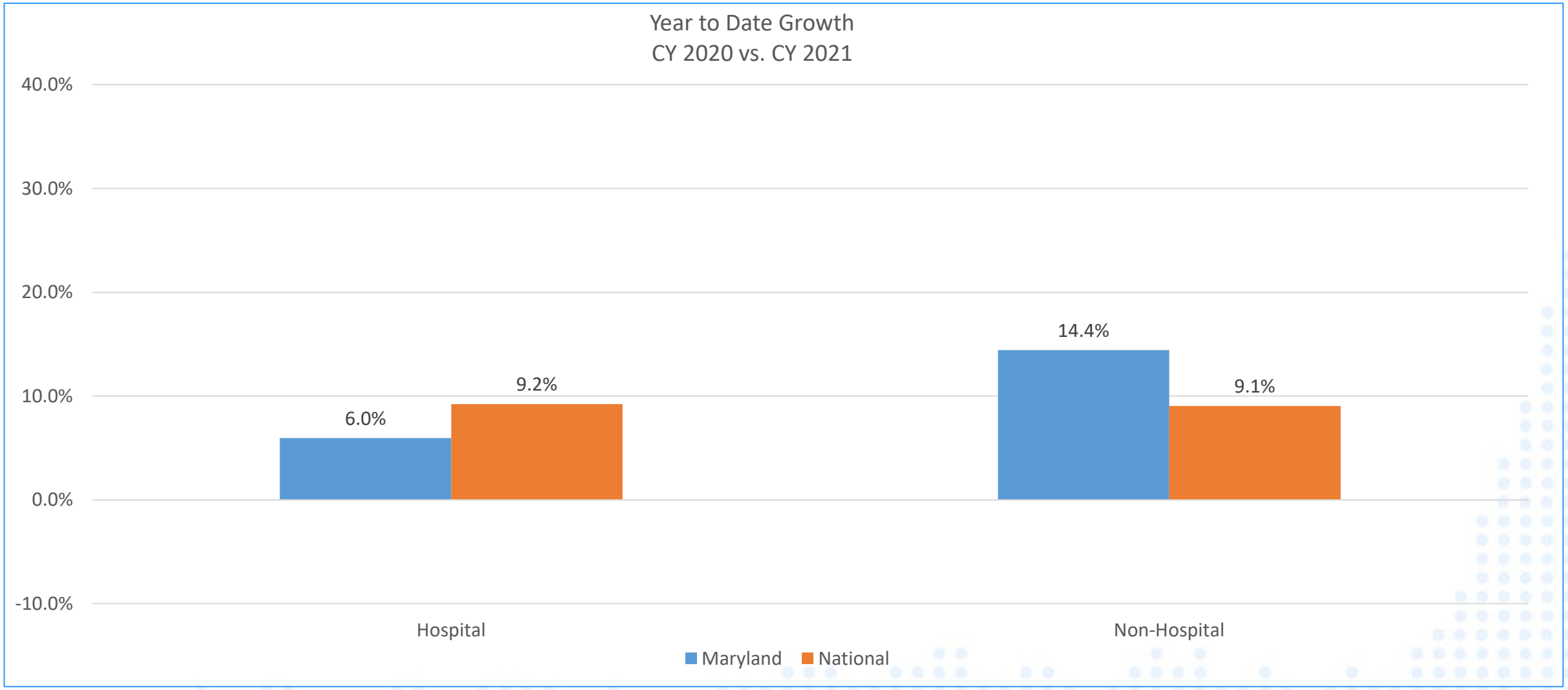
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)

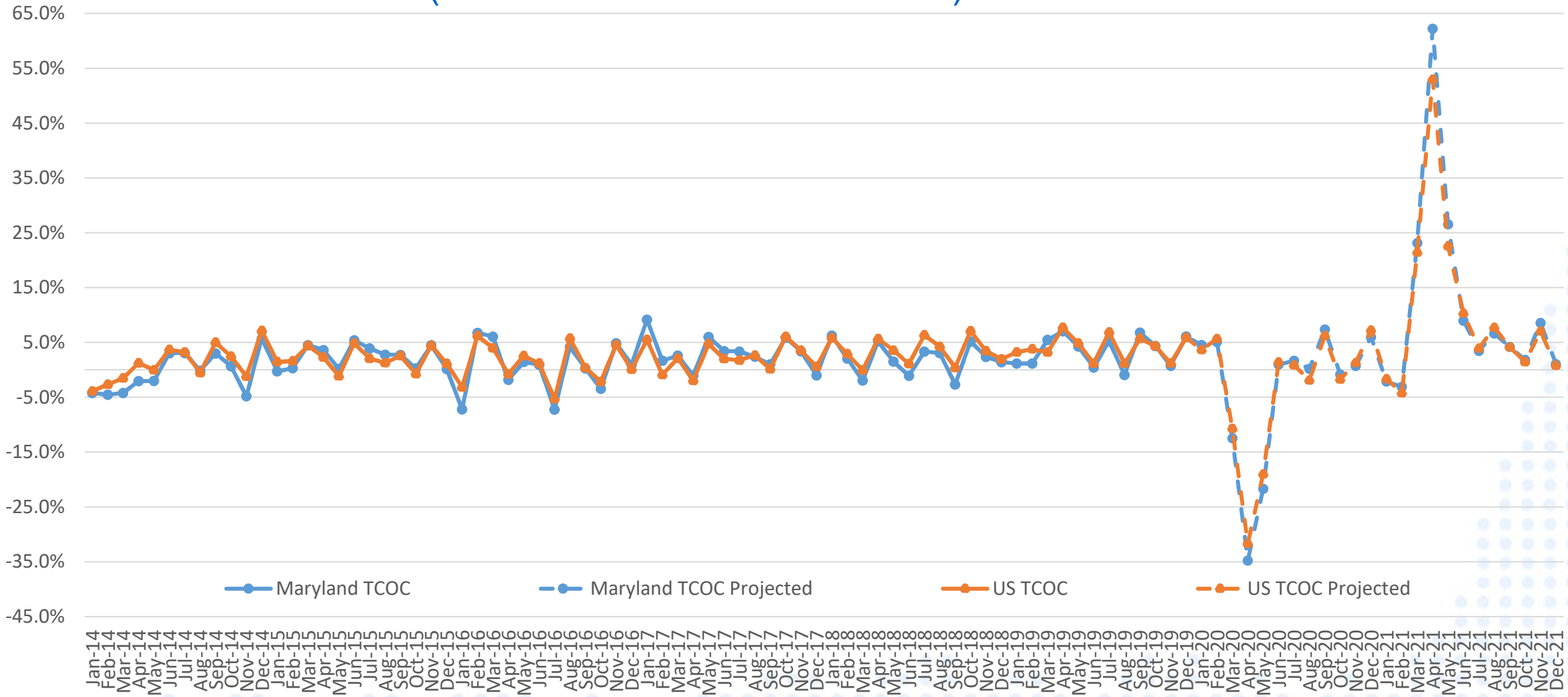


Medicare Hospital & Non-Hospital Payments per Capita



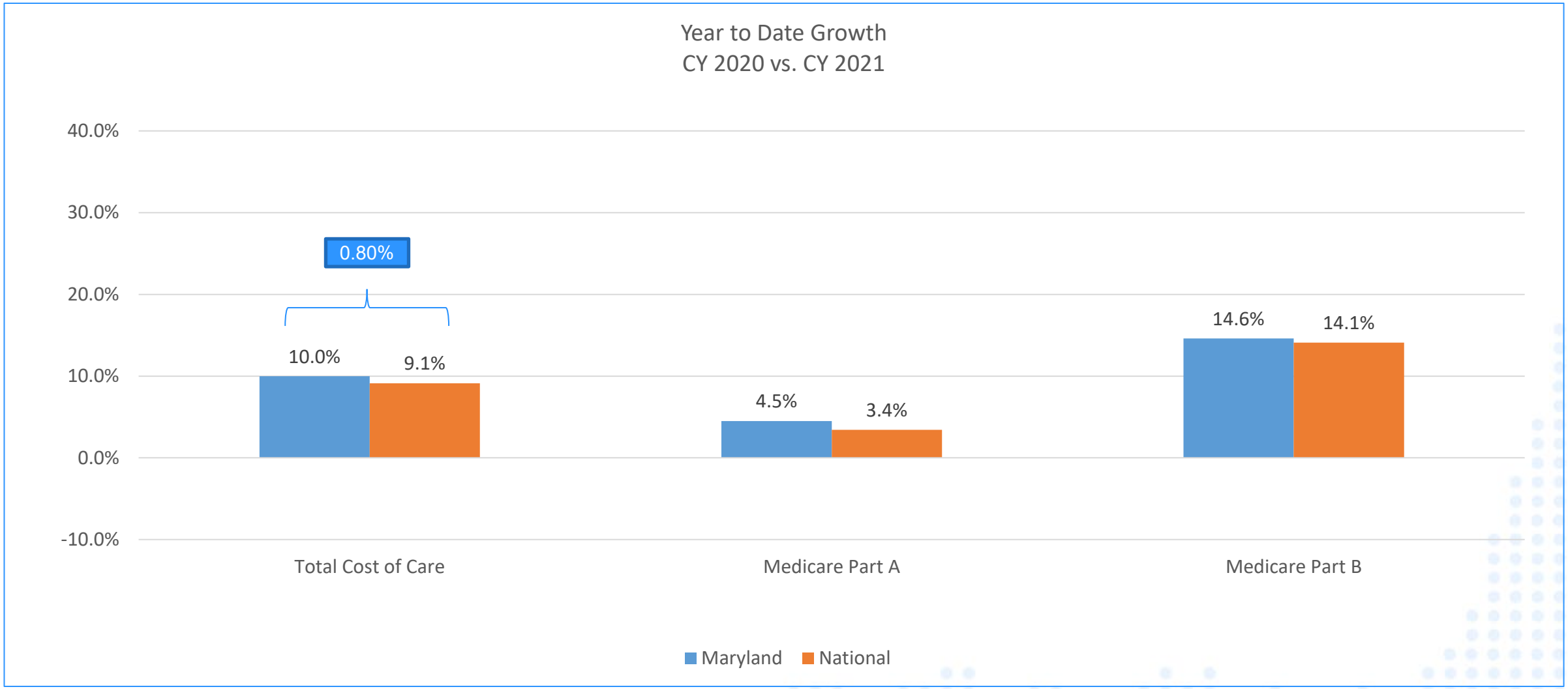
Medicare Total Cost of Care Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)



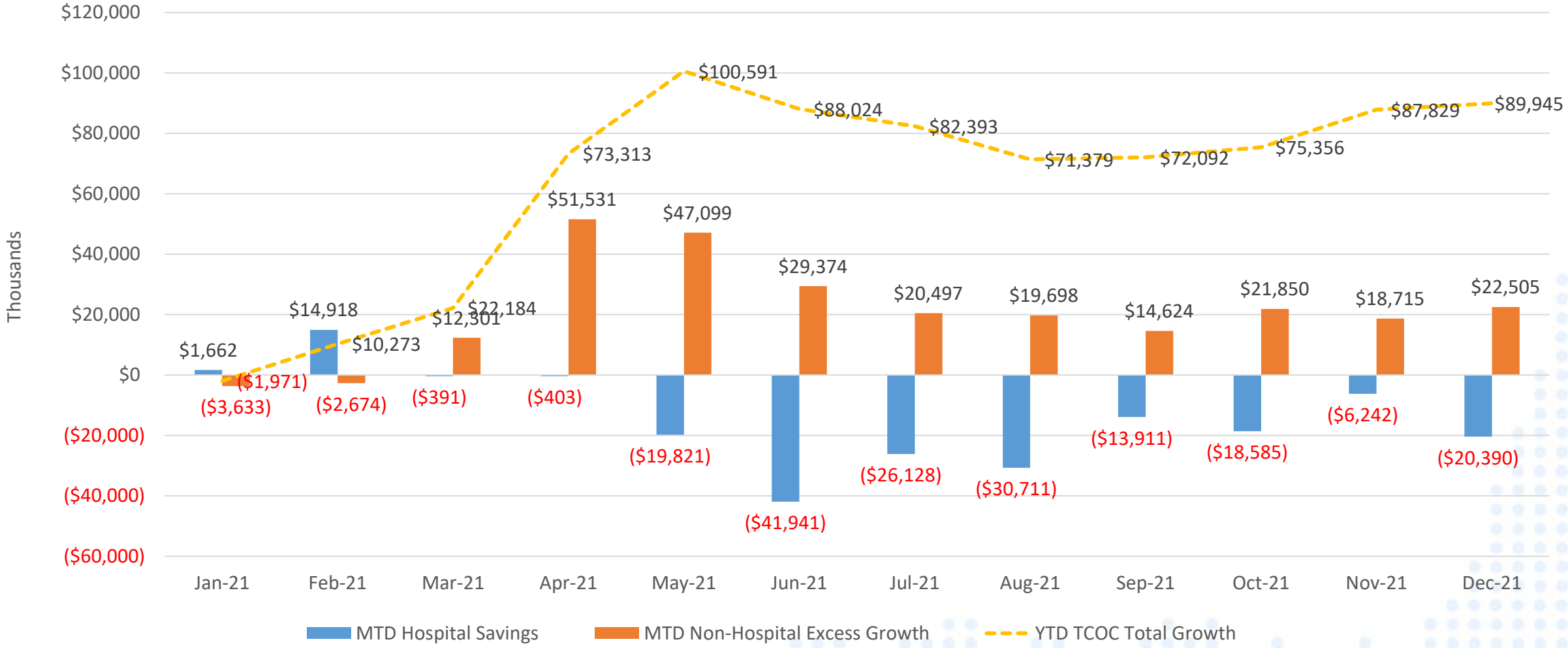
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through December 2021



maryland
health services
cost review commission

Legislative Update

HSCRC April 2022 Commission Meeting

April 13, 2022

Budget

Bill #	Description	Status
HB 300 SB 290	**Budget Bill for FY 2023 (The Governor's Budget)**	To Governor

- The Budget Bill now includes $50 million to MDH for hospital workforce. The money will be distributed based on a plan developed by the HSCRC.

User Fee Bill

Bill #	Description	Position	Status
HB 510 SB 917	**Health Care Facilities – Health Services Cost Review Commission – User Fee Assessment**	Support	To Governor

- This bill originally sought to change HSCRC's user fee assessment cap from a flat $16M to the greater of -
  - 0.1% of budgeted, regulated gross hospital revenue or
  - the largest amount of the cap for a fiscal year in the prior 5 fiscal years.
- The bill was amended so that this new methodology applies in FY 23-FY 25 and creates a flat cap amount in subsequent years. This will require HSCRC to come back to the legislature to extend the methodology prior to FY 26 (2025 Legislative Session).

Medical Bill Reimbursement

Bill #	Description	Position	Status
HB 694 SB 944	**Hospitals – Financial Assistance – Medical Bill Reimbursement**	Letter of Information	To Governor

- The original bill required hospitals to provide refunds to patients who were eligible for free care but paid a bill in 2017-2021.
- Amended to direct HSCRC, in conjunction with DHS, MHA, CRISP and the Comptroller's office, to develop a process that provides refunds to patients.

Value-Based Payment

Bill #	Description	Position	Status
HB 1148 SB 834	**Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments – Authorization**	Letter of Information	To Governor

- Permits insurers and certain non-hospital providers to enter certain value-based payment arrangements.
- A few small amendments were added to the original bill to protect physicians.

Medicaid Coverage of Doulas

Bill #	Description	Position	Status
HB 669 SB 503 HH 765 SB 166	**Maryland Medical Assistance Program – Doula Services – Coverage**	Letter of Information & Amendment	HB669 and SB166 – To Governor

- Seeks to codify Medicaid regulations re: funding doulas.
- Due to amendments, including an amendment that protects HSCRC rate setting authority, SB 166 and HB 669 are identical. SB 503 and HB 765 did not move forward.

Hospital-Adjacent Urgent Care

Bill #	Description	Position	Status
HB 1084 SB 840	**COVID-19 Response Act of 2022**	Letter of Information with Amendment	Did not cross over by the 3/21 deadline

- Stipulates the operation of hospital-adjacent urgent care centers as an unregulated service.
- This bill would not change current allowance for unregulated urgent care centers on a hospital campus.
- Bill failed to crossover by the deadline.

2022 Interim Work

- Plan for $50M for hospital workforce
- JCR reports:
  - MDPCP and outcomes-based credits, expected due date: 10/1/22
  - COVID-19 & hospital financial stability, expected due date: 10/1/22
- Participating in studies and workgroups:
  - MHCC-led Study on Expansion of Interstate Telehealth (HB 670), report due 12/1/23
  - MHCC-led Workgroup on primary care (SB 734), annual report due 12/1
  - MDH-led MLARP Advisory Council (SB 626), annual report due 10/1
- Implementing new laws:
  - Change to user fee cap (HB 510), ongoing
  - Reimbursement bill (HB 694), report due 1/1/2023

Questions?

Hannah Friedman-Bell

Analyst

hannah.friedman-bell@maryland.gov

Megan Renfrew

Associate Director of External Affairs

megan.renfrew1@maryland.gov

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: April 13, 2022

RE: Hearing and Meeting Schedule

May 11, 2022 To be determined - GoTo Webinar

June 8, 2022 To be determined - GoTo 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.