maryland
health services
cost review commission

**618th Meeting of the Health Services Cost Review Commission**

**March 13, 2024**

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

**CLOSED SESSION**
**12:00 pm**

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

**PUBLIC MEETING**
**1:00 pm**

1. Review of Minutes from the Public and Closed Meetings on February 14, 2024

**Informational**

2. Presentation from Advanced Research Projects Agency for Health (ARPA-H)

**Specific Matters**

3. Docket Status – Cases Closed

   2642N University of Maryland Medical Center
   2643N Brook Lane Hospital

4. Docket Status – Cases Open

   2630R UM Shore Medical Center at Easton
   2644A Johns Hopkins Health System

**Subjects of General Applicability**

5. Report from the Executive Director
   a. Model Monitoring
   b. Legislative Update
6. Confidential Data Request: The Injury Outcome Data Evaluation System (IODES) project
7. Final Recommendation on Traditional Medicare Performance Adjustment (MPA)
8. Update Factor: Discussion of Process

9. ED policy development and implementation
    a. ED Best Practices Incentive Policy Development Plan
    b. EDDIE Update

10. Policy Development and Workgroup Updates
    a. Community Benefits Reporting Workgroup
    b. Out Of State & Deregulation Volume Policy Development Plan

11. Hearing and Meeting Schedule

# MINUTES OF THE
# 617th MEETING OF THE
# HEALTH SERVICES COST REVIEW COMMISSION
# February 14, 2024

Chairman Joshua Sharfstein called the public meeting to order at 11:38 a.m. In addition to Chairman Sharfstein, in attendance were Commissioners Joseph Antos, PhD, James Elliott, M.D., Adam Kane, Ricardo Johnson, Maulik Joshi, and Nicki McCann, J.D. Upon motion made by Commissioner Kane and seconded by Commissioner Joshi, the Commissioners voted unanimously to go into Closed Session. The Public Meeting reconvened at 1:00 p.m.

## REPORT OF FEBRUARY 14, 2024, CLOSED SESSION

Paul Katz, Analyst, External Affairs and Policy, summarized the items discussed at the February 14, 2024, Closed Session.

## ITEM I
## REVIEW OF THE MINUTES FROM THE JANUARY 10, 2024, PUBLIC MEETING, AND CLOSED SESSION

The Commission voted unanimously to approve the minutes of the January 10, 2024, Public Meeting, and Closed Session and to unseal the Closed Session minutes.

## ITEM II
## CLOSED CASES

2640A - University of Maryland Medical Center
2641R - UM Upper Chesapeake Behavioral Health Pavilion

## ITEM III
## OPEN CASES

### 2642N University of Maryland Medical Center

On December 14, 2023, University of Maryland Medical Center ("UMMC" or "the Hospital") submitted a partial-rate application requesting the creation of a new rebundled rate for Ambulance – Rebundled (AMR) services. A rebundled rate provides hospitals with a way to bill for services provided by 3rd parties off-site to hospital inpatients. The Hospital requests that the rebundled AMR rate be set at the state-wide median and be effective March 1, 2024.

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. As this service will be provided by a third-party contractor as a rebundled service, no cost finding is necessary. The state-wide median for AMR services is $6.24 per RVU.

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

1. That a rate of $6.24 be approved effective March 1, 2024, for AMR services.
2. That no change be made to the Hospital's Global Budget Revenue for the AMR services.
3. That AMR as a rebundled service is exempt from rate realignment.

Commissioners voted unanimously in favor of the Staff's recommendation.

**2463N Brook Lane Health Services**

On January 11, 2024, Brook Lane Health Services ("the Hospital") submitted a partial rate application requesting to bundle therapy revenue from Individual Therapy (ITH) and Group Therapy (GTH) into the room charge Psychiatric Adult (PAD) and Psychiatric Child and Adolescent (PCD) rates for Inpatient services and into the daily rate for Psychiatric Day/Night (PDC) effective January 1, 2024. These services were previously billed separately.

The Hospital's new proposed rates are as follows:

| | Budgeted Volumes | Approved Revenue | Recommended Unit Rate |
|---|---|---|---|
| Psychiatric Adult (PAD) | 6,248 | $ 8,517,559 | $1,363.23 |
| Psychiatric Child and Adolescent (PCD) | 11,459 | $15,955,211 | $1,392.38 |
| Psychiatric Day/Night (PDC) | 3,699 | $ 2,146,708 | $ 580.35 |

Staff recommendation is as follows:

1. That the Hospital be allowed to collapse Individual Therapy (ITH) and Group Therapy (GTH) into the Psychiatric Adult (PAD) and Psychiatric Child and Adolescent (PCD), and Psychiatric Day/Night (PDC) rate centers;
2. That rates outlined for Psychiatric Adult (PAD) and Psychiatric Child and Adolescent (PCD), and Psychiatric Day/Night (PDC) be approved effective January 1, 2024; and
3. That the rates approved herein be revenue neutral.

Jeff O'Neal, Chief Executive Officer, Brooklane requested that Staff's recommendation be revised with an approval start date of March 1st. Staff agreed to this revision.

Commissioners voted unanimously in favor of the Staff's revised recommendation. Commissioner Joshi recused himself from discussion and vote.

## ITEM IV
## UNIVERSITY OF MARYLAND REHABILITATION AND ORTHOPAEDIC INSTITUTE

Jon Kromm, Executive Director, presented Staff's recommendation concerning the University of Maryland Rehabilitation and Orthopedic Institute Trauma Reunification Project (see "University of Maryland Rehabilitation and Orthopedic Institute Trauma Reunification Project" available on the HSCRC website).

On November 15, 2023, the University of Maryland Medical System (UMMS) provided a Letter of Intent (LOI) on behalf of UM Downtown Baltimore hospitals - University of Maryland Rehabilitation and Orthopedic Institute (UMROI), University of Maryland Medical Center (UMMC) and University of Maryland Medical Center Midtown Campus (UMMC Midtown) - requesting to move global budget revenue in future years from UMROI to UMMC and UMMC Midtown with no intended reduction in net services. Specifically, the LOI outlined that UMMS, as part of its "Trauma Reunification Project," will transfer from UMROI, as early as the second quarter of 2027, 25 acute inpatient rehab traumatic brain injury beds, 18 acute inpatient rehab spinal cord injury beds, and 5 chronic care beds to UMMC, as well as 10 dually licensed acute inpatient rehab and chronic beds to UMMC. Together, these system realignments constitute 27 percent of UMROI's global budget. Concurrent with the relocation of beds to UMMC, UMROI's medical and surgical acute care volumes, approximately 48 percent of UMROI's global budget, will be absorbed by existing operating room capacity and acute hospital facilities, primarily those within the UMMS system, at which time UMROI plans to close its four acute care hospital beds. UMROI's pediatric dental surgical volumes will be relocated to the UMMC downtown campus, and UMMS intends to relocate UMROI's dental clinic volumes to UMMC Midtown. UMMS also intends to shift UMROI's outpatient clinic services to other UMMS campuses including the UMMC Midtown Campus. Finally, for the remainder of UMROI's care delivery (25 percent of revenue) UMMS is investigating new locations for the construction of a freestanding facility to provide non-trauma acute inpatient rehabilitation care, inclusive of neurology and stroke, in a modern setting. Until a site is identified, which UMROI envisions will be approximately 60 beds, the hospital will continue to provide these services and chronic care at its existing campus. UMROI intends to pursue an exemption from rate regulation from the HSCRC for the special acute inpatient rehabilitation and chronic care hospital that will remain at its existing campus.

UMROI is licensed as an acute care, specialty rehabilitation, and specialty chronic hospital in southwest Baltimore City with 2 licensed medical/surgical/gynecological/addictions beds, 102 licensed rehabilitation beds, and 40 licensed chronic hospital beds, including 16 dually licensed chronic/rehabilitation beds. UMROI is a provider of orthopedic surgery, the largest state provider of outpatient pediatric dental services, and the largest inpatient rehabilitation hospital and provider of rehabilitation services in the State of Maryland. The Hospital's total approved revenue cap for Fiscal Year 2024 is $148,915,470. In CY 2022, which is a fairly representative year, approximately 23 percent of its revenues came from Baltimore city residents, 20 percent came from Baltimore county residents, 13 percent came from Anne Arundel county residents, 9 percent from Howard county residents, 8 percent came from Carroll and Harford county residents, 6 percent came from Prince George's county residents, 4

percent came from out-of-state residents, and the remaining 17 percent was derived from all other counties in Maryland.

Dr. Kromm stated that the $21.5M in system savings will be the largest amount generated by a facility conversion to date. Including the $7.3M dedicated to population health investment, total savings on the Staff's recommendation would be $28.8M. Dr. Kromm noted that UMMS' proposal is a net benefit to Marylanders and the care delivery system.

Staff's recommendation is as follows:

1. Utilize a 100 percent variable cost factor to realign rehabilitation and chronic care services from UMROI to UMMC.
2. Utilize a 65 percent variable factor to realign acute care services from UMROI to UMMC Downtown and Midtown Campuses.
3. Utilize a 50 percent variable cost factor to realign acute care services from UMROI to non-UMMS facilities.
4. Utilize a 15 percent variable cost factor to realign other rehabilitation services from UMROI to an unregulated freestanding rehabilitation facility.
5. Funding agreements for each realignment outlined in recommendations 1-4 are contingent on actual volume changes being equivalent to projected volumes. If volumes deviate from projected shifts, staff will adjust accordingly.
6. Exempt UMROI from the Integrated Efficiency Policy in RY 2025 and each year until the Trauma Reunification Project is completed.
7. Earmark $7.3 million from the proposed system savings for population health investments to be approved each year through the Revenue for Reform policy.
8. Direct staff to enter into a contractual agreement with the UMMS to codify service level agreements that the system must satisfy as part of this facility conversion.
9. Direct staff to develop a facility conversion policy in CY 2024 that will be used for all future care delivery realignments.

Commissioner Johnson asked for clarification on the mechanisms available to the HSCRC to take back revenue if the actual volume shifts do not align with the projections.

Dr. Kromm stated that this mechanism would be built into the contract so that Commissioners would not need to vote on it again.

Dr. Andrew Pollak, Chief Clinical Officer, UMMS, explained that the current delivery model adversely impacts patients by forcing them to be transported between campuses (UMMC and UMROI) when they hit a certain stability threshold.

The rationale for deregulating the existing UMROI facility is that stroke rehab services can be treated in a model that better aligns with the rest of the country and is better suited for an unregulated setting.

Dr. Pollack assured Commissioners that UMMS is fully committed to maintaining access to the services that will be deregulated, as it is integral to UMMS strategic plan for neurology. Dr. Pollak explained that the goal is not to increase system revenue through unregulated care, since they assume there will be a decrease in unregulated volumes once the transformation is complete.

Commissioner Kane expressed concerns about carrying forward the Integrated Efficiency exemption, which allows UMROI to retain $2.3M in permanent revenue. Mr. Kane stated that the project duration extends the inflation applied to fixed costs, resulting in higher overall project costs. Commissioners agreed that the HSCRC needs to establish a conversion incentive and limit project duration to a reasonable extent.

Commissioners voted unanimously in favor of ITEM IV Staff's recommendation.

**FINAL RECOMMENDATION ON MARYLAND HOSPITAL ACQUIRED CONDITIONS PROGRAM**

Diane Feeney, Associate Director, Quality Initiatives, presented staff's final recommendation on the Maryland Hospital Acquired Conditions Policy for RY 2026 (see "Final Recommendation for The Maryland's Hospital Acquired Conditions Policy for Rate Year 2026" available on the HSCRC website).

The quality programs operated by the HSCRC, including the Maryland Hospital Acquired Conditions program (MHAC), are intended to ensure that any incentives to constrain hospital expenditures under the TCOC Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the TCOC Model, while guarding against unintended consequences and penalizing poor performance.

The MHAC program is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.

The MHAC policy currently holds 2 percent of inpatient hospital revenue at-risk for complications that may occur during a hospital stay because of treatment rather than the underlying progression of disease. Examples of the types of hospital acquired conditions included in the current payment program are respiratory failure, pulmonary embolisms, and surgical-site infections.

This policy affects a hospital's overall GBR and so affects the rates paid by payers at that hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.

Historically the MHAC policy included the better of improvement and attainment, which incentivized hospitals to improve poor clinical outcomes that are often emblematic of disparities. The protection of improvement has since been phased out to ensure that poor clinical outcomes and the associated health disparities are not made permanent, which is especially important for a measure that is limited to in-hospital complications. In the future, the MHAC policy may provide direct hospital incentives for reducing disparities, like the approved readmission disparity gap improvement policy. Also for future

consideration is inclusion of electronic Clinical Quality Measures to address areas such as maternal complications, which disproportionately impact lower income, minority patients.

Staff received a comment letter from Maryland Hospital Association (MHA). supporting averaging the 20 percent observed over expected ratios of the worst and best performing hospitals' results to establish the performance standard. This results in similar benchmark and threshold values but is less sensitive to the influence of outliers than using a single percentile. MHA is also supportive of other components as they are unchanged from the RY2025 policy.

The MHAC policy was redesigned in Rate Year (RY) 2021 to modernize the program for the new Total Cost of Care Model. This RY 2026 final recommendation, in general, maintains the measures and methodology that were developed and approved for RYs 2022 through 2025.

These are the final recommendations for the RY 2026 MHAC program:

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.

    a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
    b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
    c. Engage hospitals on specific PPC increases as indicated/appropriate to understand trends and discuss potential quality concerns.

2. Use more than one year of performance data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CYs 2023 and 2024.

3. Continue to assess hospital performance on attainment only, with adjustment to performance standards for increased stability.

4. Continue to weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.

5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.

6. Future Considerations:

a. Assess options for streamlining (or simplifying) the quality programs overall, or for the hospital acquired complication measures that are currently included in both the QBR Safety Domain and the MHAC program.
b. Assess digitally specified quality measures such as electronic Clinical Quality Measures (eCQMs) for future inclusion in quality programs.

Commissioners voted unanimously to approve the Staff's recommendation.

## ITEM VI
## FINAL RECOMMENDATION ON MULTI-VISIT PATIENTS

Oseizame Emasealu, Population Health Project Manager, Quality and Population Based Methodologies, presented Staff's final recommendation for establishing the Emergency Department Avoidable Utilization Program for RY 2026 (see "Final Recommendation for Establishing the Emergency Department Potentially Avoidable Utilization Program for Rate Year 2026" available on the HSCRC website).

In CY 2021, the Commission asked staff to begin development of a policy providing hospital payment incentives for reduction of avoidable ED utilization. The rationale for addressing ED utilization includes concerns about cost, volume, and impact on emergency department patient experience. Nationally, avoidable ED visits are estimated to account for 19.6% of ED encounters and $64.4 billion in costs. ED volume is also recognized as a driver of extended ED length of stay, which is an important consideration given that Maryland hospitals have some of the longest ED length of stay averages in the nation.

To understand the visit volume and cost related to multi-visit patients (MVPs), staff analyzed inpatient and outpatient case mix data across several years. MVPs were defined as those patients with four or more ED visits in a calendar year. This definition, which has been used commonly in the health services research literature, includes both visits that result in an inpatient admission and those that result in a discharge from the ED.

The analysis found that in 2019 MVPs accounted for 30% of all ED visits, and 32% of ED charges. MVP utilization in 2019 totaled $326 million. Most MVP visits resulted in discharge from the ED, which is consistent with the pattern seen in visits by patients who are not MVPs.

The analysis found that more than 45% of MVPs in 2019 received all their ED care from a single hospital. Most MVPs visited one or two hospitals during the year for all their ED care. When those visits involved multiple hospitals, those hospitals tended to be within the same healthcare system.

Finally, the analysis indicated that there is minimal overlap between visits addressed by the current Potentially Avoidable Utilization (PAU) program and the proposed Emergency Department Potentially Avoidable Utilization (ED-PAU) program, both of which include in part and whole, respectively, Prevention Quality Indicators (PQI) that are administered by the Agency for Healthcare Research and Quality (AHRQ). The PAU incentive applies to inpatient stays, and thus excludes roughly four out of five ED visits, because those patients are discharged from the ED without admission. Of the MVPs admitted to the hospital, slightly more than a third meet the PQI specifications in the PAU program. Thus, the

Commission can be confident that addressing MVPs will not create incentives that duplicate or compete with those in the existing PAU program.

Final Recommendations for Rate Year 2026 Emergency Department Potentially Avoidable Utilization Program

1. Implement a Rate Year 2026 pay-for-performance policy incentivizing reduction in MVP visits on a reward-only and improvement-only basis.
2. Set Calendar Year 2023 as the base year.
3. Establish the threshold for performance reward at 5% improvement.
4. Reward hospitals for improvement as follows:
    a. Calendar Year 2024 improvement of 5-20%: 0.125% of total revenue
    b. Calendar Year 2024 improvement of >20%: 0.25% of total revenue.
5. Require hospitals to prospectively register MVP interventions with the Commission.
6. Develop reporting to assess health disparities.

Brian Sims, Vice President, Quality & Equity, MHA, raised concerns that the Staff recommendation does not account for factors outside hospital walls that may cause patients to use emergency rooms disproportionately. MHA proposes that this policy be voluntary and incentivize collaboration between hospital and nonhospital stakeholders.

Commissioner Johnson questioned the use of a reward-only policy when value-based models are moving more toward two-way risk structures.

Geoff Dougherty, Deputy Director, Population-Based Methodologies, Analytics, and Modeling responded that the initial phase of the policy being reward-only is to allow for a runway to evaluate performance without unintended consequences. Mr. Dougherty further explained that they intend to incentivize data submission to better understand potential outcomes.

Dr. Dougherty noted that there are no exclusions for vulnerable populations,

Commissioner Elliot highlighted the importance of adding these exclusions to the recommendation.

Dr. Kromm stated that there is room for improvement, but this policy is the best avenue to start solving the issue of MVPs.

Commissioners agreed that there needs to be a way to track improvements and aggregate data on this issue and that utilizing policy to implement a data request will help drive the necessary changes.

Commissioner Johnson proposed an amendment to the Staff's Recommendation to remove financial incentives (Recommendation #3 and #4) from the Staff's Recommendation.

Commissioners voted on an amended recommendation:

1. Continue monitoring existing performance data on multi-visit patients.
2. Require hospitals to provide information on MVP interventions with the Commission to track outcomes associated with those interventions.
3. Develop reporting to assess health disparities related to MVPs.
4. Staff will return at a later date to discuss outcomes associated with the registered interventions and to discuss next steps for policy related to MVPs.

Commissioners voted unanimously in favor of the amended recommendation.

## ITEM VII
## DRAFT RECOMMENDATION ON READMISSION REDUCTION INCENTIVE PROGRAM RY 2026

Princess Collins, Chief, Quality Initiatives, presented a report for the Readmission Reduction Incentive Program (RRIP) for Rate Year 2026 (see "Draft Recommendation for the Readmission Reduction Incentive Program for Rate Year 2026" available on the HSCRC website).

The quality programs operated by the HSCRC, including the RRIP, are intended to ensure that any incentives to constrain hospital expenditures under the TCOC Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the TCOC Model, while guarding against unintended consequences and penalizing poor performance.

The RRIP policy is one of several pay for performance quality initiatives that provide incentives for hospitals to improve and maintain high quality patient care and value over time.

The RRIP policy currently holds up to 2 percent of hospital revenue at-risk for performance relative to predetermined attainment or improvement goals on readmissions occurring within 30-days of discharge, applicable to all payers and all conditions and causes.

This policy affects a hospital's overall GBR and so affects the rates paid by payers at that hospital. The HSCRC quality programs are all payer in nature and so improve quality for all patients that receive care at the hospital.

Currently, the RRIP policy measures within-hospital disparities in readmission rates, using an HSCRC-generated Patient Adversity Index (PAI), and provides rewards for hospitals that meet specified disparity gap reduction goals. The broader RRIP policy continues to reward or penalize hospitals for improvement and attainment, which incentivizes hospitals to improve poor clinical outcomes that may be correlated with health disparities. It is important that persistent health disparities are not made permanent.

While there are no proposed changes to the readmission measure, Staff recommended that additional analytics be conducted over the coming year to assess hospital revisits to the emergency department and/or observation, which Staff believes will complement some of the other workstreams the Commission currently is engaging in to improve emergency room length of stay. Finally, Staff provided a performance

summary on the disparity gap measure and recommended continuing this targeted focus on high-adversity patients.

Staff's draft recommendation for the Maryland Rate Year (RY) 2026 RRIP is as follows:

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Set statewide 4-year improvement target of -5.5 percent from 2022 base period through 2026.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining 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 pace for 50 percent reduction in disparity gap measure over 8 years, and;
    - 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. Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits of EDAC in the RRIP program.

No Commission action is necessary as this is a draft recommendation.

## ITEM VIII
## POLICY UPDATE AND DISCUSSION

### Update on Financial Condition for FY23

William Henderson, Director, Medical Economics & Data Analytics, presented an update on the hospital's financial condition for RY 2023 (see "Update on Hospital Financial Condition for RY23" available on the HSCRC website).

### AHEAD Model Update

Dr. Kromm presented an AHEAD Model update (see "AHEAD Model Update" available on the HSCRC website").

The Centers for Medicare & Medicaid Services (CMMS) released a Notice of Funding Opportunity (NOFO) for the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. The Maryland Department of Health (MDH) and HSCRC are carefully reviewing the AHEAD Model NOFO. The AHEAD Model is an option that would allow Maryland to continue state-wide efforts to improve healthcare quality and control costs under the TCOC Model agreement with CMMS.

AHEAD is a state TCOC model that seeks to drive state and regional health care transformation and multi-payer alignment, with the goal of improving the total health of a state population and lowering costs across all payers, including Medicare, Medicaid, and private coverage. The model aims to support the delivery of high-quality care, improved population health, greater care coordination, and advanced health equity by supporting underserved patients. AHEAD aims to increase resources available to participating states to improve the overall health of their population, support primary care, and transform health care in their communities.

The State submitted a Letter of Intent on February 2, 2024, to participate in Cohort 1 of AHEAD.

The HSCRC and MDH formed three committees to advise the State on the future of Maryland's agreement with CMS, including evaluating the AHEAD Model. These committees will advise the State in the development of the AHEAD NOFO response if the State decides to apply to AHEAD.

1. The Population Health Transformation Advisory Committee (P-TAC) will provide advice to MDH and HSCRC to transform the state's approach to equity-centered population health improvement.
2. The Healthcare Transformation Advisory Committee (H-TAC) will provide advice on all-payer cost savings targets, hospital quality improvement, and continued transformation of Maryland's healthcare delivery system.
3. The Primary Care Program Transformation Advisory Committee (PCP-TAC) will provide advice on primary care spending targets and the future of a multi-payer aligned primary care program.

Each advisory committee will consider health equity in all their recommendations.

Dr. Kromm stated that the State plans to apply to AHEAD on March 18, 2024.

**Model Monitoring**

Deon Joyce Chief of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 10 months ending October 2023. The data showed that Maryland's Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce stated that Medicare Nonhospital spending per-capita was trending close when compared to the nation. Ms. Joyce noted that Medicare TCOC spending per-capita was favorable compared to the nation. Ms. Joyce noted that the Medicare TCOC guardrail position is 2.70% below the nation through October and that Maryland Medicare hospital and non-hospital growth through October shows a savings of $259,337,000.

**Emergency Department Dramatic Improvement Effort (EDDIE) Update**

Alyson Shuster, Deputy Director, Quality Methodologies, and Jason Mazique, Population Health Project Manager, Quality and Population-Based Methodologies, presented the monthly update on the Emergency Department Dramatic Improvement Performance for January (see "Emergency Department Dramatic Improvement Effort" available on the HSCRC website).

Dr. Schuster stated that Staff received January data from all the hospitals. She noted that when the January data was compared to the June data there were five hospitals that had more than a 10% decrease in their length of stay, however, about 50% of the hospitals reported more than a 10% increase. Dr. Schuster noted that seasonality may be the reason for the fluctuation.

Mr. Mazique presented the hospital's EDDIE data for January. Data shows minimal movement of hospitals across categories for January with three hospitals improving in performance and two hospitals declining in performance.

Dr. Schuster reviewed the QBR ED LOS Measure Development Plan.

Subgroup 1-QBR ED-1 Measure

- Develop a mechanism to collect ED length of stay data for patients admitted to the hospital.
- The workgroup convened its first meeting on 2/2/24.
- Workgroup presented on the ED LOS at the Maryland's Health Finance and Management Association meeting.
- The workgroup developed a draft work plan for best practices as follows:

ED Best Practices Incentive Policy Development

Objective:

- Develop a series of process, structural, and/or outcome measures that will address systematically longer ED length of stay (LOS) in the State.
- Will incentivize hospital best practices, alignment with EDDIE, and value-based arrangements with non-hospital providers that will improve hospital throughput and by extension ED LOS.

Description:

- Subgroup will advise on the development of 3-5 measures that will constitute a 1% revenue at risk program for CY 2025 performance.
- Workgroup will need to include those who are familiar with quality measurement, emergency department/hospital operations, non-hospital operations/policy (including home health, behavioral health, and skilled nursing facilities), and pay-for-performance/value-based payments.
- Will convene starting in March/April and should complete the task within 4-5 monthly subgroups.
- Monthly updates on progress will be provided to Commissioners as part of EDDIE presentations.

**Legislative Update**

Mr. Paul Katz presented the Legislative Update (see "Legislative Update" available on the HSCRC website).

Mr. Katz noted that Staff is monitoring the following bills:

- SB 694/ HB 887- Maryland Department of Health – Health Commissions and Maryland Insurance Administration - Study
- HB 784 – Task Force on Reducing Emergency Department Wait Times
- HB 1143 – Emergency Medical Services – Maryland Emergency Department Wait Time Reduction Commission and Standardized Protocols - Establishment
- SB 784/ HB 935- Comprehensive Community Safety Funding Act
- SB 1092- Vehicle Registration – Emergency Medical System Surcharge – Increase and Distribution of Funds
- HB 1439 – Public Health – Funding for Trauma Centers and Services
- SB 1006 – Medical Debt Collection – Sale of Patient Debt
- HB 328 – Hospitals – Financials Assistance Policies – Revisions
- SB 1103/ HB 1149- Hospitals and Related Institutions – Outpatient Facility Fees
- SB 1020/HB1194- Hospitals – Clinical Staffing Committees and Plans – Establishment
- SB 332/HB 84 – Hospitals and Urgent Care Centers – Sepsis Protocol (Lochlin's Law)
- SB 705/HB 728 – Health Insurance – Qualified Resident Enrollment Program (Access to Care Act)
- SB 360/ HB 350 – Budget Bill (Fiscal Year 2025)

Staff had two briefings before Legislative Committees in January:

- HSCRC Overview of the Total Cost of Care Model, AHEAD Model, and Improving ED Wait Times for the House Health Government Operations Committee.
- Improving ED Wait Times Overview for the Senate Finance Committee.

Staff has submitted four legislative reports.

- Annual Governor's Report
- Evaluation of the Maryland Primary care Program
- Summary of UMMS Board of Directors Financial Disclosure
- Maryland Hospital Community Benefit Report: FY 2022

**Process Updates**

Erin Schurmann, Chief, Provider Alignment and Special Projects, presented an update on the HSCRC policy development and workgroup process (see "Workgroup Processes Updates" available on the HSCRC website).

**Policy Calendar Update**

Ms. Schurmann presented a review of the HSCRC policy calendar for the period of January 2024 to June 2025 (see" Policy Calendar January 2024 – June 2025" available on the HSCRC website).

**EQIP Primary Care Group**

Mr. Henderson presented an update on EQIP Primary Care Group Program

- The program is to provide incremental funding for primary care in underserved areas.
- The program was approved by the Commission and CMS at the end of last year. Staff is working on implementation targeting a 2025 go-live.
    - RFI was completed in January and responses are being compiled.
    - Stakeholder sub-group will be hosted by MedChi.
        - Initial meeting tentatively scheduled at 11 Am on February 28th.
        - For more information or to be included on the relevant distribution, email: hscrc.tcoc@maryland.gov

**ITEM X**
**HEARING AND MEETING SCHEDULE**

| | |
|---|---|
| March 13, 2024 | Times to be determined- 4160 Patterson Ave<br>HSCRC Conference Room |
| April 10, 2024 | Times to be determined- 4160 Patterson Ave.<br>HSCRC Conference Room |

There being no further business, the meeting was adjourned at 4:22 p.m.

**Closed Session Minutes**
**of the**
**Health Services Cost Review Commission**

**February 14, 2023**

Chairman Sharfstein stated reasons for Commissioners to move into administrative session. Upon motion made in public session, Chairman Sharfstein called for adjournment into administrative session

The Administrative Session was called to order by motion at 11:38 a.m.

In addition to Chairman Sharfstein, in attendance were Commissioners Antos, Elliott, Johnson, Joshi, Kane, and McCann.

In attendance representing Staff were Jon Kromm, William Henderson, Claudine Williams, Alyson Schuster, Cait Cooksey, Erin Schurmann, Bob Gallion, Christa Speicher, and Paul Katz.

Also attending was Assistant Attorney General Ari Elbaum, Commission Counsel

Attending virtually was Assistant Attorney General Stan Lustman Commission Counsel.

## Item One

William Henderson, Director, Medical Economics & Data Analytics, updated the Commission and the Commission discussed Maryland Medicare Fee-For-Service TCOC versus the nation.

## Item Two

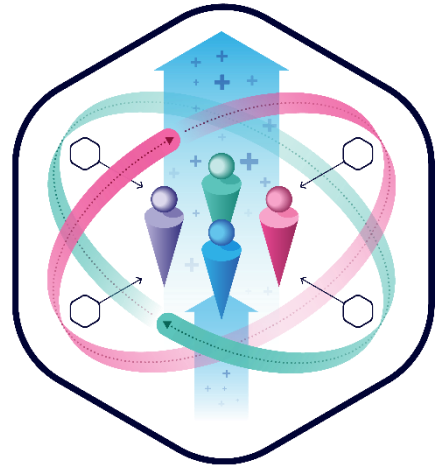
Mr. Henderson briefly updated the Commission on the hospitals' unaudited financial performance through December 2023.

The Administrative Session was adjourned at 12:14 p.m.

# HEROES Program Deep Dive

**Darshak Sanghavi, MD**
ARPA-H HEROES Program Manager

9:20 AM



ARPA-H

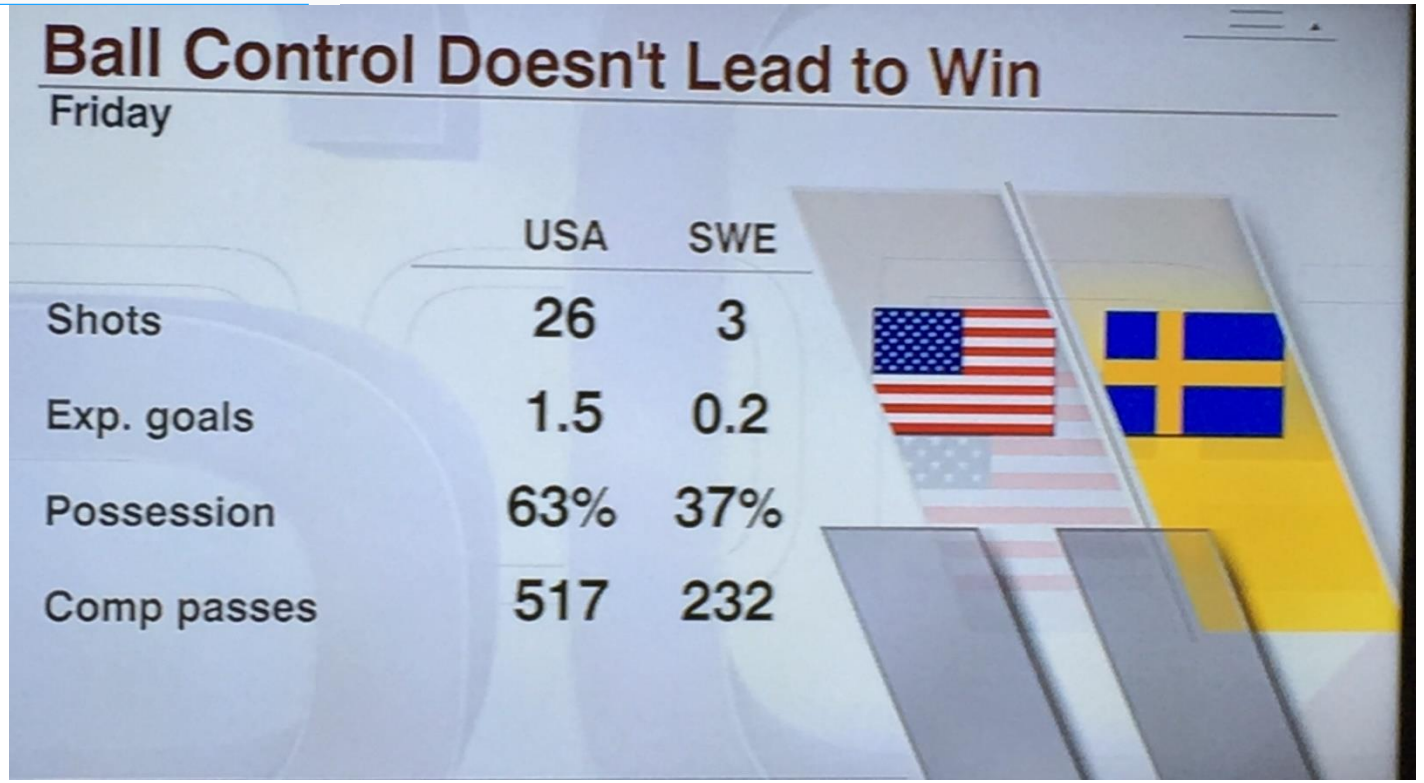
# What if… we moved from a sick care system to a system that truly rewards better health?

ARPA H

# Basketball Season Results: What Is Going On Here?

| Season | Wins | Losses | Winning Percentage |
|---|---|---|---|
| 2008-09 | 66 | 16 | .805 |
| 2009-10 | 61 | 21 | .744 |
| 2010-11 | 19 | 63 | .232 |
| 2011-12 | 21 | 45 | .318 |
| 2012-13 | 24 | 58 | .293 |
| 2013-14 | 33 | 49 | .402 |
| 2014-15 | 53 | 29 | .646 |
| 2015-16 | 57 | 25 | .695 |

# Can we explain this?

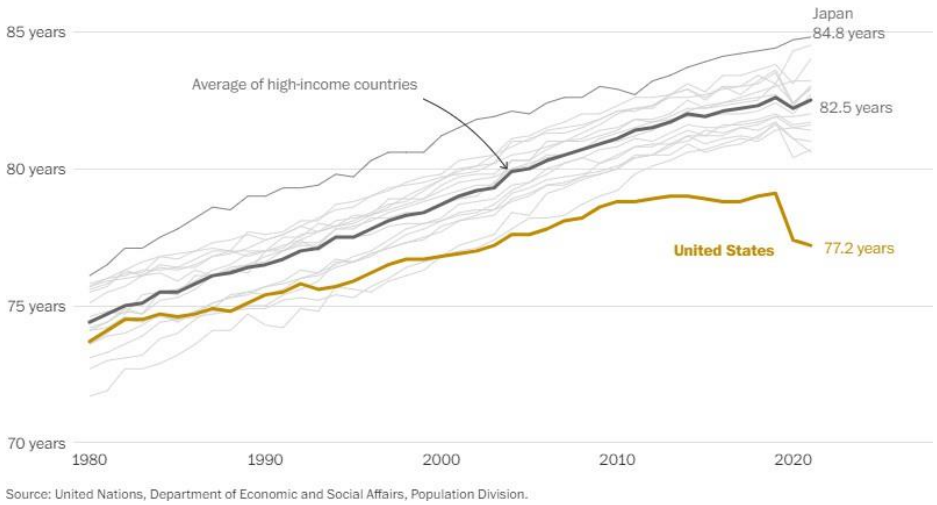
# Strong Link Versus Weak Link Sports (h/t Revisionist History)


Strong Link Sport: Basketball

Weak Link Sport: Soccer

# Preventive Health Care is Not Working for Many Americans

## American life expectancy has been flat for decades and is declining, trailing other nations.




Source: United Nations, Department of Economic and Social Affairs, Population Division.

## Despite massive spending, a high burden of preventable morbidity and mortality drives poor outcomes.

Significantly lower than mean | Statistically Indistinguishable from mean | Significantly higher than mean

| | Ischemic heart disease | Lung cancer | Road injuries | Self-harm | COPD | Cerebrovascular disease | Alzheimer disease | Drug use disorders | Diabetes | Congenital anomalies |
|---|---|---|---|---|---|---|---|---|---|---|
| United States | 1,696.6 | 781.7 | 614.5 | 511.7 | 471.8 | 456.5 | 422.1 | 359.3 | 310.0 | 299.6 |
| Comparison group average | 1,181.8 | 645.1 | 317.4 | 420.1 | 299.3 | 555.5 | 300.2 | 131.3 | 151.3 | 232.4 |

Years of Life Lost Per 100,000, All Ages, Age-Adjusted, from Global Burden of Disease, http://www.healthdata.org/united-states

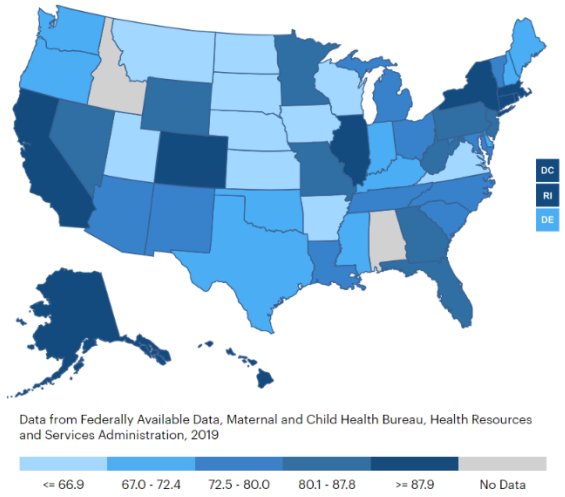
ARPA H

# Challenges in Addressing Preventable Illness

Promising Technological, Engagement, and Clinical interventions may exist, but we are not getting the right interventions to the people and places who most need them because of broken incentives.

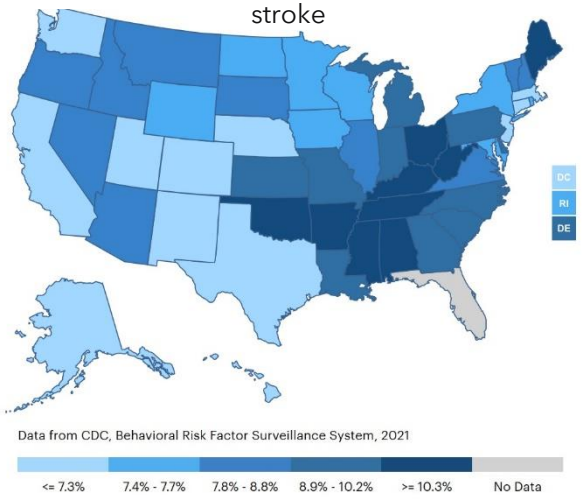
**Maternal Health**

Number of significant life-threatening maternal complications during delivery per 10,000 delivery hospitalizations



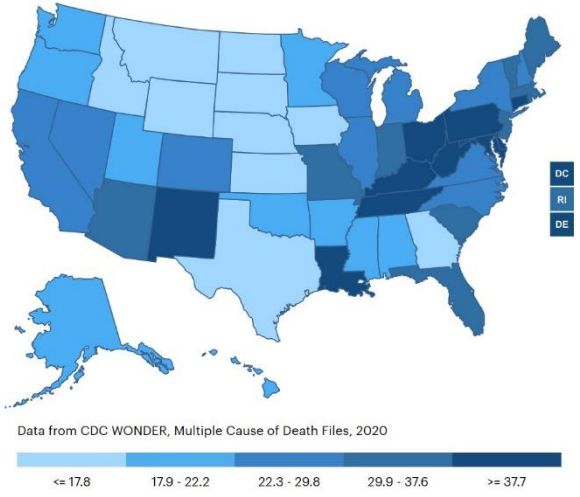

**Cardiovascular Disease**

Percentage of adults who reported ever being told by a health professional that they had angina or coronary heart disease; a heart attack or myocardial infarction; or a stroke



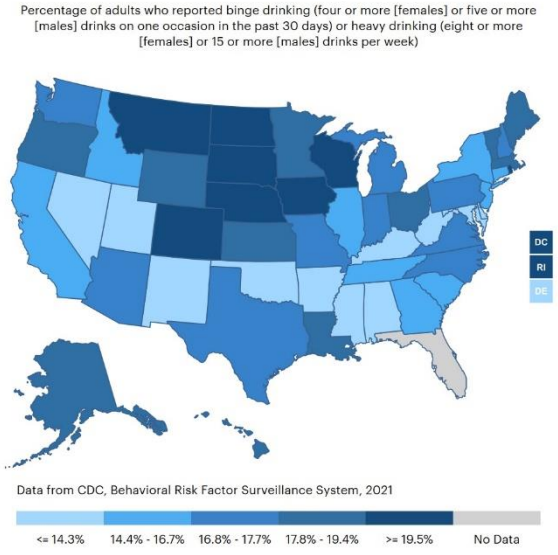

**Opioid Overdoses**

Deaths due to opioid overdoses (unintentional, suicide, homicide or undetermined) per 100,000 population (1-year)




**Alcohol-Related Harms**

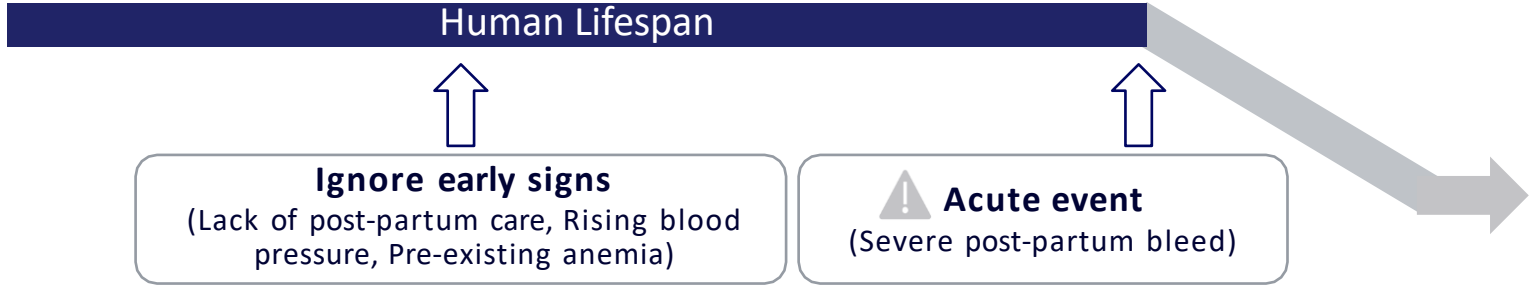
Percentage of adults who reported high risk alcohol-related behaviors




ARPA-H

# Health Care Outcomes: Current vs. Future State

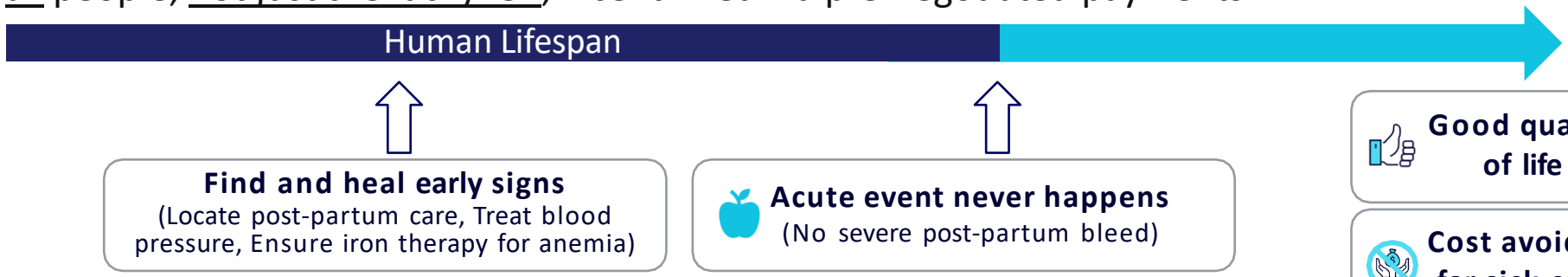
**Current State:** Health care organizations don't have strong financial incentives to fix early signs – and most people aren't lucky enough to get the right care at the right time.





- **No Accountability:** Pay for expensive treatments, no focus on prevention.
- **Inequity:** Fragmented care, inability to make broad system investments.
- **Flying blind:** No timely data on health of the whole population.

**Future State:** HEROES rewards fixing early warning signs to deliver better outcomes for all people, not just the lucky few, incentivized via pre-negotiated payments.

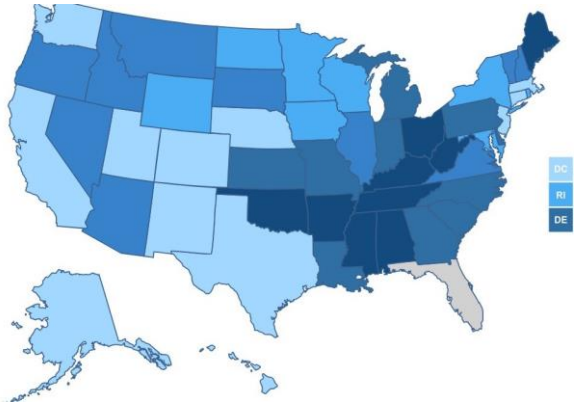




- **Accountability**: Payment only if preventive targets achieved.
- **Equity:** Whole geographic population is included.
- **Evidence-driven interventions:** Timely data to drive rapid-cycle improvement.

# How HEROES Aligns Incentives with Geographies






Health Accelerators will propose a high-need geographic region in **one of two** possible health outcomes.

Each Health Accelerator will need to meet a population-specific goal that has been projected to generate at least $60M value to society (across health care, productivity, and social service costs) over 3 years.

**Maternal Health Outcomes**

**Significance:** The U.S. experiences higher rates of Severe Obstetric Complications (SOC) than most other developed countries, and rates continue to rise.

**Goal:** Within a population of 5M, reduce rate of SOC during delivery hospitalization and 60 days after delivery by 20%.

**Heart Attack and Stroke**

**Significance:** Heart disease (#1) and Stroke (#5) are among the leading causes of death in the U.S. Annually, there are about 805,000 Heart Attacks and 795,000 Strokes.

**Goal:** Within a population of 700,000, reduce 10-year aggregate risk of Heart Attack and Stroke for people aged 40-70 years by 1% point.

**Opioid Overdose**

**Significance:** Opioid Use Disorder (OUD) affects over 2.1 million individuals and causes over 100,000 deaths annually in the U.S. Fewer than 10% of patients with diagnosed OUD receive medication-assisted treatment (MAT).

**Goal**: Within a population of 500,000, reduce the number of emergency medical service calls for opioid overdoses by 10%.

**Alcohol-Related Health Harms**

**Significance:** An estimated 1 in 5 deaths of people ages 20 - 49 result from excessive alcohol use. There are more than 140,000 alcohol-related deaths per year in the U.S.; excessive drinking, including binge drinking, costs the U.S. $249B annually.

**Goal:** Within a population of 500,000, reduce the number of emergency medical service calls for alcohol-related emergencies by 10%.

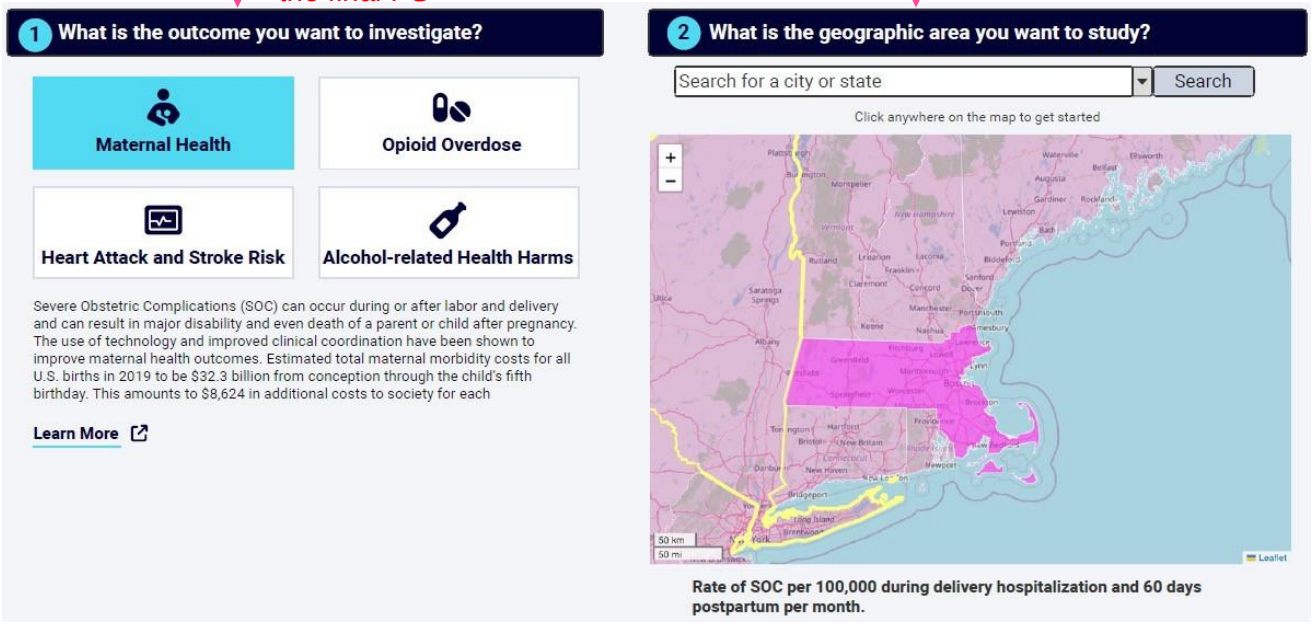
# HEROES Outcome Toolkit

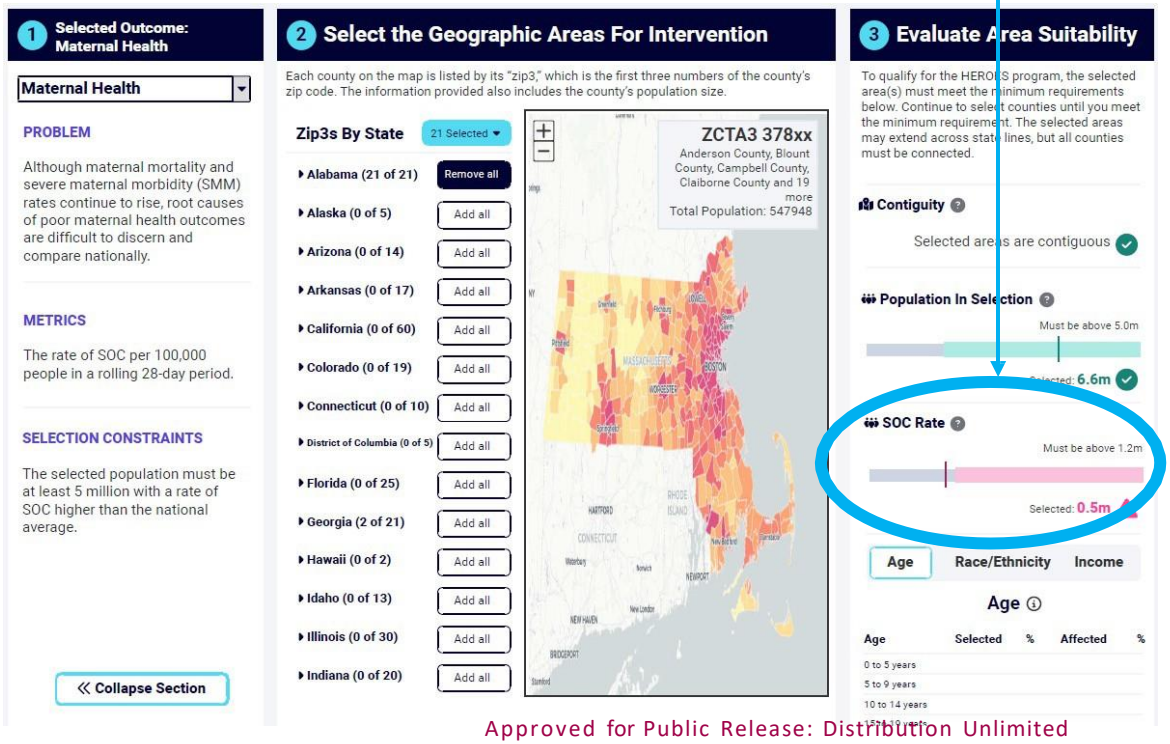
OUTCOME SELECTION:
Chosen* for maximum impact on health disparities

GEOGRAPHIC INCLUSION:
Health Accelerators must choose an entire geographic region and must serve <u>every person</u> in the area

SITE AND PERFORMER SELECTION:
Performers must choose a geographic area with performance <u>worse</u> than the national average and <u>must</u> have a plan to reach all people

*Outcome Toolkit will only display the selected 2 health outcomes detailed in the final PS



# How HEROES Creates Incentives

## Pick Targets

**Health Accelerator selects an outcome and target geographic area.**

## Identify Outcome Buyers

**Health Accelerator secures promise of *future* payment for successful health outcomes from ARPA-H and Outcome Buyers (e.g., employers, health plans).**

## Raise Funding

**Health Accelerator raises money to be used in prevention-oriented care to fund new technologies and operations.**

## Help People

**Health Accelerator deploys innovative, evidence-based technologies at scale to improve health outcomes in the specified geographic area.**

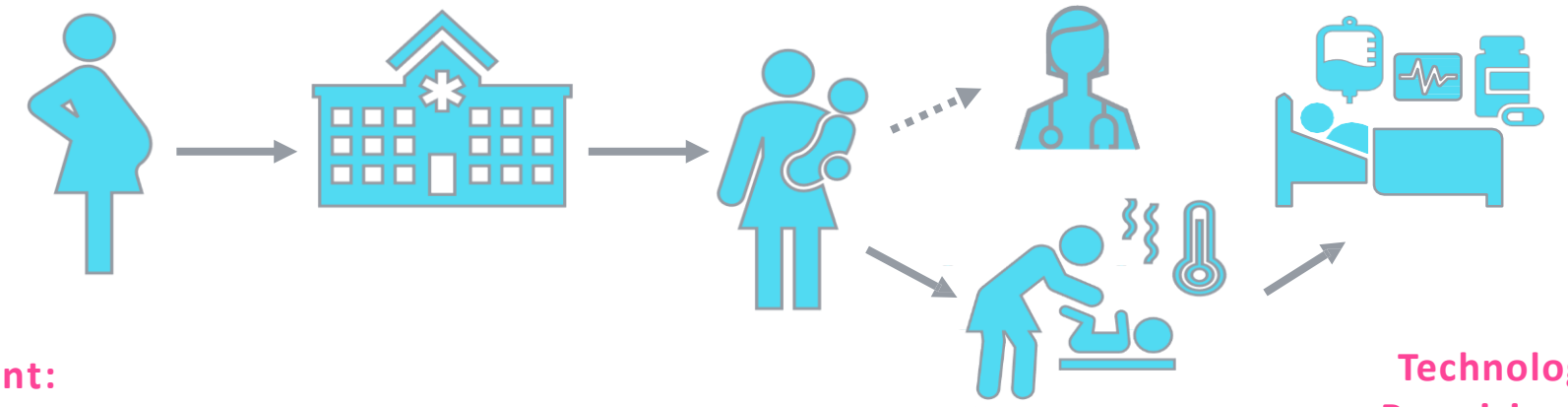
## Get Rewarded

**If outcome achieved, ARPA-H and Outcome Buyers reward Health Accelerator.**

| | | | | |
|---|---|---|---|---|
| **Population Benefit Over Three Years:** At least $60M of value | **Possible Incentive:** Outcome buyers contribute $45M ($15M ARPA-H plus 2:1 match) | **Build Capacity:** Create tech and a community that is engaged in preventive care | **Public Health Win:** Outcomes, like heart attack risk or opioid overdoses, improve | **Fiscal Win-Win:** Outcome buyers create $60M value for $45M |

# How HEROES Could Transform Care in Communities: Current State Example Maternal Health Patient Journey





**Engagement:**

**Disparities are invisible until it's too late**

Natalia lives in a community with limited access to care and doesn't have her first prenatal care visit until her 7th month of pregnancy.

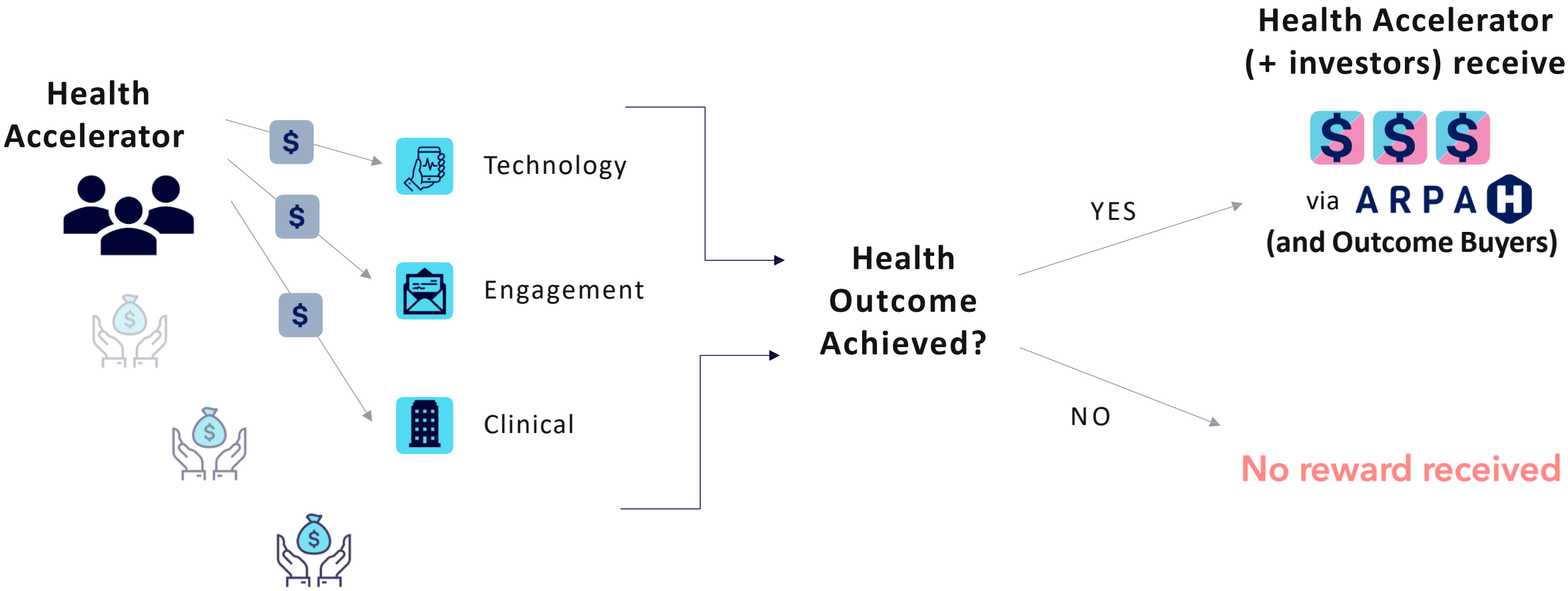
**Clinical Interventions: Mothers with newborns suffer through intense and reactive treatment plans only after experiencing a poor outcome**

Natalia experiences significant blood loss and develops an infection, both of which are preventable with improved hospital protocols.

**Technology Advancements: Promising technologies go to select few**

Natalia develops dangerously high blood pressure after returning home with her infant, resulting in a rehospitalization that could have been prevented with home blood pressure monitoring technology.

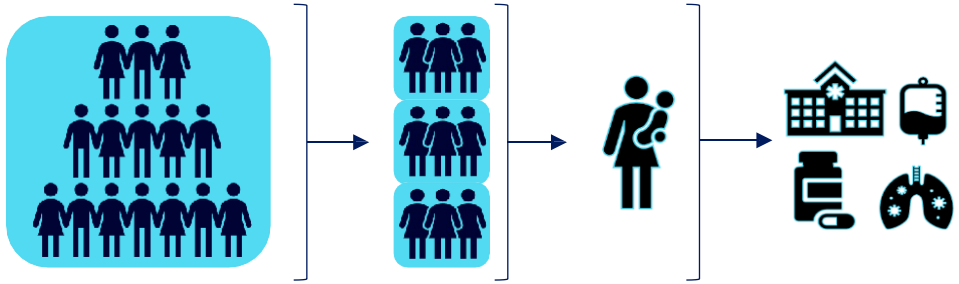
# HEROES: How the rewards flow




**Investors contribute to Health Accelerator plan for equity in reward payment**

# Prospective approach to generate >$60M economic value (>30% ROI) from the Severe Obstetric Complications (SOC) program

**Current state in target geography**



Population of 5,000,000 → 2,525,000 females → 55,000 births → ~1000 SOC cases per year[1]

× ~$107,000
Average societal cost of each case[2]

= ~$107M
Total annual economic cost

**Potential impact in target geography**

Reducing ~200 SOC cases per year for 3 years
(~20% annual reduction relative to national average)

~600 SOC cases prevented

= ~$62M
Estimated economic cost savings over 3-year program

**Potential annual economic value if successfully rolled out across the US**

= ~$1.4B
Total annual economic savings

1) Claims-based prevalence of severe obstetric complications based on US-wide averages
2) Excludes costs associated with reduced quality of life and therefore represents a minimum societal cost estimate

# Hypothetical Reward Example for Maternal Health



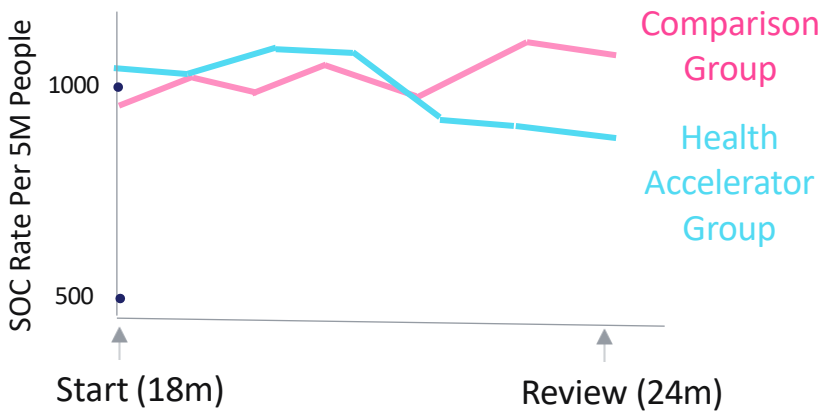
**Step 1:**
Agree to "rate card" at the start

| Rate Card at 24 months | |
|---|---|
| **Change Relative to Comparison Group** | **Outcome Payment** |
| 0% or worse | None |
| 5% | $1.875M |
| 10% | $3.75M |
| 15% | $5.6M |
| 20% or better | $7.5M |

Calculation going into the contract:

- Performance period 36 months, paid every 6 months.
- Total Outcome Buyer Commitment = $45M ($15M from ARPA-H + $30M from partners).
- Target Outcome = 20 percentage point improvement weighted over 3 years.

**Step 2:**
Every 6 months, review metrics




- In Comparison Group, rate worsens from start time by 5% (from its baseline).
- In Health Accelerator Group, rate improves from start time by 10% (from its baseline).
- Thus, Health Accelerator showed 15% improvement relative to Comparison.

**Step 3:**
Pay Health Accelerator per rate card

| Change Relative to Comparison Group | Outcome Payment ($375K per 1% change) |
|---|---|
| 0% or worse | None |
| 5% | $1.875M |
| 10% | $3.75M |
| 15% | $5.6M |
| 20% or better | $7.5M |

$

- ARPA-H / Outcome Buyers disburse $5.6M reward payment to Health Accelerator.
- 6-month cycle restarts.

ARPA-H

# Evaluating Effectiveness of Interventions and Progress Towards Financial Sustainability

## Health Outcomes

HEROES will evaluate if Health Accelerators achieve health outcome milestones.

### Tools to Monitor Success and Estimate Payout

HEROES will use metrics to:

- **Track progress toward health outcome goals at 6-month intervals** for ARPA-H funded Health Accelerators.
- **Determine the expected payout** based on changes in the outcome relative to the adjusted national average.

## Interventions

HEROES learns and shares what works and what doesn't to drive impact.

### Evaluation to Understand Intervention Effectiveness

HEROES will work with Health Accelerators to:

- **Understand which interventions were delivered to whom** to understand how population-level improvements were achieved, or why they weren't achieved.
- **Evaluate the impact of interventions on subgroups** to learn what strategies were (and weren't) effective in different demographic groups, and which strategies were effective in closing equity gaps.
- **Convene workshops for learning and diffusion among Health Accelerators** to build infrastructure for collaboration and trust.

## Sustainability

HEROES supports a path to sustainability for the program performers.

### Drivers of Financial Sustainability

Through data collected from Health Accelerators and key stakeholders, HEROES will:

- **Track Outcome Buyer and Investor activity** to determine whether the financial incentives are operating as intended.
- **Monitor financial outcomes** for all stakeholders to determine whether each Outcome Buyer and Investor met financial goals.
- **Identify which Health Accelerators successfully scaled to long-term contracts or new geographies** through renewed or expanded contracts (with Outcome Buyers and Investors) by the end of the HEROES period.

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# Today's Financing Models

| Key organizational attributes | Traditional Payers (Medicare, Medicaid, Commercial) | Public Health Departments and Agencies | Venture Capital and Private Equity-Backed Companies | HEROES |
|---|---|---|---|---|
| **Payment for prevention** | ◔ *Limitations:* Churn, provider focus | ● *Strengths:* Prevention focus | ◔ *Limitations:* Focused on high acuity patients | ● *Strengths:* Upstream outcomes |
| **Geographic accountability** | ◔ *Limitations:* Small fraction of the population | ◑ *Limitations:* Geographic scope, but no accountability | ◔ *Limitations:* Narrow population focus | ● *Strengths:* Population-wide accountability |
| **Population-level outcomes measurement** | ◔ *Limitations:* Primarily hospital-based | ◑ *Limitations:* Long lags in surveillance data | ◔ *Limitations:* Primarily hospital-based | ● *Strengths:* Near real-time population measurement |
| **Sustainable business model that integrates private capital** | ● *Strengths:* Established contracting approaches | ◔ *Limitations:* Largely grant-funded, unstable | ◑ *Limitations:* Unproven | ● *Strengths:* Meaningful business case |

**Key**

◔ Minimal alignment with program requirement
◑ Moderate alignment with program requirement
● Complete alignment with program requirement

# QUESTIONS?

ARPA-H

# Cases Closed

The closed cases from last month are listed in the agenda

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# Open Cases Overview

February 14, 2024

# Open Cases

- 2630R: UM Shore Medical Center at Easton - Full Rate Application - *No action required at this time*
- 2644A: Johns Hopkins Health System - ARM - OptumHealth Care Solutions, Inc. - *Solid Organ and Bone Marrow Transplants* **- Approved for One Year**

| | | | |
|---|---|---|---|
| **IN RE: THE APPLICATION FOR** | ***** | **BEFORE THE MARYLAND HEALTH** | |
| **ALTERNATIVE METHOD OF RATE** | ***** | **SERVICES COST REVIEW** | |
| **DETERMINATION** | ***** | **COMMISSION** | |
| **JOHNS HOPKINS HEALTH** | ***** | **DOCKET:** | **2024** |
| **SYSTEM** | ***** | **FOLIO:** | **2454** |
| **BALTIMORE, MARYLAND** | ***** | **PROCEEDING:** | **2644A** |

**Staff Recommendation**

**March 13, 2024**

## I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on February 28, 2024, 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 global rate arrangement for heart failure services and solid organ and bone marrow transplants with Optum Health, a division of United HealthCare Services, for a period of one year beginning April 1, 2024.

## II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will 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 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

The staff found the experience for this arrangement last year to be favorable.

## VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for heart failure, solid organ, and bone marrow transplant services for a one-year period commencing April 1, 2024. 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.

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# Update on Medicare FFS Data & Analysis

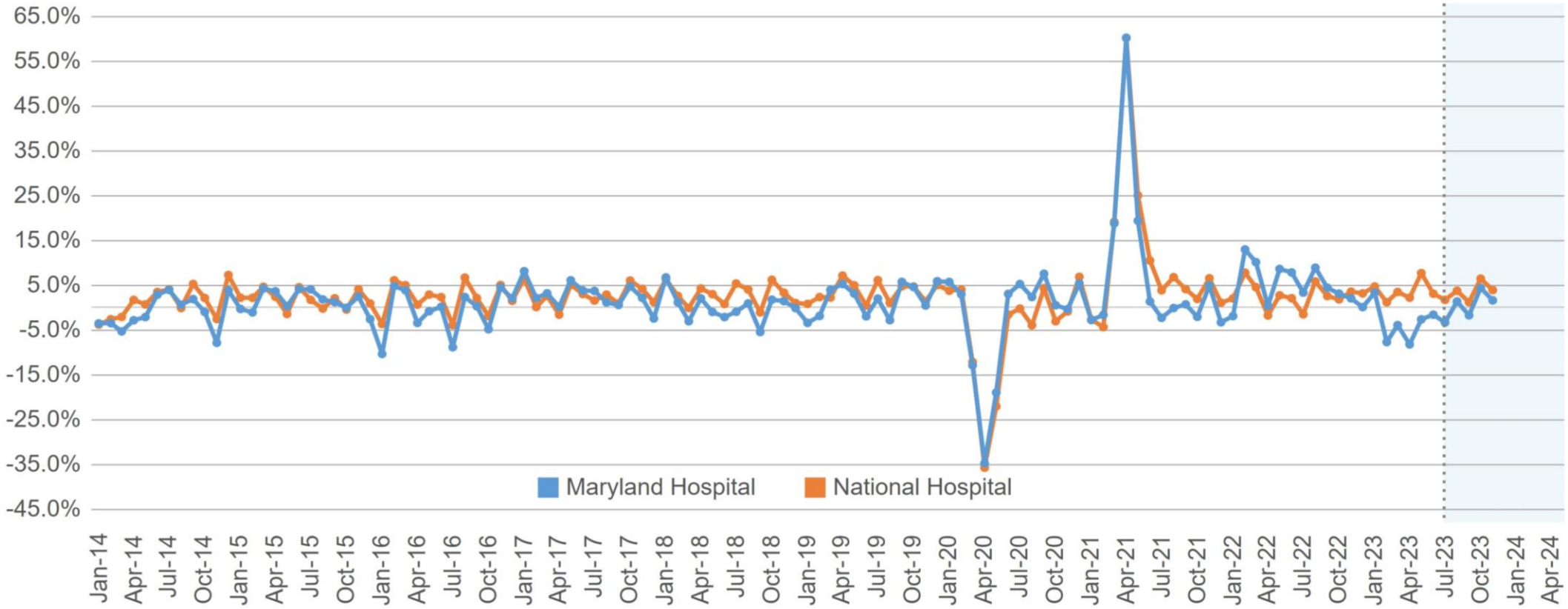
## March 2024 Update

Data through November 2023, Claims paid through January 2023

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

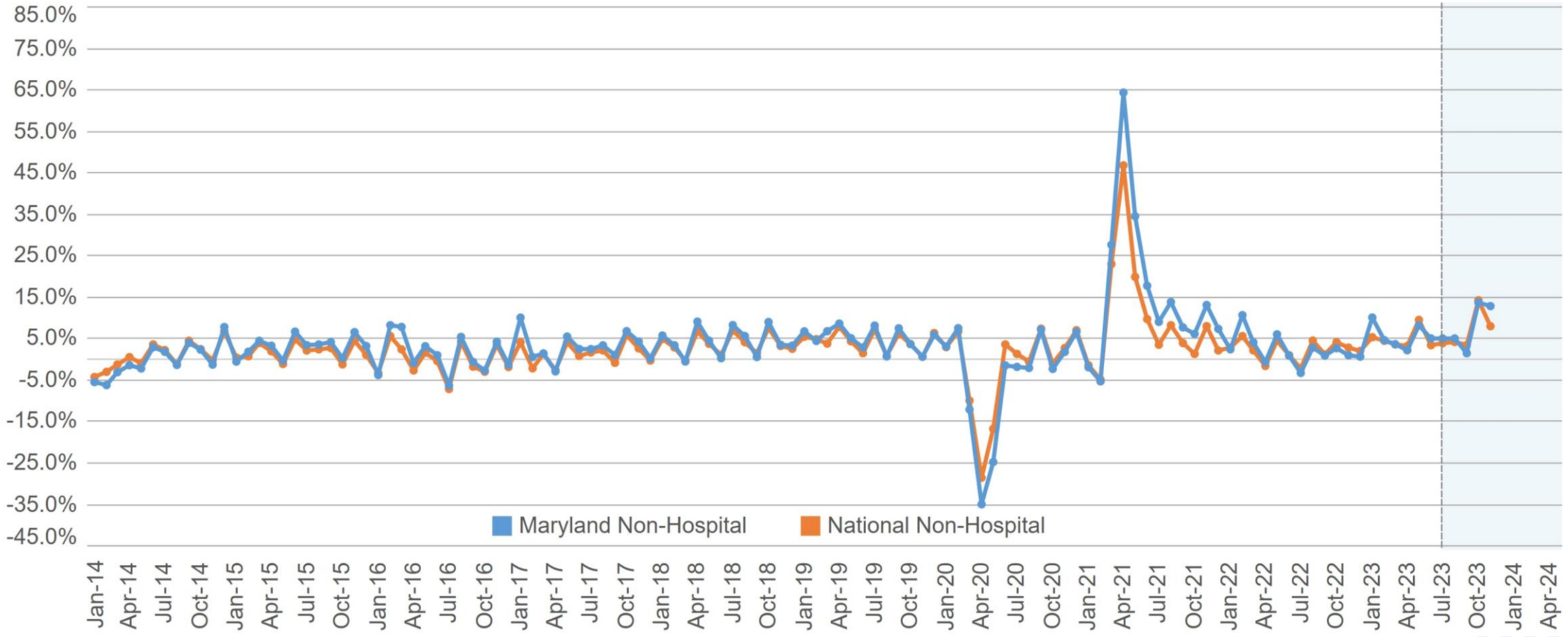
## Actual Growth Trend (CY month vs. Prior CY month)



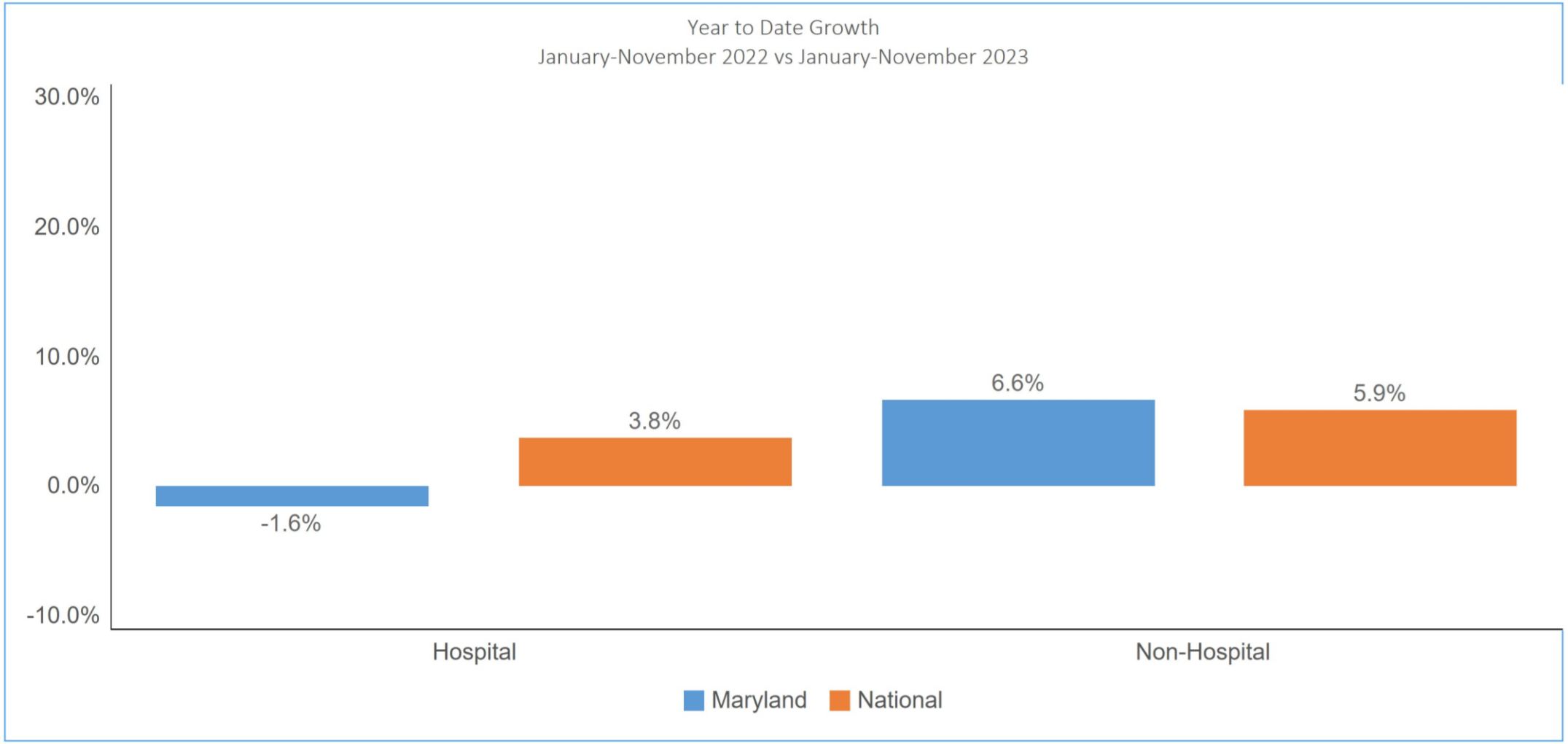

CY16 has been adjusted for the undercharge.

# Medicare Non-Hospital Spending per Capita

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

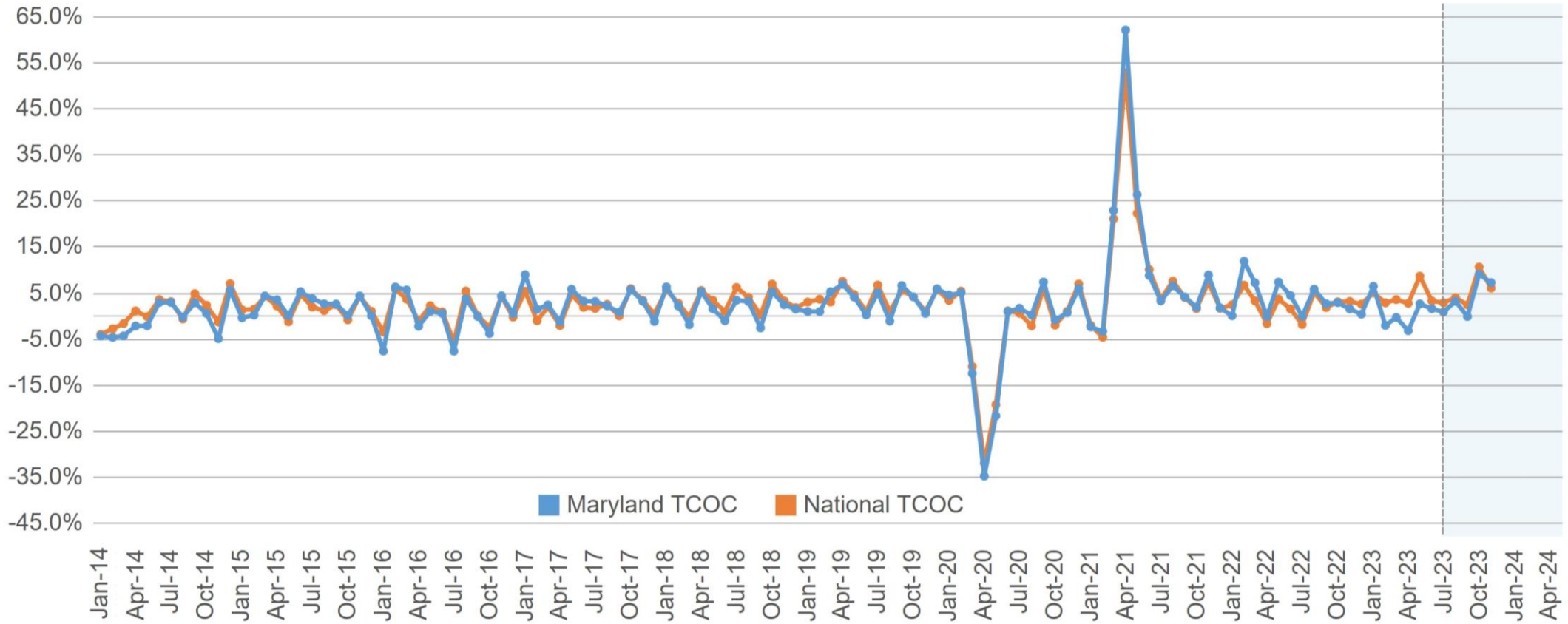


# Medicare Hospital and Non-Hospital Payments per Capita



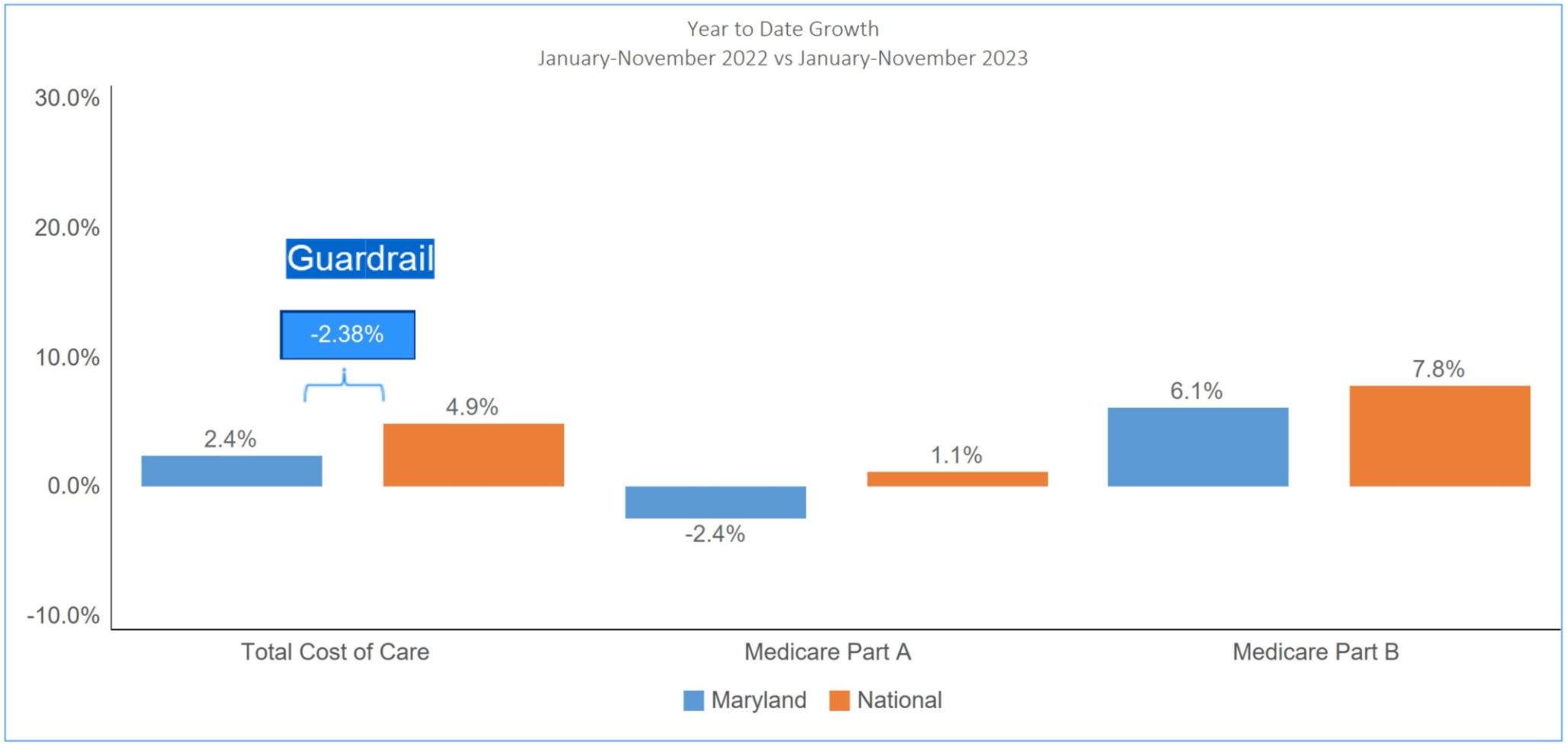
# Medicare Total Cost of Care Spending per Capita

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



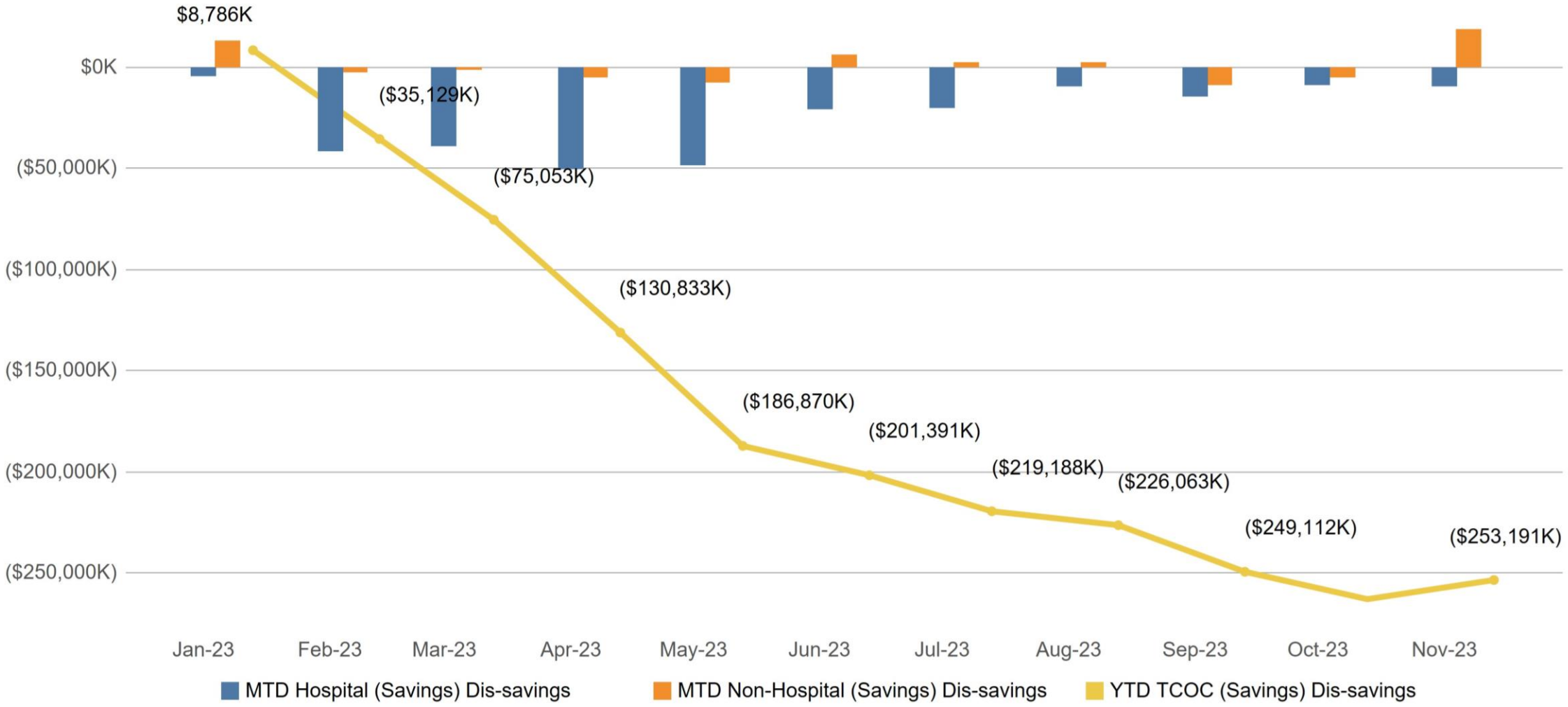

CY16 has been adjusted for the undercharge

# Medicare Total Cost of Care Payments per Capita



# Maryland Medicare Hospital & Non-Hospital Growth

## CYTD through November 2023



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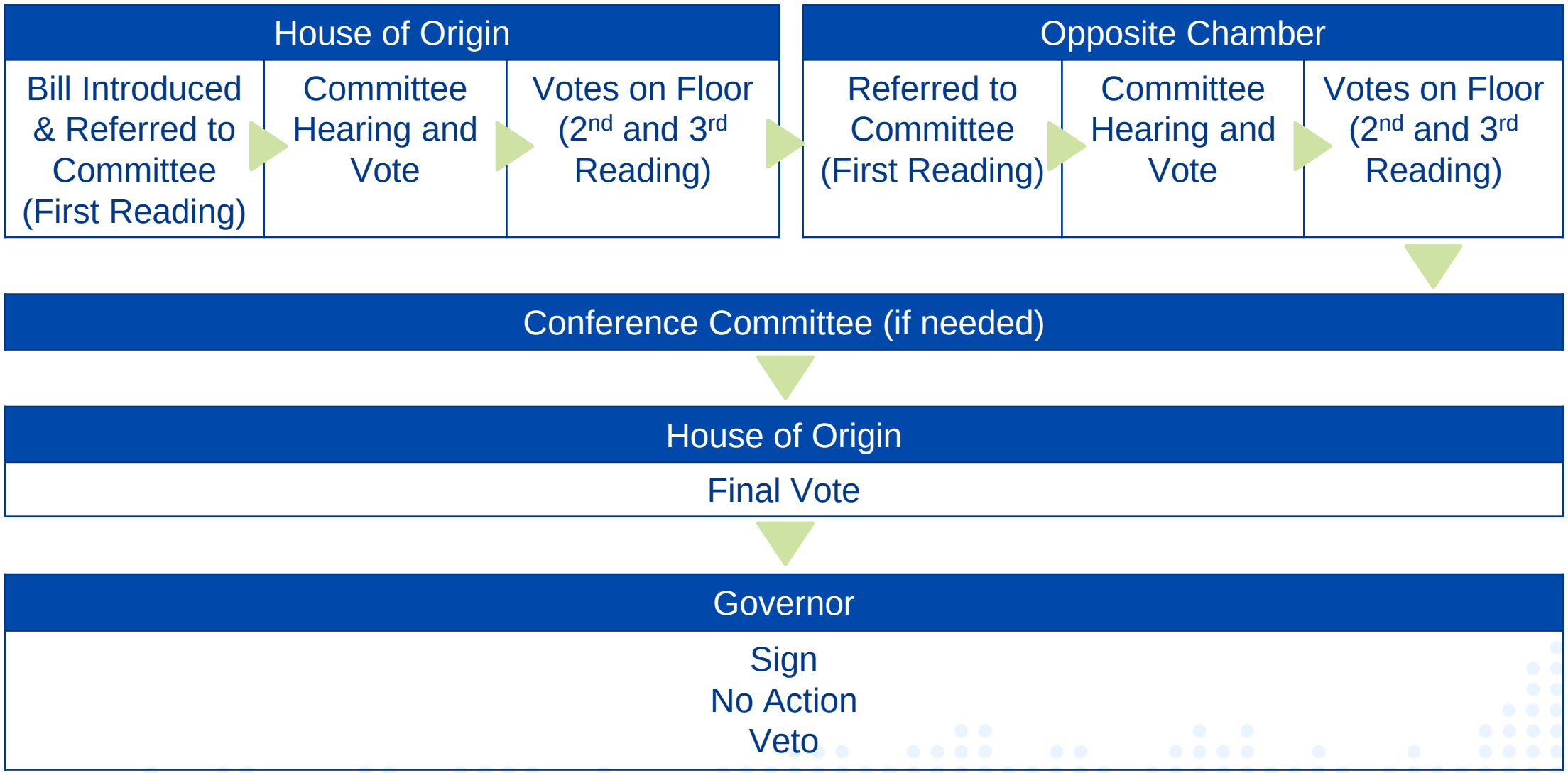
# Legislative Update

## HSCRC March 2024 Commission Meeting

March 13, 2024

# Maryland Legislative Session – Process



# MDH Study of Health Commissions and MIA

| SB 694<br>HB 887 | **Maryland Department of Health - Health Commissions and Maryland Insurance Administration - Study** | Position<br>Support |
|---|---|---|
| MDH will hire an independent consultant to study the Health Services Cost Review Commission, the Maryland Health Care Commission, the Maryland Insurance Administration, and the Maryland Community Health Resources Commission. The study will-<br>• examine overlap of the statutory and regulatory duties performed by these agencies,<br>• identify duties that should reside in MDH or another agency, and how agencies could be streamlined to reduce overlap and to improve effectiveness and efficiency.<br>MDH will report recommendations to the legislature by January 1, 2026. | | Status:<br>House and Senate bills passed house of origin |

# Maryland Commission on Health Equity

| | | |
|---|---|---|
| HB 1333 | **Maryland Commission on Health Equity - Membership and Statewide Health Equity Plan** | Position<br>Support |
| The AHEAD Model requires both the State and hospitals to create health equity plans and specifies membership and duties of the entity that develops the State health equity plan. This bill modifies the existing Health Equity Commission to allow it to play a key role in AHEAD governance, including the development of the required State Health Equity Plan. | | Status:<br>3/6 – HGO hearing |

# Emergency Department Wait Times

| | | |
|---|---|---|
| HB 1143 | **Emergency Medical Services - Maryland Emergency Department Wait Time Reduction Commission and Standardized Protocols - Establishment** | Support with Amendment |
| Establishes the Maryland Emergency Department Wait Time Reduction Commission in MIEMSS. Requires MIEMMS to develop certain standardized operational protocols and establish a system for monitoring emergency department performance. | | Status:<br>2/28 – HGO hearing<br>3/6 – HGO subcommittee |

| | | |
|---|---|---|
| HB 784 | **Task Force on Reducing Emergency Department Wait Times** | No Position |
| Establishes the Task Force on Reducing Emergency Department Wait Times to monitor and make legislative, regulatory, or other policy recommendations for reducing emergency department wait times. The Task Force must report its findings and recommendations to the General Assembly by January 1, 2026. | | Status:<br>2/28 – HGO hearing |

# Trauma Funding (1/2)

| | | |
|---|---|---|
| SB 784<br>HB 935 | **Comprehensive Community Safety Funding Act** | No Position |
| This bill creates an excise tax on firearms, accessories, and ammunition.<br>• 44% of the funding will go to the Trauma Physicians Services Fund<br>• 29% will go to Shock Trauma.<br>• The balance will be used for violence prevention and supporting victims. | | Status:<br>2/22 – Ways & Means Hearing<br>2/14 – Budget & Tax Hearing |

| | | |
|---|---|---|
| SB 1092 | **Vehicle Registration - Emergency Medical System Surcharge - Increase and Distribution of Funds** | No Position |
| Increases the motor vehicle registration emergency medical system surcharge from $17.00 to $40.00 per year.<br>• $5 will go to the Trauma Physicians Services Fund<br>• $9 will go to Shock Trauma.<br>• The balance will go to the Maryland Emergency Medical System Operations Fund. | | Status:<br>2/29 – Budget & Tax Hearing |

# Trauma Funding (2/2)

| HB 1439 | **Public Health – Funding for Trauma Centers and Services** | No Position |
|---|---|---|
| • Changes the Trauma Fund statute to allow funding for other practitioners, in addition to physicians.<br>• Increases reimbursement rates and makes other changes to the fund.<br>• Adds a requirement that the annual report to the legislature include the amount that HSCRC allowed in hospital rates for trauma costs.<br>• Increases the motor vehicle registration surcharge to provide $7.5 more to the Trauma Physicians Services Fund.<br>• Adds a new funding source (fines from DUIs).<br>• Provides at least $10M/year to Shock Trauma. | | Status:<br>2/28- Appropriations Hearing |

# Financial Assistance and Debt Collection

| | | |
|---|---|---|
| SB 1006 | **Medical Debt Collection - Sale of Patient Debt** | Letter of Information |
| Medical debt normally cannot be sold in MD. This bill allows governmental entities to purchase medical debt from hospitals for the sole purpose of absolving individuals of their debt obligations. Requires reporting to the HSCRC to adjust UCC. | | Status:<br>3/8 - Finance Hearing |

| | | |
|---|---|---|
| HB 328 | **Hospitals - Financial Assistance Policies - Revisions** | Support |
| This bill removes language that allows hospitals to only provide reduced cost care to patients in their service area. It also prohibits hospitals from using asset tests to determine eligibility for free and reduced-cost care. | | Status:<br>The House passed the bill |

# Notice of Outpatient Facility Fees

| | | |
|---|---|---|
| SB 1103<br>HB 1149 | **Hospitals and Related Institutions - Outpatient Facility Fees** | Letter of Support with Amendment |
| This bill strengthens consumer notice requirements for outpatient facility fees by requiring notices for all outpatient services, not just the clinic rate center. HSCRC is required to do a study to make recommendations for changes to hospital outpatient facility fees on cost, access, and health equity. | | Status:<br>3/6 - HGO Hearing<br>3/8 - Finance Hearing |

# Hospital Staffing Committees

| | | |
|---|---|---|
| SB 1020<br>HB 1194 | **Hospitals - Clinical Staffing Committees and Plans - Establishment** | No Position |
| This bill requires hospitals to establish staffing committees which will create annual clinical staffing plans indicating-<br>• how many patients are assigned to each RN, and<br>• the number of nurses and ancillary staff present on each unit and shift.<br>The bill would require HSCRC to:<br>• collect staffing plans from hospitals and post the plans on our website;<br>• investigate complaints about failure of a hospital to establish a staffing committee and/or adopt a staffing plan;<br>• publicly post infractions, require corrective action plans, and apply civil penalties,<br>• Hold a workgroup and submit an annual report to the legislature. | | Status:<br>3/13 – HGO Hearing<br>3/14 – Finance Hearing. |

# Hospitals - Quality

| | | |
|---|---|---|
| SB 332<br>HB 84 | **Hospitals and Urgent Care Centers - Sepsis Protocol (Lochlin's Law)** | Letter of Information |
| This bill requires each hospital and urgent care center to implement a protocol and periodic training for the early recognition and treatment of a patient with sepsis, severe sepsis, or septic shock. | | Status:<br>The House passed HB 84 with an amendment.<br>The Finance Committee amended SB 332. |

# Access to Insurance

| | | |
|---|---|---|
| SB 705<br>HB 728 | **Health Insurance - Qualified Resident Enrollment Program (Access to Care Act)** | Support |
| Pending approval by CMS, allows Maryland residents who do not qualify for Medicaid, CHIP, or premium tax credits through the Maryland Health Connection to buy qualified health insurance through the Maryland Health Connection with no tax credits. | | Status:<br>House and Senate bills were amended and passed house of origin. |

# Budget

| | | |
|---|---|---|
| SB 360<br>HB 350 | **Budget Bill (Fiscal Year 2025)** | No Position |
| Includes HSCRC's operating budget, funding for CRISP, and the uncompensated care fund. | | Status:<br>3/8 – Budget & Tax Committee made decisions.<br>TBD –Appropriations Committee decisions. |

# Questions?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# Final Staff Recommendation for the Release of HSCRC Confidential Patient Level Data to

# The University of Maryland School of Medicine (UMSOM) Shock Trauma and Anesthesiology Research Center, and the National Study Center for Trauma and EMS (NSC)

**Health Services Cost Review Commission**

**4160 Patterson Avenue, Baltimore, MD 21215**

March 13, 2024

**This is a final recommendation for Commission consideration at the March 13, 2024, Public Commission Meeting.**

## SUMMARY STATEMENT

The University of Maryland School of Medicine (UMSOM), and the National Study Center (NSC) for Trauma and EMS, is requesting access to the Health Services Cost Review Commission (HSCRC) Inpatient and Outpatient Hospital Data, that includes limited confidential information ("the Data") for the Injury Outcome Data Evaluation System (IODES). The Commision last approved access to the Data for this project on January 11, 2023.

## OBJECTIVE

The IODES project is designed to make data related to injury available for analysis. The Data will be used for analysis of injuries to persons treated at Maryland hospitals. To fulfill a key component of the IODES effort, the Data will be linked (where possible) to police crash reports, EMS run sheets, and other datasets as required for further analysis. The NSC has been working with the Maryland Department of Transportation, Maryland Highway Safety Office (MDOT MDHSO) and other partners on the Crash Outcome Data Evaluation Systems (CODES) project for more than a decade.

Investigators received approval from the Maryland Department of Health (MDH) IRB on February 7, 2024, and the MDH Strategic Data Initiative (SDI) office on January 12, 2024. The Data will not be used to identify individual hospitals or patients. This project is designed as an umbrella project that will continue to address individual approved projects and tasks to improve the public health of Marylanders with injuries, and has no end date. However, the Project Principal Investigator will notify the HSCRC if the project were terminated, and at that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

## REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee is composed of representatives from HSCRC and the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements described below and to make recommendations for approval to the HSCRC at its monthly public meeting.

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

The Review Committee unanimously agreed to recommend that UMSOM be given access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

## STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by UMSOM for the Data for Calendar Years 2021 through 2026 be approved.

2. This access will include limited confidential information for subjects meeting the criteria for the research.

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# MPA Final Recommendation

March 13, 2024

# MPA Final Recommendations for CY 2024

- This final recommendation reflects the removal of the CTI buyout provision which CMS did not approve. Includes the following revisions:
  - **Increase maximum revenue at risk under the traditional MPA to 2%**
    - This has been a stated goal of CMS for the last two years
    - Increasing the revenue at risk to 2% doubles it under the traditional portion of the MPA and applies only to the amount by which the TCOC performance exceeds the TCOC target
  - **Add Population Health Measure with weight of 4% of bonus/penalty**
    - Consistent with prior recommendation, adds to 4% currently at risk for RRIP (2%) and MHAC (2%)
    - Quality values are doubled so total quality risk to 16% of penalty/bonus (total risk = ±2.32%)
  - **Cap downside risk of a hospital under the CTI program to 2.5% of total Medicare payments**
    - Redistribution of additional risk across all hospitals in order to maintain revenue neutrality
    - Currently there is no cap on downside risk so this creates greater predictability for hospitals

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# Medicare Performance Adjustment Calendar Year 2024

## Final Recommendation

February 2024

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# Table of Contents



This document contains the staff final recommendations for the Medicare Performance Adjustment for Calendar Year 2024.

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# Recommendations For CY 2024 MPA Policy

1. Increase the maximum at risk under the traditional MPA to 2%
2. Implement the population health quality measure adopted by the Commission into the MPA quality score as outlined in last year's final MPA recommendation.

In 2021, Staff completed a major policy review of the MPA. As a result of the review, the Commission revised the attribution algorithm and the methodology for calculating the rewards / penalties under the MPA. During the review, stakeholders emphasized that the MPA policy had changed numerous times and stressed the need for consistency in the future. Correspondingly, Staff recommend keeping the majority of the MPA unchanged. However, Staff are recommending the limited changes described above to keep the MPA aligned with other State and federal policymaking. The following discussion provides rationale and detail on each of these recommendations.

In addition, Staff recommend the following revision to the Medicare Performance Adjustment Framework (MPA Framework) approved by the Commission in October 2019:

1. Cap the downside risk of a hospital under the CTI program to 2.5% of total Medicare Payments and redistribute additional risk across all hospitals to maintain the overall savings neutrality in the program.

The following discussion provides rationale for this recommendation.

# Policy Overview

| Policy Objective | Policy Solution | Effect on Hospitals | Effect on Payers/Consumers | Effect on Health Equity |
|---|---|---|---|---|
| The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1) | This MPA recommendation fulfills the requirements to determine an MPA policy for CY 2024 and makes incremental improvements to the current policy | The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care. | This policy does not affect the rates paid by payers. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area. | This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost |

| | | | | |
|---|---|---|---|---|
| Attribute 95 percent of all Maryland Medicare beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed TCOC and the benchmark. | and to the related MPA Framework. | Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by CMS and not on the amount charged by the hospital. In other words, this policy does not change the GBR or any other rate-setting policy that the HSCRC employs and – uniquely – is applied only on a Medicare basis. | | of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care. |

# Introduction to MPA Policies

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area.

The MPA includes three "components": (a) a Traditional Component, which holds hospitals accountable for the Medicare total cost of care (TCOC) of an attributed patient population, (b) a Reconciliation Component, which rewards hospitals for the care redesign interventions and (c) a Savings Component that allows the Commission to adjust hospital rates to achieve the Medicare Total Cost of Care Model (the Model) savings targets.

The Traditional Component is governed via annual updates to the MPA policy adopted by the Commission. This document represents the update for Calendar Year 2024 (also known as MPA Year 6). The Efficiency and Savings Component are governed via the MPA Framework. The recommendation to cap CTI risk at 2.5% is a change to the Reconciliation Component and is the first change in the MPA Framework related to the Reconciliation Component since it was adopted. This policy does not relate to the Savings

Component. These three components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount to inflator to the amount that Medicare pays on each claim submitted by the hospital.

# Recommendations Related to the MPA Traditional Component

## Recap of Current Program

The following recaps the traditional MPA as it was implemented for Calendar Year 2023, it is included as a reference. The approaches described were adopted incrementally in the Calendar Year 2021, 2022 and 2023 MPA polices, and those policies remain in effect except where changes are specifically denoted in the next section.

The first step in the process is to attribute beneficiaries to hospitals. The Model requires 95% of beneficiaries be attributed to hospitals under the MPA. The current attribution is as follows:

1. Hospitals, except Academic Medical Centers (AMCs) are attributed the costs and beneficiaries in zip codes that comprise 60% of their volume. AMCs are assigned all zip codes for Baltimore City for their geographic attribution. Beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share of equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMADs are calculated from Medicare FFS claims for Calendar Year 2019. ECMADs are also used in calculating the volumes in the 60% test.
2. Zip codes not assigned to any hospital under step 1 are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed a 30-minute drive-time from the hospital's PSA.
3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.
4. A second layer is added for AMCs. AMCs are also attributed where beneficiaries with a CMI of greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as to the hospital under the standard attribution. The AMC outcome becomes a blend of this approach and the standard geographic approach.

The MPA then penalizes or rewards hospitals based on their attributed TCOC. Hospitals are rewarded if the TCOC growth of their attributed population is less than national growth. Beginning in 2021, the HSCRC scaled the growth rate target for hospitals based on how expensive that hospital's service area is during the baseline period relative to other geographic areas elsewhere in the nation. This policy is intended to ensure that hospitals which are expensive relative to their peers bear the burden of meeting the Medicare savings

targets, while hospitals that are already efficient relative to their peers bear proportionally less of the burden. The TCOC growth rate adjustments are shown in Table 1 below.

*Table 1: Scaled Growth Rate Adjustment*

| Hospital Performance vs. Benchmark | TCOC Growth Rate Adjustment |
|---|---|
| 1st Quintile (-15% to + 1% Relative to Benchmark) | 0.00% |
| 2nd Quintile (+1% to +10% Relative to Benchmark) | -0.25% |
| 3rd Quintile (+10% to +15% Relative to Benchmark) | -0.50% |
| 4th Quintile (+15% to +21% Relative to Benchmark) | -0.75% |
| 5th Quintile (+21% to +28% Relative to Benchmark) | -1.00% |

Historically, hospitals were required to beat the national TCOC growth rate each year. But in 2021, the HSCRC changed the way that the TCOC is calculated for hospitals. The HSCRC will trend the hospital's baseline TCOC forward based on the national growth rate and the TCOC adjustment factors. This was intended to create more predictability for hospitals. A hospital can now predict what their target will be two or three years out. An example of the methodology to calculate the TCOC targets is shown in Table 2 below. This example covers 2019 to 2021, for each additional year another year of trend similar to item C in Table 2 is added. Each additional year is also adjusted for the Growth Adjustment Factor (item D in Table 2).

*Table 2: Calculation of the MPA Targets*

| Variable | Source |
|---|---|
| A = 2019 TCOC | Calculation from attributed beneficiaries |
| B = 2020 National TCOC Growth | Input from national data |
| C = 2021 National TCOC Growth | Input from national data (assumed to be 3% in example below) |
| D = Growth Rate Adjustment Factor | From Growth Rate Table (applies to 2021 and all subsequent years) |
| E = MPA TCOC Target | A x (1 + B) x (1 + C - D) = E |
| Example Calculation of MPA Targets | |

| Hospital | Quintile | Target Growth Rate | 2019 TCOC | 2020 MPA Target | 2021 MPA Target |
|---|---|---|---|---|---|
| Hospital A | 1 | 3% - 0.00% = 3.00% | $11,650 | $12,000 | $12,359 |
| Hospital B | 2 | 3% - 0.25% = 2.75% | $11,193 | $11,529 | $11,846 |
| Hospital C | 3 | 3% - 0.50% = 2.50% | $11,169 | $11,504 | $11,792 |
| Hospital D | 4 | 3% - 0.75% = 2.25% | $11,204 | $11,540 | $11,800 |
| Hospital E | 5 | 3% - 1.00% = 2.00% | $10,750 | $11,073 | $11,294 |

The hospital is rewarded or penalized based on how their actual TCOC compares with their TCOC target. Through last year the rewards and penalties were scaled such that the maximum reward or penalty was 1% which will be achieved at a 3% performance level (the recommendation advanced later in this proposal is to increase this to 2% and 6%). Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage. An example of the hospital's rewards/penalties is shown in the table below.

*Table 3: Example of MPA Reward & Penalty Calculations (excluding quality adjustments)*

| Variable | Input |
|---|---|
| E = MPA Target | See previous section |
| F = 2021 MPA Performance | Calculation |
| G = Percent Difference from Target | (E - F) / E |
| H = MPA Reward or Penalty | (G / 3%) x 1% |
| I = Revenue at Risk Cap | Greater / lesser of H and + / - 1% |

Example MPA Performance Calculations

| Hospital | MPA Target | MPA Performance | % Difference | Reward (Penalty) |
|---|---|---|---|---|
| Hospital A | $12,359 | $12,235 | -1.00% | 0.30% |
| Hospital B | $11,846 | $11,941 | 0.80% | -0.30% |

| | | | | |
|---|---|---|---|---|
| Hospital C | $11,792 | $11,556 | -2.00% | 0.70% |
| Hospital D | $11,800 | $12,154 | 3.00% | -1.00% |
| Hospital E | $11,294 | $11,859 | 5.00% | -1.00% |

In addition, the agreement with CMS requires that a quality adjustment be applied that reflects hospital quality outcomes, this is in addition to the revenue-at-risk for Total Cost of Care. These quality adjustments are derived from those in the Commission's all-payor Readmission Reductions Incentive Program (RRIP) and Maryland Hospital Acquired Conditions (MHAC) program. Revisions to the quality adjustment for CY2024 are outlined below.

## Recommended Revisions to the traditional MPA

### Increase Maximum Revenue-at-Risk

Staff recommends increasing the amount of revenue-at-risk for Total Cost of Care performance under the Traditional MPA to ±2%. Increasing the revenue at risk under the MPA has been a stated goal of the Center for Medicare and Medicaid Services (CMS) for the last two years. In their approval of the current year MPA dated January 18, 2023, CMS noted "As stated in the MPA PY 2022 CMS response letter issued October 10, 2021, CMS expects the State to increase the revenue-at-risk (± 1%) under the traditional MPA in 2024".

The increase to 2% is consistent with this directive from CMS to increase the revenue-at-risk. Staff are recommending setting the new level at ±2% based on further input from CMS and discussions with stakeholders about the reasonable level of increase. The translation between actual results and the revenue-at-risk would not be changed from the current 3:1 ratio. Therefore, the revenue-at-risk would be reached at ±6%.

### Add Population Health Measure

In last year's final recommendation, the Commission approved adding a population health metric to the quality adjustment included in the Traditional MPA once a measure had been identified. This expected addition was also noted by CMS in their January 18, 2023, approval letter. The Commission is now considering a population health measure, Staff recommend including that measure, once finalized, in the Calendar Year 2024 MPA adjustment according to the formula approved last year (adjusted for 2% revenue-at-risk):

*TCOC results x 1/3 (capped at 2% of Medicare revenue) x (1 + 2 x (RRIP + MHAC Reward/Penalty + Population Health Quality Measure) where the Population Health Quality Measure is scaled to generate a result of ±4%.*

This formula will result in total revenue-at-risk of ±2.32% of Medicare payments.

# Recommendations Related to the MPA Framework Reconciliation Component

## Recap of Current Program

In the MPA Framework recommendation Staff noted that under GBRs hospitals do not capture utilization savings that occur outside their GBR and therefore any successes they achieve help the State meet the TCOC Model savings target but do not help the hospitals. The Commission adopted the MPA Framework recommendation and implemented the CTI program as a response to this disconnect. The recommendation noted the following principles in order to strengthen hospital incentives:

- Hospitals should keep the savings from their CTIs up to 100% to the extent feasible.
- Incentives should be structured to reward participation in CTIs and penalize non-participation.
- New and Existing CTIs that transform care across the entire delivery system should be supported.

The Framework also included the use of the MPA-RC to pay incentives earned under CTIs and to offset those incentives by reducing Medicare Fee-for-service payments to all hospitals to create a net zero adjustment (the Offset). This approach was adopted as per the Staff's October 2019 Final MPA Framework Recommendation, "First, it mitigates the possibility that these care transformation payments will result in a net increase in the TCOC run rate. Second, when a hospital captures the savings from their CTIs, the resulting increased costs will be spread as an offset across all hospitals resulting in non-participating hospitals being 4 penalized for their non-participation."

The CTI program has just completed its second performance year (on June 30, 2023) and the third performance year is underway. Staff shared results from the first performance year with the Commission in October 2023. These results reflected significant participation with 107 total CTIs, $130 Million of gross scored savings and revenue redistribution from unsuccessful to successful hospitals of $56 Million. In Year 3 the number of CTIs increased to 249.

## Recommended Revisions – Cap Hospital Downside Risk

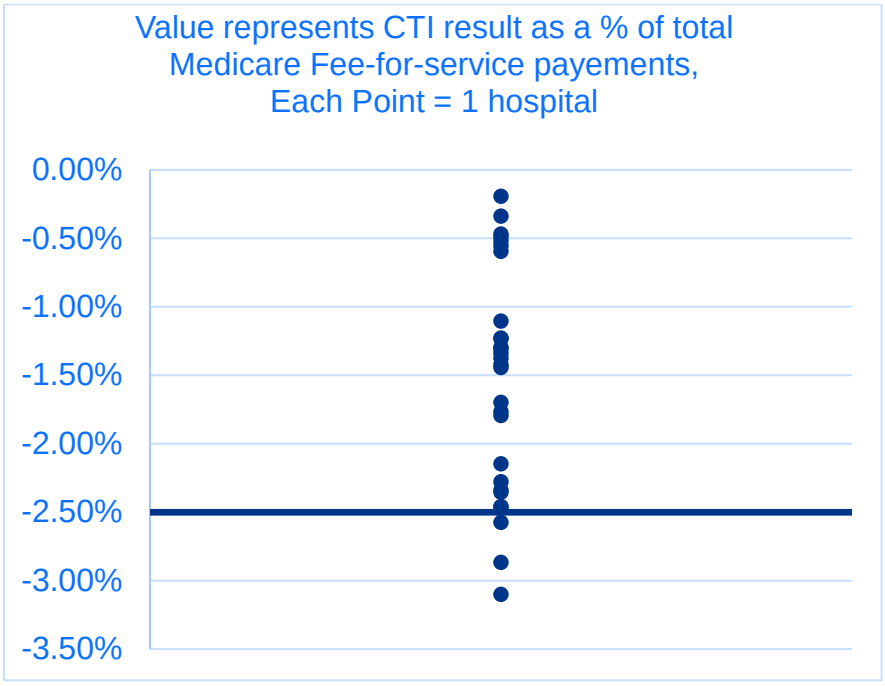
As discussed above one of the principles of CTIs was that "hospitals should keep the savings from their CTIs up to 100% to the extent feasible." One result of that principle is that there can be no cap on downside risk to hospitals in the Offset or else hospitals would not be able to realize their full benefit and maintain overall neutrality. The implication of this approach is that hospitals have theoretically unlimited downside risk and the amount of actual risk is hard to quantify as it depends on the level of success achieved by other hospitals.

For these reasons hospitals have advocated for a cap on downside risk after implementation of the Offset. Staff have been concerned that such a cap would dilute the incentives for hospitals by allowing them to "choose" the downside cap rather than aggressively pursuing care transformation. This concern was particularly acute when there was no insight into the actual level of downside risk in the program.

Now that the first year of CTI performance results are available Staff believes setting a downside cap at the outer edge of actual experience to create greater predictability for hospitals is appropriate. Therefore, Staff recommends the Commission cap the downside risk of a hospital under the CTI program to 2.5% of total Medicare Payments, effective with the second program year (Fiscal Year 2023) and redistribute additional risk across all hospitals to maintain the overall savings neutrality in the program (note the redistribution would include the capped hospitals resulting in an effective cap slightly higher than 2.5%).

The recommendation of a cap equal to 2.5% is based on the actual results from the first year. These results are summarized in Exhibit 1. This level was selected to avoid creating immunity from harm for hospitals while still providing a level of protection that is relevant to the outcomes of the program.

## Exhibit 1: Distribution of Loss Values, First CTI Performance Year



# Discussions of Comments Received

## Background

As with all recommendations this draft recommendation was developed with substantial community input including ideas and commitments resulting from prior recommendations, a series of specific workgroups and ongoing dialog with stakeholders. However, a formal comment period and Staff discussion of those responses is usually held for the final recommendation. Staff departed from this practice for this draft recommendation because this recommendation will be the basis for requesting approval from CMS for the MPA Policy, as required under the TCOC Model Agreement. Should CMS not approve the approach outline herein those changes will be addressed in the Final Recommendation.

In addition to discussion during the workgroups, Staff held two more formal comment submission periods during the workgroup process, one prior to the October 25, 2024, Total Cost of Care Workgroup and a second prior to the submission of this recommendation. The next section recaps these comments along with staff response. Across the two rounds letters were received from MHA, the University of Maryland Medical System. Medstar Health, Johns Hopkins Health System and Adventist Health System in the first round.

## Recap of Comments

Major areas of focuses addressed by multiple stakeholders include:

**Support for the CTI Buy Out:** Industry stakeholders strongly supported the re-introduction of the CTI Buy Out.

**Support for capping downside risk on CTIs:** Industry stakeholders strongly supported a cap on downside risk on CTIs to create a level of predictability for hospitals. Staff changed the proposed cap from 3.0% to 2.5% based on this feedback.

**Concerns about overall level of total cost of care risk:** Stakeholders acknowledge the need to raise the revenue-at-risk under MPA to 2%. Industry raised concerns that under the combination of MPA, CTI and Commission Efficiency policy, hospitals have significant revenue at risk related to total cost of care. Staff included in this recommendation a quantification of that total risk exposure and plans to include a similar discussion in the MPA request to CMS. While most comments pertained to the level of risk being potentially too high, one commenter noted that the 3:1 translation of performance in the MPA (i.e. it takes a 6% win/miss to generate a 2% reward/penalty) dilutes the rewards for strong MPA performance and significantly and may be a disincentive to effective management. Staff believes the Commission should consider a change to this approach in the future.

**Population Health Measure:** There were significant concerns raised about the proposed diabetes-related quality measure to be used in the population health element of the MPA quality adjustment. This recommendation is silent on the specific measure to be used and Staff believe those concerns will be addressed in the relevant recommendation. Staff notes that the inclusion of a population health metric in the MPA has long been a request of CMS and that the Commission needs to identify a meaningful measure for inclusion within this recommendation.

**Other CTI Provisions:** Stakeholders identified a number of concerns related to specific technical elements of the CTI program and the need for continual education on these programs. Staff continually review the specifics of these programs. Staff working with CRISP have established a Learning Collaborative to provide information to hospitals and other stakeholders on these programs.

**Data Analytics:** One stakeholder identified areas where the Commission could strengthen analytics related to the various care transformation programs. Staff continually work with CRISP to enhance reporting under these programs.

**Benchmarking:** One stakeholder suggested the Commission should revisit the benchmarks used to set the MPA targets as performance may have changed since the base year of 2019. Staff are currently planning to refresh the total cost of care benchmarks starting in the summer of 2024 for 2025 implementation.

**Continued interest in revising the beneficiary algorithm used in the MPA:** Industry commentator acknowledge the challenges with the old primary care-based attribution in the MPA but also continued to raise concerns that the current geographic-based attribution does not properly incent care transformation. Staff believe the combination of the geographic MPA and the hospital-targeted CTI policy is the best available alternative given current constraints and does not believe revisiting this issue is merited in the short-term.

**Impact of CTI offset on Academic Institutions:** One commenter noted that *"The linkage of these policies [CTI-related policies] to Medicare revenue disproportionately impacts the state's academic medical centers (AMCs) compared to others in the state, because AMCs receive patients from across the state and country due to the regional and national programs they support. This provides less opportunity to engage in and impact longitudinal care or outcomes for some patients who reside outside of the immediate area of the hospital."* Staff understands the concern that the opportunity for AMCs under CTI may be less than their relative revenue under the policy as the offsetting revenue to CTI savings is distributed based on fee-for-service Medicare revenue. However, Staff does not believe a policy change is merited absent quantification of the relative lack of opportunity and an alternative method of distributing the offset that was fair to all parties.

# Appendix A: CTI Representation Analysis

Exhibit A1 compares the representations of certain populations in implemented CTIs ("Attributed" column) to their representation were the same set of CTI definitions implemented Statewide for all Medicare Fee-for-service beneficiaries ("Unattributed" column). The results are not consistent with systematic underrepresentation among the underserved populations that we analyzed. There is a slight underrepresentation in implemented CTIs in rural areas and a slight over-representation in Health Professional Shortage areas (see note 2). Both of these are populations with relatively small representation in total and therefore it only takes 1 or 2 CTIs to create this phenomenon. Staff will work with rural hospitals during the next enrollment period to determine if there are any systematic barriers.

## Table A1: Representativeness of Attributed CTI Episodes Relative to Unattributed CTI Episodes

| | All Potential CTI Episodes | | |
|---|---|---|---|
| **Population** | **Attributed** | **Unattributed** | **MSD (1)** |
| **N** | 345,357 | 16,374,896 | - |
| **Black or African American** | 26.4% | 26.5% | -0.001 |
| **Hispanic** | 1.3% | 1.3% | -0.001 |
| **Asian/Pacific Islander, American Indian/Alaska Native, Other/Unknown** | 7.4% | 7.4% | 0.000 |
| **Dual Medicaid Eligibility** | 20.3% | 17.7% | 0.069 |
| **Disabled** | 19.4% | 19.4% | 0.000 |
| **High-Deprivation Neighborhood** | 12.6% | 13.7% | -0.031 |
| **Rural Census Tract** | 3.4% | 7.3% | -0.148 |
| **Health Professional Shortage area** | 3.2% | 1.7% | 0.117 |

Notes:

1. MSD: The Mean Standardized Difference is the difference in means between two groups as a fraction of the standard deviation in the measure.
2. An MSD below 0.10 is generally considered ignorable small and many sources consider an MSD less than 0.20 as ignorable.
    a. An MSD > 0 indicates that attributed EQIP episodes have more representation of a given underserved population than in the pool of statewide unattributed episodes.
    b. An MSD < 0 indicates that attributed EQIP episodes have less representation.

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# Update Factor Model Review

March 13, 2024

# Update Factor Model Review

# HSCRC Payment Model Work Group Roster

**Ed Beranek**
Vice President of Revenue Management and Reimbursement
John Hopkins Health Systems

**Barbara Brocato**
Founder and President
Barbara Marx Brocato and Associates

**Susan Nelson**
Executive Vice President & Chief Financial Officer
MedStar Health

**Kathy Talbot**
Senior Executive Director of Finance
Tidal Health

**Vincent DeMarco / Stan Dorn**
President
Maryland Citizens Initiative

**Lori Golden**
Vice President,
Network Management
United HealthCare

**Alicia Cunningham**
Senior Vice President
Reimbursement & Revenue Advisory Services
University of Maryland Medical System

**Stu Guterman**
Senior Scholar
Academy Health

**Arin Foreman**
Director, Health Services Cost and Affordability
CareFirst

**J. David Johnson, MBA**
Vice President & Senior Health Consultant
Bolton Health

**Amber Ruble**
Chief Financial Officer
UPMC Western Maryland

**Michael Myers**
Vice President, Regulatory Reporting & Reimbursement
LifeBridge Health

**Hannah Jacobs**
Senior Vice President & Chief Financial Officer
Frederick Regional Health System

**Wynee Hawk, RN, JD**
Director, Center for Health Care Facilities Planning & Development
Maryland Health Care Commission

**Katie Eckert, CPA**
Vice President, Reimbursement & Strategic Analytics
Adventist HealthCare

**Josh Repac**
Chief Financial Officer
Meritus Health

**Laura Russell, MPH**
Director, Health Care Payment
Maryland Hospital Association

**Tricia Roddy**
Deputy Medicaid Director
Maryland Department of Health

**Ge Bai, PhD, CPA**
Professor of Accounting
Johns Hopkins Carey Business School

# Policy Objective and Update Factor Components

- The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.

- One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Total Cost of Care Agreement.

Components Include:

- Inflation
- Care Coordination
  - Regional Partnerships
- Population and Demographic Adjustments
- Quality/ PAU
  - MHAC, QBR, RRIP
- Other Adjustments
  - Unforeseen Adjustments
  - Complexity & Innovation
  - Capital Adjustments/FRA increases
- Revenue Offsets with Neutral Impact of Financial Statements
  - Deficit Assessment
  - Uncompensated Care

Balanced Update Model for RY 2024

Components of Revenue Change Link to Hospital Cost Drivers /Performance

| | | | Weighted Allowance |
|---|---|---|---|
| Adjustment for Inflation (this includes 4.80% for Wages and Salaries) | | | 3.35% |
| - Outpatient Oncology Drugs | | | 0.00% |
| **Gross Inflation Allowance** | **A** | | **3.35%** |
| | | | |
| **Care Coordination/Population Health** | | | |
| - Reversal of One-Time Grants | | | -0.22% |
| - Regional Partnership Grant Funding RY24 | | | 0.19% |
| **Total Care Coordination/Population Health** | **B** | | **-0.03%** |
| | | | |
| **Adjustment for Volume** | | | |
| -Demographic /Population | | | 0.39% |
| -Drug Population/Utilization | | | 0.00% |
| | | | |
| **Total Adjustment for Volume** | **C** | | **0.39%** |
| **Other adjustments (positive and negative)** | | | |
| - Set Aside for Unknown Adjustments | D | | 0.10% |
| - Low Efficiency Outliers | E | | 0.00% |
| - RY 2022 Surge Funding | F | | 0.20% |
| - Complexity & Innovation | G | | 0.10% |
| -Reversal of one-time adjustments for drugs | H | | -0.04% |
| -Capital Funding & Estimated Increase for Full Rate Applications | I | | 0.41% |
| | | | |
| **Net Other Adjustments** | **J=** | **Sum of D thru I** | **0.77%** |
| | | | |
| **Quality and PAU Savings** | | | |
| -PAU Savings | K | | -0.38% |
| -Reversal of prior year quality incentives -QBR, MHAC, Readmissions | L | | -0.32% |
| -Current Year Quality Incentives | M = | | -0.25% |
| **Net Quality and PAU Savings** | **N =** | **Sum of K thru L** | **-0.95%** |
| | | | |
| **Total Update First Half of Rate Year 23** | | | |
| Net increase attributable to hospitals | **O =** | Sum of A + B + C + J + N | **3.53%** |
| Per Capita First Half of Rate Year (July - December) | **P=** | (1+O)/(1-0.16%) | **3.70%** |
| **Adjustments in Second Half of Rate Year 24** | | | |
| -Oncology Drug Adjustment | Q | | 0.00% |
| -Current Year Quality Incentives | R | | 0.00% |
| **Total Adjustments in Second Half of Rate Year 24** | **S =** | Q+ R | **0.00%** |
| **Total Update Full Fiscal Year 24** | | | |
| Net increase attributable to hospital for Rate Year | **T =** | O + S | **3.53%** |
| Per Capita Fiscal Year | **U =** | (1+T)/(1-0.16%) | **3.70%** |
| Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements | | | |
| -Uncompensated care, net of differential | V | | 0.05% |
| -Deficit Assessment | W | | 0.00% |
| Net decreases | **X =** | V + W | **0.05%** |
| **Total Update Full Rate Year 24** | | | |
| Revenue growth, net of offsets | **Y =** | O + X | **3.58%** |
| Per Capita Revenue Growth First Half of Rate Year | **Z =** | (1+Y)/(1-0.16%) | **3.75%** |

# Guardrail Test & Saving Projections

- Maryland's performance on the Guardrail test and Savings are evaluated on a calendar year.  HSCRC set rates on a fiscal year.
- In effort to ensure we are balancing the calendar year and fiscal year relationship, staff must convert the recommended RY25 update (Hospital Part A) to a calendar year (CY24) growth estimate.
- Staff model different scenarios to *project* the calendar year guardrail position for TCOC.
  - Estimates are divided into the following buckets:  Hospital Part A, Hospital Part B, Non-Hospital Part A, and Non-Hospital Part B.
    - **The only bucket we have control over is the revenue in Hospital Part A.**
    - All other buckets utilize growth estimates are based on historical Medicare data.

# Revenue Scenario

| Estimated Position on Medicare Test | | |
|---|---|---|
| Actual Revenue January - June 2022 | | 10,053,288,206 |
| Actual Revenue July-December 2022 | | 9,932,049,353 |
| Actual Revenue CY 2022 | | 19,984,015,293 |
| **Step 1:** | | |
| Approved Blended GBR RY 2023 | | 20,185,681,779 |
| Actual Revenue 7/1/22-12/31/22 | | 9,932,049,353 |
| Approved Revenue 1/1/23-6/30/23 | | 10,253,632,426 |
| Projected FY23 Undercharge | | -12,292,753 |
| Anticipated Revenue 1/1/23-6/30/23 | **A** | **10,241,339,673** |
| Expected Revenue Growth 1/1/23-6/30/23 | | ***1.87%*** |
| **Step 2:** | | |
| Final Approved GBR RY 2023 | | 20,293,387,021 |
| Reverse One Time Extraordinary Adjustments: | | |
| Final Adjusted GBR RY 2023 | | 20,293,387,021 |
| Projected Approved GBR RY 2024 | | 21,019,936,050 |
| Permanent Update RY 2024 | | 3.58% |
| Adjusted Change from GBR RY 2023 | | 3.58% |
| **Step 3:** | | |
| Estimated Revenue 7/1/23-12/31/23 (after 49.73% & seasonality) | | 10,453,214,198 |
| Projected Revenue 7/1/23-12/31/23 | **B** | **10,453,214,198** |
| Expected Revenue Growth 7/1/23 - 12/31/23 | | ***5.25%*** |
| **Step 4:** | | |
| **Estimated Revenue CY 2023** | **A+B** | **20,694,553,870** |
| Increase over CY 2022 Revenue | | **3.56%** |
| Per Capita Increase over CY 2022 | | **3.72%** |

# CY24 Projection & Performance Considerations

- YTD CY23 Medicare Monitoring results (2.8% < guardrail) reflect the benefit of some one-time adjustments:
  - $64 M MPA saving component reduction that was reversed in December but is still reflected in YTD September data shown
  - 1% increase in differential implemented in April 2023 that expires on June 30, 2024
  - 0.20% All-Payer cut lapses ended on December 31

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# Emergency Department Dramatic Improvement Effort (EDDIE)

## March Commission Meeting

# Today’s Presentation

- EDDIE data update
- QBR ED-1 Subgroup update and next steps
- ED Best Practices Development
- Next Steps

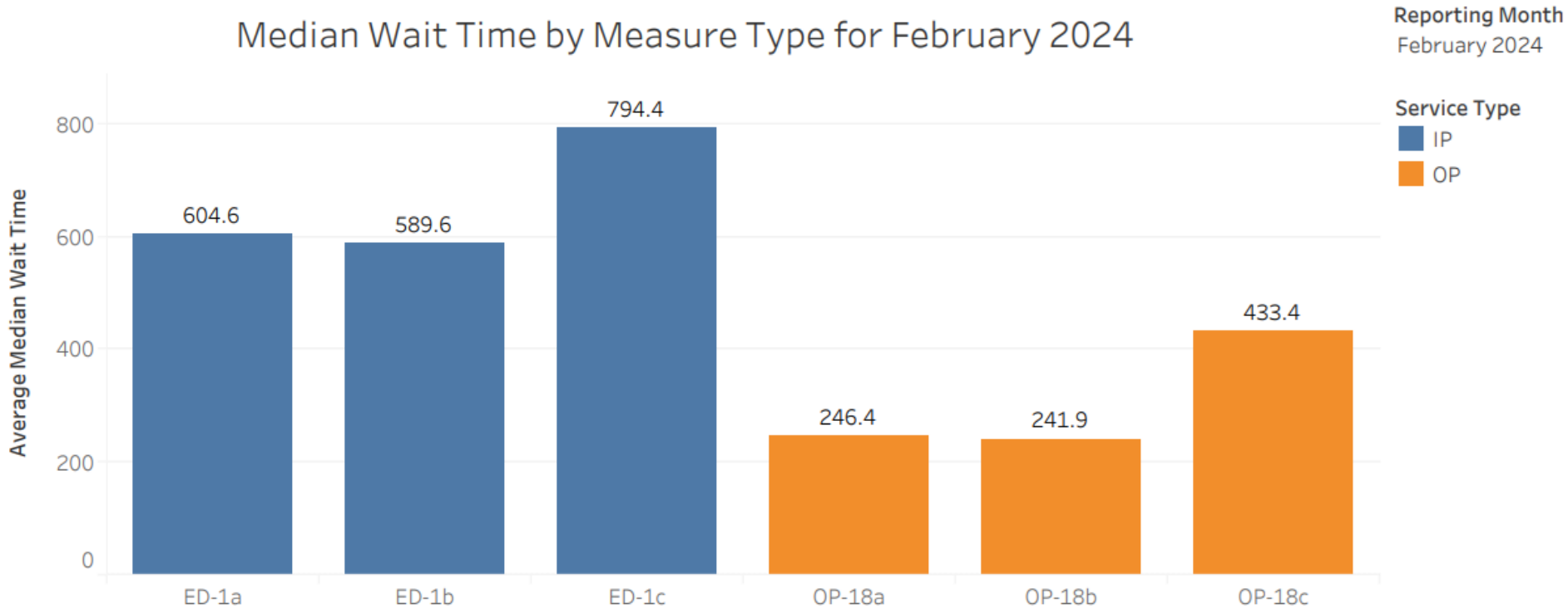
# ED Length of Stay and EMS Turnaround Data

- Monthly, unaudited data on ED length of stay for February 2024 was received from all hospitals
  - CRISP has automated Tableau graphs and provided new visualizations

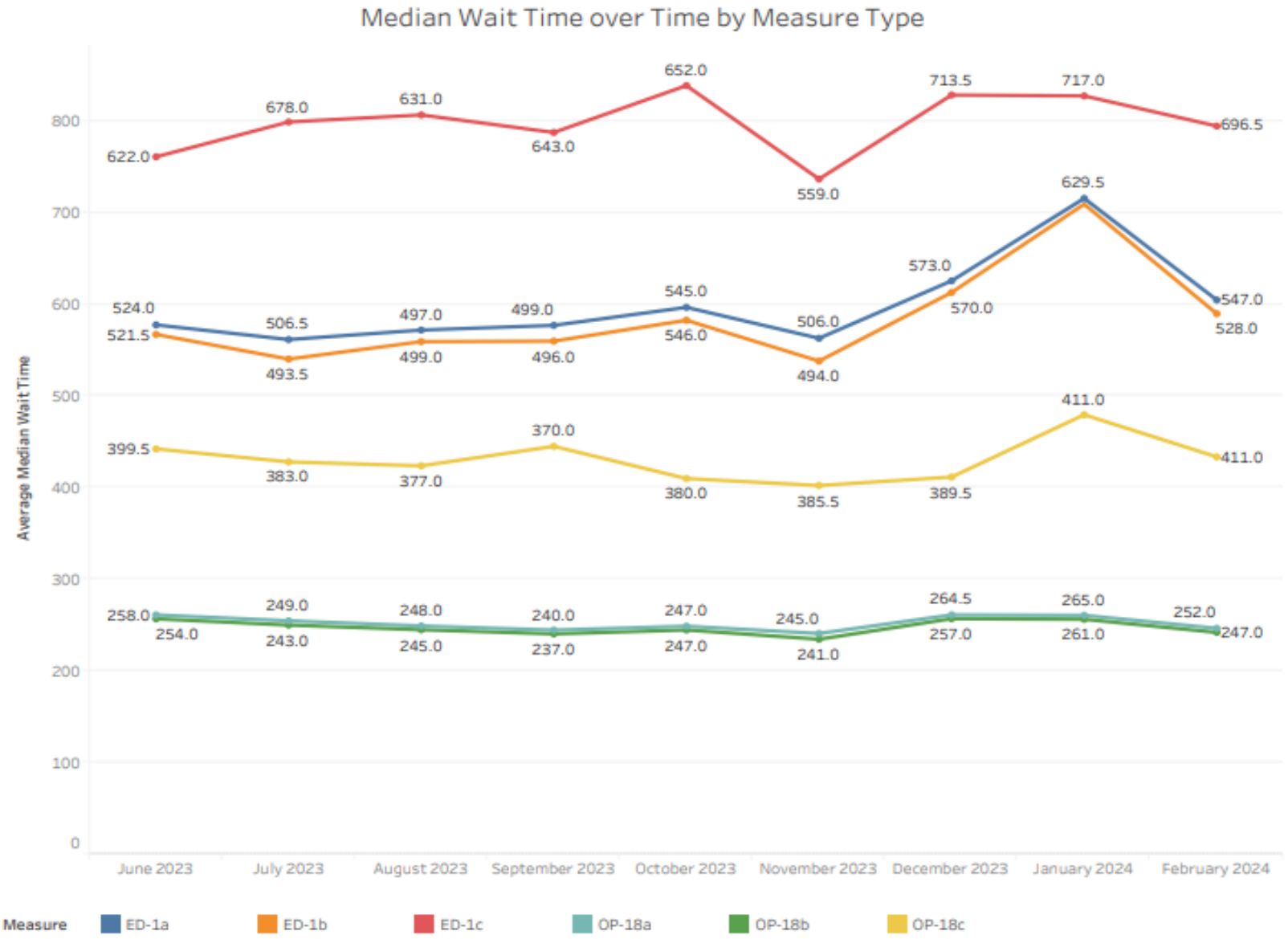
- EMS turnaround time data shows substantial movement of hospitals across categories for February 2024, with eight hospitals improving in performance and one hospitals declining in performance

See Appendix for graphs and data for all measures

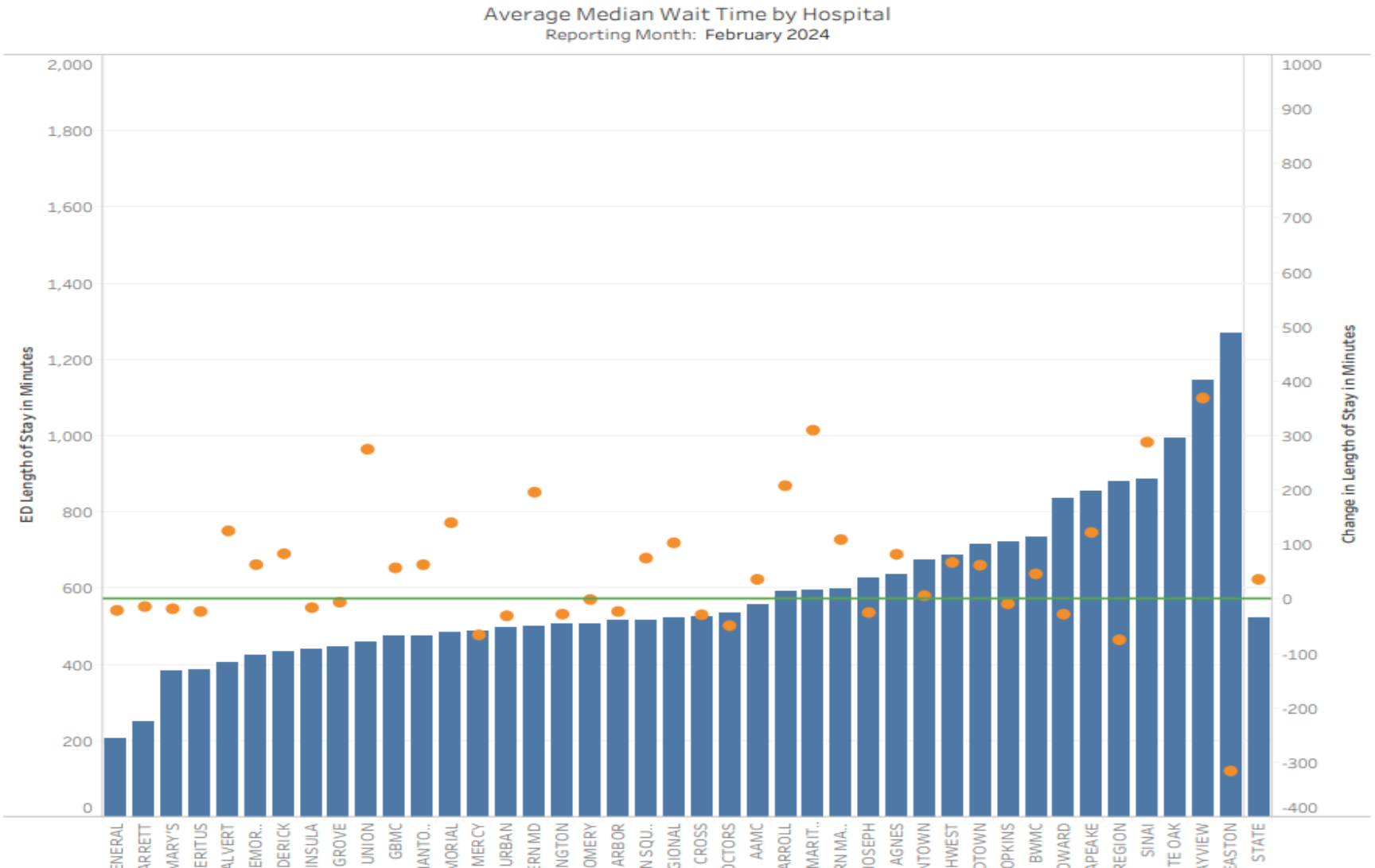
# ED Median Wait Time



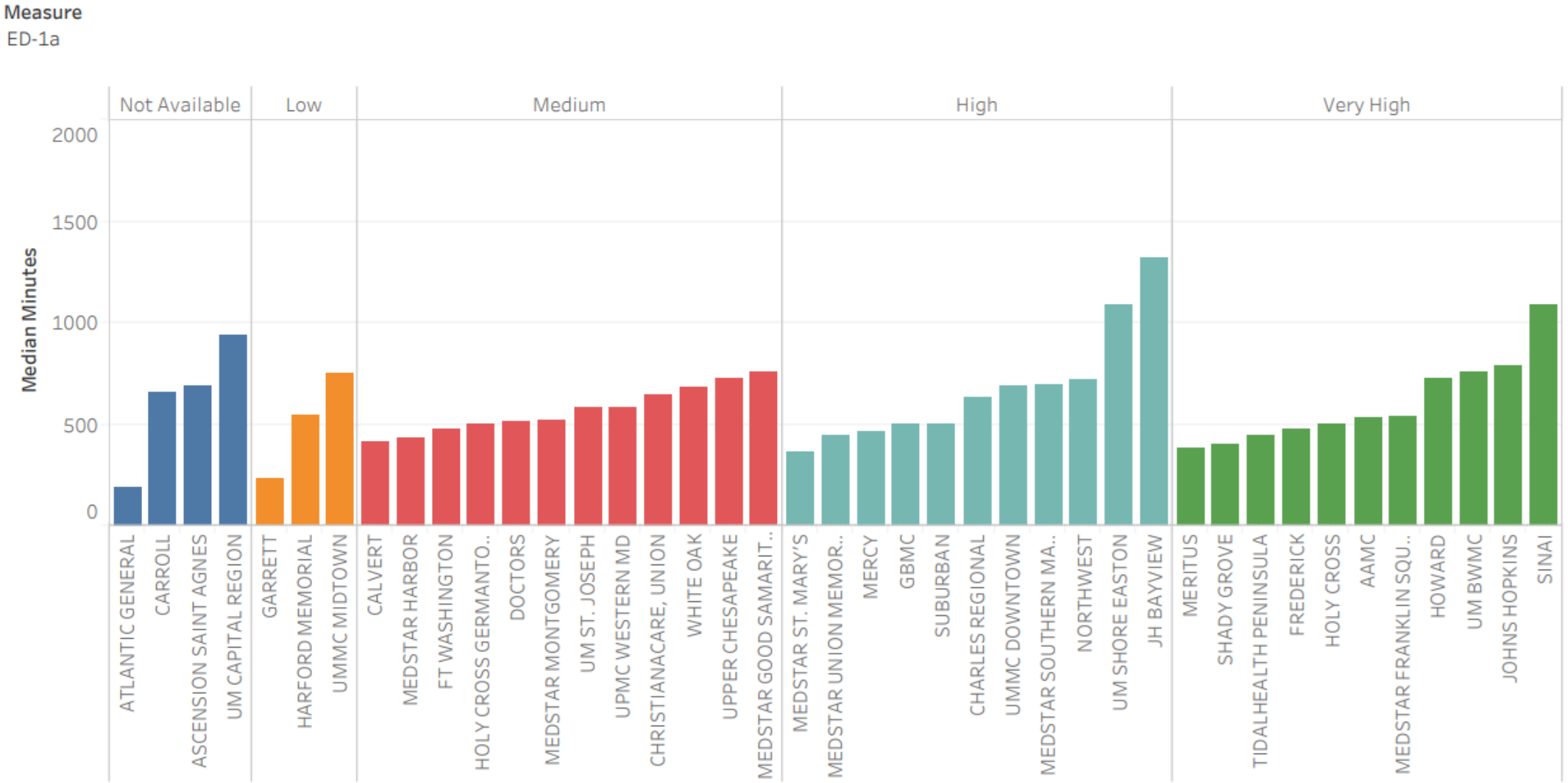
# ED Median Wait Time Over Time



# ED 1a: ED Arrival to Inpatient Admission

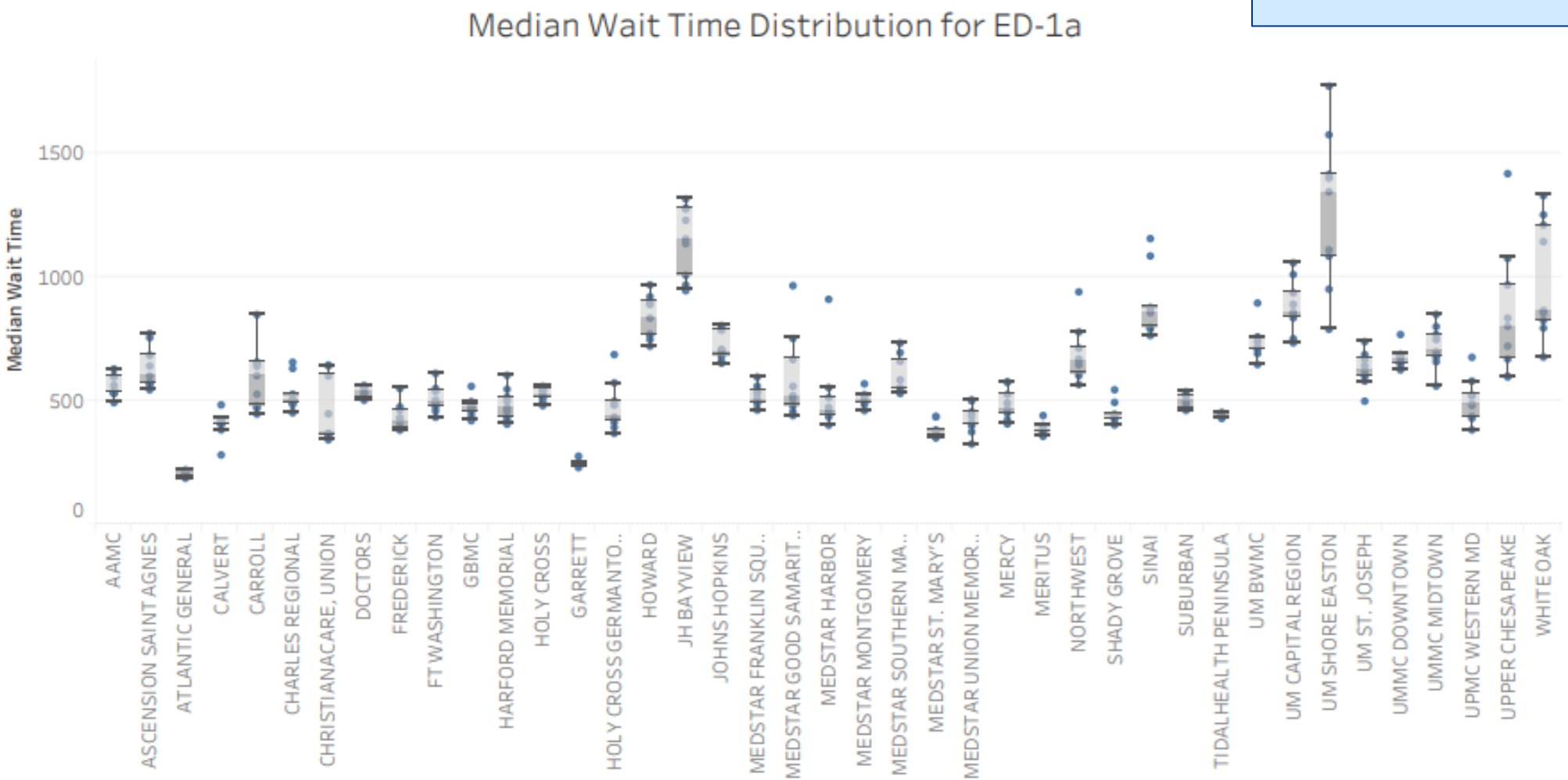


# ED 1a: ED Arrival to Inpatient Admission Time
# Latest Month Median By Volume--Latest Month



# ED 1a: ED Arrival to Inpatient Admission

Hospitals with wider distributions could be looked into further to understand trends and QA data



# ED 1a: ED Arrival to Inpatient Admission

Heat Graph:
Colors are relative to June/first month reported.

Red = higher wait time
Green = lower wait time

## Average Median Wait Time All Hospitals for ED-1a

Measure
ED-1a

Change from Base
-610 819

| Hospital Name | June 2023 | July 2023 | August 2023 | September 2023 | October 2023 | November 2023 | December 2023 | January 2024 | February 2024 |
|---|---|---|---|---|---|---|---|---|---|
| AAMC | 493 | 532 | 540 | 534 | 563 | 601 | 629 | 597 | 530 |
| ASCENSION SAINT AG.. | 601 | 564 | 545 | 574 | 641 | 576 | 755 | 772 | 684 |
| ATLANTIC GENERAL | 210 | 218 | 221 | 212 | 195 | 189 | 216 | | 190 |
| CALVERT | 282 | 383 | 411 | 425 | 405 | 409 | 484 | 426 | 408 |
| CARROLL | 447 | 527 | 481 | 640 | 602 | 470 | 654 | 848 | 656 |
| CHARLES REGIONAL | 527 | 486 | 497 | 453 | 492 | 455 | 508 | 656 | 631 |
| CHRISTIANACARE, UN.. | 369 | 351 | 370 | 343 | 360 | 448 | 641 | 601 | 645 |
| DOCTORS | 561 | 514 | 537 | 503 | 559 | 529 | 555 | 559 | 513 |
| FREDERICK | 392 | 388 | 382 | 395 | 416 | 432 | 464 | 550 | 476 |
| FT WASHINGTON | 503 | 434 | 488 | 493 | 550 | 539 | 611 | 460 | 476 |
| GARRETT | | | 244 | | 246 | 244 | 277 | 254 | 231 |
| GBMC | 439 | 467 | 456 | 475 | 482 | 420 | 476 | 559 | 497 |
| HARFORD MEMORIAL | 406 | 499 | 424 | 437 | 472 | 459 | 515 | 603 | 547 |
| HOLY CROSS | 524 | 481 | 540 | 513 | 547 | 518 | 546 | 559 | 496 |
| HOLY CROSS GERMAN.. | 435 | 393 | 428 | 369 | 483 | 414 | 573 | 687 | 499 |
| HOWARD | 748 | 770 | 765 | 834 | 968 | 921 | 902 | 889 | 721 |
| JH BAYVIEW | 945 | 1,007 | 1,153 | 968 | 1,135 | 1,276 | 1,229 | 1,277 | 1,315 |
| JOHNS HOPKINS | 794 | 680 | 652 | 697 | 704 | 708 | 661 | 804 | 786 |
| MEDSTAR FRANKLIN S.. | 463 | 467 | 493 | 492 | 532 | 509 | 560 | 596 | 539 |
| MEDSTAR GOOD SAM.. | 441 | 479 | 522 | 456 | 559 | 506 | 667 | 965 | 752 |
| MEDSTAR HARBOR | 458 | 553 | 474 | 910 | 513 | 402 | 441 | 457 | 436 |
| MEDSTAR MONTGOM.. | 518 | 461 | 486 | 495 | 525 | 497 | 505 | 569 | 518 |
| MEDSTAR SOUTHERN .. | 585 | 544 | 539 | 530 | 542 | 554 | 660 | 733 | 695 |
| MEDSTAR ST. MARY'S | 380 | 351 | 362 | 354 | 362 | 382 | 436 | 437 | 363 |
| MEDSTAR UNION ME.. | 375 | 456 | 412 | 326 | 407 | 400 | 504 | 500 | 439 |
| MERCY | 526 | 577 | 575 | 407 | 450 | 423 | 466 | 492 | 461 |
| MERITUS | 400 | 377 | 377 | 397 | 389 | 357 | 374 | 441 | 378 |
| NORTHWEST | 645 | 778 | 669 | 566 | 602 | 608 | 661 | 940 | 713 |
| SHADY GROVE | 408 | 427 | 446 | 435 | 545 | 494 | 428 | 437 | 403 |
| SINAI | 796 | 796 | 877 | 861 | 764 | 856 | 791 | 1,155 | 1,085 |
| SUBURBAN | 527 | 462 | 467 | 480 | 537 | 469 | 499 | 521 | 497 |
| TIDALHEALTH PENINS.. | | 453 | 448 | 447 | 432 | 430 | 445 | 450 | 438 |
| UM BWMC | 711 | 740 | 691 | 708 | 717 | 647 | 756 | 895 | 758 |
| UM CAPITAL REGION | 1,010 | 853 | 858 | 751 | 890 | 734 | 835 | 1,057 | 936 |
| UM SHORE EASTON | 1,399 | 951 | 1,344 | 1,414 | 1,109 | 789 | 1,574 | 1,770 | 1,084 |
| UM ST. JOSEPH | 604 | 600 | 641 | 667 | 687 | 499 | 621 | 739 | 580 |
| UMMC DOWNTOWN | 680 | 625 | 648 | 688 | 658 | 650 | 670 | 768 | 687 |
| UMMC MIDTOWN | 685 | 849 | 800 | 658 | 768 | 560 | 698 | 677 | 748 |
| UPMC WESTERN MD | 383 | 430 | 438 | 481 | 522 | 523 | 489 | 676 | 580 |
| UPPER CHESAPEAKE | 598 | 669 | 599 | 834 | 801 | 968 | 1,075 | 1,417 | 721 |
| WHITE OAK | 1,251 | 865 | 1,143 | 855 | 1,328 | 1,210 | 794 | 825 | 677 |

# QBR ED-1 Subgroups

# Methods of Data Collection

## From 1st Subgroup Meeting

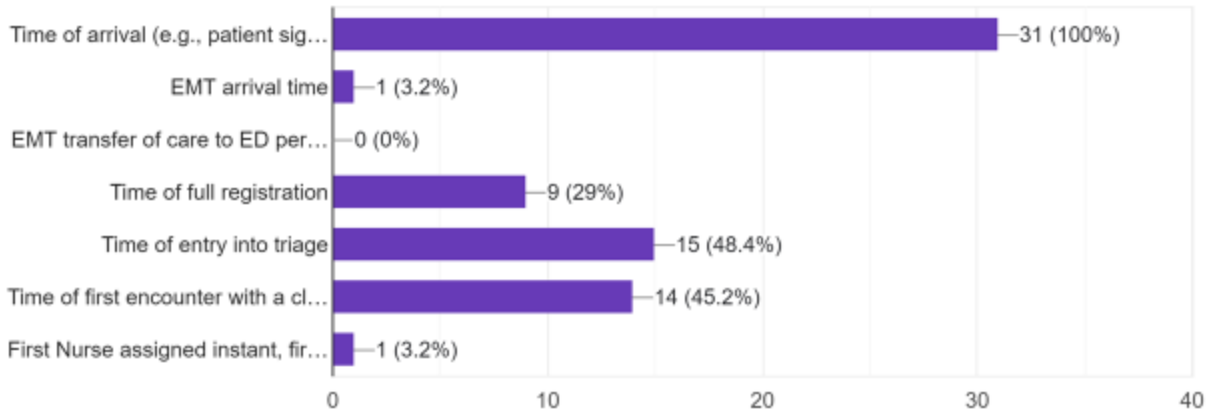
1. Add date and timestamps and other needed variables to monthly HSCRC case-mix data
2. Allow hospitals to calculate summary measures and submit to HSCRC (similar to EDDIE reporting)
3. Use retired ED1 electronic clinical quality measure/Adapt ED2 eCQM to capture time of admission and observation stays


- Takes advantage of existing data collection method and edit check processes
- HSCRC calculates measure for all hospitals
- Additional time stamps can be collected (i.e., start of observation)
- Can stratify or risk-adjust ED LOS data

# ED-1 Data Survey Findings: Patient Arrival

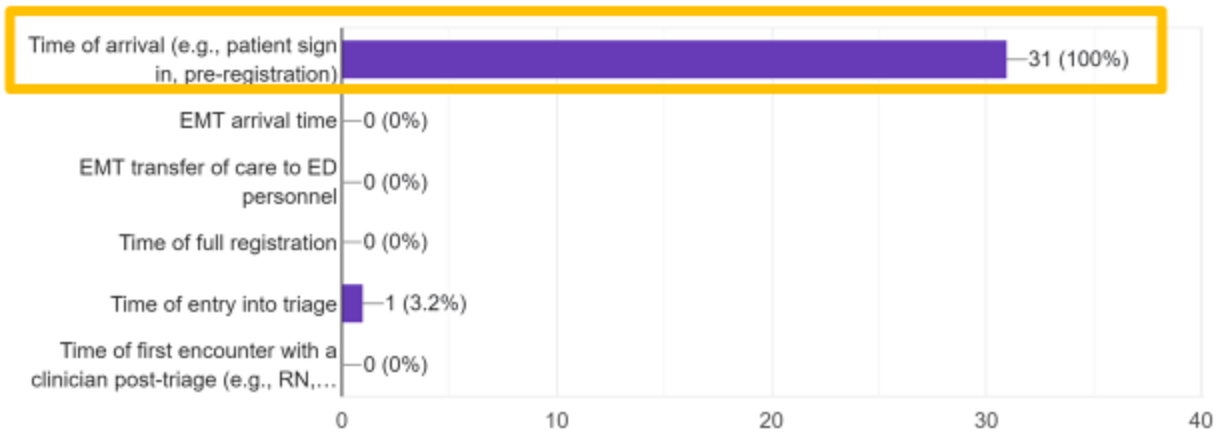
4. What time stamps does your EHR capture for arrival? (Check all that apply)

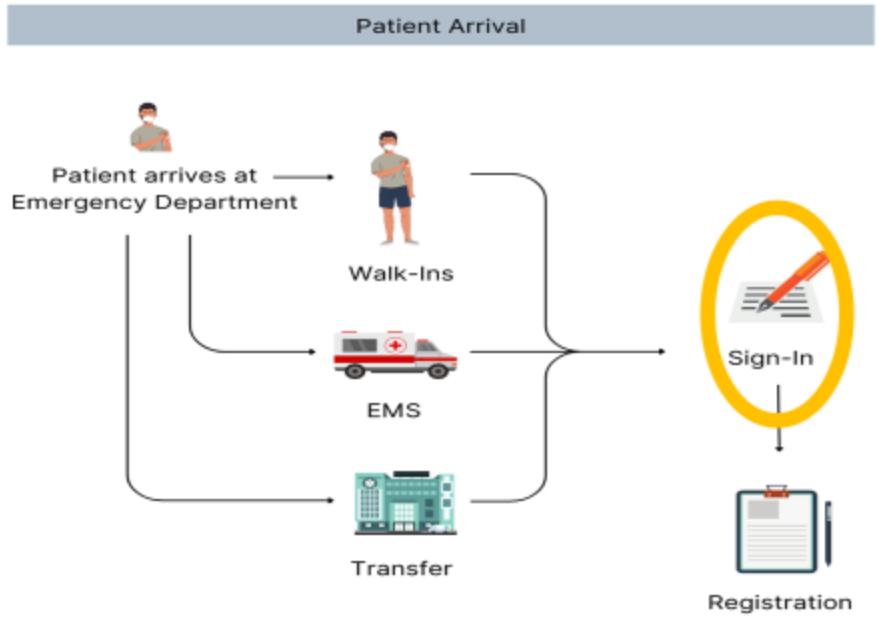
31 responses




5. Which time stamp does your EHR capture to determine arrival for ED-1?

31 responses

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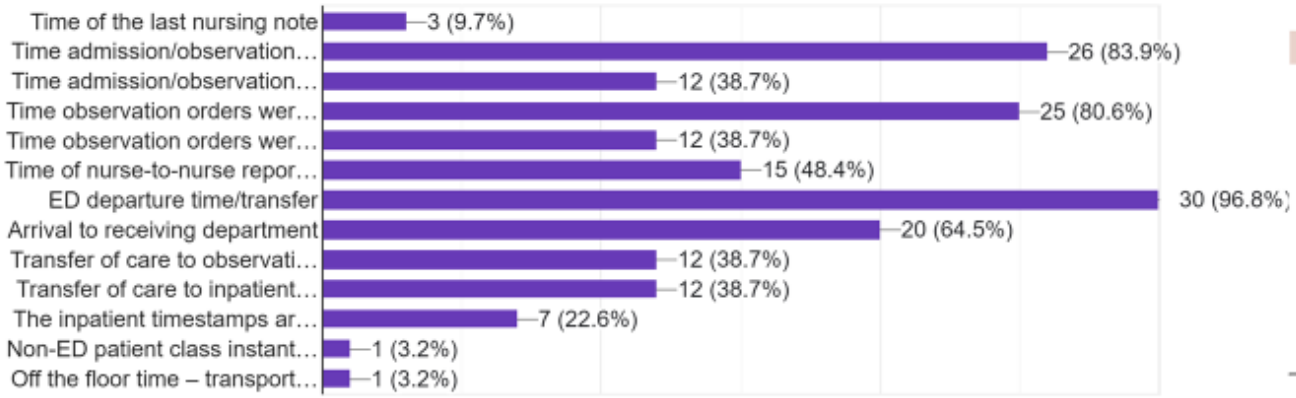
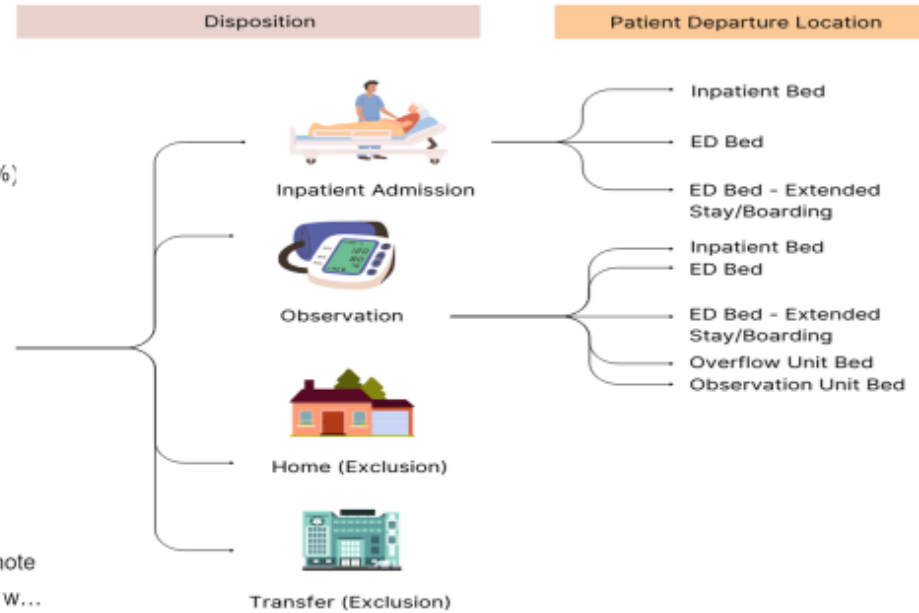
# ED-1 Data Survey Findings

8. What time stamps does your EHR capture for departure? (Check all that apply)

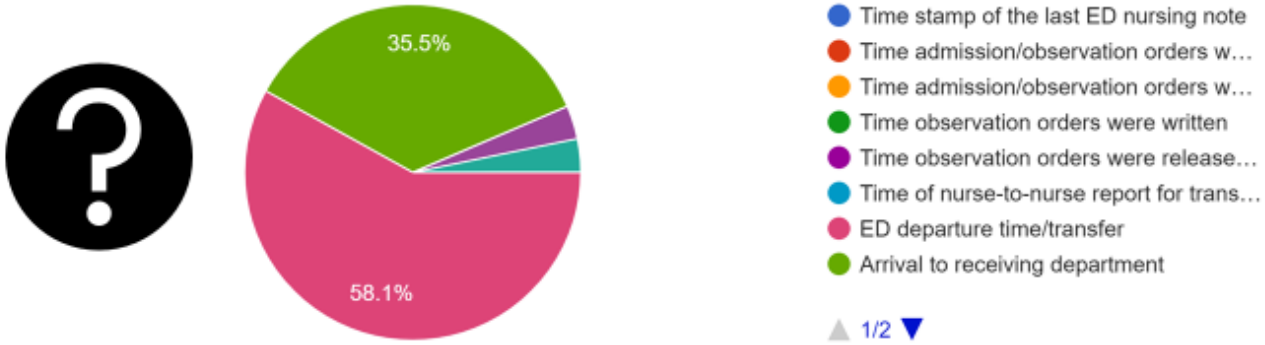
31 responses




9. Which time stamp does your EHR capture departure time for ED-1?

31 responses

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# ED Best Practices Discussion

# ED Best Practices Incentive Policy Development

Feedback/Discussion

**Objective:**

- Develop a series of process, structural, and/or outcome measures that will address systematically longer ED length of stay (LOS) in the State.
- Will incentivize hospital best practices, alignment with EDDIE, and value based arrangements with non-hospital providers that will improve hospital throughput and by extension ED LOS.

**Description:**

- Subgroup will advise on the development of 3-5 measures that will constitute a 1% revenue at risk program for CY 2025 performance.
- Workgroup will need to include those who are familiar with quality measurement, emergency department/hospital operations, non-hospital operations/policy (including home health, behavioral health, and skilled nursing facilities), and pay-for-performance/value-based payments.
- Will convene starting in March/April and should complete the task within 4-5 monthly subgroups.
- Monthly updates on progress will be provided to Commissioners as part of EDDIE presentations.

# Next Steps

- Continue monthly EDDIE data collection from hospitals and MIEMSS
  - Discuss next steps for MHA quality improvement initiative?
  - Invite hospital or other speakers?
- QBR ED Length of Stay measure
  - Finalize QBR ED LOS Data subgroup
  - Convene QBR ED LOS Measure and Incentive subgroup
- Finalize work plan for additional subgroup on Best Practices (1 percent idea)
  - Consult with experts in and outside of Maryland on types of best practices to consider
  - Recruit participants
  - Establish meeting agendas and dates

# Appendix

# EDDIE Overview

- Maryland has underperformed most other states on ED throughput measures since before the start of the All-Payer model
- EDDIE is a Commission-developed quality improvement initiative that began in June 2023 with two components:

**EDDIE: Improved ED Experience for Patients**

**Quality Improvement**

- Rapid cycle QI initiatives to meet hospital set goals related to ED throughput/length of stay
- Learning collaborative
- Convened by MHA

**Commission Reporting**

- Public reporting of monthly data for three measures
- Led by HSCRC and MIEMSS

# February Data 2024 Reporting

## Monthly, public reporting of three measures:

- ED1-like measure:  ED arrival to inpatient admission time for all admitted patients
- OP18-like measure:  ED arrival to discharge time for patients who are not admitted
- EMS turnaround time (from MIEMSS):  Time from arrival at ED to transfer of patient care from EMS to the hospital

## February data received for all hospitals

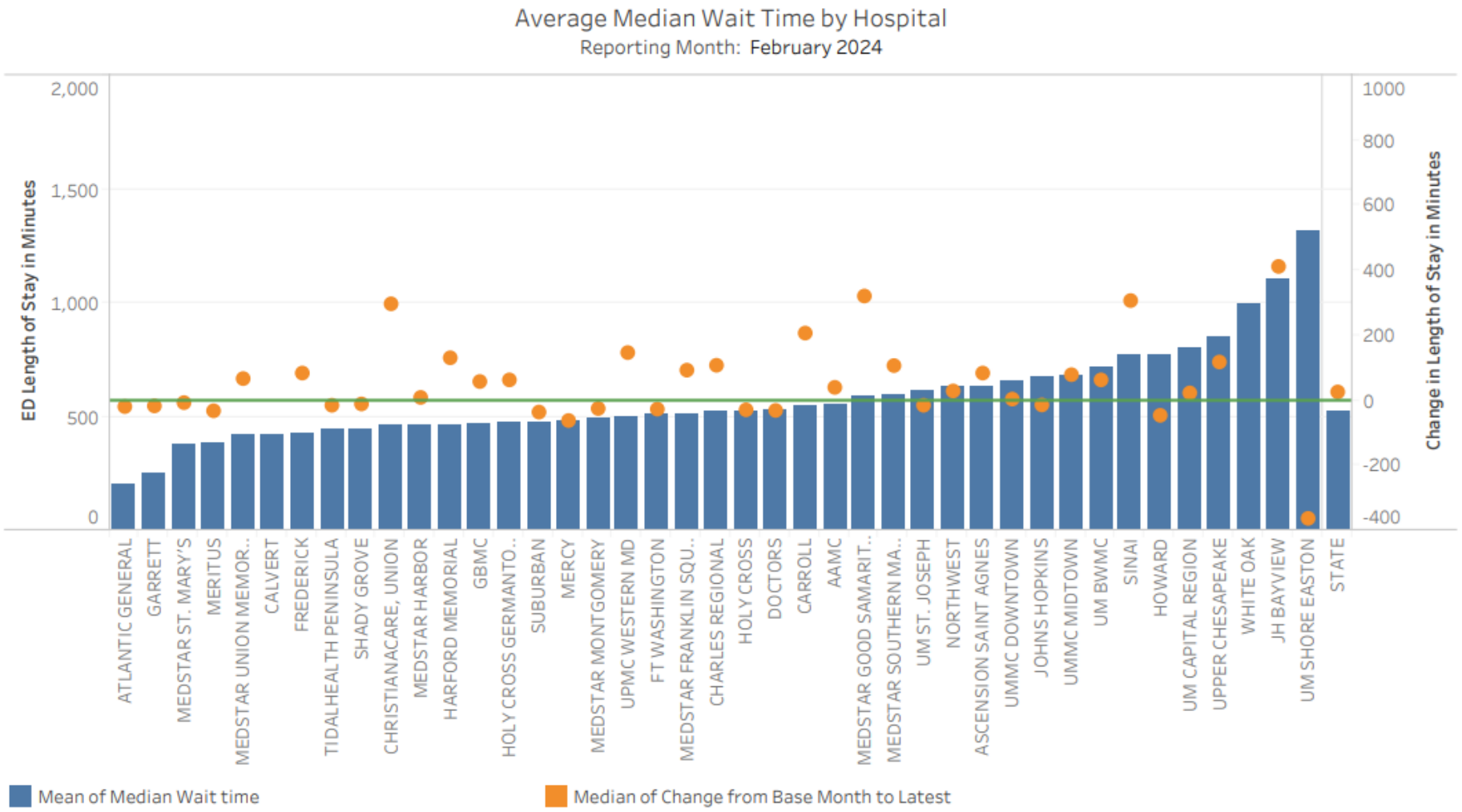
- These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month)
- These data are being collected for hospital quality improvement and have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital
- Data may be updated over time if issues are identified or specifications change
- One health system asked for reporting extension

## Graphs:

- Starting with February data, CRISP automated several new types of graphs/charts to illustrate EDDIE data using Tableau.
- Rolling median (June-Latest Month) and change from June/first month provided
- Latest month grouped by CMS ED volume category (Volume data is from CMS Care Compare or imputed by hospital, volume categories were recently updated on CMS Care Compare.)
- Graphs have not been QAed by hospitals due to fast turnaround time

# ED 1b:  ED Arrival to Inpatient Admission Time - Non-Psychiatric

**Measure**
ED-1b



# ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric

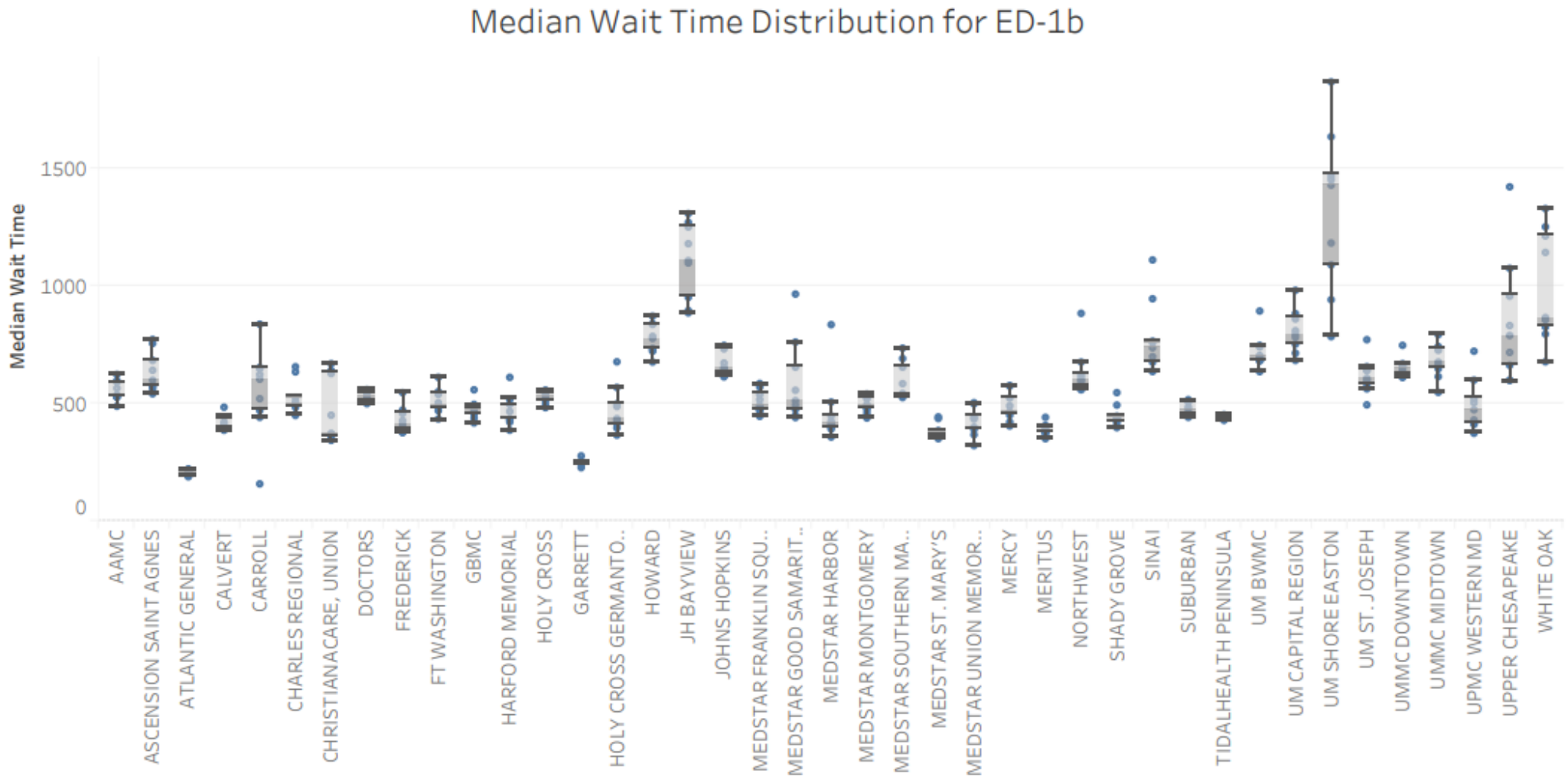
## Average Median Wait Time All Hospitals for ED-1b

Measure
ED-1b

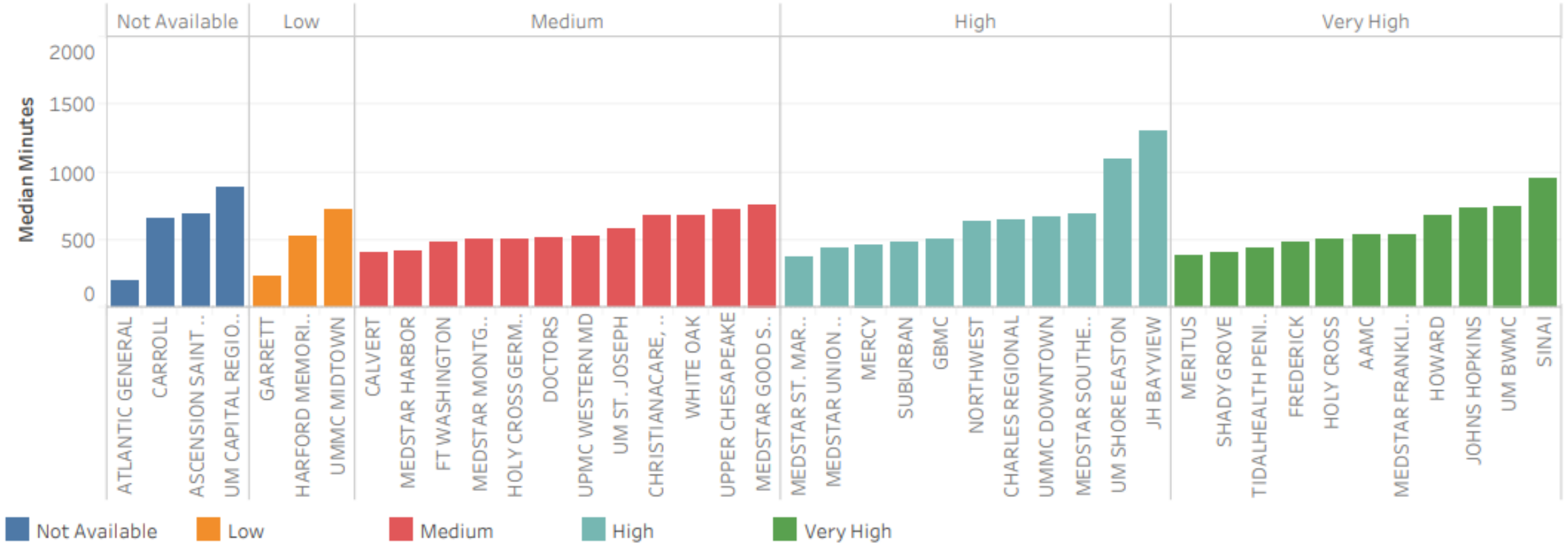
Change from Bas
-668

| Hospital Name | June 2023 | July 2023 | August 2023 | September 2023 | October 2023 | November 2023 | December 2023 | January 2024 | February 2024 |
|---|---|---|---|---|---|---|---|---|---|
| AAMC | 488 | 527 | 536 | 529 | 565 | 597 | 623 | 591 | 528 |
| ASCENSION SAINT AG.. | 599 | 563 | 541 | 573 | 641 | 576 | 755 | 772 | 683 |
| ATLANTIC GENERAL | 209 | 203 | 222 | 212 | 195 | 189 | 216 | | 190 |
| CALVERT | | 386 | 403 | 420 | 390 | 408 | 484 | 443 | 404 |
| CARROLL | 441 | 520 | 470 | 623 | 603 | 158 | 653 | 837 | 648 |
| CHARLES REGIONAL | 526 | 484 | 499 | 449 | 489 | 456 | 507 | 656 | 634 |
| CHRISTIANACARE, UN.. | 372 | 351 | 370 | 343 | 356 | 450 | 640 | 627 | 669 |
| DOCTORS | 541 | 503 | 525 | 499 | 559 | 523 | 547 | 543 | 510 |
| FREDERICK | 388 | 376 | 378 | 391 | 410 | 427 | 458 | 546 | 472 |
| FT WASHINGTON | 503 | 434 | 488 | 493 | 550 | 539 | 611 | 469 | 476 |
| GARRETT | | | 244 | | 246 | 244 | 277 | 255 | 227 |
| GBMC | 438 | 467 | 455 | 475 | 481 | 417 | 476 | 558 | 496 |
| HARFORD MEMORIAL | 386 | 466 | 432 | 429 | 435 | 421 | 496 | 611 | 517 |
| HOLY CROSS | 524 | 482 | 540 | 513 | 544 | 518 | 546 | 557 | 495 |
| HOLY CROSS GERMAN.. | 435 | 396 | 427 | 365 | 487 | 414 | 568 | 677 | 498 |
| HOWARD | 722 | 734 | 729 | 776 | 871 | 839 | 836 | 785 | 676 |
| JH BAYVIEW | 895 | 951 | 1,107 | 885 | 1,097 | 1,250 | 1,179 | 1,270 | 1,307 |
| JOHNS HOPKINS | 746 | 631 | 613 | 650 | 672 | 652 | 617 | 744 | 732 |
| MEDSTAR FRANKLIN S.. | 445 | 471 | 492 | 484 | 516 | 471 | 570 | 585 | 538 |
| MEDSTAR GOOD SAM.. | 440 | 474 | 512 | 449 | 556 | 494 | 654 | 965 | 761 |
| MEDSTAR HARBOR | 407 | 506 | 424 | 835 | 391 | 357 | 399 | 447 | 416 |
| MEDSTAR MONTGOM.. | 520 | 459 | 478 | 477 | 525 | 438 | 490 | 540 | 495 |
| MEDSTAR SOUTHERN .. | 584 | 542 | 536 | 525 | 540 | 533 | 654 | 735 | 691 |
| MEDSTAR ST. MARY'S | 368 | 350 | 362 | 356 | 362 | 385 | 436 | 443 | 361 |
| MEDSTAR UNION ME.. | 367 | 442 | 397 | 321 | 398 | 389 | 498 | 503 | 434 |
| MERCY | 523 | 576 | 574 | 404 | 450 | 421 | 464 | 490 | 461 |
| MERITUS | 407 | 377 | 380 | 395 | 388 | 350 | 375 | 441 | 375 |
| NORTHWEST | 595 | 676 | 613 | 558 | 575 | 561 | 600 | 883 | 624 |
| SHADY GROVE | 408 | 424 | 446 | 434 | 546 | 493 | 427 | 437 | 397 |
| SINAI | 638 | 636 | 759 | 699 | 675 | 765 | 737 | 1,110 | 945 |
| SUBURBAN | 510 | 441 | 445 | 457 | 516 | 455 | 485 | 506 | 474 |
| TIDALHEALTH PENINS.. | | 452 | 446 | 447 | 429 | 430 | 447 | 448 | 437 |
| UM BWMC | 684 | 704 | 681 | 683 | 699 | 635 | 740 | 893 | 747 |
| UM CAPITAL REGION | 859 | 752 | 781 | 714 | 809 | 683 | 793 | 981 | 882 |
| UM SHORE EASTON | 1,452 | 941 | 1,468 | 1,428 | 1,182 | 784 | 1,634 | 1,867 | 1,089 |
| UM ST. JOSEPH | 598 | 562 | 641 | 656 | 640 | 494 | 607 | 771 | 583 |
| UMMC DOWNTOWN | 658 | 610 | 625 | 669 | 636 | 622 | 651 | 747 | 662 |
| UMMC MIDTOWN | 647 | 792 | 735 | 614 | 742 | 547 | 676 | 664 | 726 |
| UPMC WESTERN MD | 373 | 417 | 411 | 473 | 599 | 503 | 430 | 722 | 520 |
| UPPER CHESAPEAKE | 599 | 662 | 598 | 831 | 789 | 956 | 1,074 | 1,421 | 717 |
| WHITE OAK | 1,251 | 865 | 1,142 | 855 | 1,328 | 1,212 | 795 | 825 | 677 |

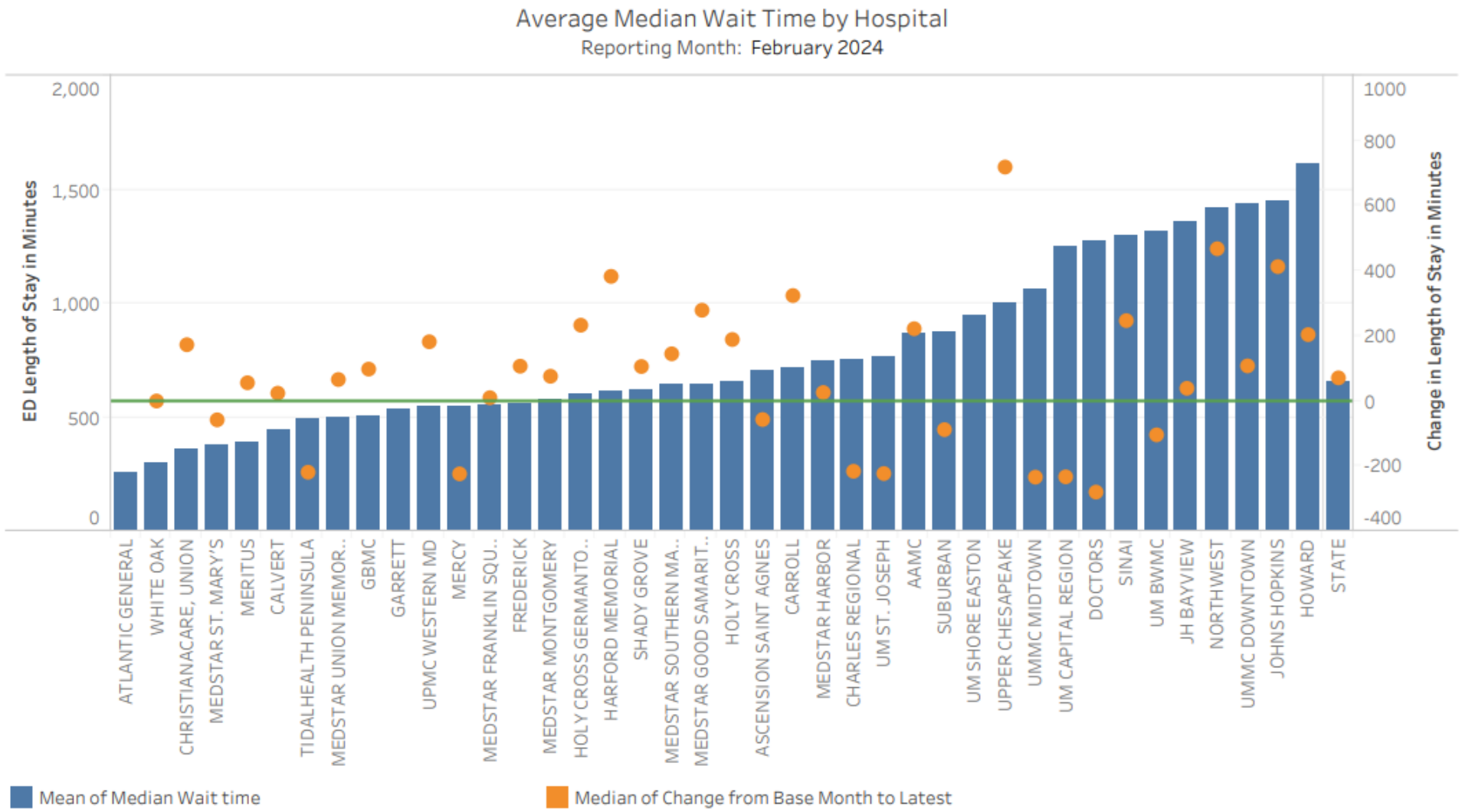
# ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric



# ED 1b: ED Arrival to Inpatient Admission Time by Volume Non-Psychiatric ED Visits



# ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



# ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric

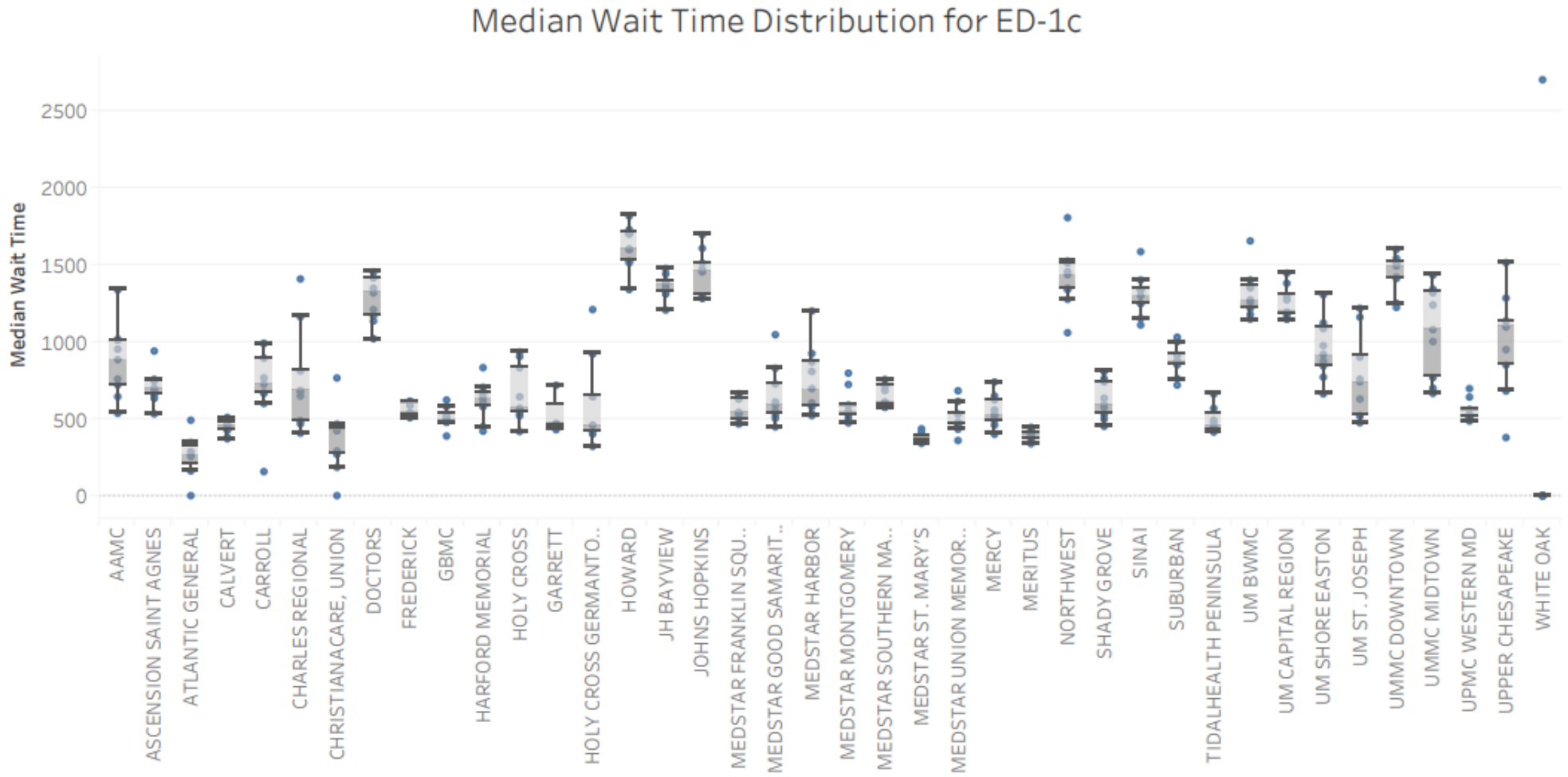
## Average Median Wait Time All Hospitals for ED-1c

Measure
ED-1c

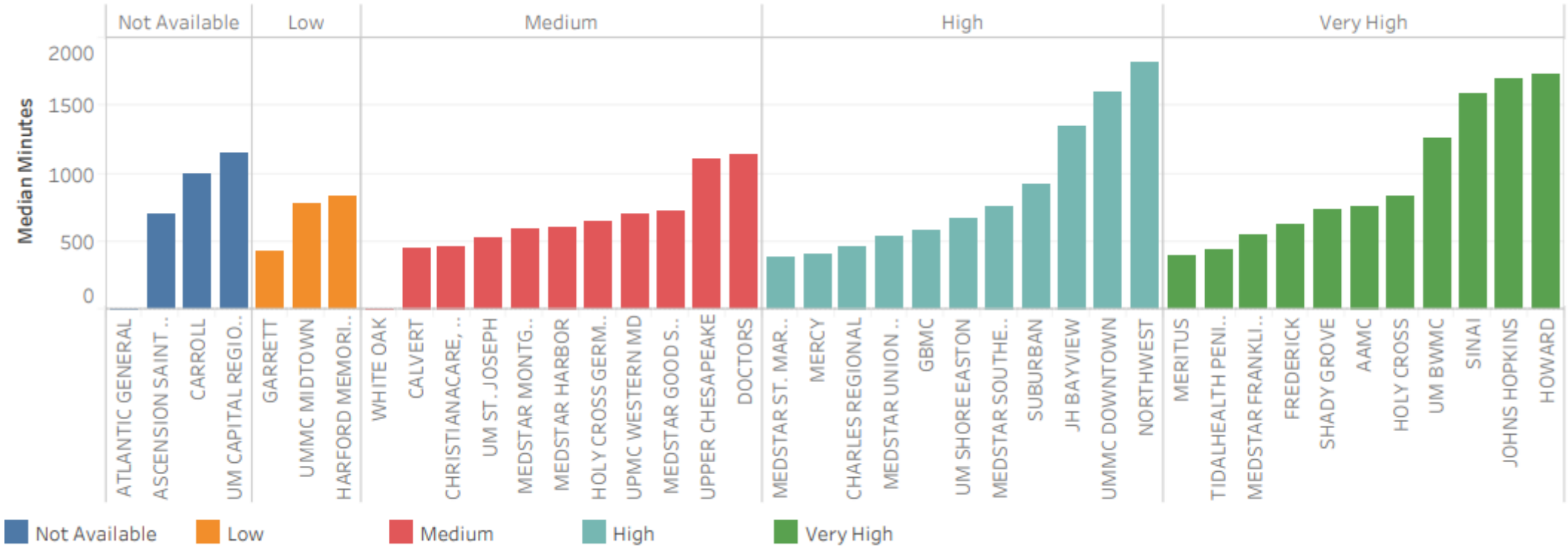
Change from Base
-509

| Hospital Name | June 2023 | July 2023 | August 2023 | September 2023 | October 2023 | November 2023 | December 2023 | January 2024 | February 2024 |
|---|---|---|---|---|---|---|---|---|---|
| AAMC | 535 | 883 | 719 | 643 | 1,335 | 951 | 1,009 | 1,017 | 757 |
| ASCENSION SAINT AG.. | 755 | 939 | 631 | 691 | 652 | 531 | 682 | 745 | 698 |
| ATLANTIC GENERAL | | 345 | 160 | 262 | 286 | 490 | 255 | | 0 |
| CALVERT | 425 | 379 | 457 | 471 | 508 | 427 | 501 | 369 | 449 |
| CARROLL | 665 | 667 | 764 | 893 | 598 | 156 | 724 | 988 | 989 |
| CHARLES REGIONAL | 682 | 678 | 487 | 810 | 1,407 | 406 | 1,161 | 647 | 466 |
| CHRISTIANACARE, UN.. | 290 | 184 | 268 | 0 | 424 | 422 | 764 | 431 | 463 |
| DOCTORS | 1,414 | 1,316 | 1,167 | 1,019 | 1,418 | 1,453 | 1,347 | 1,208 | 1,134 |
| FREDERICK | 506 | 517 | 540 | 514 | 613 | 534 | 586 | 609 | 613 |
| GARRETT | | | | | | | 470 | 717 | 428 |
| GBMC | 480 | 387 | 479 | 476 | 508 | 526 | 498 | 621 | 578 |
| HARFORD MEMORIAL | 448 | 601 | 418 | 630 | 667 | 654 | 703 | 577 | 831 |
| HOLY CROSS | 642 | 416 | 518 | 568 | 903 | 559 | 532 | 933 | 831 |
| HOLY CROSS GERMAN.. | 410 | 320 | 643 | 400 | 412 | 458 | 1,208 | 919 | 643 |
| HOWARD | 1,524 | 1,512 | 1,338 | 1,597 | 1,699 | 1,602 | 1,701 | 1,815 | 1,728 |
| JH BAYVIEW | 1,309 | 1,205 | 1,440 | 1,376 | 1,383 | 1,394 | 1,475 | 1,316 | 1,348 |
| JOHNS HOPKINS | 1,281 | 1,294 | 1,284 | 1,510 | 1,458 | 1,470 | 1,453 | 1,606 | 1,694 |
| MEDSTAR FRANKLIN S.. | 532 | 465 | 500 | 532 | 627 | 662 | 469 | 642 | 542 |
| MEDSTAR GOOD SAM.. | 446 | 502 | 590 | 549 | 608 | 522 | 827 | 1,045 | 725 |
| MEDSTAR HARBOR | 577 | 868 | 923 | 1,199 | 806 | 520 | 695 | 531 | 603 |
| MEDSTAR MONTGOM.. | 512 | 472 | 498 | 532 | 531 | 722 | 550 | 795 | 588 |
| MEDSTAR SOUTHERN .. | 609 | 575 | 586 | 573 | 601 | 714 | 683 | 717 | 754 |
| MEDSTAR ST. MARY'S | 434 | 356 | 356 | 339 | 359 | 374 | 415 | 379 | 376 |
| MEDSTAR UNION ME.. | 464 | 681 | 473 | 358 | 475 | 431 | 612 | 470 | 530 |
| MERCY | 622 | 648 | 738 | 490 | 458 | 531 | 518 | 556 | 398 |
| MERITUS | 337 | 401 | 351 | 402 | 425 | 406 | 369 | 443 | 393 |
| NORTHWEST | 1,337 | 1,510 | 1,454 | 1,058 | 1,435 | 1,275 | 1,347 | 1,523 | 1,805 |
| SHADY GROVE | 633 | 805 | 526 | 760 | 450 | 573 | 592 | 497 | 739 |
| SINAI | 1,337 | 1,336 | 1,108 | 1,400 | 1,248 | 1,151 | 1,299 | 1,248 | 1,584 |
| SUBURBAN | 1,000 | 849 | 875 | 865 | 1,029 | 718 | 868 | 760 | 912 |
| TIDALHEALTH PENINS.. | | 659 | 490 | 441 | 473 | 415 | 415 | 567 | 440 |
| UM BWMC | 1,359 | 1,400 | 1,349 | 1,654 | 1,216 | 1,176 | 1,146 | 1,271 | 1,255 |
| UM CAPITAL REGION | 1,379 | 1,445 | 1,189 | 1,169 | 1,299 | 1,191 | 1,147 | 1,272 | 1,146 |
| UM SHORE EASTON | 1,085 | 974 | 769 | 1,304 | 875 | 842 | 917 | 1,121 | 661 |
| UM ST. JOSEPH | 739 | 1,159 | 627 | 899 | 1,216 | 520 | 756 | 473 | 516 |
| UMMC DOWNTOWN | 1,491 | 1,410 | 1,419 | 1,222 | 1,510 | 1,519 | 1,541 | 1,249 | 1,599 |
| UMMC MIDTOWN | 1,001 | 1,341 | 1,431 | 1,078 | 1,317 | 664 | 1,238 | 698 | 767 |
| UPMC WESTERN MD | 513 | 520 | 508 | 510 | 525 | 484 | 560 | 640 | 695 |
| UPPER CHESAPEAKE | 377 | 1,135 | 679 | 1,513 | 948 | 1,283 | 1,096 | 848 | 1,096 |
| WHITE OAK | 0 | 0 | 2,701 | 0 | 0 | 0 | 0 | 0 | 0 |

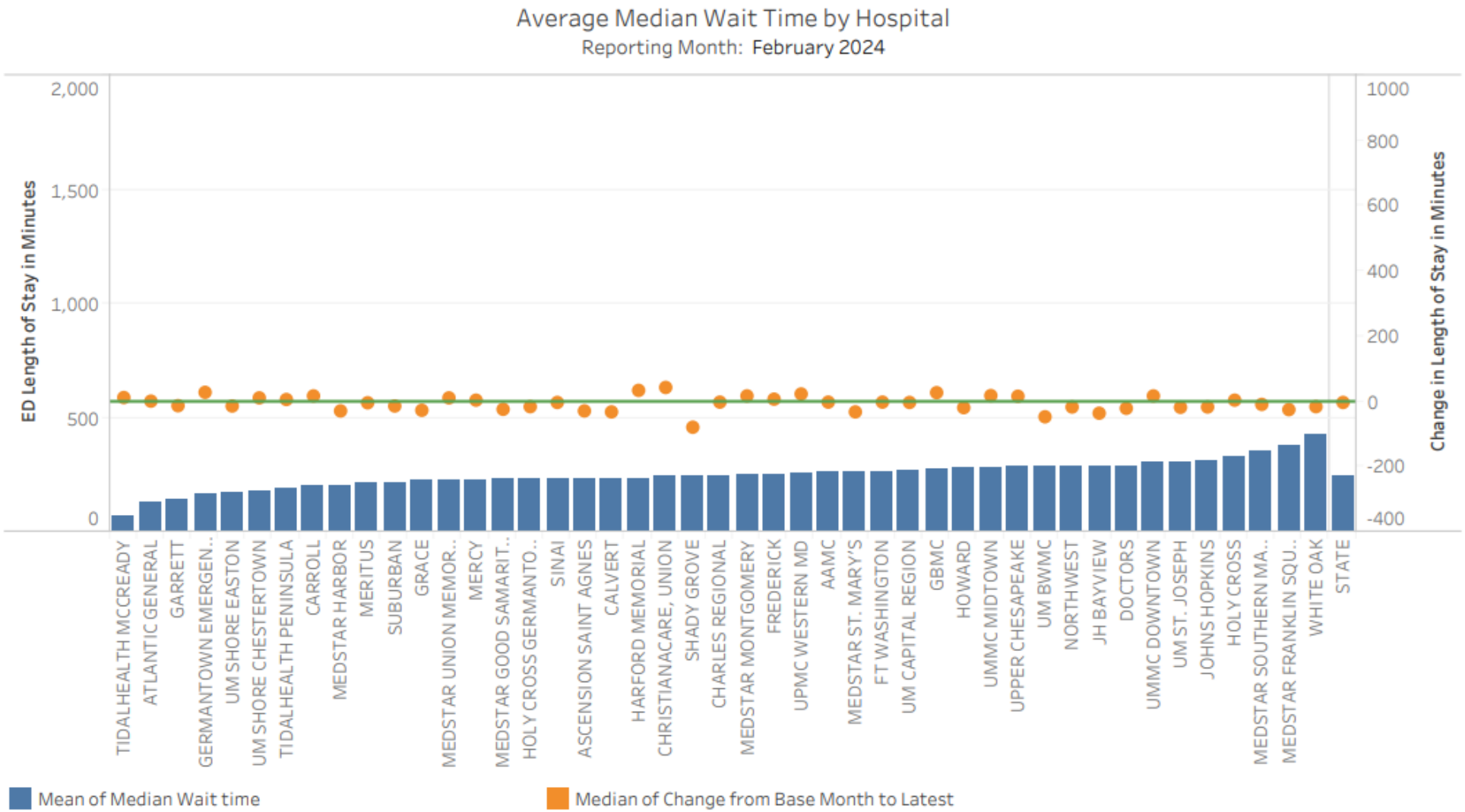
# ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



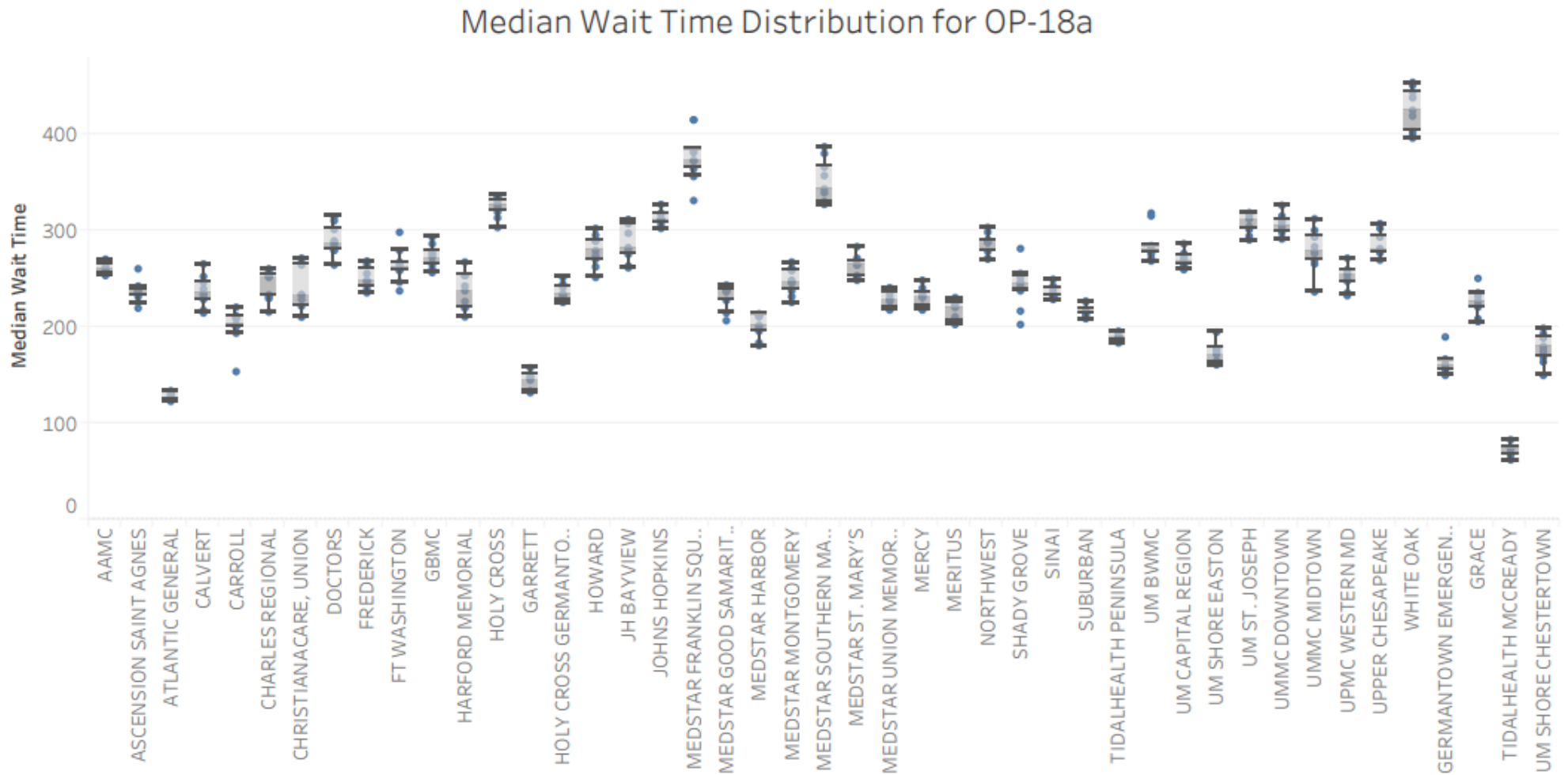
# ED 1c: ED Arrival to Inpatient Admission Time by Volume Psychiatric ED Visits



# OP18a: ED Arrival to Discharge Time by Month



# OP18a: ED Arrival to Discharge Time by Month



# OP18a: ED Arrival to Discharge Time by Month

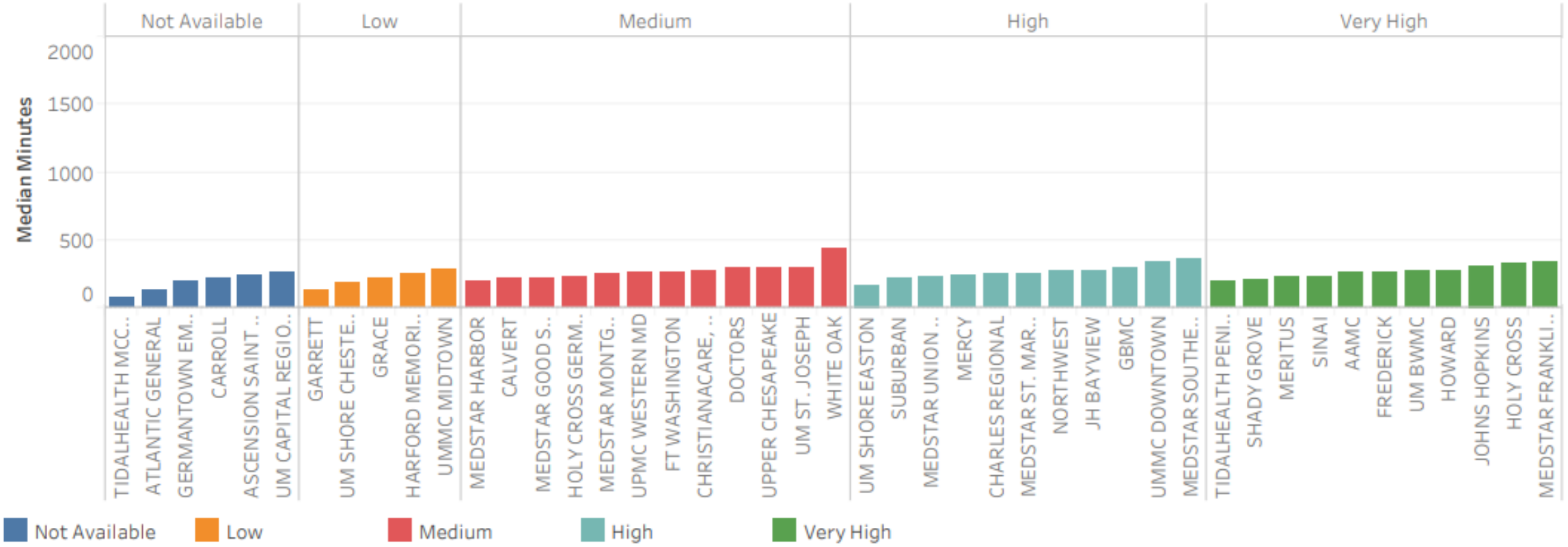
## Average Median Wait Time All Hospitals for OP-18a

| Hospital Name | June 2023 | July 2023 | August 2023 | September 2.. | October 2023 | November 20.. | December 20.. | January 2024 | February 202 |
|---|---|---|---|---|---|---|---|---|---|
| AAMC | 258.0 | 255.0 | 260.0 | 254.0 | 266.0 | 263.0 | 271.0 | 268.0 | 256.0 |
| ASCENSION SAINT AG.. | 261.0 | 238.0 | 236.0 | 243.0 | 220.0 | 226.0 | 239.0 | 238.0 | 232.0 |
| ATLANTIC GENERAL | 124.0 | 127.0 | 131.0 | 133.0 | 128.0 | 123.0 | 134.0 | | 125.0 |
| CALVERT | 247.0 | 229.0 | 240.0 | 233.0 | 253.0 | 235.0 | 266.0 | 218.0 | 215.0 |
| CARROLL | 194.0 | 203.0 | 201.0 | 201.0 | 221.0 | 154.0 | 212.0 | 209.0 | 211.0 |
| CHARLES REGIONAL | 254.0 | 253.0 | 232.0 | 216.0 | 230.0 | 234.0 | 258.0 | 261.0 | 252.0 |
| CHRISTIANACARE, UN.. | 229.0 | 234.0 | 222.0 | 211.0 | 211.0 | 234.0 | 271.0 | 265.0 | 272.0 |
| DOCTORS | 311.0 | 288.0 | 280.0 | 265.0 | 281.0 | 285.0 | 315.0 | 302.0 | 290.0 |
| FREDERICK | | 249.0 | 248.0 | 236.0 | 240.0 | 244.0 | 265.0 | 269.0 | 256.0 |
| FT WASHINGTON | 268.0 | 238.0 | 262.0 | 247.0 | 260.0 | 259.0 | 299.0 | 280.0 | 266.0 |
| GARRETT | | | 145.0 | | 150.0 | 147.0 | 158.0 | 134.0 | 132.0 |
| GBMC | 267.0 | 257.0 | 261.0 | 273.0 | 279.0 | 266.0 | 287.0 | 276.0 | 294.0 |
| GERMANTOWN EMER.. | 162.0 | 156.0 | 159.0 | 150.0 | 167.0 | | | | 190.0 |
| GRACE | 236.0 | 251.0 | 226.0 | 221.0 | 228.0 | 206.0 | 233.0 | 227.0 | 209.0 |
| HARFORD MEMORIAL | 220.0 | 227.0 | 211.0 | 238.0 | 221.0 | 254.0 | 268.0 | 243.0 | 254.0 |
| HOLY CROSS | 320.0 | 304.0 | 335.0 | 333.0 | 327.0 | 314.0 | 329.0 | 337.0 | 324.0 |
| HOLY CROSS GERMAN.. | 242.0 | 227.0 | 252.0 | 233.0 | 235.0 | 228.0 | 245.0 | 234.0 | 226.0 |
| HOWARD | 290.0 | 290.0 | 303.0 | 252.0 | 275.0 | 263.0 | 296.0 | 280.0 | 271.0 |
| JH BAYVIEW | 312.0 | 312.0 | 308.0 | 281.0 | 283.0 | 262.0 | 264.0 | 298.0 | 276.0 |
| JOHNS HOPKINS | 328.0 | 319.0 | 318.0 | 309.0 | 312.0 | 303.0 | 305.0 | 313.0 | 311.0 |
| MEDSTAR FRANKLIN S.. | 357.0 | 373.0 | 382.0 | 365.0 | 374.0 | 385.0 | 416.0 | 416.0 | 332.0 |
| MEDSTAR GOOD SAM.. | 239.0 | 237.0 | 244.0 | 228.0 | 239.0 | 207.0 | 239.0 | 241.0 | 215.0 |
| MEDSTAR HARBOR | 213.0 | 213.0 | 211.0 | 202.0 | 214.0 | 181.0 | 196.0 | 200.0 | 184.0 |
| MEDSTAR MONTGOM.. | 232.0 | 226.0 | 247.0 | 238.0 | 259.0 | 246.0 | 262.0 | 268.0 | 249.0 |
| MEDSTAR SOUTHERN .. | 367.0 | 344.0 | 331.0 | 328.0 | 340.0 | 329.0 | 388.0 | 381.0 | 358.0 |
| MEDSTAR ST. MARY'S | 284.0 | 269.0 | 272.0 | 251.0 | 254.0 | 249.0 | 265.0 | 265.0 | 252.0 |
| MEDSTAR UNION ME.. | 218.0 | 227.0 | 230.0 | 221.0 | 241.0 | 219.0 | 241.0 | 235.0 | 229.0 |
| MERCY | 232.0 | 241.0 | 231.0 | 219.0 | 218.0 | 222.0 | 233.0 | 249.0 | 236.0 |
| MERITUS | 225.0 | 207.0 | 207.0 | 221.0 | 211.0 | 203.0 | 225.0 | 231.0 | 221.0 |
| NORTHWEST | 288.0 | 291.0 | 304.0 | 279.0 | 291.0 | 290.0 | 299.0 | 272.0 | 271.0 |
| SHADY GROVE | 282.0 | 256.0 | 252.0 | 242.0 | 247.0 | 246.0 | 238.0 | 217.0 | 203.0 |
| SINAI | 232.0 | 240.0 | 250.0 | 232.0 | 233.0 | 233.0 | 243.0 | 236.0 | 229.0 |
| SUBURBAN | 227.0 | 216.0 | 227.0 | 217.0 | 219.0 | 210.0 | 209.0 | 214.0 | 213.0 |
| TIDALHEALTH MCCRE.. | | | 62.0 | 73.0 | 83.0 | 67.0 | 75.0 | 68.0 | 74.0 |
| TIDALHEALTH PENINS.. | | 184.0 | 190.0 | 196.0 | 195.0 | 191.0 | 192.0 | 184.0 | 190.0 |
| UM BWMC | 316.0 | 319.0 | 285.0 | 282.0 | 277.0 | 280.0 | 278.0 | 272.0 | 269.0 |
| UM CAPITAL REGION | 265.0 | 277.0 | 271.0 | 265.0 | 269.0 | 260.0 | 287.0 | 274.0 | 262.0 |
| UM SHORE CHESTERT.. | 169.0 | 175.0 | 164.0 | 180.0 | 193.0 | 150.0 | 189.0 | 199.0 | 180.0 |
| UM SHORE EASTON | 178.0 | 165.0 | 172.0 | 174.0 | 163.0 | 161.0 | 178.0 | 195.0 | 164.0 |
| UM ST. JOSEPH | 313.0 | 305.0 | 313.0 | 319.0 | 319.0 | 291.0 | 318.0 | 302.0 | 295.0 |
| UMMC DOWNTOWN | 310.0 | 312.0 | 306.0 | 299.0 | 292.0 | 293.0 | 304.0 | 316.0 | 327.0 |
| UMMC MIDTOWN | 266.0 | 294.0 | 277.0 | 279.0 | 270.0 | 237.0 | 301.0 | 313.0 | 284.0 |
| UPMC WESTERN MD | 233.0 | 236.0 | 248.0 | 250.0 | 272.0 | 260.0 | 259.0 | 256.0 | 256.0 |
| UPPER CHESAPEAKE | 278.0 | 280.0 | 278.0 | 270.0 | 280.0 | 282.0 | 308.0 | 303.0 | 294.0 |

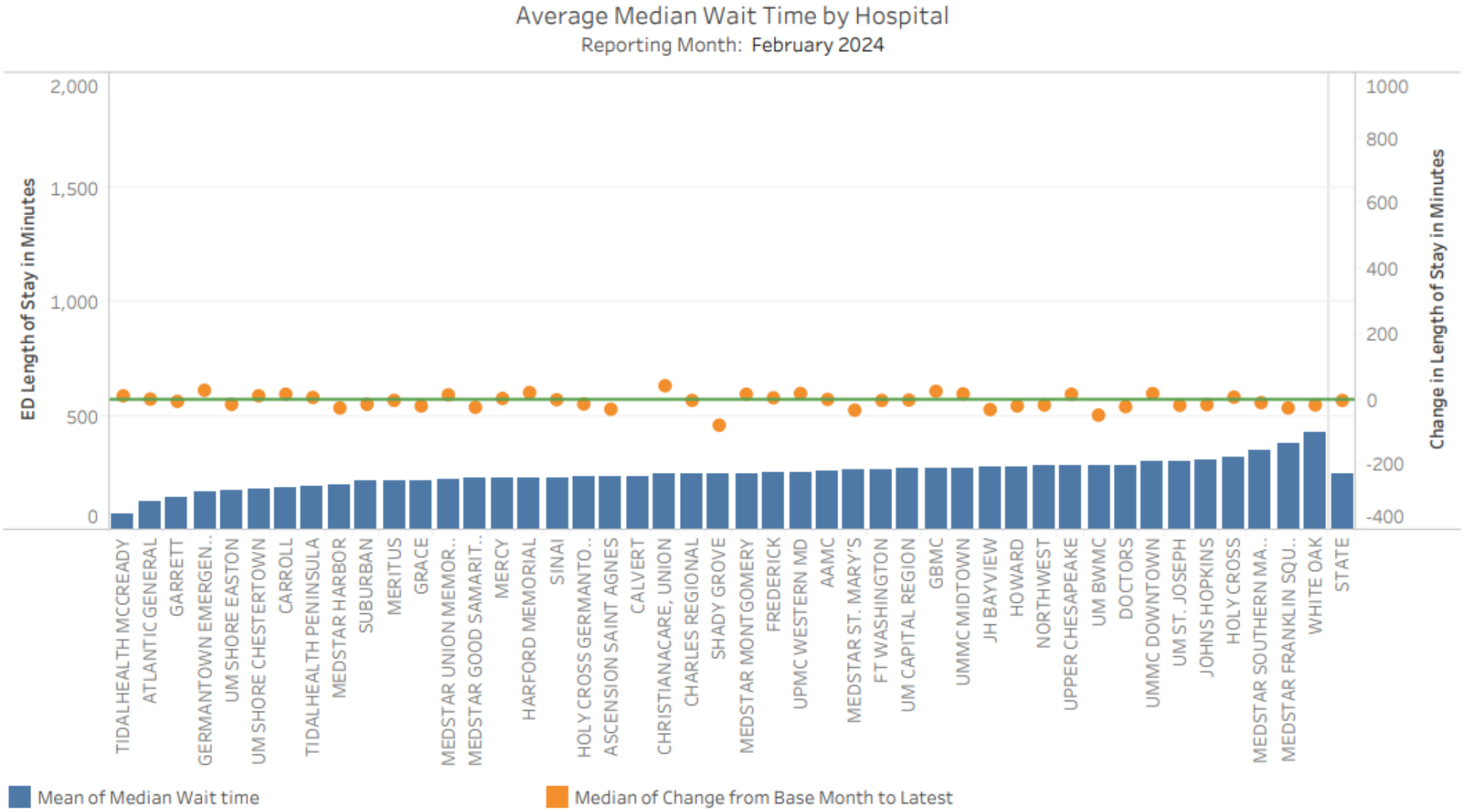
Measure
OP-18a

Change from Base
-79.0

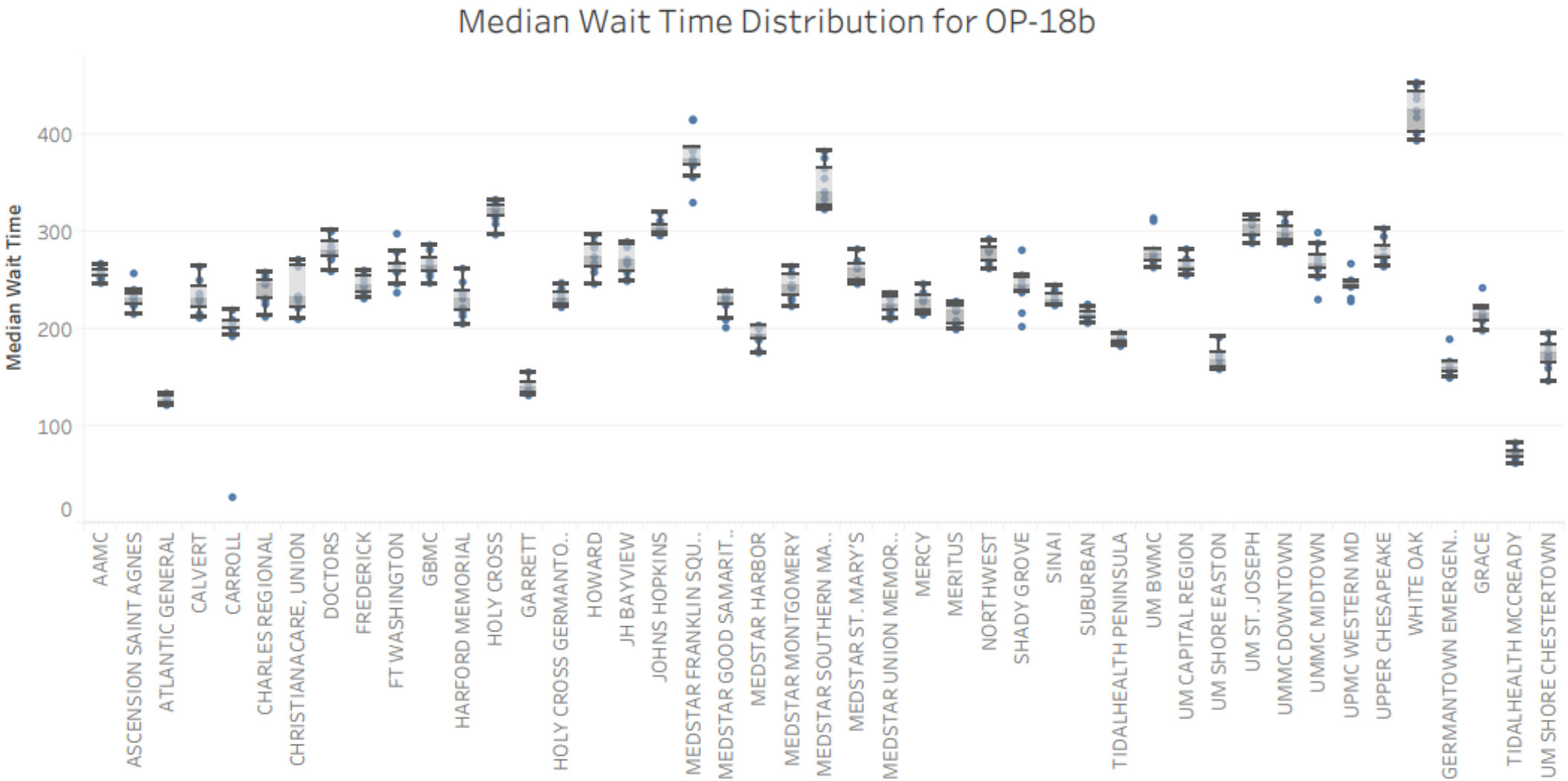
# OP18a: ED Arrival to Discharge Time
# Latest Month Median By Volume--Latest Month



# OP18b: ED Arrival to Discharge Time - Non-Psychiatric



# OP18b: ED Arrival to Discharge Time - Non-Psychiatric



# OP18b: ED Arrival to Discharge Time - Non-Psychiatric

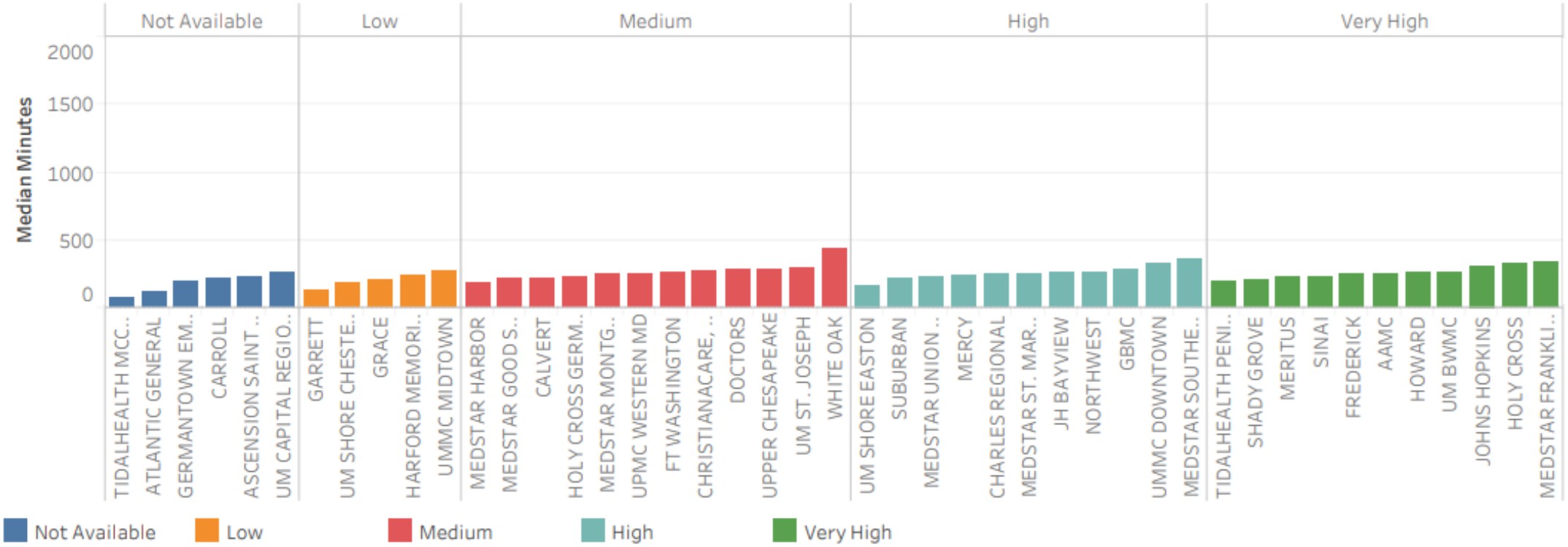
Average Median Wait Time All Hospitals for OP-18b

Measure
OP-18b

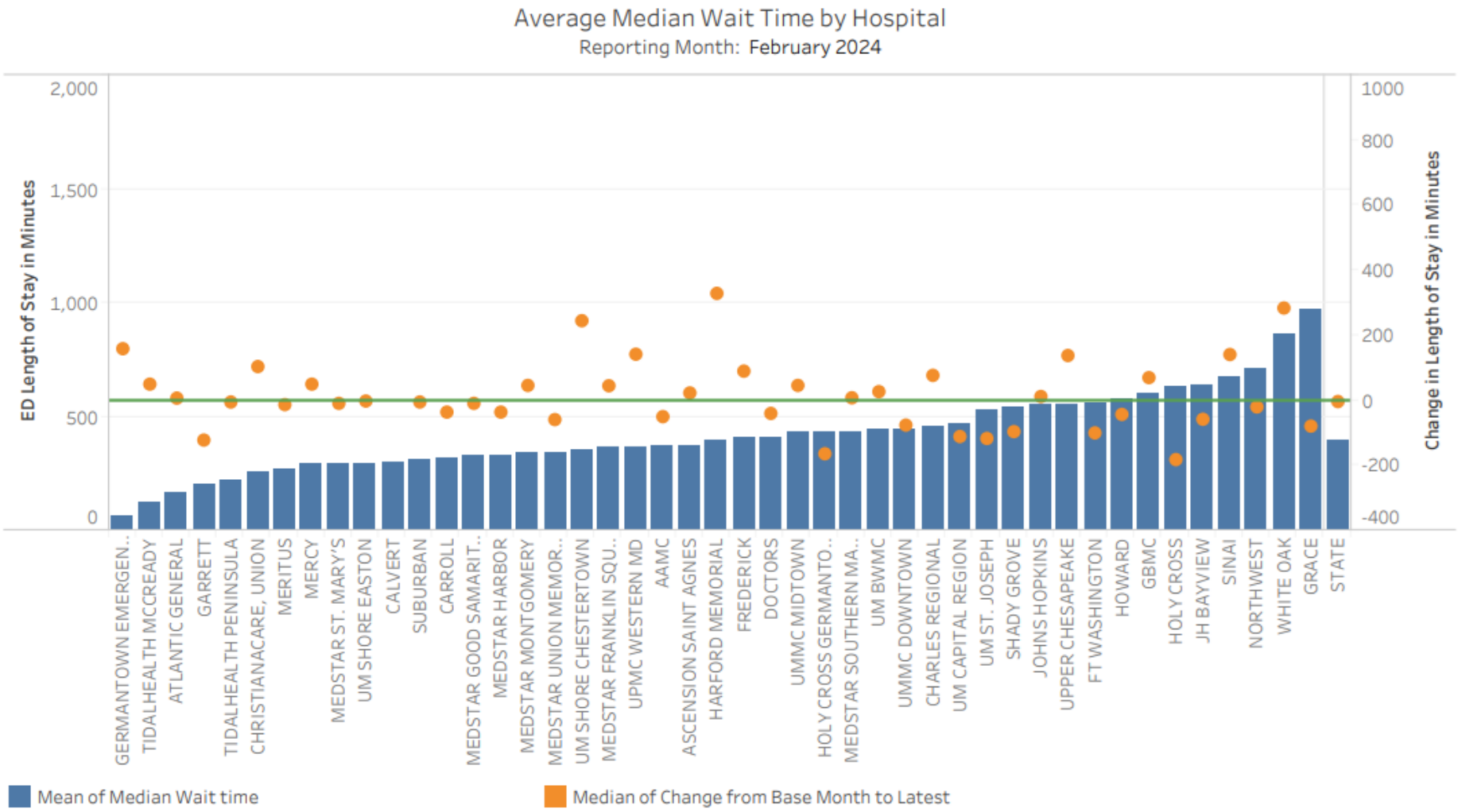
Change from Base
-166.0 60.0

| Hospital Name | June 2023 | July 2023 | August 2023 | September 2.. | October 2023 | November 20.. | December 20.. | January 2024 | February 202 |
|---|---|---|---|---|---|---|---|---|---|
| AAMC | 254.0 | 251.0 | 257.0 | 248.0 | 256.0 | 260.0 | 268.0 | 266.0 | 254.0 |
| ASCENSION SAINT AG.. | 258.0 | 235.0 | 232.0 | 241.0 | 216.0 | 225.0 | 225.0 | 234.0 | 228.0 |
| ATLANTIC GENERAL | 123.0 | 126.0 | 130.0 | 132.0 | 127.0 | 122.0 | 134.0 | | 124.0 |
| CALVERT | | 229.0 | 237.0 | 231.0 | 251.0 | 233.0 | 265.0 | 216.0 | 212.0 |
| CARROLL | 193.0 | 201.0 | 200.0 | 201.0 | 220.0 | 27.0 | 210.0 | 207.0 | 209.0 |
| CHARLES REGIONAL | 250.0 | 247.0 | 230.0 | 213.0 | 226.0 | 232.0 | 255.0 | 259.0 | 247.0 |
| CHRISTIANACARE, UN.. | 230.0 | 234.0 | 222.0 | 211.0 | 211.0 | 234.0 | 272.0 | 265.0 | 272.0 |
| DOCTORS | 302.0 | 272.0 | 274.0 | 260.0 | 285.0 | 280.0 | 301.0 | 291.0 | 280.0 |
| FREDERICK | | 246.0 | 245.0 | 232.0 | 235.0 | 239.0 | 256.0 | 261.0 | 251.0 |
| FT WASHINGTON | 268.0 | 238.0 | 261.0 | 247.0 | 260.0 | 259.0 | 299.0 | 280.0 | 265.0 |
| GARRETT | | | 138.0 | | 145.0 | 144.0 | 156.0 | 133.0 | 132.0 |
| GBMC | 262.0 | 248.0 | 255.0 | 265.0 | 273.0 | 259.0 | 282.0 | 269.0 | 287.0 |
| GERMANTOWN EMER.. | 162.0 | 156.0 | 159.0 | 150.0 | 167.0 | | | | 190.0 |
| GRACE | 220.0 | 243.0 | 218.0 | 209.0 | 212.0 | 199.0 | 223.0 | 215.0 | 200.0 |
| HARFORD MEMORIAL | 218.0 | 222.0 | 206.0 | 232.0 | 214.0 | 249.0 | 263.0 | 236.0 | 239.0 |
| HOLY CROSS | 315.0 | 298.0 | 330.0 | 328.0 | 324.0 | 309.0 | 326.0 | 334.0 | 322.0 |
| HOLY CROSS GERMAN.. | 237.0 | 224.0 | 248.0 | 232.0 | 232.0 | 225.0 | 242.0 | 230.0 | 223.0 |
| HOWARD | 284.0 | 287.0 | 297.0 | 247.0 | 268.0 | 259.0 | 289.0 | 275.0 | 264.0 |
| JH BAYVIEW | 290.0 | 290.0 | 288.0 | 268.0 | 272.0 | 252.0 | 250.0 | 285.0 | 259.0 |
| JOHNS HOPKINS | 320.0 | 312.0 | 308.0 | 299.0 | 304.0 | 297.0 | 298.0 | 302.0 | 304.0 |
| MEDSTAR FRANKLIN S.. | 357.0 | 373.0 | 384.0 | 369.0 | 376.0 | 387.0 | 417.0 | 416.0 | 331.0 |
| MEDSTAR GOOD SAM.. | 234.0 | 231.0 | 239.0 | 225.0 | 234.0 | 202.0 | 237.0 | 238.0 | 210.0 |
| MEDSTAR HARBOR | 204.0 | 204.0 | 201.0 | 190.0 | 203.0 | 176.0 | 189.0 | 193.0 | 178.0 |
| MEDSTAR MONTGOM.. | 230.0 | 224.0 | 245.0 | 233.0 | 256.0 | 243.0 | 258.0 | 265.0 | 246.0 |
| MEDSTAR SOUTHERN .. | 366.0 | 342.0 | 328.0 | 324.0 | 335.0 | 325.0 | 384.0 | 377.0 | 356.0 |
| MEDSTAR ST. MARY'S | 283.0 | 268.0 | 271.0 | 250.0 | 251.0 | 247.0 | 263.0 | 263.0 | 250.0 |
| MEDSTAR UNION ME.. | 211.0 | 221.0 | 226.0 | 218.0 | 235.0 | 215.0 | 237.0 | 232.0 | 225.0 |
| MERCY | 230.0 | 238.0 | 229.0 | 217.0 | 215.0 | 219.0 | 233.0 | 247.0 | 233.0 |
| MERITUS | 223.0 | 205.0 | 205.0 | 219.0 | 209.0 | 200.0 | 224.0 | 229.0 | 220.0 |
| NORTHWEST | 280.0 | 282.0 | 293.0 | 270.0 | 284.0 | 283.0 | 293.0 | 266.0 | 263.0 |
| SHADY GROVE | 282.0 | 256.0 | 252.0 | 241.0 | 247.0 | 245.0 | 238.0 | 217.0 | 203.0 |
| SINAI | 226.0 | 236.0 | 245.0 | 226.0 | 228.0 | 230.0 | 240.0 | 232.0 | 225.0 |
| SUBURBAN | 226.0 | 214.0 | 224.0 | 214.0 | 217.0 | 207.0 | 207.0 | 211.0 | 211.0 |
| TIDALHEALTH MCCRE.. | | | 62.0 | 73.0 | 83.0 | 66.0 | 75.0 | 67.0 | 73.0 |
| TIDALHEALTH PENINS.. | | 184.0 | 190.0 | 195.0 | 196.0 | 190.0 | 191.0 | 183.0 | 190.0 |
| UM BWMC | 312.0 | 315.0 | 282.0 | 279.0 | 271.0 | 277.0 | 274.0 | 269.0 | 264.0 |
| UM CAPITAL REGION | 261.0 | 273.0 | 267.0 | 260.0 | 264.0 | 256.0 | 283.0 | 270.0 | 259.0 |
| UM SHORE CHESTERT.. | 166.0 | 171.0 | 160.0 | 176.0 | 184.0 | 147.0 | 185.0 | 196.0 | 177.0 |
| UM SHORE EASTON | 176.0 | 162.0 | 169.0 | 171.0 | 161.0 | 159.0 | 175.0 | 192.0 | 161.0 |
| UM ST. JOSEPH | 308.0 | 296.0 | 309.0 | 314.0 | 313.0 | 289.0 | 317.0 | 298.0 | 290.0 |
| UMMC DOWNTOWN | 301.0 | 306.0 | 298.0 | 293.0 | 289.0 | 290.0 | 299.0 | 311.0 | 319.0 |
| UMMC MIDTOWN | 254.0 | 276.0 | 267.0 | 265.0 | 262.0 | 231.0 | 289.0 | 300.0 | 271.0 |
| UPMC WESTERN MD | 229.0 | 232.0 | 246.0 | 244.0 | 268.0 | 249.0 | 251.0 | 249.0 | 247.0 |
| UPPER CHESAPEAKE | 269.0 | 275.0 | 272.0 | 265.0 | 275.0 | 276.0 | 304.0 | 296.0 | 285.0 |

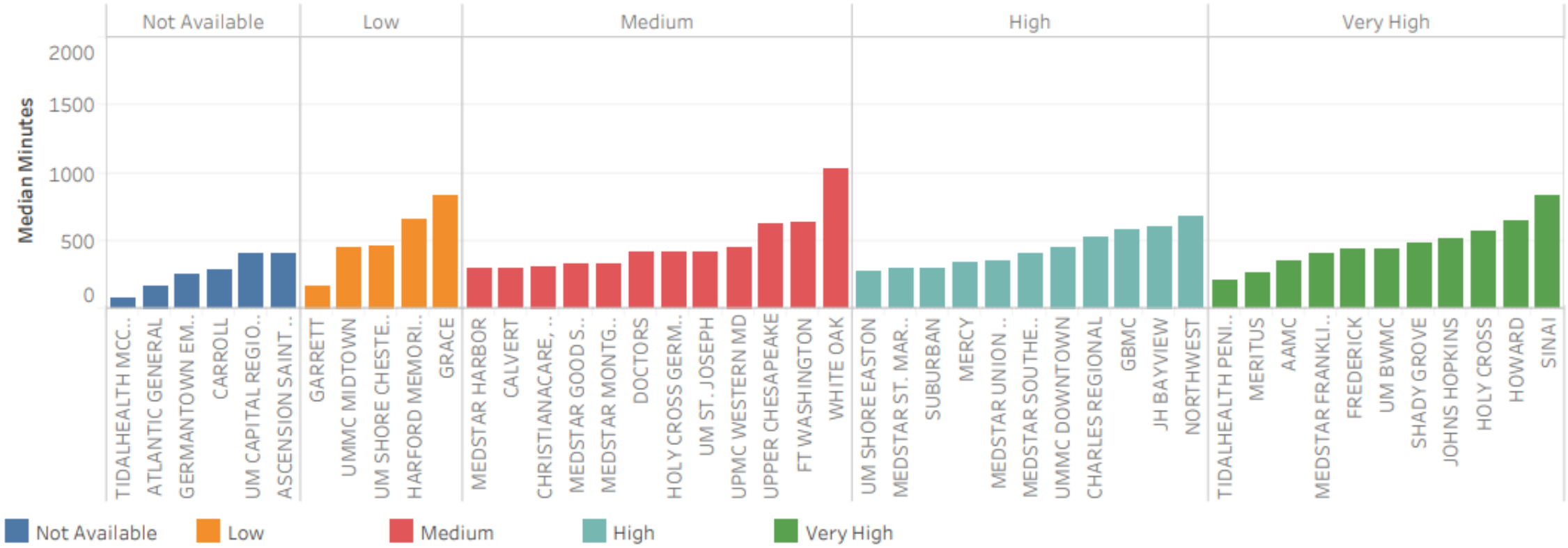
# OP18b: ED Arrival to Discharge Time by Volume Non-Psychiatric ED Visits



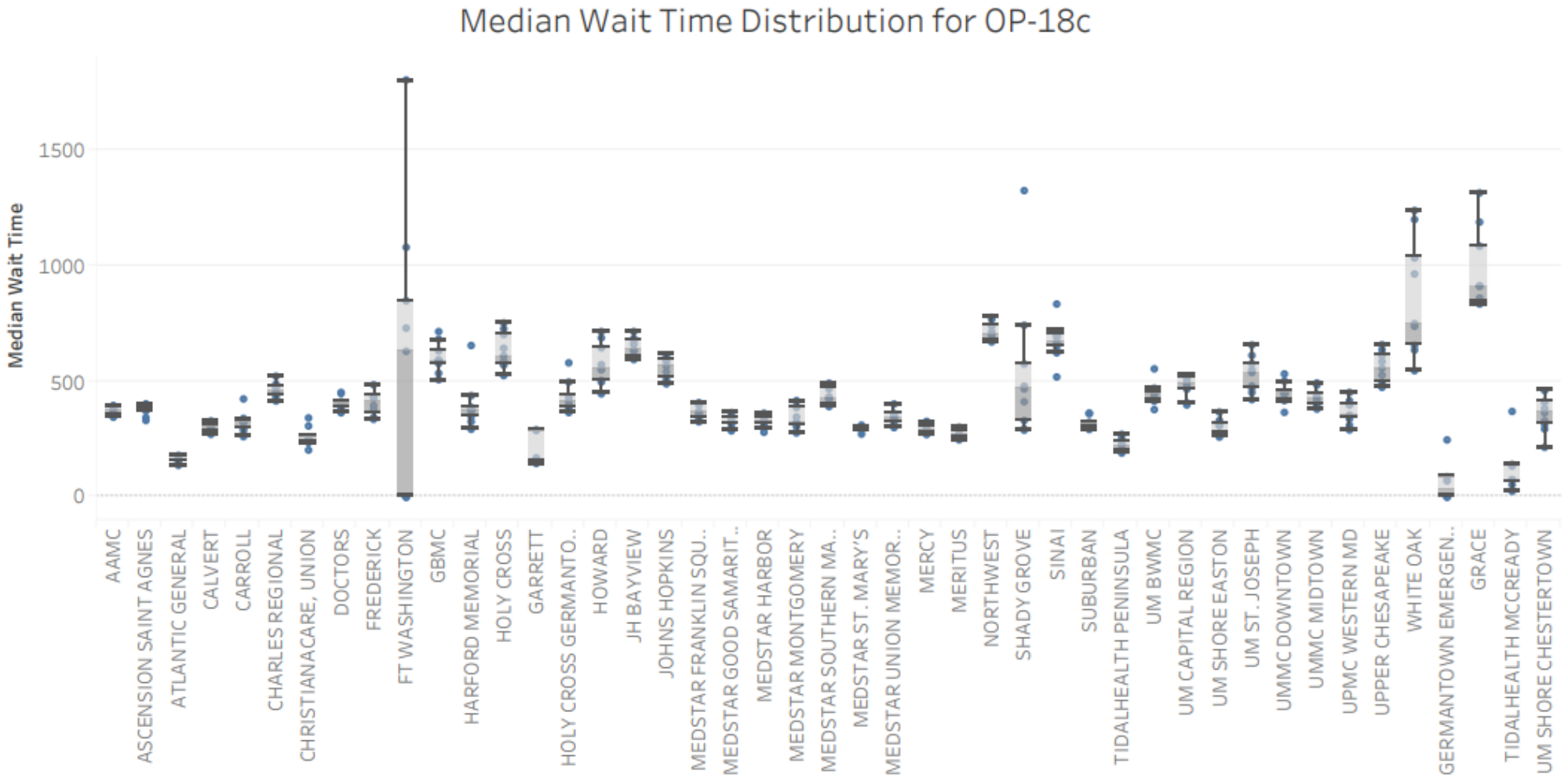
# OP18c: ED Arrival to Discharge Time by Month



# OP18c: ED Arrival to Discharge Time by Month



# OP18c: ED Arrival to Discharge Time by Month



# OP18c: ED Arrival to Discharge Time by Volume Psychiatric ED Visits

## Average Median Wait Time All Hospitals for OP-18c

| Hospital Name | June 2023 | July 2023 | August 2023 | September 2.. | October 2023 | November 20.. | December 20.. | January 2024 | February 202 |
|---|---|---|---|---|---|---|---|---|---|
| AAMC | 394 | 383 | 353 | 385 | 393 | 372 | 363 | 349 | 34 |
| ASCENSION SAINT AG.. | 379 | 342 | 389 | 330 | 371 | 384 | 387 | 391 | 40 |
| ATLANTIC GENERAL | 164 | 179 | 175 | 151 | 156 | 136 | 158 | | 17 |
| CALVERT | | 282 | 302 | 302 | 318 | 270 | 328 | 283 | 30 |
| CARROLL | 322 | 423 | 323 | 260 | 296 | 339 | 325 | 329 | 28 |
| CHARLES REGIONAL | 444 | 433 | 419 | 453 | 476 | 487 | 475 | 414 | 52 |
| CHRISTIANACARE, UN.. | 202 | 236 | 238 | 260 | 253 | 250 | 237 | 341 | 30 |
| DOCTORS | 451 | 363 | 389 | 393 | 380 | 397 | 404 | 447 | 41 |
| FREDERICK | | 343 | 335 | 376 | 426 | 395 | 435 | 484 | 43 |
| FT WASHINGTON | 729 | 847 | 1,078 | 0 | 0 | 0 | 0 | 1,801 | 62 |
| GARRETT | | | 288 | | 288 | 167 | 154 | 144 | 16 |
| GBMC | 506 | 681 | 587 | 631 | 534 | 714 | 592 | 586 | 57 |
| GERMANTOWN EMER.. | 87 | 69 | 0 | 0 | 0 | | | | 24 |
| GRACE | 912 | 845 | 1,083 | 1,313 | 1,187 | 909 | 859 | 837 | 83 |
| HARFORD MEMORIAL | 325 | 375 | 292 | 347 | 380 | 387 | 437 | 371 | 65 |
| HOLY CROSS | 751 | 609 | 726 | 701 | 586 | 642 | 524 | 577 | 56 |
| HOLY CROSS GERMAN.. | 579 | 496 | 386 | 364 | 426 | 434 | 383 | 406 | 41 |
| HOWARD | 687 | 445 | 503 | 550 | 571 | 496 | 549 | 714 | 64 |
| JH BAYVIEW | 659 | 678 | 714 | 598 | 635 | 684 | 630 | 593 | 60 |
| JOHNS HOPKINS | 496 | 488 | 583 | 595 | 564 | 540 | 612 | 598 | 50 |
| MEDSTAR FRANKLIN S.. | 353 | 365 | 337 | 324 | 328 | 370 | 405 | 406 | 39 |
| MEDSTAR GOOD SAM.. | 324 | 333 | 292 | 314 | 364 | 285 | 337 | 351 | 31 |
| MEDSTAR HARBOR | 333 | 336 | 322 | 346 | 361 | 279 | 316 | 330 | 29 |
| MEDSTAR MONTGOM.. | 276 | 320 | 302 | 345 | 386 | 309 | 392 | 416 | 32 |
| MEDSTAR SOUTHERN .. | 390 | 426 | 422 | 399 | 467 | 432 | 479 | 491 | 39 |
| MEDSTAR ST. MARY'S | 302 | 293 | 310 | 271 | 289 | 295 | 297 | 290 | 29 |
| MEDSTAR UNION ME.. | 401 | 332 | 307 | 325 | 359 | 299 | 359 | 346 | 34 |
| MERCY | 276 | 302 | 287 | 274 | 289 | 275 | 269 | 324 | 32 |
| MERITUS | 269 | 251 | 246 | 262 | 266 | 301 | 284 | 293 | 25 |
| NORTHWEST | 700 | 776 | 698 | 767 | 677 | 669 | 713 | 739 | 68 |
| SHADY GROVE | 574 | 294 | 741 | 1,323 | 466 | 411 | 288 | 330 | 47 |
| SINAI | 692 | 672 | 648 | 717 | 622 | 518 | 698 | 659 | 83 |
| SUBURBAN | 300 | 322 | 359 | 299 | 362 | 300 | 291 | 308 | 29 |
| TIDALHEALTH MCCRE.. | | | 24 | 52 | 140 | 369 | 74 | 133 | 7 |
| TIDALHEALTH PENINS.. | | 202 | 225 | 254 | 189 | 270 | 227 | 208 | 19 |
| UM BWMC | 413 | 469 | 377 | 446 | 420 | 446 | 553 | 443 | 44 |
| UM CAPITAL REGION | 508 | 473 | 488 | 522 | 406 | 491 | 514 | 465 | 39 |
| UM SHORE CHESTERT.. | 214 | 313 | 411 | 329 | 382 | 293 | 363 | 411 | 45 |
| UM SHORE EASTON | 276 | 265 | 330 | 314 | 275 | 258 | 307 | 366 | 27 |
| UM ST. JOSEPH | 537 | 656 | 548 | 611 | 576 | 451 | 469 | 479 | 42 |
| UMMC DOWNTOWN | 531 | 419 | 448 | 500 | 416 | 365 | 443 | 450 | 45 |
| UMMC MIDTOWN | 398 | 440 | 420 | 483 | 379 | 390 | 426 | 492 | 44 |
| UPMC WESTERN MD | 309 | 415 | 289 | 398 | 337 | 399 | 353 | 349 | 45 |
| UPPER CHESAPEAKE | 473 | 556 | 526 | 495 | 482 | 585 | 657 | 634 | 61 |

Measure
OP-18c

Change from Base
-729 1,072

# EMS Turnaround Public Reporting Measure

- Currently, MIEMSS provides weekly data reflecting turnaround time at the 90th percentile by hospital
  - Provides visibility on delays that have most impact on system performance
  - Not all hospitals have elected to receive this data
- MIEMSS provides monthly reporting on 90th percentile turnaround times by hospital for use in HSCRC programs

# EMS Turnaround Times: February Performance

- 23 hospitals reported the 90th percentile of turnaround time was <=35 minutes
  - Net increase of 2 Hospitals from last month
- 27 hospitals reported the 90th percentile of turnaround time was 35-60 minutes
  - Net increase of 3 Hospitals from last month
- 2 hospitals reported the 90th percentile of turnaround time was over 60 minutes
  - Net decrease of 5 Hospitals from last month
- Hospitals with improving performance
  - (Average to high performing): Cambridge Freestanding ED, Good Samaritan Hospital, Grace Medical Center
  - (Low performing to average): Doctors Community Medical Center, Fort Washington Medical Center, Howard County Medical Center, St. Agnes Hospital, White Oak Medical Center
- Hospitals with declining performance
  - (High performing to average): Shady Grove Medical Center
  - (Average to low performing) : N/A

# EMS Turnaround Times: February 2024 Performance

## 90th Percentile: 0-35 Minutes

Atlantic General Hospital
Cambridge Freestanding ED +
Chestertown
Frederick Health Hospital
Garrett Regional Medical Center
Germantown Emergency Center
Good Samaritan Hospital +
Grace Medical Center +
Harford Memorial Hospital
Holy Cross Germantown Hospital
Holy Cross Hospital
Johns Hopkins Hospital PEDIATRIC McCready Health Pavilion
Meritus Medical Center
Montgomery Medical Center
Peninsula Regional
Queenstown Emergency Center
R Adams Cowley Shock Trauma Center
St. Mary's Hospital
Union Hospital
Union Memorial Hospital
Walter Reed National Military Medical Center
Western Maryland

## >35 Minutes

Anne Arundel Medical Center
Baltimore Washington Medical Center
Bowie Health Center
Calvert Health Medical Center
Carroll Hospital Center
Charles Regional
Doctors Community Medical Center +
Easton
Fort Washington Medical Center +
Franklin Square
Greater Baltimore Medical Center
Harbor Hospital
Howard County Medical Center +
Johns Hopkins Bayview
Johns Hopkins Hospital ADULT
Laurel Medical Center
Mercy Medical Center
Midtown
Northwest Hospital
Shady Grove Medical Center -
Sinai Hospital
St. Agnes Hospital +
St. Joseph Medical Center
Suburban Hospital
University of Maryland Medical Center
Upper Chesapeake Medical Center
White Oak Medical Center +

## >60 Minutes

Capital Region Medical Center
Southern Maryland Hospital

**(+)**: Hospital improved by one or more categories; **(-)**: Hospital declined by one or more categories

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# Hospital Community Benefit Reporting Instructions Workgroup

March 13, 2024

# Hospital Community Benefit Reporting Instructions Workgroup

- Workgroup focused on updating reporting instructions:
  - Indirect Cost Ratios
  - CHNA- Aligned Spending
- Timeline (updated)
  - March: Recruit Members
  - April: 1st Workgroup Meeting
  - May: 2nd and 3rd Workgroup Meeting
  - June: Final Workgroup Comments on Edits to Reporting Instructions
  - July 1: Final Reporting Instructions Released.

# Questions?


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# Hospital Community Benefit Reporting Instructions Workgroup Charge

## March 2024

Maryland law requires the Maryland Health Services Cost Review Commission (HSCRC) to collect community benefit information from individual hospitals and compile it into a statewide, publicly available annual Community Benefit Report (CBR).[1] HSCRC updated the community benefits reporting requirements for FY 2021, with mandatory reporting on the new data elements beginning for FY 2022. The primary purpose of these reporting changes was to collect more information about the relationship between hospital community benefit activities and community health needs assessments (CHNAs).[2]

After reviewing the results of the FY 2022 community benefits reports from hospitals, two topics were identified as priorities for possible revision of the reporting requirements. HSCRC staff plan to convene a short-term workgroup to review reporting instructions in the following areas:

- Indirect Cost Ratios. There was wide variation between the indirect cost ratios reported by hospitals. Many hospitals reported very high ratios. The workgroup will review the methodology for calculating indirect cost ratios, and make recommendations about possible changes to this methodology, including whether caps on indirect cost ratios are appropriate.
- CHNA-Aligned Spending. There was wide variation between hospitals in the percentage of community benefit expenditures that were reported as being aligned with the hospital's CHNA initiatives. The workgroup will review the criteria hospitals are using to determine whether expenditures are CHNA-related. The workgroup will make

[1] MD. CODE. ANN., Health-Gen. § 19-303. Maryland law defines community benefit as a planned, organized, and measured activity that is intended to meet identified community health needs within a service area.

[2] The changes to reporting included requirements that hospitals 1) report on initiatives that directly address needs identified in the CHNA; 2) self-assess the level of community engagement in the CHNA process; 3) separately itemize all physician subsidies claimed as community benefits by type and specialty; and 4) list the tax exemptions the hospital claimed during the immediately preceding tax year. Reporting of items 1 and 2 by hospitals was optional for fiscal year (FY) 2021 but was mandatory for FY 2022.

recommendations about whether HSCRC's reporting instructions should provide additional guidance to hospitals on this topic.

## Timeline

| Activity | Timeline |
|---|---|
| Finalize Workgroup Charge | Early March |
| Schedule Workgroup Meetings | Early March |
| Recruit Workgroup Members | Early March |
| Brief Commissioners | March 13 |
| Meeting 1 | Week of April 8 |
| Meeting 2 | Week of April 22 |
| Meeting 3 | Week of May 6 |
| Final Workgroup Comments on Reporting Instruction Edits | May 28 |
| Release Final FY 2024 Reporting Instructions | July 1, 2024 |

## Proposed Meeting Agendas

### Meeting 1

- Introductions
- Brief background/history of Community Benefit reporting in Maryland
- Review workgroup charge and timeline
- Discussion topic: indirect cost ratios
    - Review hospital reporting results showing wide variation
    - Review current reporting instructions, which are tied to the HSCRC Annual Cost Report Schedule M, including consultation with HSCRC staff responsible for the Cost Report
    - Discuss options for revisions to reporting instructions
- Provide an overview of the agenda for next meeting

## Meeting 2

- Introductions
- Review any follow-ups from previous meeting on indirect cost ratios
- Discussion topic: reporting CHNA-related expenditures
    - Review hospital reporting results showing wide variation
    - Review current reporting instructions
    - Review best practices identified in FY 22 reports
    - Discuss options for revisions to reporting instructions
- Provide an overview of the agenda for next meeting

## Meeting 3

- Introductions
- Review any follow-ups from previous meeting
- Discussion topic: updates to reporting instructions
    - Staff to review draft changes based on discussions in previous meeting
    - Collect comments/feedback
- Summarize next steps for finalizing instructions

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# Volume Subgroup Overview

March 13, 2024

# Global Budget Volume Policy Background

- The HSCRC adjusts global budgets for anticipated changes in demographics/volume patterns and observed shifts in the market
- To that end, the Commission implements the following volume adjustments:

| Volume Adjustment | Approved Policy | Stand Alone | Purpose |
|---|---|---|---|
| Demographic Adjustment | X | | Annual age adjusted population funding for in-state use rate growth |
| Marketshift | X | | Semi-annual adjustments for regulated market shifts (zero sum) |
| Out-of-State | | | Annual adjustments for material changes to out-of-state volumes |
| Deregulation | | | As needed reductions for observed shifts to unregulated settings |
| Complexity and Innovation | X | X | Prospective funding to Academic Medical Centers for growth in unique quaternary services |
| CDS-A | X | X | Funding for changes in volume for select drugs (only volume variable methodology) |

# Agenda for CY 2024 Volume Subgroup

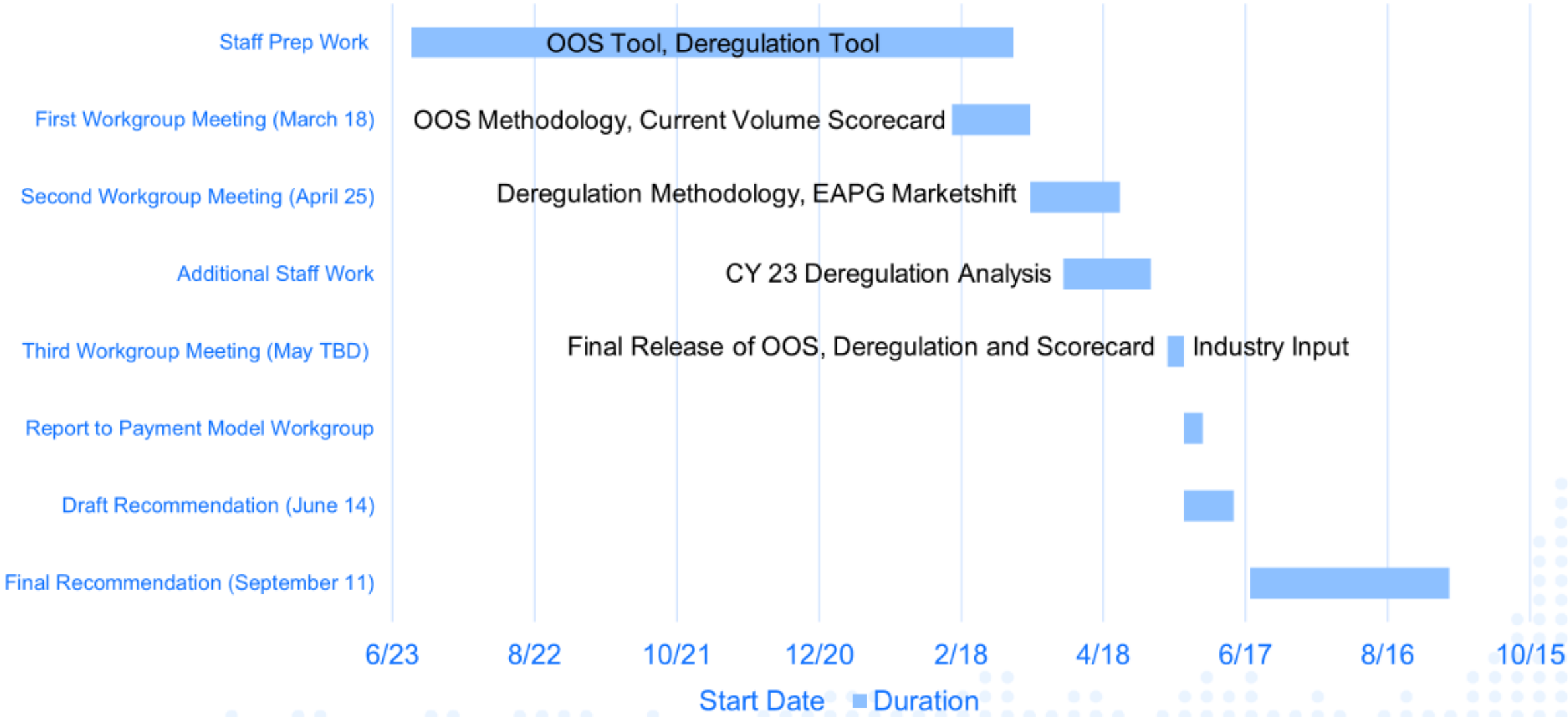
- Volume technical subgroup provides input to Payment Models Workgroup
- Will provide input for a formal policy on out-of-state and deregulation volume adjustments
  - Established policy will allow for routine adjustments
  - Will create greater transparency and predictability in the system
- To this end, workgroup will evaluate methodologies that have been used for adjustments related to out-of-state and deregulated volumes. Considerations include:
  - Data sources and granularity of analysis
  - Materiality thresholds
  - Time periods for assessment and potential one-time adjustments
  - Implementation schedule
  - Interaction with other policies (e.g., EQIP, total volume policies)

# Agenda for CY 2024 Volume Subgroup

- Workgroup will also advise on development of comprehensive volume scorecard that accounts for 5 volume policies
  - Current scorecard is strictly an assessment of Marketshift and Demographic Adjustment funding for growth in in-state volumes (excluding PAU, high cost drugs, innovation, and chronic cases)
  - Future scorecard will incorporate adjustments for out-of-state volumes, deregulation and PAU as well as adjustments related to Efficiency policies
  - Future scorecard will not incorporate CDS-A and Complexity and Innovation, as those policies are stand alone

- While there are several tools that prevent gaming under global budgets (see below), a comprehensive scorecard will allow staff to better assess questions about whether these policies are working as intended. These tools include:
  - Rate Corridors
  - Marketshift
  - Deregulation
  - Efficiency assessments

# Timeline for CY 2024 Volume Workgroup




Timeline subject to change if data is delayed or workgroup requires more deliberation

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**TO**: HSCRC Commissioners

**FROM**: HSCRC Staff

**DATE**: March 13, 2024

**RE**: Hearing and Meeting Schedule

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April 10, 2024 To be determined - Zoom

May 8, 2024 To be determined - Zoom

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.