

**609th Meeting of the Health Services Cost Review Commission
June 14, 2023**

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

**CLOSED SESSION
11:30 am**

1. Discussion on Planning for Model Progression - Authority General Provisions Article, §3-103 and §3-104
2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104
3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104

**PUBLIC MEETING
1:00 pm**

1. Review of Minutes from the Public and Closed Meetings on May 10, 2023
2. Final Recommendation on the Update Factor - FY 2024
3. Docket Status – Cases Closed
2608R Shady Grove Adventist Medical Center
4. Docket Status – Cases Open
2620T Howard County General Hospital 2622N MedStar St. Mary's Hospital
2623N MedStar St. Mary's Hospital 2625A Johns Hopkins Health System
5. Confidential Data Request by University of Maryland School of Medicine, Department of Anesthesiology
6. Final Recommendation on Revision and Updates to The Physical Therapy & Occupational Therapy Relative Value Units
7. Draft Recommendation on Updates to Efficiency Policies
8. Policy Update and Discussion
 - a. Model Monitoring
 - b. Final Recommendation on CRISP Funding - FY 2024
 - c. Emergency Department Wait Time Initiatives
9. Hearing and Meeting Schedule



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Final Recommendation for the Update Factors for Rate Year 2024

June 14, 2023

This is a final recommendation for Commissioner consideration at the June 14, 2023 meeting.

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List of Abbreviations

ACA	Affordable Care Act
CAGR	Compounded Annual Growth Rate
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year, refers to the period of October 1 through September 30
FY	Fiscal year
GBR	Global Budget Revenue
GSP	Gross State Product
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital Acquired Conditions
MPA	Medicare Performance Adjustment
MPA-SC	Medicare Performance Adjustment - Saving Component
OACT	Office of the Actuary
PAU	Potentially avoidable utilization
QBR	Quality Based Reimbursement
RRIP	Readmission Reduction Incentive Program
RY	Rate year, which is July 1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
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.	The final recommendation provides an annual update factor of 3.75 percent per capita, a revenue increase of 3.58 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 3.35 percent for hospitals not under Global Budgets which includes psych hospitals and Mt. Washington Pediatrics.	The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2024. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, uncompensated care, and others as deemed necessary.	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. Applied to all payers in the system, the update factor determination ensures that the increases to hospital rates borne by all purchasers of hospital services, including consumers, is reasonable and affordable.	The annual update factor contains the growth of costs for all payers and reflects ongoing investments in population health and health equity through the Regional Partnership programs. The update factor also reflects quality measures, including within hospital disparities, that aim to improve health disparities across the State.

Executive Summary

The following report includes a final recommendation for the Update Factor for Rate Year (RY) 2024. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness and to keep healthcare affordable in the State of Maryland.

This recommendation generally follows approaches established in prior years for setting the update factors. One notable exception is that staff had to account for the one-time actions taken during the December 2022 Commission meeting to improve total cost of care performance in Calendar Year (CY) 2023. Thus, in the modeling of TCOC savings in this recommendation staff accounted for the December 2022 actions of a \$40 million one-time all-payer rate reduction, a temporary increase of 1 percent to the governmental payer discount (known as the differential) and an increase to the Medicare Performance Adjustment Savings

Component (MPA SC) of \$64 million, which reduces Medicare reimbursement levels (not rates). Reductions to hospital payments were partially offset by a \$50 million reduction to the Medicaid Deficit Assessment - a hospital provider tax that supports the Maryland Medicaid program.

All analyses herein do not contemplate TCOC savings in 2024, as the various financial tests that are considered in determining the reasonableness of the Update Factor are always predicated on the current calendar year and projecting two-year growth for national total cost of care and Maryland non-hospital providers would likely be inaccurate. Nevertheless, it should be noted that any calculated savings rates in CY 2023, when measured on a permanent go forward basis, are overstated,¹ because the one time actions taken in the December 2022 Commission meeting will be reversed in CY 2024 - the lone exception is the increase to the differential which will remain in rates for the entirety of RY 2024 and then eliminated in the second half of the calendar year.

Staff recognizes that the ripple effect of the COVID-19 crisis, workforce shortage and subsequent high rates of inflation continue to create significant uncertainty in the healthcare industry, which is why the Commission elected to implement one-time and mostly Medicare specific TCOC improvement actions during the December Commission meeting. Staff will continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis and its lingering effects on healthcare in the State of Maryland. Specifically, Staff believes that the Commissioners should consider revising the annual inflation allotment provided in the RY 2024 Update Factor recommendation to align with the Medicare Inpatient and Outpatient Prospective Payment System rule when the final Medicare payment increases are known. Additionally, if Maryland's TCOC performance should worsen or not meet expectations compared to the nation, the Commission should consider ways to ensure that Maryland meets its CY 2023 contractual obligations by implementing an all-payer reduction and/or requesting to increase the MPA SC later in the year. Additionally, Staff believe the Commissioners should consider endorsing a workgroup to develop and assess financial condition benchmarks that will help inform future actions the Commission may take to stabilize the Maryland hospital market.

As with all HSCRC policies, the aim is equity and fairness for all hospitals and payers that balances the need to provide sufficient resources for operational readiness and necessary investment, while simultaneously ensuring affordability for consumers and purchasers of hospital services, as well as meeting all of the State's contractual obligations with the federal government.

Staff requests that Commissioners consider the following final recommendations:

¹ Staff estimates that the reversal of the one-time TCOC improvement actions that were approved in the December 2022 Commission meeting will likely yield an additional dissavings of ~1% or ~\$100 million.

For Global Revenues:

- a. Provide all hospitals with a base inflation increase of 3.35 percent.
- b. Provide an overall increase of 3.58 percent for revenue (including a net increase to uncompensated care) and 3.75 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- c. Convene a workgroup to establish benchmarks and methods for a Financial Condition Assessment that will, at a minimum, evaluate operating margins, cash position, debt coverage ratios, and capital investments.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- a. Provide an overall update of 3.35 percent for inflation.
- b. Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Introduction & Background

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy-related adjustments, other adjustments related to performance, and settlements from the prior year. For this upcoming fiscal year, the HSCRC is considering the continued long-term impact that COVID-19 is having on the healthcare industry in the development of the update factor. As in all the HSCRC policies, this final recommendation strives to achieve a fair and equitable balance between providing sufficient funds to cover operational expenses and necessary investments, while keeping the increase in hospital costs affordable for all payers.

In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. Under the new TCOC Model, the State committed to continue to limit the growth in hospital costs in line with economic growth, reach an annual Medicare total cost of care savings rate of \$300 million by CY2023 ("the Medicare TCOC Savings Requirement"), continue quality improvements, and improve the health of the population. It is worth mentioning that Maryland exceeded the 5-year total cost of care savings requirement under the Total Cost of Care Agreement in 2021, but this

performance stalled in 2022, i.e. there was a deterioration of the annual run rate in CY 2022 below that which was achieved at the end of CY 2021. While the Commission did take significant actions in December of 2022 to ensure that the State meets the total cost of care savings run rate of \$300 million in 2023, progress must be sustained through CY 2023, as the savings requirement is not a cumulative test and 2023 will be the last year the current Model is evaluated.

To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure, after the COVID-19 crisis abates, that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will also need to continue to ensure that the Medicare TCOC savings requirement is met. The approach to developing the RY 2024 annual update is outlined in this report, as well as Staff's estimates on calendar year Model tests.

Hospital Revenue Types Included in this Recommendation

There are two categories of hospital revenue:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority. The proposed update factor for hospitals under Global Budget Revenues is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.
2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals is strictly related to price, not volume.

This recommendation proposes Rate Year (RY) 2024 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2024, HSCRC staff is proposing an update of 3.75 percent per capita for global budget revenues and an update of 3.35 percent for non-global budget revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's First Quarter 2023 market basket growth estimate with a capital growth estimate. For RY 2024, HSCRC Staff combined 91.20 percent of Global Insight's First Quarter 2023 market basket growth of 3.40 percent with

8.80 percent of the capital growth estimate of 2.80 percent, calculating the gross blended amount as a 3.35 percent inflation adjustment.

Consideration of Hospital Financial Conditions

Hospital industry representatives have raised concerns over hospital financial performance in several forums. Staff recognize that Fiscal Years 2022 and 2023 have been more financially challenging for hospitals than prior years and that several hospitals are challenged to meet their system debt service coverage ratios. As noted in the Hospital Financial Condition Report released in May, hospital regulated margins for Fiscal Year 2022 were 6.46 percent, down from 9.70 percent in Fiscal Year 2021. While total operating margins (including unregulated business) were 0.77 percent, down from 4.01 percent over the same time window. Unaudited data received by the HSCRC shows that year-to-date Fiscal 2023 margins through February have declined further to 2.93 percent regulated margins and 0.35 percent total operating margins. However, staff notes that unaudited results may change based on final year submissions and final audit allocations.

This recommendation does not include any specific accommodations for these results beyond recommending that the Commission work with stakeholders to develop a more comprehensive financial condition assessment. While Staff acknowledges the deterioration of the margin during FY 22 and 23, at this time, Staff is not recommending any special accommodations given the fact that overall hospital balance sheets remain well above levels seen prior to the beginning of the GBR system in 2014 and have followed a period of many years of strong margin. Furthermore, statewide average regulated margins remain positive, meaning that any extra funding would effectively be directed at unregulated operations, over which the Commission has no regulatory authority and limited ability to evaluate appropriateness (although Staff acknowledge some of these costs may be inherent in operating a hospital). A more thoughtful approach is needed to consider covering additional costs needed to run a hospital. Individual hospitals with more significant financial challenges can and have been taking advantage of the various avenues to appeal for specific relief.

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC Staff proposes applying the inflation adjustment of 3.35 percent. The pandemic's effect on hospitals continues to result in historically low volumes. For this reason, HSCRC staff propose to withhold the productivity adjustment from this year's gross blended inflation amount. It is important to note that these hospitals receive an adjustment based on their actual volume change, rather than a population adjustment. HSCRC staff continues to include these non-global budget hospitals in readmission calculations for global budget hospitals and may implement quality measures for these hospitals in future rate years.

Table 1

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.35%	3.35%
Productivity Adjustment	N/A	SUSPENDED
Proposed Inflation Update	3.35%	3.35%

Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the Total Cost of Care Model, HSCRC staff sought to achieve balance among the following conditions:

- Meeting the requirements of the Total Cost of Care Model agreement, including achieving \$300 million in annual Medicare savings by the end of CY 2023;
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model;
- Incorporating quality performance programs; and
- Ensuring that healthcare remains affordable for all Marylanders.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates net revenue growth (before accounting for changes in uncompensated care and assessments) of 3.58 percent and per capita growth of 3.75 percent for RY 2024.

To measure the proposed update against financial tests, which are performed on Calendar Year results, Staff split the annual Rate Year revenue into six-month targets. Staff intends to apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2024 estimated revenue used to evaluate the Rate Year year-end target. HSCRC staff will adjust the revenue split to accommodate their normal seasonality for hospitals that do not align with the traditional seasonality described above.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC Staff’s final recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

Table 2

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	L	-0.32%
-QBR, MHAC, Readmissions		
-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 Financial Statements		
-Uncompensated care, net of differential	V	0.05%
-Deficit Assessment	W	0.00%
Net decreases	X = V + W	0.05%
Total Update First Half of 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%
Total Update Full Rate Year 24		
Revenue growth, net of offsets	AA = T + X	3.58%
Per Capita Fiscal Year	BB = (1+Z)/(1-0.16%)	3.75%

Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

HSCRC Staff accounted for several factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 3.35 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's First Quarter 2023 market basket growth of 3.40 percent with 8.80 percent of the capital growth index change of 2.80 percent. The adjustment for inflation includes 4.80 percent for wage and compensation.
- **Outpatient Oncology and Infusion Drugs:** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting led to the creation of separate inflation and volume adjustment for these drugs. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drugs.

In addition to the drug inflation allowance, the HSCRC provides a utilization adjustment for these drugs. Half of the estimated cost changes due to usage or volume changes are recognized as a one-time adjustment and half are recognized as a permanent adjustment. This process is implemented separately from this Update Factor so only the inflation portion is addressed herein.

Starting in Rate Year 2021, Staff began using a standard list of drugs based on criteria established with the industry in evaluating high-cost drug utilization and inflation. This list was used to calculate the inflation allowance as well as the drug utilization adjustment component of funding for these high-cost drugs. Rate Year 2024 continues this practice. While volume continues to grow for these drugs, Staff analysis shows that the price per drug of the drugs covered has stabilized and the need for a higher inflation rate on this component of spending has been mitigated. This trend was recognized in Rate Year 2021 through a lowering of the drug inflation factor from 10 percent to 6 percent and then again with a lowering to 1 percent for RY 2023. This year Staff reviewed trends from 2018 to 2022 and determined that price and mix have been minimal over the recent period.

Therefore, Staff is proposing a 0 percent drug inflation factor for RY 2024 for outpatient oncology and infusion drugs.

- **Care Coordination / Population Health:** There were several grant programs aimed at Care Coordination and Population Health in RY 2023 hospital revenues. These programs include Regional Partnership Catalyst Programs for Diabetes and Behavioral Health, Maternal and Child Health Improvement Fund Assessment, Population Health Workforce Support for Disadvantaged Areas, and transition funding for Regional Partnership Legacy Grants. These funds were provided to hospitals on a one-time basis. For this reason, you will see a line in Table 2 reversing out grant funding in RY 2023 of -0.22 percent. RY 2024 funding is expected to be approximately 0.19 percent and includes continued funding for Diabetes and Behavioral Health, as well as Maternal and Child Health.
- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for RY 2024 is -0.16 percent; however, as noted by staff in Payment Model Workgroup Meetings and in Commission meetings, the projected population declines are relative to a revised July 1, 2020 base in which the Department of Planning accounted for the ten year forecasting error that was identified in the 2010-2020 census. Specifically, in the RY 2023 Demographic Adjustment, the Department of Planning revised the base upwards by 1.93 percent, an increase of 116,283 lives, and then projected a population decline of -0.12 percent from that revised base. The Commission only reflected the decline of -0.12 percent in the RY 2023 Demographic Adjustment, thereby reducing global budgets for 27 hospitals by approximately \$79 million. In light of the revision to the census, Staff is recommending that the Commissioners a) reverse the population declines that were scored for 27 hospitals in RY 2023 b) implement a 0 percent RY 2024 Demographic Adjustment for all hospitals in lieu of the Department of Planning projection of -0.16 percent and c) consider expediting the review process to provide additional demographic funding in hospital rates for the population growth that was not accounted for from 2010-2020.
- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining inefficient hospitals in the TCOC Model. This policy will utilize the Inter-Hospital cost comparisons to compare relative cost-per case efficiency. This policy will also use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals or potentially for reinvestment through the proposed Revenue for Reform policy. Staff is simultaneously recommending modifications to the Integrated Efficiency policy in the June Commission meeting, and as such will not reflect potential adjustments related to Integrated Efficiency Policy in the Final

Update Factor Recommendation. Staff does note, however, that if the Commission were to approve the Integrated Efficiency policy in the July Commission meeting, TCOC savings in CY 2023 would improve by a range of approximately \$8 million.

- **Set-Aside for Unforeseen Adjustments:** The intention of the set-aside is to use these funds for potential Global Budget Revenue enhancements and other potentially unforeseen requests that may occur at hospitals. Staff is recommending 0.10 percent for RY 2024.
- **FY2022 Surge Funding:** A policy (COVID-19 Surge Policy) was adopted by the Commission in April 2020 under which hospitals would be reimbursed for COVID-19 cases that exceeded their GBR during designated periods. Two periods were designated eligible for this funding, one coinciding with the onset of the COVID-19 crisis in the spring and summer of 2020 and one during the winter of that year, ending in early 2021. With the severe spike of COVID-19 cases in the winter of 21/22 the Commission expressed a commitment to evaluate a similar approach for FY 2022, upon completion of the fiscal year and after modifying the policy to take into consideration the different circumstances in FY2022. Consideration of this policy was delayed due to the Medicare savings challenges during CY 2022, but Staff is now proposing an approach to meet this commitment. The outcome of that approach is a 0.20 percent overall impact as shown in this update factor. Details of the specific approach can be found in Appendix A of this document. Staff recommends this adjustment be the last special adjustment for COVID for both prior and future periods, except in the event of a major recurrence of the crisis.
- **Complexity and Innovation (formerly Categorical Cases):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, the HSCRC Staff developed an approach to provide a higher variable cost factor (100% for drugs and supplies, 50% for all other charges) to in-state, inpatient cases when a hospital exhibits dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center in RY 2017, 2018, 2019, 2020, 2021, and 2022. Based on this analysis, staff concluded that the historical average growth rate was 0.38 percent, which equates to a combined state impact of 0.10 percent for the RY 2024 Update Factor.

- **PAU Savings Reduction:** The statewide RY 2024 PAU savings adjustment, of -0.38 percent, is calculated based on update factor inflation and demographic adjustment applied to CY 2022 PAU performance.
- **Quality Scaling Adjustments:** The quality pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP) including the Disparity Gap Incentive, and Quality Based Reimbursement program (QBR). Despite the suspension of payment incentives and modifications for COVID in RY 2022 and RY 2023, in RY 2024 all three quality programs will be implemented. Preliminary QBR adjustments will be implemented with the July rate orders and adjustments will be made in the January rate orders to reflect the full measurement period. The January QBR adjustments may also include changes to the preset revenue adjustment scale to reflect reduced performance standards in line with lower scores nationally, as approved in the RY 2024 final policy. The current revenue adjustments across the three programs is -0.25 percent (with preliminary QBR). The Update Factor recommendation also reflects the reversal of prior year Quality adjustments, which in RY 2023 were higher than historical adjustments at 0.32 percent, as the only incentives that were put in place were the RRIP, inclusive of the Disparity Gap Incentive.
- **Capital Funding and Estimated Increase for Full Rate Applications:** The Greater Baltimore Medical Center (GBMC) received an approved Certificate of Need (CON) in August 2020 to construct an expansion of the main lobby. This project is estimated to increase the budget by 0.01 percent, or \$2 million, in RY2024.

Preliminary modeling indicates that efficient hospitals may be entitled to approximately \$80 million through the Full Rate Application Policy. This value is subject to change based on quality assurance reviews of Inter-hospital Cost Comparison (ICC) methodology and the Marketshift Policy, which has an effect on the final revenues evaluated in the ICC. Additionally, the values may also change based on Commission consideration of proposed revisions to the Full Rate Application policy, which will be released as a Draft Recommendation in the June Commission meeting.

Central Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with a neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2024 will be 0.05 percent. The amount in rates was 4.22 percent in RY 2023, and the proposed amount for RY 2024 is 4.27 percent, an increase of 0.05 percent.

- **Deficit Assessment:** In line with the Commission's Total Cost of Care improvement actions taken in December 2022, the legislature proposed a \$50 million decrease to the Deficit Assessment; however, the Commission indicated during its deliberations in December 2022, that any reduction should be attributable to hospital profits and thus has no impact on hospital charges. As a result, this line item is 0.00 percent.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

PAU Savings Updated Methodology

The PAU Savings Policy prospectively reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY 2020, the calculation of the statewide value of the PAU Savings was included in the Update Factor Recommendation; however, a PAU measurement report was presented separately to the Commission in March of 2019.

For RY 2024, the incremental amount of statewide PAU Savings reductions is determined formulaically by using inflation and the demographic adjustment applied to the amount of PAU revenue (see Table 3). This will result in a RY 2024 permanent PAU savings reduction of -0.39 percent statewide, or \$76,384,056 (this value does not include revenue from McCready or freestanding EDs). Hospital performance on avoidable admissions per capita and 30-day readmissions, the latter of which is attributed to the index hospital, determines each hospital's share of the statewide reduction.

Table 3

Statewide PAU Reduction	Formula	Value
RY 2023 Total Estimated Permanent Revenue	A	\$19,585,655,296
RY 2024 Inflation Factor*	B	3.74%
CY 2022 Total Experienced PAU \$	C	\$2,066,535,838
RY 2024 Proposed Revenue Adjustment \$	$D = B * C$	-\$77,288,440
RY 2024 Proposed Revenue Adjustment %	$E = D / A$	-0.39462%
RY 2024 Adjusted Proposed Revenue Adjustment %**	$F = \text{ROUND}(E)$	-0.390000%

RY 2024 Adjusted Proposed Revenue Adjustment \$ **	$G = F * A$	-\$76,384,056
Total PAU %	H	10.44%
Total PAU \$	$I = A * H$	\$2,044,485,050
Required Percent Reduction PAU	$J = G / I$	-3.74%

* Inflation factor is subject to revisions related to updated data and Commission approval

**Does not include revenue from McCready, or freestanding EDs, thus the reduction on a statewide basis is equal to -0.38%..

Change in Differential

In December 2022 the Commission voted, and CMMI subsequently approved, an increase of 1 percent to the public payer differential, from 7.7 percent to 8.7 percent, effective April 1, 2023. This increase was implemented for the remainder of RY 2023 and the duration of RY 2024. While the overall impact to hospitals will be revenue neutral, hospital markups, rates, and GBRs will be adjusted to account for a lower public payer payment. The adjustments will be hospital specific, as they are based on the percentage of services attributable to public payers.

Consideration of Total Cost of Care Model Agreement Requirements & National Cost Figures

As described above, the staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Staff's considerations regarding the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

This test requires the Model to generate \$300 million in annual Medicare fee-for-service (FFS) savings in total cost of care expenditures (Parts A and B) by the end of CY 2023. The TCOC Model Medicare Savings Requirement is different from the previous All-Payer Model Medicare savings requirement in several ways. First, as previously discussed, Maryland's Total Cost of Care Model Agreement progresses to setting savings targets based on total costs of care, which includes non-hospital cost increases, as opposed to the hospital-only requirements of the All-Payer Model. This shift ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from Model implementation. Additionally, the change to the total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care.

Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were summed to determine total *hospital* savings. The TCOC Model requires that the State reach an annual total cost of care savings of \$300 million relative to the national growth rate by 2023, relative to a 2013 base year. Thus, there must be sustained improved performance overtime to meet the new TCOC Medicare Savings Requirements. In CY 2022, the annual TCOC run rate in Maryland deteriorated from a high of \$379 million. Current estimates put the CY 2022 annual TCOC run rate between \$219-\$259 million, which is below the required run rate of \$267 million. While the Commission did take significant actions in December of 2022 to ensure that the State meets the total cost of care savings run rate of \$300 million in 2023, progress must be sustained through CY2023, as the savings requirement is not a cumulative test and 2023 will be the last year the current Model is evaluated.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In past years, Staff compared Medicare growth estimates to the all-payer spending limits, to estimate that Model savings and guardrails were being met. Prior to the pandemic staff established an approach whereby prior year national trend was used as the stand-in to estimate national trend. However, due to the ongoing COVID-19 pandemic and the related uncertainty and volatility, Staff created an alternative approach to measure projected savings and compliance with the Total Cost of Care guardrails for RY 2023. For RY 2024 Staff are using a combination of these approaches. Scenario 3 represents the prior year trend test used prior to the pandemic; the other 3 scenarios are similar to those used in the more recent periods.

Actual revenue resulting from RY 2024 updates affect the CY 2023 results. As a result, Staff must convert the recommended RY 2024 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2023 to assist in estimating the impact of the recommended update factor together with the projected RY 2024 results. The overall increase from the bottom of this table is used in Tables 5a-5d.

Table 4.

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 43.73% & 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%

Steps to explain Table 4 are described as below:

The table begins with actual revenue for CY 2022.

- Step 1: The approved blended GBR for RY 2023 is \$20,185,681,779. This blends the approved budgeted revenues from rate orders effective beginning July, March, and April. It is necessary to account for anticipated charges in the first six months of CY 2023. Hospitals currently project they will not be able to charge all of RY 2023 revenue by the end of the Rate Year, the estimated shortfall is \$12.3 million (the RY 2023 undercharge).

- Step 2: The final approved GBR for RY 2023 is \$20,293,387,021 which includes the change in differential. This step applies the proposed update of 3.58 percent, as shown in Table 2, to the adjusted RY 2023 GBR amount to calculate the projected revenue for RY 2024.
- Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2024 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2024.
- Step 4: This step shows the resulting estimated revenue for CY 2023 and then calculates the increase over actual CY 2022 Revenue. The CY 2023 increase based on this year's recommended update is 3.56 percent. The 3.56 percent is used to estimate CY2023 hospital spending per capita for Maryland in our guardrail policy, which is explained in the next policy.

Staff modeled four different scenarios to project the CY 2023 guardrail position. Each scenario is described in more detail below. The one data element that is constant in each scenario is Maryland hospital growth. Because global budget revenues are a known data element, Staff applied the estimated CY 2023 growth of 3.56 percent, shown in Table 4 to Maryland hospital spending per capita from 2022. In addition, the temporary mitigation adopted by the Commission in December 2022 for CY2023 discussed above has been added to the Guardrail Scenario tests. Some aspects of these interventions are included in Table 4 because they directly impact all-payer charges, while others that manifest through other mechanisms, such as the differential and the MPA Savings Component, are not. The incremental impact of the interventions that is not reflected in Table 4 is a 1.13 percent reduction in per capita costs, this incremental savings is reflected in the tables below. The net impact of these temporary interventions is approximately 1 percent. As these interventions all terminate on either December 31, 2023, or June 30, 2024, this 1 percent of savings will need to be replaced by permanent savings in order for the State to meet CY2024 savings goals. These analyses assume that Medicare growth equals All-Payer growth.

Scenario 1, shown in Table 5a, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. This takes the average trend from 2017 to 2019 and trends the data forward using 2022 as the base.

Table 5a

Scenario 1 Guardrail Projections			
	Maryland	US	
2022	\$13,652	\$11,887	
2023	\$14,015	\$12,358	Predicted Variance
YOY Growth	2.66%	3.96%	-1.31%
Estimated CY2023 Savings Run Rate (assuming CY22 = \$219 M)			\$365 M

Scenario 2, shown in Table 5b, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 2 takes the average trend from 2015 - 2019 and trends the data forward using 2022 as the base. This is the most conservative estimate of the four scenarios as average national trends for that period were low. Utilizing a longer period to establish the “typical” trend results in a lower trend estimate, as the more recent 2017 to 2019 period utilized in Scenario 1 was a relatively high trend window.

Table 5b

Scenario 2 Guardrail Projections			
	Maryland	US	
2022	\$13,652	\$11,887	
2023	\$13,944	\$12,226	Predicted Variance
YOY Growth	2.14%	2.86%	-0.72%
Estimated CY2023 Savings Run Rate (assuming CY22 = \$219 M)			\$295 M

Scenario 3, shown in Table 5c, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B)

which are then added together to calculate a total per capita estimate. Scenario 3 takes the trend from the prior period (2021-2022) and trends the data forward using 2022 as the base. Staff added this scenario assuming that the post-pandemic trend of 2021 over 2022 reflects the go forward trend. This approach is consistent with the pre-pandemic approach of using the prior year trend to guide current year savings targets. This approach results in a slightly higher estimate of national trends and slightly larger projected savings than Scenario 2.

Table 5c

Scenario 3 Guardrail Projections			
	Maryland	US	
2022	\$13,652	\$11,887	
2023	\$13,884	\$12,189	Predicted Variance
YOY Growth	1.70%	2.55%	-0.84%
Estimated CY2023 Savings Run Rate (assuming CY22 = \$219 M)			\$300 M

Scenario 4, shown in Table 5d, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 4 takes the average trend from 2015 - 2019 and trends the data forward using 2019 as the base. The trend used is the same as Scenario 2 but it is applied to a 2019 base rather than 2022, which eliminates the impact of the pandemic on total cost of care. As the overall impact of the pandemic years was to lower total costs this scenario results in a higher projection for 2023 total cost of care. While the pandemic could be viewed as a temporary disruption rather than a permanent change to total cost of care patterns, Staff's review of the data so far does not show a rebound to pre-pandemic patterns of care. This rebound may still occur but assuming it will occur in CY2023 is likely an optimistic assumption.

Table 5d

Scenario 4 Guardrail Projections			
	Maryland	US	
2022	\$13,652	\$11,887	
2023	\$13,985	\$12,318	Predicted Variance
YOY Growth	2.44%	3.63%	-1.19%
Estimated CY2023 Savings Run Rate (assuming CY22 = \$219 M)			\$360M

In addition to modeling the CY 2023 guardrail position, Staff also modeled estimated savings under each scenario; these are shown in each table above. The savings target for CY 2023 is \$300 million. Achieving an annual run rate of \$300 million in CY2023 is crucial as we move to the next phase of Model negotiations because this year will serve as the basis for the federal government’s evaluation of the Model.

In three of the four scenarios above, Maryland is set to achieve the savings target for CY 2023 with varying degrees of cushion. In the most conservative scenario, the savings target is closely achieved with a \$5 million dollar shortfall. Therefore, this recommendation proposes funding inflation as reported by Global Insights for RY 2024 but does not provide additional funding based on higher prior inflation or anticipated future inflation.

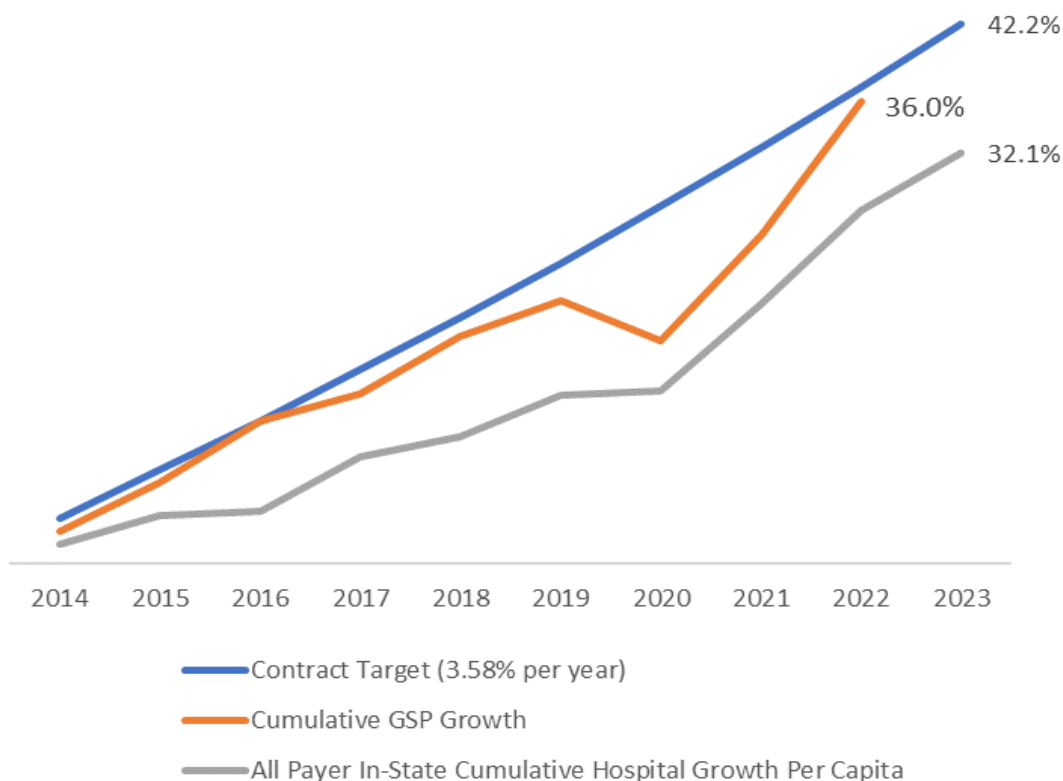
All-Payer Affordability

Under the Total Cost of Care Contract all-payer test, all-payer in-state hospital charge growth cannot grow at above 3.58 percent per annum over the life of the contract (3.58 percent was intended as an approximation of typical per annum Gross State Product (GSP) growth). As shown in Figure 1 the cumulative value of this target through CY2023 is 42.2 percent. Actual all-payer in-state hospital charge growth through CY2022 is 27.6² percent, inflating this to 2023 using the recommended update factor on a per capita basis yields 32.1 percent. This means that Maryland is approximately 10 percentage points below this target, as seen in Figure 1. Staff also notes that through CY2022 all-payer in-state hospital

² All GSP and charge growth figures in this section All use an estimate of Maryland population that does not reflect the increase resulting from the correction of the forecasting error discussed in the “Adjustments for Volume section”. This correction was omitted because it is not yet reflected in the all-payer test submitted to CMS. Correcting this value will improve Maryland’s performance on the All-Payer test by approximately 1%. It will not change relative performance on the other GSP tests because the same population value is used in calculating both GSP and in-state acute hospital charges per capita.

charges are not just well below the all-payer target but also below the actual cumulative GSP growth through 2022 of 36.0 percent, which is an indication of the savings generated by the Model that accrue to all payers and consumers.

Figure 1. Affordability Scorecard – Cumulative GSP Test with CY 2023 Projection



Staff also compared the all-payer in-state hospital charges to economic growth in Maryland as measured by the GSP for the most recent 5 years. The purpose of this modeling is to ensure that healthcare remains affordable in the State, for this purpose Staff believes it is not sufficient to only look at the cumulative test embedded in the Total Cost of Care Contract. Therefore, Staff calculated the cumulative growth for five years using the most updated State GSP numbers available (CY18-CY22). The 5-year calculation shows a cumulative per capita growth of 20.1 percent. Staff then compared that number to the 5-year cumulative growth in in-state acute hospital charges using (CY19-CY23). Staff was able to estimate CY 2023 charges using the proposed RY 2023 update factor. The cumulative growth for in-state hospital charges also equated to 20.1 percent, meaning the recommended update factor would keep the cumulative in-state hospital charge growth equal to the GSP growth over a 5-year window.

Medicare's Proposed National Rate Update for FFY 2024

CMS released its proposed rule for the change to the Inpatient Prospective Payment System's (IPPS) payment rate on April 11, 2023. In the proposed rule, CMS would increase rates by approximately 2.80 percent which includes a market basket increase of 3.00 percent, and a productivity reduction of -0.20 percent. This proposed increase will not be finalized until August 2023 and will not go into effect until October 1, 2023. This also does not take into account volume changes, nor does it take into account projected reductions in Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments as well as potential reductions for additional payments for inpatient cases involving new medical technologies and Medicare Dependent Hospitals. As noted above, Staff believes that one way to be responsive to the uncertain TCOC national performance is to make a revision to the annual inflation allotment provided in the RY 2024 Update Factor recommendation to align with the Medicare Inpatient and Outpatient Prospective Payment System rule when the final Medicare payment increases are known.

Stakeholder Comments

Beginning in early CY 2023, HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed update for RY 2024. Comments generally focused on 6 areas: unfunded inflation, unfunded population growth, modifying the QBR scaling program, financial condition assessment, All-Payer hospital test and TCOC savings test, and market shift and surge policy concerns.

MHA submitted a proposal outlining the increase requested for its member hospitals. In addition to MHA's letter, the following hospitals submitted comments: Luminis Health, University of Maryland Medical System, Johns Hopkins Health System, Holy Cross Health, MedStar Health, Tidal Health, Frederick Health and Ascension St. Agnes. The request and comments outlined by MHA and echoed by member hospitals are outlined below with staff's response in italics.

1. All hospitals requested that the Commission fund appropriate revenues to cover operating costs, boosting the annual payment update by 1.15% to recognize recent, extraordinary inflation growth.
 - a) Tidal Health requested that additional inflation funding should be scaled and targeted to efficient hospitals by either a) shifting a portion of this amount to the set aside to target and allow for a larger distribution to efficient hospitals or b) scaling the full 1.15% to apply more inflation to efficient hospitals and less inflation to hospitals with retained revenue.
 - b) Johns Hopkins did note their belief that hospitals should not receive inflation on retained revenues citing that areas of the state with the largest retained revenues could not prove they were engaging in meaningful population health strategies.

- c) University of Maryland requested that full inflation is funded, but that it should not be provided on retained revenues prior to CY 2019.

HSCRC Staff Response: There is no policy basis for going back in time to fund inflation in line with historical over/underfunding. From RY 2014 to RY 2021, the Commission cumulatively overfunded inflation by 1.97% and never considered reconciling it to actual inflation. The same principle should apply for both underfunding and overfunding.

Staff would additionally note that the Commission already has the Integrated Efficiency policy as its main tool to scale inflation based on efficiency and TCOC effectiveness (both of which will reflect excessive retained revenue that does not yield positive TCOC outcomes).

- 2. Almost all hospitals requested that the Commission apply the full demographic adjustment correction, adding 1.36% back on July 1 and work with HSCRC staff to validate population underfunding and related calculations.
 - a) Hopkins noted that it supported the staff's phased-in approach to handling the Demographic Adjustment.
 - b) Tidal Health stated that if the full demographic makeup would not be funded in RY24, that inflation should be scaled based on efficiency.
 - c) Frederick requested that the demographic adjustment be funded equitably to ensure that the fastest growing counties are adequately supported.

HSCRC Staff response: Staff's recommendation already accounts for 0.39% of the 1.36% requested. This funding reverses negative adjustments that were implemented in RY 2023; thus, hospitals in the fastest growing counties of the State (and received positive adjustments in RY 2023) are better off than other hospitals. While there is a policy rationale for the remainder of the request (0.97%), as the Model always intended to fund full population growth in lieu of funding volume through volume variable methodologies, the Commission must first a) weigh this request against the spending limits imposed by the all-payer hospital test AND TCOC test and b) develop a revised methodology to establish the scope of the catch up and how to distribute it.

Staff believe its current estimation of the census catch up is reasonable, but it has yet to hear feedback from stakeholders or Commissioners on the proposal. While CY 2022 final performance is still to be confirmed by CMMI, staff believe that the inclusion of national population-based non-claims based payments will improve the annual run rate by a magnitude of up to \$40 million. If indeed there is an increase in the final calculated run rate, staff believe that the release of some of the demographic catch up would not on its own jeopardize the CY 2023 TCOC test.

	Population Count	% of RY 2022 Funded Population
Census Catchup	116,877	1.93%
Less 30%	(35,063)	-0.58%
Less Pop Growth Provided Since RY 2023	(15,161)	-0.25%
Less RY 2024 DOP Cumulative Reduction Credit	(8,019)	-0.13%
Potential Remaining HSCRC Census Catchup	58,634	0.97%

Should stakeholders and Commissioners agree that a census catchup of 0.97% is warranted (or some other amount), staff believe a few additional considerations should be taken into account to effectuate that proposal.

- 1) Staff believe strongly that the funding should be distributed by the Demographic Adjustment methodology and not some new allocation method, e.g., efficiency, as that would conflate and potentially duplicate revenue adjustments*
- 2) To ensure that hospitals that missed population growth funding in the last decade receive that funding, the base year before the census catch up needs to be locked (i.e. CY 2021 Claritas base); projected population growth from that base will be distributed based on the current casemix adjusted market share*
- 3) Any census catch up has to be offset by increased PAU Shared Savings reductions in line with the GBR contracts (section IV. B. 2. g)*
- 4) A policy rider must be established to ensure a similar catch up is accounted for in the 2030 census (in either direction)*

As a result of the comments staff received in support of funding the full demographic adjustment catch up, staff modeled our savings with the 0.97 percent population catchup and the offsetting Potentially Avoidable Utilization reduction of 0.11 percent under the most conservative approach, i.e. the scenario that yielded \$295 million, slightly less than the \$300 million required under the contract. In this modeling, staff additionally noted the likely revision to the CY 2022 run rate due to the federal government's accounting of larger than anticipated non-claims payments. Although this value is not yet finalized, staff are noting the

likely revision of up to \$40 million more in additional savings, because it could provide the necessary room to fund the entire census catchup of 0.97 percent.

Scenario 2 Guardrail Projections with full demographic catch up			
	Maryland	US	
2022	\$13,652	\$11,887	
2023	\$14,123	\$12,226	Predicted Variance
YOY Growth	3.45%	2.86%	0.60%
Estimated CY2023 Savings Run Rate (assuming CY22 = \$219 M)			\$272 M*
Additional Savings Allotment based on updated NCBP payments			\$40 M
Updated Estimated CY2023 Savings Run Rate			\$312

Although staff did not provide a savings run rate under each of its 4 scenarios, each one was modeled and yielded a consistent reduction to the Estimated CY2023 Run Rate of approximately \$22 million. Thus, based on estimated growth rates for Maryland and the Nation (inclusive of the full census catchup, the offsetting PAU reduction, and the \$40 million revision to the CY 2022 run rate), the State will likely meet its CY 2023 Savings target under the four staff scenarios.

3. Reset quality payment policy scaling, supported by national performance, reducing the 2024 offset by an estimated 0.15%, consistent with HSCRC’s Performance Measurement Work Group discussion.

HSCRC Staff response: This will be reviewed at a later date and settled when final data is available. The implementation will occur in the January rate files and future adjudication on this item will be processed through the Performance Measurement Work Group.

4.MHA requested that the Commission complete a full financial condition assessment of Maryland hospitals and set appropriate financial targets to balance revenue growth with sustainability. MHA recommends this review be conducted by an independent consultant or with significant input from independent voices, including rating agencies, banks, and other financial experts.

HSCRC Staff response: Staff agree that this should be taken up in the next fiscal year in line with the staff recommendation on this topic. Staff also welcomes the idea that independent subject matter experts be included in the evaluation.

5. MHA noted that data show Maryland's all-payer hospital and total spending per capita growth remain below national growth and the contract limits. As such, the HSCRC should adequately fund hospital costs to ensure long-term success. MHA further noted that Maryland's Medicare Total Cost of Care spend is projected to grow only 2.51%. If the nation grows at least 3.50%, we will achieve the savings target.

HSCRC Staff response: Staff strongly agree that the Maryland Model has made healthcare more affordable in Maryland while at the same time creating greater financial stability than what hospitals experienced prior to the All-Payer Model (and certainly relative to the nation in the current period). This is evidenced by all-payer hospital growth that is less than State GSP growth coupled with improved financial positions relative to 2013, albeit with recent signs of worsening financial conditions.

Staff would further note that prior to the pandemic, the nation from 2015 to 2019 only grew faster than 3.50% in one year (2019 over 2018). That said, staff agree that the long-term success of the Model is predicated on funding hospital costs adequately, and thus will continue to work with the industry to identify opportunities for improving hospitals' current financial condition.

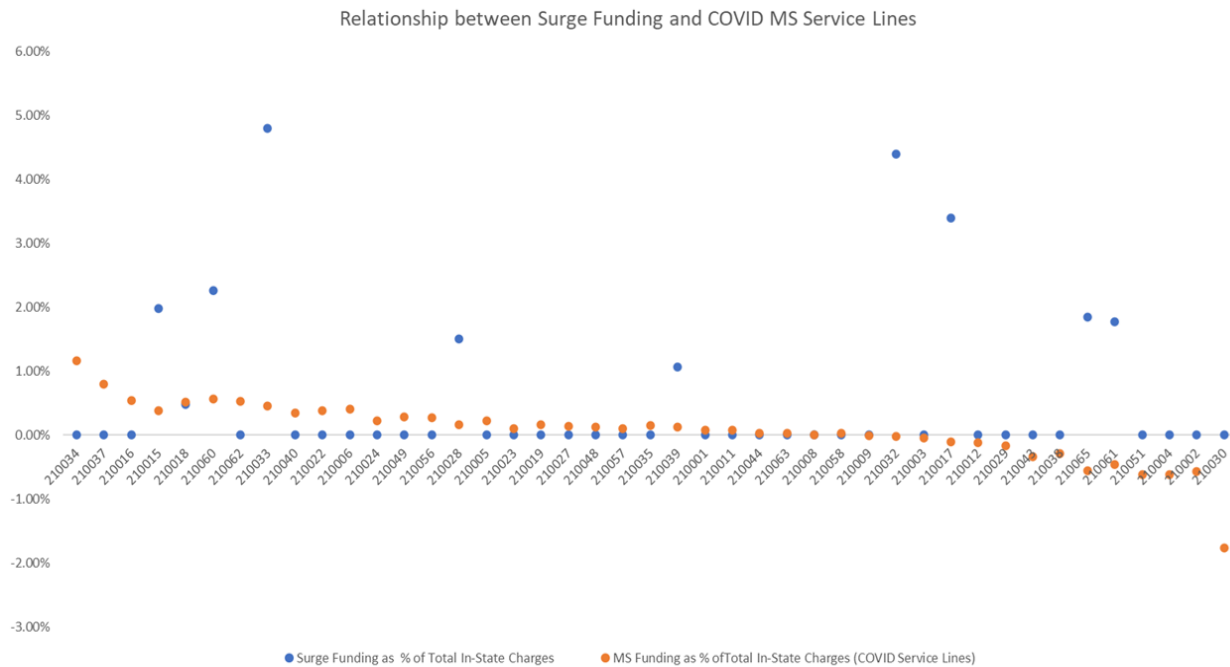
6. UMMS noted the overlap of the Surge Funding policy with Market Shift should be eliminated as the calendar year 2022 vs calendar 2019 Market Shift adjustment is implemented. The proposed surge funding policy evaluates volume growth in FY 2022, which includes quarters 1 and 2 of calendar year 2022. Both the surge and market shift policies, as proposed, would include volume funding for the Omicron surge, which occurred during quarter 1 and quarter 2 calendar year 2022. The Omicron surge was a one-time event resulting in increased volume and should therefore be funded on a one-time basis. The calendar year 2022 Market Shift is a permanent adjustment and as proposed, includes the COVID influenced service lines. It is inappropriate to fund the volume increase in two different policies and on a permanent basis when as we have seen with calendar year 2023, there have been no further surges in COVID hospital volume.

HSCRC Staff response: Staff share UMMS concern that there could be overlap between surge funding and market shift for Covid influence service lines; however, there appears to be limited relationship between the two revenue adjustments. Staff isolated the COVID influenced service lines in the CY 2022 marketshift and found limited relationship between surge funding provided and marketshift adjustments.

- *To remove scale, denoted all adjustments against total in-state charges*
- *In several cases, hospitals with no surge funding received marketshift adjustments (among them the three largest MS adjustments in terms of % of in-state revenue)*

- In several other cases, hospitals with no marketshift adjustment received surge funding.

Figure 2



Recommendations

Based on the currently available data and the Staff’s analyses to date, the HSCRC Staff provides the following final recommendations for the RY 2024 update factors.

For Global Revenues:

- Provide all hospitals with a base inflation increase of 3.35 percent.
- Provide an overall increase of 3.58 percent for revenue (including a net change to uncompensated care) and 3.75 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

- c. Convene a workgroup to establish benchmarks and methods for a Financial Condition Assessment that will, at a minimum, evaluate operating margins, cash position, debt coverage ratios, and capital investment.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- a. Provide an overall update of 3.35 percent inflation.
- b. Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Appendix A: FY2022 Surge Funding Methodology

Under the original COVID surge policy (in place for FY2020 and FY2021), funding was set equal to the greater of:

1. \$0
2. COVID Standardized Charge - (GBR - Non-COVID Standardized Charge)

Where Standardized Charges are equal to the relevant volume times the rate on the hospital's final issued rate order.

The FY2022 funding starts with this approach and then adds three refinements.

1. COVID cases are limited to those which either had (1) a primary diagnosis of COVID-19 or (2) a primary diagnosis of Sepsis (A41.48) and a non-primary COVID diagnosis. Previously, any case with a COVID diagnosis was considered a COVID case and considered for funding. The change was made as Staff felt that, as the crisis progressed and routine volumes returned to hospitals, there was a much greater prevalence of cases which would reflect a COVID diagnosis, but which were primarily care that was already funded under the GBR. By focusing on COVID primary and Sepsis cases, the policy is focused on hospitals experiencing a spike in COVID volumes. This is consistent with the direction outlined to HSCRC Commissioners in January 2022.
2. The amount awarded under the approach is further capped at the amount by which the hospital's COVID Standardized Charges exceeded the statewide average share of COVID Standardized Charges for FY2022 (2.3%). Staff added this element as, during FY2022, all hospitals faced some degree of COVID cases. Limiting the incremental funding to those with above state average experience focuses the funding on hospitals with differential COVID experience rather than those with heavy, non-COVID volume (as the GBR is not generally a volume funded approach). This limitation becomes particularly relevant given the State's position on the Medicare savings test (and resulting limited funds) and is consistent with the direction previously outlined to HSCRC Commissioners in January 2022.
3. Standard rates were calculated using FY2021 rates on the hospital's final issued rate order trended forward based on the change in total GBR from FY2021 to FY2022. This was done to remove the impact of volume rebasing reflected in FY2022 rates with reduced capacity in the GBR.

Staff intends for these to be the only adjustments made to the previously existing COVID Surge policy methodology. Staff does not intend to further offset these amounts for other funding sources (e.g. PRF dollars).

Appendix B: Reconciliation of Set Aside for RY 22 and RY23

Distribution of Set Aside for RY 2022			
RY 2022 GBR Revenue		\$19,638,102,984	
Set Aside %		0.25%	
Set Aside \$		\$49,095,257	
Hospital	Set Aside \$ Value	Set Aside %	Reason
Fort Washington	\$6,253,680	0.03%	Integrated Efficiency
Howard County	\$12,500,000	0.06%	Integrated Efficiency
Holy Cross	\$8,704,705	0.04%	Integrated Efficiency
Anne Arundel	\$1,364,501	0.01%	Cardiac Program Funding
Garrett	\$2,072,192	0.01%	New Services: LIT, Pain Mgmt, Pop Health.
Dorchester	\$3,400,000	0.02%	Integrated Efficiency
Sinai	\$5,500,000	0.03%	Integrated Efficiency (one-time)
PRMC	9,300,179	0.05%	Population Health, Behavioral Health, & Integrated Efficiency
Total	\$49,095,257	0.25%	

Distribution of Set Aside for RY 2023

RY 2023 GBR Revenue		\$20,185,681,779	
Set Aside %		0.10%	
Set Aside \$		\$20,185,682	
Hospital	Set Aside \$ Value	Set Aside %	Reason
Garrett	\$3,677,333	0.02%	RY22 Integrated Efficiency, CDS-A underfunding, & OOS volume growth
Christiana Care, Union of Cecil	\$1,356,937	0.01%	OOS volume growth
Holy Cross Germantown	\$2,958,467	0.01%	OOS volume growth, FY22 surge funding, & OB malpractice
Total	\$7,992,737	0.04%	
Remaining	\$12,192,945	0.06%	

May 9, 2023

Mr. Adam Kane, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Commissioner Kane:

Over the next few months, there are several very important staff recommendations that are being brought forward for vote. We hope that as these recommendations are discussed a strong consideration is made to build policy incentives that reward efficient low-cost providers. We also hope that strong consideration is made to appropriately remove and reallocate revenue from inefficient hospitals that have retained revenue since the implementation of the Global Budget Revenue System.

Being proposed right now is the Draft Staff Recommendation related to the FY24 Update Factor. We hope the Commission and the Commission Staff would build in a scaled approach to the Final Update Factor Recommendation. This is one step that could begin to bridge the significant gap that currently exists and has grown significantly between low-cost and high-cost providers. This approach has been deployed in the past and should be re-introduced. We would recommend a quartile approach that provides at the least a 1.0% spread to the base inflation adjustment for FY24. This would mean overall inflation of 3.16% would provide top quartile (high cost) hospitals 2.16%, and bottom quartile (low cost) hospitals 4.16%. This would not rectify the issue, but we believe would be a step in the right direction.

We know that all hospitals are experiencing significant financial burden. However, we would argue that inefficient hospitals have more opportunity to reduce that burden through overhead reductions.

Thank you for strong consideration of this request, and feel free to reach out should you have any questions.

Sincerely,



Stephanie Gary
Chief Financial Officer

cc: Katie Wunderlich, Executive Director, HSCRC
Jerry Schmith, Principal Deputy Director
HSCRC Commissioners



Ascension Saint Agnes

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

May 22, 2023

Dear Ms. Wunderlich,

I am writing today on behalf of Ascension Saint Agnes to provide comments on the recommendation by the staff of the Health Services Cost Review Commission (HSCRC) regarding the Fiscal Year 2024 rate update. I appreciate the work that the HSCRC staff has put into developing the recommendation, including soliciting feedback from the hospital field.

Ascension Saint Agnes, like the rest of our colleagues in Maryland, continue to face unprecedented financial challenges. Hospital operating margins have deteriorated significantly, with hospitals around the country laying off parts of their workforce, reducing or eliminating services, and contemplating closures of entire facilities. One of the strengths of the Maryland model historically has been that it provided for predictable and reasonable reimbursement to promote more equitable access to care, regardless of payer. With the financial strain that Maryland's hospitals find themselves under, continuing to maintain the current level of services may prove to be untenable, an outcome that none of us wants to see.

While we understand the State's savings target obligations under the Total Cost of Care (TCOC) Agreement with the Center for Medicare and Medicaid Innovation (CMMI), Ascension Saint Agnes would encourage the HSCRC to provide additional financial relief to Maryland's hospitals. Appropriately correcting the demographic adjustment and increasing the rate update to reflect inflation more accurately would serve to place Maryland's hospitals in a stronger financial position and prevent the possibility of reductions in services.

Ascension Saint Agnes also firmly believes that any rate update should be equitably applied based on existing methodologies such as the efficiency methodology that have been fully vetted and discussed by the industry.

Thank you for the opportunity to comment on the FY 2024 rate update.

Sincerely,



Beau Higginbotham
Interim CEO

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
Maulik Joshi, Dr.P.H.
James Elliott, M.D.
Stacia Cohen, R.N.
Sam Maholtra

May 22, 2023

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich,

Thank you for allowing Luminis Health to provide written comments on the draft staff recommendation for the Fiscal Year 2024 annual rate update. We appreciate the time and effort that the Health Services Cost Review Commission (HSCRC) has put into the process, including several discussions with the industry.

Luminis Health continues to be concerned with the HSCRC's conservative approach to the annual rate update. Although we recognize the State's contractual obligations to achieve specific savings targets each year, given the improved TCOC performance and the actions already taken by the HSCRC to generate an additional \$125M savings in CY2023, we are requesting that the HSCRC fund unfunded inflation to address the unprecedented inflationary pressures and deteriorating financial positions of Maryland's hospitals. Luminis Health supports the Maryland Hospital Association's position on the annual rate update and believes it is a reasonable approach that balances achieving needed savings while providing additional revenue beyond the staff recommendation.

Luminis Health was also disappointed that the staff recommendation does not entirely correct for age-adjusted population growth forecasting error. Moreover, accurately and appropriately accounting for population growth, and adjusting revenue accordingly, is a foundational pillar of the system. Combined with the underfunding of inflation, this decision does not promote predictability and exacerbates an already challenging environment.

We would encourage the HSCRC to revisit the staff recommendation and make adjustments to fund Maryland's hospitals appropriately.

Sincerely,



Kevin L. Smith
Chief Financial Officer

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
James Elliott, M.D.
Maulik Joshi, Dr. P.H.
Sam Malholtra



Charlene MacDonald
Senior Vice President
Chief Government Affairs Officer

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
Tel. 202-680-5207
Charlene.MacDonald@carefirst.com

May 24, 2023

Adam Kane, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Kane:

CareFirst BlueCross BlueShield (“CareFirst”) is grateful for the opportunity to comment on the proposed update factor for Rate Year 2024. We remain committed to working with the HSCRC to further its vision. As the HSCRC contemplates rate updates for the industry, it must prioritize retention of the Model that has served the State so well for the last 50 years, even against the backdrop of a global pandemic. During the COVID-19 pandemic, hospitals faced unprecedented uncertainty, labor shortages, and other challenges, leading to turbulent financial conditions. However, thanks to the flexibility and support the waiver offers, Maryland ranked 6th nationally among states for COVID-19 health system performance. While Maryland hospitals saw the same reduction in patient volumes as their peers in other states, the HSCRC swiftly intervened and ensured the financial stability of essential healthcare services.

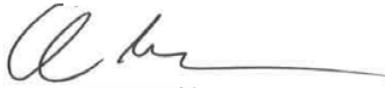
To ensure Marylanders and hospitals continue to benefit from the flexibility and stability provided by this Model, we must prioritize the long-term viability of the waiver. However, we recognize the inherent challenge of updating payment rates in such a way that both provides hospitals the financial support they need and ensures the state meets its \$300 million savings target. We appreciate and encourage the HSCRC’s collaboration with stakeholders from a variety of industries, offering an opportunity for all key voices in the healthcare delivery system to work together to best serve the people of Maryland. The future of our great experiment is at a crossroads, and it is evident that CMMI’s evaluation will focus heavily on the Model’s 2023 savings target performance. Thus, as the Commission contemplates the update factor for RY2024, it is imperative that Model performance remains the top priority.

While we applaud the Model’s population-based methodology and believe any miscalculations should be corrected, corrections that come at the expense of the waiver’s long-term viability would be irresponsible. It is not only possible, but advisable, to honor both our commitment to the methodology and to the Model itself by phasing in the demographic adjustment over several years, thereby mitigating the burden on a single year’s savings test performance. This is more crucial now than ever as CMS considers the waiver’s future and places its performance under the microscope.

Much like the rest of the economy, hospitals were forced to contend with high inflation in 2023, a significant burden that we agree must be properly addressed. CareFirst fully supports the HSCRC's work to balance the long-term solvency of the Model with the importance of equipping hospitals to care for their communities. As such, we support the Staff's recommendation to fund core inflation and reserve 0.4% for full rate applications to be evaluated, which they project would put the State at approximately the \$300 million target. For the good of the Model and the Marylanders it serves, any changes to the update factor must not trip the savings target guardrails without a plan in place to recover the foregone savings in full. We must keep Marylanders' best interests at the center of every decision we make.

Thank you again for the opportunity to comment on this important matter. We look forward to our continued partnership with hospitals, the HSCRC, and CMMI to transform health care. Together, we can ensure the waiver's long-term viability and best serve the people of Maryland.

Sincerely,

A handwritten signature in black ink, appearing to read 'Charlene MacDonald', with a long horizontal flourish extending to the right.

Charlene MacDonald

May 24, 2023

Adam Kane
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Kane,

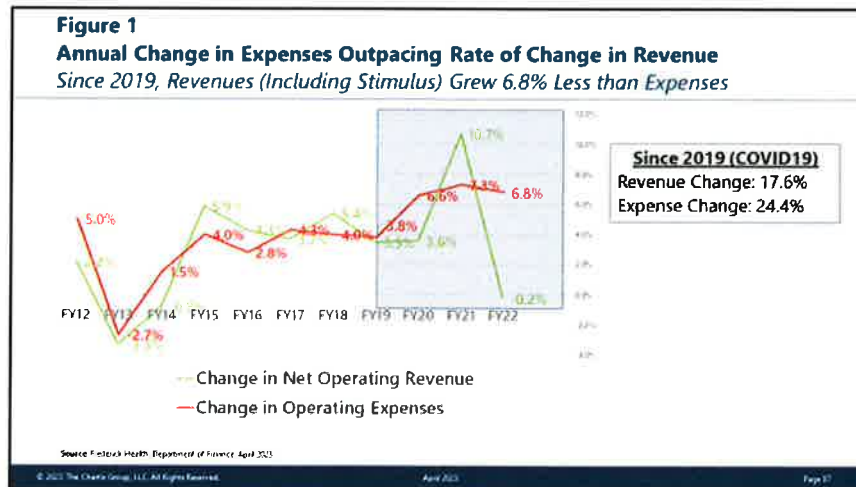
Compensating hospitals for inflation and population growth are foundational tenets of the Maryland Model. I am writing to ask for the Health Services Cost Commission's (HSCRC) support of the Maryland Hospital Association's (MHA) draft recommendation for the Fiscal Year 2024 annual rate update as well as the following be considered:

- Fully fund the proposed incremental inflation allowance of 1.15%. As the MHA letter correctly states, Maryland's hospitals continue to face challenging financial circumstances due to escalating labor pressures and inflation. This has resulted in significant underfunding of inflation over the past several years. Given the improved Total Cost of Care (TCOC) performance and the actions already taken by the HSCRC to generate an additional \$125M in savings in CY2023, we are requesting that the HSCRC fund unfunded inflation of 1.15% to stabilize the hospital's financial position.
- Fully fund the demographic correction. The recommendation by the staff to not fully correct for the demographic forecasting error which has significantly underfunded age-adjusted population growth that negatively impacts the hospital industry, further compounds these challenges and is inherently out of line with a basic tenet of our reimbursement system. We would encourage the HSCRC to revisit this decision in the final recommendation.
- Equitably fund FY24 demographic adjustment for growing counties. Frederick County is the fastest-growing county in Maryland. These funds are critical to ensure adequate support is provided. **As currently recommended by staff, the fastest-growing county in the state would receive \$0 for incremental demographic growth revenue in FY24.**
- Adjust quality-based reimbursement (QBR) to account for national performance, -0.42%. We feel the National performance standards should be equal for Maryland hospitals.

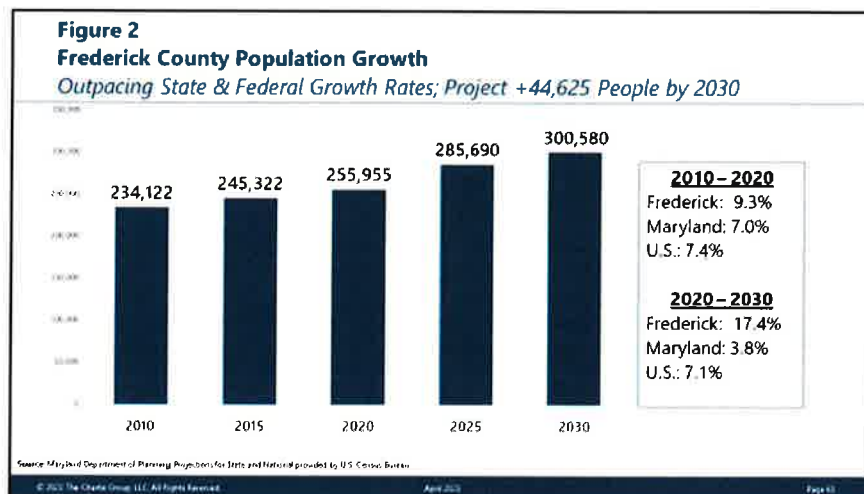
Understanding Frederick Health's Position

1. Frederick Health's Economic Sustainability is Challenged Without Funding for Population Growth and Inflation. Frederick Health is the sole hospital provider for Frederick County. Its economic sustainability is critical to ensure timely access to care. For illustrative purposes, **Frederick Health is the third busiest Emergency Department in Maryland caring for nearly 80,000 visits annually**. Without funding to account for inflation and population growth, which is fueling increased operating costs and service demand, Frederick Health may be required to reduce services that are important for the community's health and achieve a reduction in the total cost of care. Frederick Health has already been forced to reduce 5% of our workforce and delay and/or modify capital projects that would have increased access to care for those living in outlying parts of Frederick County.

Frederick Health's economic sustainability is challenged in part due to the lack of reimbursement for inflation-based increases in operating expenses while service demand associated with robust population growth has increased. Frederick Health has had a consistent negative operating income since November 2022 (15 months). In FY22, Frederick Health's operating margin was negative at 4.2%. The operating margin year-to-date FY23 (March 31) has remained unchanged from FY22, negative 4%. Before 2019, the HSCRC reimbursement models were consistent with actual operating expenses (*Figure 1*). Alternatively, between 2019 and 2022, **reimbursements have not kept pace with inflation and increased service demands by nearly \$100 million.**



- Inflationary Costs Increased Beyond Traditional Expectations (Labor, Supplies, and Pharmaceuticals).** The increase in general inflation between 2019 and 2022 was roughly \$40 million. Another roughly \$20 million was required to ensure adequate staffing to ensure safe care delivery. Between 2019 and 2022, labor costs nationally increased by 25% ([McKinsey & Co, 2022](#)). Like other hospitals, Frederick Health responded by increasing wages to ensure patient safety was maintained.
- Increased Demand Associated with Robust Population Growth.** Frederick County has the highest population growth in Maryland ([Maryland Matters, 2022](#)). Between 2010 and 2020, Frederick County's population increased by 9.3% (roughly 22,000 people), which was greater than the Maryland and United States growth rate, 7.0% and 7.4%, respectively (*Figure 2*). **Between 2020 and 2030, an estimated incremental 45,000 (17.4%)** are projected to reside in Frederick County. During the same period, the Maryland and United States projected growth rates are 3.8% and 7.1%, respectively. Any policy that does not recognize and fund this growth **annually and consistently** is inherently at odds with a basic principle of our reimbursement system.

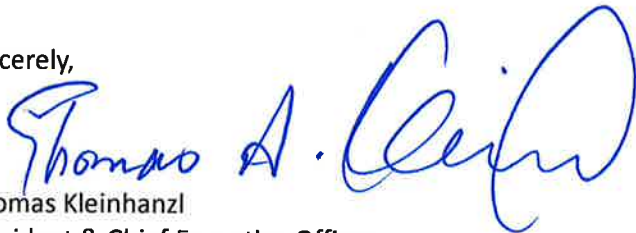


Furthermore, Frederick Health recognizes the need to address the question of retained savings as we move into the next phase of the model. We encourage hospital collaboration with the HSCRC over the summer to assess the impact of retained savings on the goals of the TCOC model and global budgeted revenue incentives and to consider how retained savings will be handled in the future within the context of the other policies under the model.

Frederick Health would like to encourage, consistent with MHA's position, a more robust annual rate update to address inflation growth, unfunded inflation, and unfunded demographic growth. We believe that this measured approach will provide much-needed relief while still adhering to the savings goals of the model. Without this relief, we may need to take action of reducing services similar to what has occurred nationally.

Thank you again for the opportunity to comment.

Sincerely,



Thomas Kleinhanzl
President & Chief Executive Officer

cc: Joseph Antos, Ph.D., Vice Chairman
Katie Wunderlich, Executive Director, HSCRC
Laura Herrera Scott, MD, Secretary of Health
Victoria W. Bayless
Maulik Joshi, Dr. P.H.
James Elliot, M.D.
Sam Maholtra
Brett McCone, SVP, Maryland Hospital Association
Hannah Jacobs, Chief Financial Officer, Frederick Health



Kevin W. Sowers, MSN, RN, FAAN

President

Johns Hopkins Health System

Executive Vice President

Johns Hopkins Medicine

May 24, 2023

Adam Kane, Esq.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Kane,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the staff recommendation on the FY24 payment update. JHHS appreciates the challenges the Health Services Cost Review Commission (HSCRC) faces in balancing the financial strains of hospitals with ensuring the model savings targets are met.

JHHS's comments and recommendations are outlined below.

Demographic adjustment

JHHS is in agreement with the staff's recommendation regarding the demographic adjustment. We believe that it is important, in a population health-based system/model to ensure that demographic changes are appropriately funded. JHHS thanks the HSCRC for their commitment to resolve any additional funding the Commission should provide to account for the ten-year forecasting error that occurred in the preceding decade and making sure hospitals are fully funded for demographic changes moving forward. We look forward to participating in those discussions and methodology development.

Lack of alignment with the purpose of the update factor

JHHS is concerned with the proposed recommendation, as it is not consistent with the purpose of the update factor as stated by the HSCRC, nor the goals of the Maryland Model. According to the draft recommendation, the purpose of the update factor is to "provide hospitals with reasonable inflation to maintain operational readiness and to keep healthcare affordable within the State of Maryland¹." The recommendation as currently proposed is inconsistent with the purpose of the update factor.

¹ Health Services Cost Review Commission. (May 10, 2023). *Draft Recommendation for the Update Factors for RY 2024*.

Generally, the update factor is applied evenly across all hospitals regardless of volume and capacity. Hospitals with low volume or retained revenue receive inflation beyond their operational needs. These hospitals receive inflation and funding for volumes, patients, and costs that do not currently exist.

Some stakeholders and staff believe inflation should be distributed evenly because retained revenues should be dedicated to population health investments. However, there are no data or outcomes to support that these investments have been made with retained revenues. Certain Baltimore City hospitals have the highest representation of retained revenue, yet represent some of the greatest health disparities in the state. Analysis of Baltimore City multi-visit patients indicates that 33,895 high utilizers² in Baltimore City represented 21% of unique patients from the city, and represented 57% of total hospital charges; this population generated \$1.2B of the \$2.2B of total hospital charges, with the most common chronic conditions being hypertension, chronic kidney disease, and mental health diagnoses, among others. Zip code analyses of Baltimore City demonstrate that the highest concentration of high utilizers and multi-visit patients can be found in zip codes that surround hospitals with retained revenues. There is no evidence that hospitals with retained revenue are engaged in meaningful population and community health strategies and investments.

This issue has compounded over time, and must be resolved over a number of years in order to stabilize the model. Fully inflating retained revenue for the period of 2014 through 2019 has contributed over \$140M in excess cost to the Maryland Model, however applying a 50% variable cost factor would reduce the excess amount to \$70M.

Impact on affordability for patients

Furthermore, the overfunding of inflation at hospitals with low volumes and retained revenues impacts affordability for patients who seek care at those hospitals; patient bills are inflated to ensure the hospital can then meet its global budget revenue (GBR). JHHS urges the HSCRC to continue to prioritize affordability for patients, and to consider the impact of this recommendation as proposed.

Funding of inflation

While historically this process may have worked well for the industry, hospitals are currently operating in extraordinary circumstances with unprecedented nursing and staffing costs due to COVID-19 and its ongoing impact. It is critical for hospitals providing medically necessary care to be appropriately funded for the previous two years. JHHS urges the HSCRC to provide further support to hospitals in these extraordinary circumstances. The HSCRC has expressed legitimate concerns that there must be a conservative approach to the update factor due to the need to achieve our model savings targets. However, there is sufficient capacity to provide a reasonable update factor that fully funds inflation for hospitals that are providing medically necessary care if strategies are pursued to address retained revenue.

Lack of alignment with the goals of the Maryland Model

² Defined as 3+ inpatient/emergency department/observation visits within the year; based on FY21 analysis

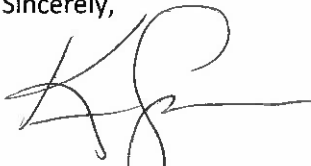
As proposed, the recommendation reflects the fundamental concerns that JHHS has repeatedly expressed regarding the direction and goals of the Maryland Model. As designed by CMMI, the model is intended to be a population health model in which targeted population health investments lead to improved health outcomes and reduced hospital utilization in certain diseases or communities, while controlling for cost and quality. However, as JHHS has previously noted, the model currently rewards any and all volume reduction, regardless of how this reduction was achieved. Hospitals that reduce or entirely eliminate services are rewarded, while hospitals that provide medically necessary care – or take on volume that was shed by other hospitals – are penalized. This approach does not align with the goals of the model, and the repeated application of inflation to retained revenues only serves to further the distortions that currently exist in the model.

Recommendations

Given the economic climate and the challenges currently faced by the healthcare industry, JHHS believes a more nuanced and balanced approach to the update factor is required. For the reasons outlined above, hospitals should not receive inflation on retained revenue, as this is funding volumes that do not exist. Additionally, because the hospital industry remains unstable and uncertain in the aftermath of the COVID-19 pandemic, retained revenue should be assessed for pre-COVID model performance years (2014-2019). JHHS believes that these recommendations will allow the HSCRC, the State, and the healthcare industry at large to further align with the total cost of care goals.

Thank you for the opportunity to share comments and concerns both written and at the Commission meeting. JHHS greatly appreciates the HSCRC's transparent process in the development and approval of the payment update, and looks forward to continued collaboration in pursuit of the goals of the Maryland Model.

Sincerely,

A handwritten signature in black ink, appearing to be 'KS', with a long horizontal line extending to the right.

Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, R.N.
Katie Wunderlich

Maulik Joshi, Dr.P.H.
James Elliott, M.D.
Sam Maholtra



10980 Grantchester Way
Columbia, MD 21044
P 410-772-6500
MedStarHealth.org

May 24, 2023

Adam Kane
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Kane:

On behalf of MedStar Franklin Square Hospital, MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MedStar Montgomery Medical Center, MedStar St. Mary's Hospital, MedStar Southern Maryland Hospital, and MedStar Union Memorial Hospital, we write to support the field's July 1, annual update rate request.

During the pandemic, Maryland Hospitals partnered with the state and the HSCRC to manage through the public health crisis and meet the healthcare needs of the citizens of Maryland, and we were glad to do it. Now more than three years since the pandemic began, Maryland hospitals are faced with a different crisis, a financial crisis.

In the aftermath of the pandemic, hospitals in Maryland & nationwide are coping with significant changes to their expense structures. During Fiscal Year 2022, hospitals were forced to take action as the impact of labor shortages, sky high agency rates and hyper-inflation began to take a toll on hospital finances. Extraordinary pay increases and other special pay programs were implemented to deal with workforce shortages and maintain healthcare services. Now, in Fiscal Year 2023, the full impact of these actions is being realized. Hospital costs have increased significantly, and permanently. In fact, MedStar's Fiscal Year 2023 annual operating expenses are projected to grow by approximately 15% when compared to Fiscal Year 2020. For that same period, the statewide median for operating expenses is projected to rise by nearly 20%.

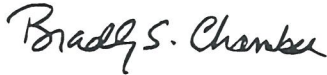
In the Maryland system, with a fixed revenue base, it is incumbent on hospitals to control expenses and the HSCRC to fund inflation. Unfortunately, the impact of the pandemic has been an increase to expenses in a way that was never anticipated and was unavoidable and uncontrollable. Meanwhile, it is estimated for Fiscal Year 2022 and 2023 alone, inflation funding in GBR has fallen short of actual inflation by a total of 3%. A 3% gap in inflation funding is a permanent, on-going shortfall that places tremendous pressure on hospital operating margins. With operating margins at or below zero since early in Fiscal Year 2022, hospitals have been forced to use financial reserves to cover operating losses. The continued use of financial reserves for these purposes is not a sustainable solution. While the industry's requested FY24 rate update does not fully fund the inflation funding gap, it is greatly needed as part of the solution.

As we look to the future and the next phase of the Maryland model, alignment of policies, incentives and methodologies will be critical to our success. We look forward to continuing to partner with the HSCRC as we prepare to build upon the achievements of the Maryland system.

It's how we treat people.

MedStar Health and its member hospitals appreciate the HSCRC staff's work on the update factor and the open conversations with the field throughout the process. Thank you for your consideration of this request and please reach out should you have any questions.

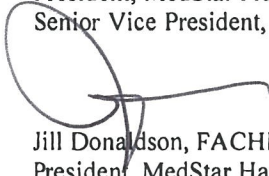
Sincerely,



Brad S. Chambers
Senior Vice President & Chief Operating Officer, Baltimore Region, MedStar Health
President, MedStar Good Samaritan Hospital
President, MedStar Union Memorial Hospital



Stuart M. Levine, MD, FACP
President, MedStar Franklin Square Medical Center and
Senior Vice President, MedStar Health




Jill Donaldson, FACHE
President, MedStar Harbor Hospital and
Senior Vice President, MedStar Health



Thomas J. Senker, FACHE
President, MedStar Montgomery Medical Center and
Senior Vice President, MedStar Health



Stephen T. Michaels, MD, FACHE
President, MedStar Southern Maryland Hospital Center and
Senior Vice President, MedStar Health



Mimi Novello, MD, MBA, FACEP
President and Chief Medical Officer,
MedStar St. Mary's Hospital and
Senior Vice President, MedStar Health

cc: Katie Wunderlich, Executive Director
Joseph Antos, PhD
Maulik Joshi, DrPH

Victoria W. Bayless
James Elliott, M.D.
Sam Malhotra



Maryland
Hospital Association

May 24, 2023

Adam Kane
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Kane:

On behalf of the Maryland Hospital Association's 60 member hospitals and health systems, we offer our comments on the Health Services Cost Review Commission's (HSCRC) July 1, 2023 annual payment update draft recommendation. MHA appreciates your support of the hospital field and collaboration on a fair annual payment update for rate year (RY) 2024.

We offer the following positions that align with and expand on the MHA March 22 position paper and reflect current data and considerations.

- 1) Fund appropriate revenues to cover operating costs, boosting the annual payment update by 1.15% to recognize recent, extraordinary inflation growth.
- 2) Apply the full demographic adjustment correct, adding 1.36% back on July 1. Work with HSCRC staff to validate population underfunding and related calculations.
- 3) Reset quality payment policy scaling, supported by national performance, reducing the 2024 offset by an estimated 0.15%, consistent with HSCRC's Performance Measurement Work Group discussion.
- 4) Complete a full financial condition assessment of Maryland hospitals and set appropriate financial targets to balance revenue growth with sustainability. MHA recommends this review be conducted by an independent consultant or with significant input from independent voices, including rating agencies, banks and other financial experts.

Maryland hospitals are facing extraordinary financial challenges. The median hospital operating margin has been hovering at or below zero for the last 18 months. As outlined in the MHA March position paper, labor, supplies, drugs and other costs remain stubbornly high. Higher costs for physician coverage in parts of the state—critical to operating hospital services—are now acute for anesthesiology, radiology, and other specialties.

HSCRC has a mission to support financially sustainable hospitals. These extraordinary times require you, the Commissioners, and the staff to think differently and activate the levers at your disposal—such as inflation and population growth which are collectively at least 2% below what is needed.

The 2023 Medicare total cost of care savings target is \$300 million. There is ample room for HSCRC to grant this request without risking the 2023 savings target as noted by these insights:

1. MHA 2023 projected Medicare hospital revenue growth—including 1.15% inflation recovery and 0.15% quality scaling, plus January 1 HSCRC actions—is 2.22%. Including a conservative estimate for non-hospital growth, Maryland’s Medicare Total Cost of Care spend is projected to grow only 2.51%. If the nation grows at least 3.50%, we will achieve the savings target.
2. Data show Maryland’s *all-payer* hospital and total spending per capita growth remain below national growth and the contract limits. HSCRC should adequately fund hospital costs to ensure long-term success.
3. In addition to favorable all-payer performance, Maryland has accumulated more than \$2.2 billion in cumulative Medicare savings beginning in 2014. As we strive for the target, it is unwise to pick the most conservative growth alternative relative to hospital financial condition when additional savings are not required.

Supporting information that supplements this letter and the MHA March position paper is attached.

MHA and the 60 hospitals providing acute care and more to communities across the state sincerely appreciate your partnership. On behalf of all hospitals and health systems in the State of Maryland, we ask HSCRC to honor this RY 2024 request.

Sincerely,



Brett McCone
Senior Vice President, Health Care Payment

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Maulik Joshi
James Elliott, M.D.
Sam Malhotra

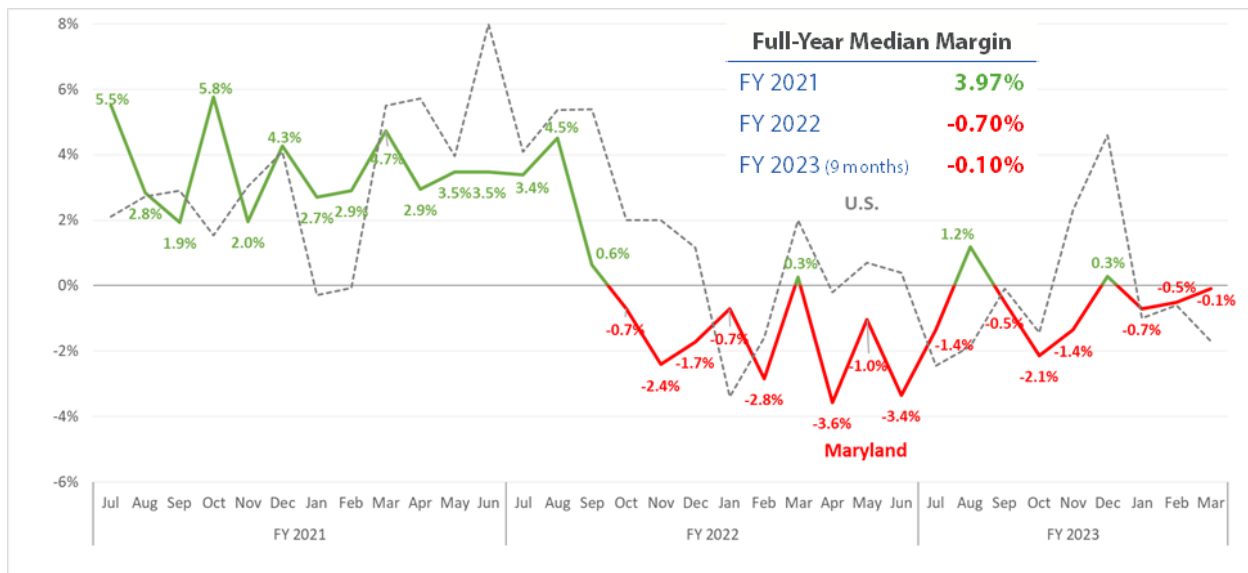
Katie Wunderlich, Executive Director
Jerry Schmith, Principal Deputy Director
Allan Pack, Principal Deputy Director
William Henderson, Principal Deputy Director

Information and Supporting Rationale

A. Adequate Revenue is Needed to Cover Costs and Improve Financial Performance¹

1) Maryland hospitals’ financial performance is severely strained, yet it is well below national operating revenue and expense per capita. Operating margins remain depressed as hospitals struggle with rising inflation for the reasons listed in the MHA position paper. Figure 1 reflects hospital monthly and annual operating margins through March 2023, showing that more than half of Maryland hospitals’ revenues are below expenses.

Figure 1: Maryland and National Monthly Margins, with Annual Summary¹



In 2022 actual inflation exceeded funded inflation by 86%, and nearly 50% including both 2022 and 2023. We agree with HSCRC staff that prospective inflation should not be adjusted every year. These are not small variances found in ordinary years. The inflation variance for 2022 and 2023 is more than 3%, equivalent to about \$600 million in funding. This request is empirically based on overall the inflation gap of 1.15%, triggered by the extraordinary difference. This amount is not likely to keep up with rising costs but would provide some financial steadiness.

As noted last year, Maryland’s rate setting system, combined with federal relief, afforded hospitals a degree of financial stability during 2020 and 2021. Calendar year 2022 figures reflect at least \$200 million of one-time inflows, which have been reversed and reduced even further in CY 2023. MHA seeks permanent, structural relief.

¹ Sources: Maryland, HSCRC monthly reporting. National, KaufmanHall Monthly Flash Report.

HSCRC must consider the impending impacts of negative margins. On May 10, S&P Global Rates released a new report, *Not-For-Profit Acute Health Care State Snapshot: Maryland*.² The first headline reads, “Global Budget is Strained After Years of Stability.” S&P concludes that HSCRC has historically provided predictability and stability, particularly through COVID. However, they acknowledge revenue growth could be stagnant, “**weaking operating performance and cash flow, which could lead us to lower ratings or revise outlooks to negative.**”

As noted by many market experts, hospitals entered this cycle with generally strong liquidity positions, providing a short-term cushion to absorb weak operating performance while recovery is underway. However, **cash positions are volatile and don’t substitute for sustainable operating performance.** Without sustainable cash flow, hospitals’ cash positions erode and the cost of capital rises, leading to an inability to sufficiently invest in programs and facilities and eventually to closures of necessary but unsustainable programs.

HSCRC presented data showing Maryland’s cash position above historical values from 10 and 20 years ago, but rating agencies and markets do not use these standards and cash reserves to cushion the recovery period are already being whittled away.

Market experts believe this cycle of industry challenges is worse and more intractable than prior ones, with no obvious path to stabilization. Rating downgrades and even defaults have accelerated, particularly in the last 6-8 months, with no sign of abatement.

Cash cushions remain sound but are only an effective bulwark against negative operations if negative performance is expected to be temporary. The current cycle, featuring stubbornly high inflation, is occurring simultaneously with the rising cost of capital and weaker investment markets. The combination has already eaten into reserves, which could erode further as the cycle continues.

Operating revenues, one of the major inputs to determine net income, is within the HSCRC’s control. Raising the update so that hospitals have revenue to cover costs is paramount to long-term success and sustainability.

2) **HSCRC should correct the demographic adjustment in full, July 1, 2023.** MHA thanks HSCRC staff and commissioners for recognizing the magnitude of the population underestimate and for working speedily to correct the methodology. MHA appreciates the HSCRC’s first step in revising its demographic adjustment to reflect corrected population growth estimates. As discussed at the May meeting, a per capita system should, at bare minimum, fund age-weighted population growth and cost inflation. We agree that the funding should be restored as quickly as possible and recommend applying the full demographic adjustment catchup of 1.36% on July 1,

² <https://www.spglobal.com/ratings/en/research/articles/230510-not-for-profit-acute-health-care-state-snapshot-maryland-12727684>

2023. This includes 0.39% to reverse 2023 offsets and 0.97% to restore the full amount. We pledge to work with HSCRC staff to validate its underfunding analysis and related calculations.

B. With MHA’s Request, Maryland Will Meet the Model Target

HSCRC’s draft recommendation repeatedly cites the 2023 Medicare \$300 million total cost of care savings target as the reason HSCRC added funding to the system—revenues to cover costs for both inflation and population growth—the two core pillars of a per capita system. HSCRC extrapolated trends showed Maryland’s savings falling to \$80 million in 2022, which proved to be untrue. According to data presented at the HSCRC May public meeting, **Maryland will end 2022 with \$219 million of savings, before considering corrective actions applied January 1.** Applying MHA’s requested update and including this corrective action, Maryland’s CY 2023 Medicare hospital spending will grow just 2.22% over CY 2022. This estimate removes any counter arguments about affordability, especially in a period of hyperinflation.

Figure 2 – CY2023 Hospital Revenue Growth

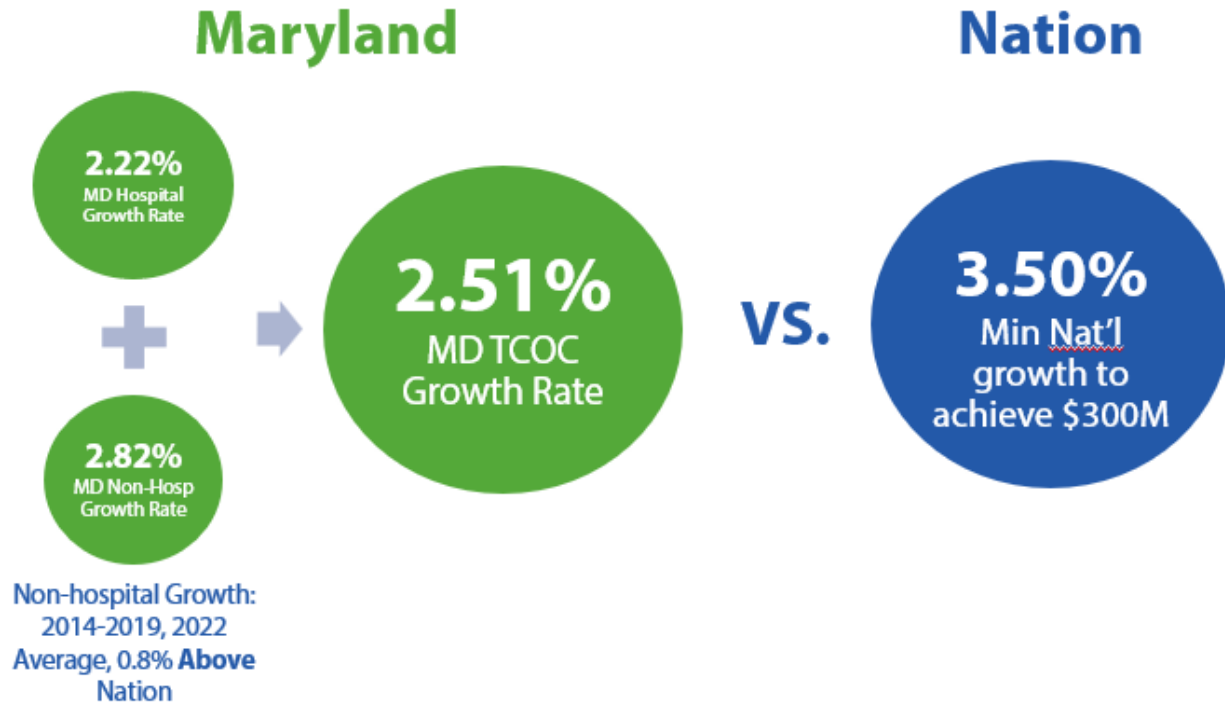
Calendar Year 2023 Hospital Revenue Growth Projections	
Jan-June Growth (RY2023)	1.67%
Jul-Dec Growth (RY2024)	7.12%
CY 2023 over CY 2022 All-Payer Growth	4.38%
Less Approved Actions Affecting Medicare:	
MPA-SC Reduction	(1.10%)
Differential Savings	(0.86%)
Subtotal:	(1.96%)
Traditional MPA	(0.19%)
CY 2023 Projected Medicare Hospital Growth	2.22%

5.42% RY 2024 Update, compared to actual Jul-Dec 2022 revenue

% of Total Medicare Hospital Payments

Coupled with a reasonable estimate for non-hospital payment growth of 2.8%, if the nation grows at or above 3.50% (less than half of last year’s assumption) Maryland will make the \$300 million target. The latest KaufmanHall figures show national discharges for March 2023 rising 7% over March 2022, suggesting that national volumes are rebounding, supporting our minimum national growth assumption. Figure 3 reflects these inputs.

Figure 3: CY2023 Projected Maryland Total Cost of Care Growth, Minimum National Growth to Equal \$300 Million Required Savings



We appreciate HSCRC staff's approach of using different assumptions to present a range of outcomes. In today's financial climate, HSCRC should not simply pick the most conservative outcome to ensure we meet the Medicare target. To achieve Maryland's aims of reducing disparities and improving population health, hospitals need adequate revenues to ensure they can meet community needs.

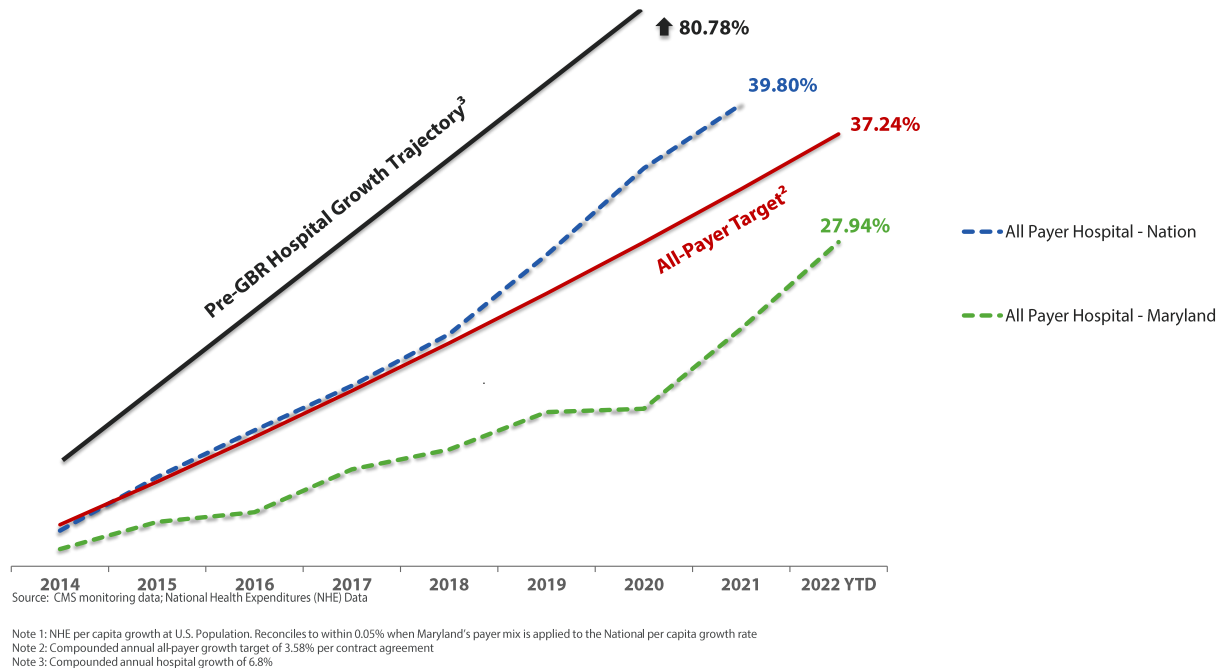
Since 2014, Maryland produced additive Medicare total cost of care savings of \$2.2 billion, likely aided by the underfunding of population growth as reflected above. From 2019 to 2021 alone, cumulative savings were more than \$600 million above the interim targets of \$1.1 billion.

C. All-Payer, Per Capita Spending Performance Demonstrates Maryland's Affordability

If all-payer growth is favorable, HSCRC should consider levers beyond Medicare growth to provide a more robust update. As show in Figure 4 below, Maryland's growth in all-payer hospital spending per capita is 9.3 percentage points below the contractually allowed limit and 11.86 percentage points below the nation.³ These data confirm hospital spending growth is not rising faster than the nation.

³ Data from National Health Expenditures (NHE) and the federal Bureau of Labor Statistics (BLS) are cited in several charts. Though data lag, they consistently show Maryland performing favorably.

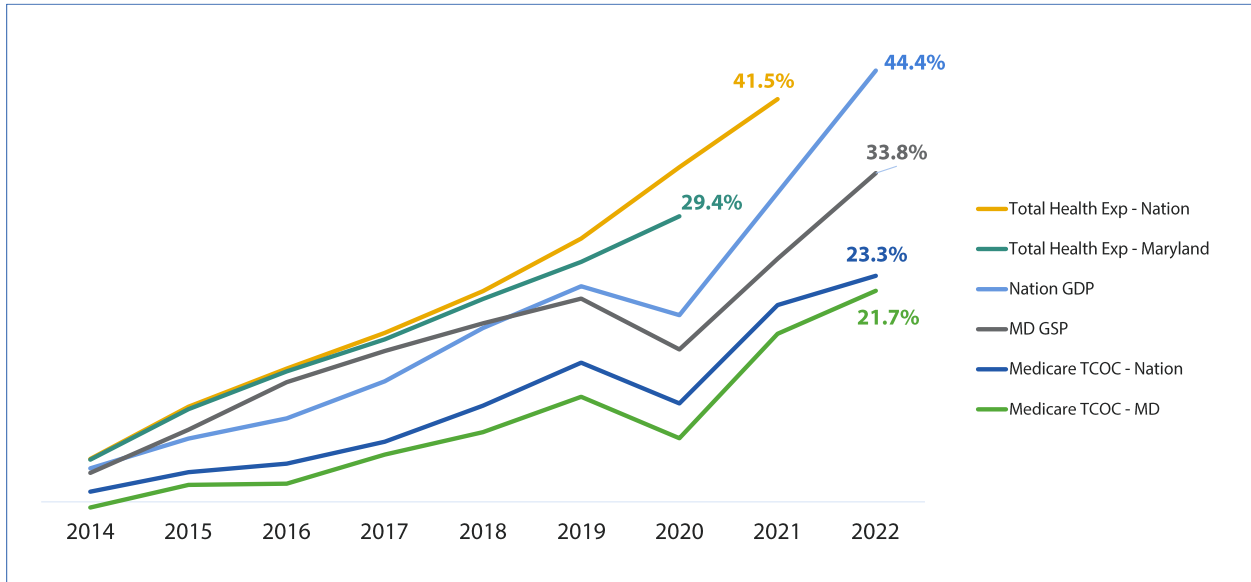
Figure 4: Maryland and U.S. All-Payer Hospital Spending per Capita; Model Target and Pre-Model Performance



Moving to a per-capita revenue system and the agreed upon target created an unprecedented bend in the hospital cost curve. As HSCRC considers the annual payment update and an overall desire to meet Medicare targets, take into account hospital savings provided to all-purchasers built into the Model from day one.

While figure 4 can be viewed as hospital only expenses, figure 5 below reflects both all-payer total cost of care growth from National Health Expenditures (NHE) data, and Medicare total cost of care growth from the Model data. NHE does not have all-payer data for the most recent years, yet Maryland remains more than 11 percentage points below the nation when comparing 2020 to 2021. The chart also references Medicare data, below the all-payer growth, and both Maryland and U.S. growth in gross domestic (state) product.

Figure 5: Maryland and U.S., All-Payer and Medicare, Total Cost of Care Growth



Finally, figure 6 notes national hospital price growth for Medicare, Medicaid and commercial insurance. Commercial price growth has nearly doubled Medicare growth during the GBR period. Since 2021, commercial insurance hospital prices grew more than three times faster than Medicare and seven times faster than Medicaid.

Figure 6: National Hospital Price Growth, GBR Period 2014 – Present

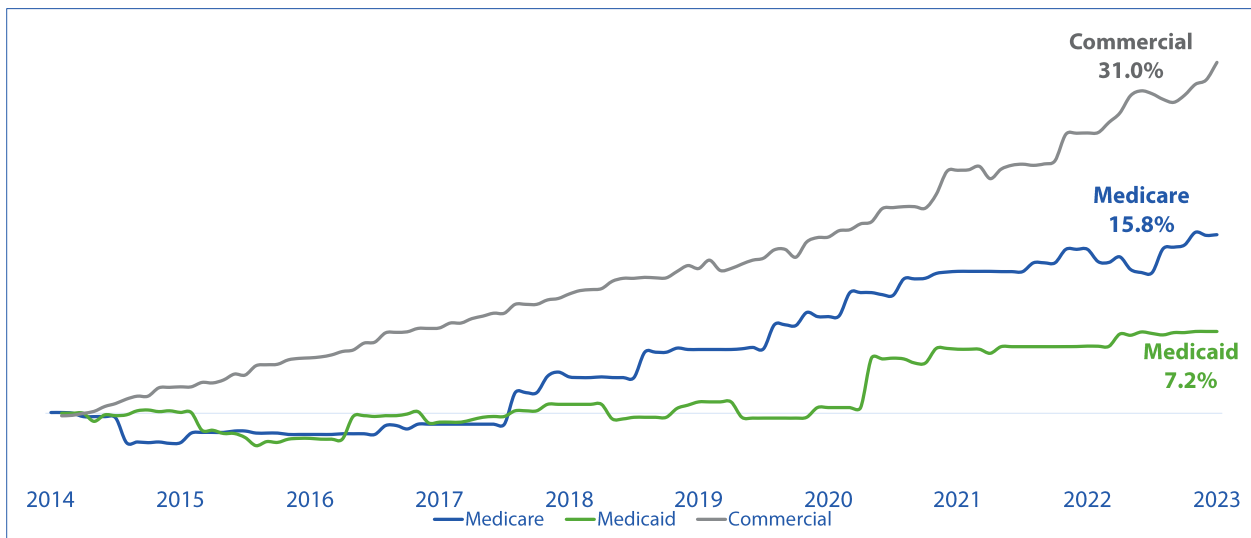


Figure 7: National Hospital Price Growth, 2021 - Present

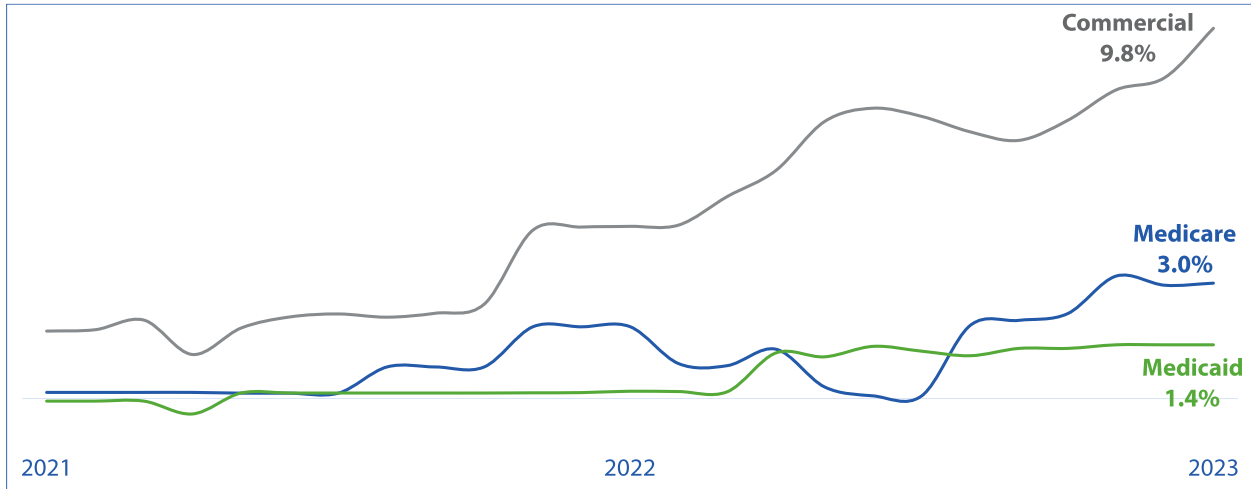
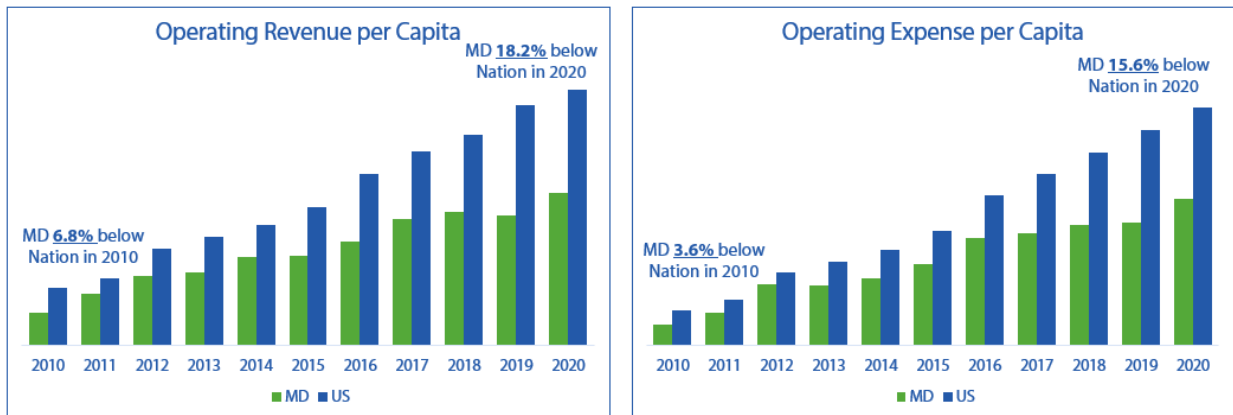


Figure 8 compares statewide Maryland hospitals’ operating revenue and expense per capita to the nation using the most recent American Hospital Association (AHA) Annual Survey data. These data were used by HSCRC as a benchmark for cost efficiency for many years.

Figure 8: Maryland and U.S. Hospital Operating Revenue, Operating Expense per Capita



Data show Maryland is 18.2% below the nation in hospital net operating revenue per capita and 15.6% below the nation in operating expense per capita, showing Maryland hospitals are relatively efficient using the same construct as the Model per capita incentive.

The breadth and depth of these data reveal that hospital care in Maryland is affordable compared to the nation. Importantly, they are measured on a per capita basis which is the foundation of Maryland’s unique Model.

D. Reset the QBR Scale

The HSCRC should adjust the FY 2024 Quality Based Reimbursement (QBR) payment scale to align with recent national performance. The intention of the QBR policy and other HSCRC quality policies is to calibrate incentives similar to national performance.

In December 2016, HSCRC approved a retrospective adjustment to the FY 2017 QBR payment scale because it determined the scale approved at the start of the year rewarded many hospitals “despite relatively poor performance” [relative to the nation]. Commissioners removed \$37 million in retrospective changes to FY 2017 adjustments, moving from a \$27 million statewide reward to a \$10 million penalty. At the same time, HSCRC staff proposed setting the Maryland payment scale based on national performance so Maryland hospitals would be rewarded for performance better than the national average and penalized for performance below the nation.

Typically, the national distribution is stable. However, Maryland and national scores fell during COVID and in the post-COVID recovery. The most recent data show national median scores on these measures at 33%. This is 8 basis points below Maryland’s 41% score. The third quartile of national performance is 41%, meaning that Maryland hospitals would need to be in the top quartile to begin earning rewards.

Resetting Maryland’s FY 2024 QBR payment scale to align with national performance would reflect a cut point of 33%, with the maximum rewards threshold remaining at 80%. This scale results in net statewide penalties of \$61 million instead of \$90 million, reducing the statewide impact by 0.15%. MHA’s modeling supports this impact and has been shared separately with HSCRC staff.

May 24, 2023

O 410-543-7111
F 410-543-7102

Adam Kane, Esq., Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Kane,

Tidal Health appreciates the opportunity to comment on the Health Services Cost Review Commission's ("HSCRC") draft staff recommendation for the Fiscal Year 2024 Update Factor. The HSCRC has the important opportunity to consider changes to the staff recommendation to fully account for inflation and population growth, as well as **to provide funding that is equitable amongst hospitals**. Both are critically important, and we hope commissioners will strongly consider the following changes to the staff recommendation:

(1) Inflation

We support MHA's request to provide additional funding to the industry to account for underfunded inflation; **We believe this additional inflation funding should be targeted to support efficient hospitals**. Therefore, We strongly support either 1) reduction of this amount to .75% and shifting of .45% to increase amount set aside for full rate applications thereby targeting/allocating more dollars to efficient hospitals or 2) Scaling the 1.15% to apply more to efficient hospitals and less towards hospitals with retained revenue (we submitted a letter on May 9, 2024 outlining the approach and justification to scale).

(2) Population Growth

We support MHA's request to fund the full amount of demographic adjustment catchup, adding 1.36% back on July 1. **If this is not going to be fully funded, we believe the HSCRC recommendation as written needs to be changed so that funding is equitable by evenly distributing to the hospitals**. At the April HSCRC Meeting, you had requested HSCRC staff to reconvene and find an equitable solution. The current recommendation we believe is not equitable amongst hospitals.

It is important to note that our recommendations are guided by a strong belief that there is inherent inequity within the Maryland model. This inequity is driven by retained revenue and inefficient hospitals where volume has fallen, but the resources for those facilities has not been adequately redistributed amongst more efficient hospitals and in our case those that provide efficient tertiary services where our volume has grown. While we respect the original guiding principles of the model allowing hospitals to retain revenue in the case of successful population

health efforts, on-going cumulative dollars embedded in inefficient hospital costs and charges to consumers has caused major inequities and does not provide the necessary funds to support the communities we serve.

Thank you again for the opportunity to comment and I am available should you have any questions.

Sincerely,



Steven E. Leonard, Ph.D., MBA, FACHE
President/CEO

cc: Joseph Antos, Ph.D., Vice Chairman
Katie Wunderlich, Executive Director, HSCRC
Laura Herrera Scott, M.D., Secretary of Health
Victoria W. Bayless
Stacia Cohen, R.N.
Maulik Joshi, Dr. P.H.
James Elliot, M.D.
Sam Malhotra
Brett McCone, SVP, Maryland Hospital Association
Stephanie Gary, Vice President and Chief Financial Officer, TidalHealth, Inc.



250 W. Pratt Street
24th Floor
Baltimore, MD 21201-6829
www.umms.org

CORPORATE OFFICE

May 24, 2023

Adam Kane, Esq.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS Comment Letter on Draft Staff Recommendation for the FY 2024 Update Factor

Dear Adam:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Update Factor for Rate Year 2024.

We appreciate the time spent by Commission Staff in developing and vetting this proposal with the industry. We would like to address specific adjustments proposed in the balanced Update and offer our support of the points outlined in MHA's comment letter.

Current Hospital Financial Conditions

Inflationary pressure continues to exert operational and financial stress on hospitals. While prices continue to be high, the unprecedented cost of labor is most impactful as the fundamental shift in the labor market created ongoing staffing shortages and permanent pressure on wages. The financial consequences of investments in our workforce are exacerbated by increases in the cost of agency staff needed to fill vacancies in critical clinical positions.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM

**University of Maryland Medical Center • University of Maryland Medical Center Midtown Campus •
University of Maryland Rehabilitation and Orthopaedic Institute • University of Maryland Baltimore Washington Medical Center •
University of Maryland Shore Regional Health – University of Maryland Shore Medical Center at Easton -
University of Maryland Shore Medical Center at Chestertown - University of Maryland Shore Medical Center at Dorchester –
University of Maryland Shore Emergency Center at Queenstown •
University of Maryland Charles Regional Medical Center • University of Maryland St. Joseph Medical Center •
University of Maryland Upper Chesapeake Health System – University of Maryland Upper Chesapeake Medical Center -
University of Maryland Harford Memorial Hospital •
University of Maryland Capital Region Health – University of Maryland Bowie Health Center –**

Like the rest of the industry, UMMS is experiencing unprecedented erosion in financial performance that risks preventing us from appropriately investing in routine capital, clinical programs, and needed investments in labor in this exacerbated market. While we continue to be focused on performance improvement and expense reductions, we will need additional rate support to stabilize operating performance in fiscal year 2024.

Provide Unfunded Inflation in Rates, Accounting for Distortions that Exist in the System

In fiscal year 2021 and 2022, hospitals have been underfunded on inflation by more than 3% during a period when costs have grown at near historical levels. UMMS recognizes the importance of achieving the Medicare savings targets established in the Maryland demonstration model. We believe, however, it is important hospitals have financial stability as the state is negotiating the next phase of Demonstration Model. As the Commission considers its decision on the Annual Update, we ask the Commission to consider the overall fundamental success of the Model, CMMI’s support of the Model, and the \$2.2 billion of cumulative savings since fiscal year 2014.

UMMS believes that, just as across-the-board suppression of the annual update factor is not a solution for achieving statewide TCOC savings targets, decisions to address extraordinary circumstances when they arise should not be handled through uniform adjustments without considering hospital capacity and retained revenue. We believe that accounting for distortions in funding decisions is the most appropriate way to ensure equitable application across hospitals. These distortions include: retained revenue (particularly prior to the COVID-19 pandemic), excess capacity, the need for payment policies to address different hospital geographies and situations (AMC, rural), among others. We understand that these are complex issues that will take time to work through, however we feel that effort is necessary to ensure the long-term success of the model, especially as the Model enters its next phase of the Model.

The HSCRC must begin to address the matter of retained revenue in the system to ensure the ongoing success of the Model. We are proposing the HSCRC withhold fiscal year 2024 inflation on retained revenue that was incurred prior to the COVID-19 pandemic (2014-2019). Until we have at least twelve months of normalized volume experience, distortions in volume since the onset of COVID-19 should be excluded from this measurement of retained revenue.

Correct the Full Amount of Demographic Error in FY 2024

Commission Staff have recently identified a 10-year forecasting error in the annual demographic adjustment. The 2020 census demonstrated a significantly larger growth in population than estimated by both Claritas and the MD Department of Planning. Commission staff have recognized this disparity and are proposing to reverse negatives applied during FY 2023 in the FY 2024 update. We agree with this proposed action. It does not,

however, address the significant underfunding of the demographic adjustment since the inception of GBR, which is estimated at 0.97% or \$191M statewide (after adjusting for pre-GBR time periods and the FY 2023 reversal of negatives). UMMS urges the Commission to swiftly correct the error in full effective July 1, 2023 to recognize the larger population being served by hospitals.

Market Shift Funding for COVID Service Lines Should be Excluded from the Methodology

The overlap of the Surge Funding policy with Market Shift should be eliminated as the calendar year 2022 vs calendar 2019 Market Shift adjustment is implemented. The proposed surge funding policy evaluates volume growth in FY 2022, which includes quarter 1 and 2 of calendar year 2022. Both the surge and market shift policies, as proposed, would include volume funding for the Omicron surge, which occurred during quarter 1 and quarter 2 calendar year 2022. The Omicron surge was a one-time event resulting in increased volume and should therefore be funded on a one-time basis. The calendar year 2022 Market Shift is a permanent adjustment and as proposed, includes the COVID influenced service lines. It is inappropriate to fund the volume increase in two different policies and on a permanent basis when as we have seen with calendar year 2023, there have been no further surges in COVID hospital volume.

Adjust the QBR Policy Cut Point to Align with National Performance

CMMI and the Commission have acknowledged that COVID does significantly affect performance in the Quality programs, as evidenced by their suspension during the peak of the pandemic. Additionally, final Staff Recommendations for all Quality Programs (MHAC, RRIP and QBR) include statements that allow the Commission to retroactively evaluate each program for COVID influences and adjust the programs as needed. For QBR, we agree that the payment scale be adjusted to account for significant COVID distortions. As previously discussed, hospitals have had to use temporary labor to ensure patients continue to receive care during the nursing crisis. Hospitals have significantly less influence over these temporary staff to ensure that all established quality protocols are followed. We therefore support MHA's proposal to adjust the QBR payment scale, specifically by adjusting the cut point, which would reduce the statewide QBR penalty by 0.15%.

UMMS Update Factor Request for Consideration

UMMS urges the Commission to consider the following modifications to the update factor proposal:

1. Provide full inflation for hospitals for FY 2024, currently 3.35%, disallowing inflation on retained revenue prior to calendar year 2019.
2. Release full amount of remaining demographic error (0.97%) on July 1.
3. Provide the 1.15% in historical update factor shortfall to fund unprecedented inflation growth.
4. Exclude COVID influenced service lines in calendar 2022 vs. calendar year 2019 market shift calculation.
5. Adjust QBR cut point to 33% to align with national performance.

Thank you for the opportunity to provide feedback. If you have any questions, please do not hesitate to contact me.

Sincerely,



Mohan Suntha, MD, MBA
President and CEO
University of Maryland Medical System

cc: Joseph Antos, PhD, Vice Chairman
Victoria W. Bayless
James Elliott, MD
Maulik Joshi, Dr. P.H.
Sam Malhotra
Katie Wunderlich, Executive Director
Jerry Schmith, Principal Deputy Director
Allan Pack, Principal Deputy Director
William Henderson, Principal Deputy Director
Michelle Lee, UMMS, CFO
Alicia Cunningham, UMMS, SVP



Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

May 25, 2023

Adam Kane, Esq.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Chairman Kane:

On behalf of the Maryland Department of Health (MDH), I am writing to communicate the Department's support of the Health Services Cost Review Commission's (HSCRC) staff recommendation for the rate year (RY) 2024 rate update factor, with a caveat about examining demographic factors for the previous 10 years.

As we saw in RY 2023, the Commission had to implement a multi-pronged approach to returning dollars to Medicare for missing savings targets under the Total Cost of Care agreement. A conservative approach to estimating the Medicare national trends and setting an appropriate update factor will help ensure the state meets our savings targets. Moreover, this will allow us to maintain the integrity of the "all payer" nature of the Total Cost of Care Model and setting hospital rates.

In light of the new State of Maryland population estimates provided by the Department of Planning, we support the HSCRC staff recommendation to reverse past negative population adjustments to hospital rates from RY 2023, a one-time adjustment totaling approximately \$80M. However, we do have a concern about the proposal in the staff recommendation to form a workgroup on a recommendation looking specifically at the Maryland Department of Planning's forecasting estimates over the previous 10 years and the suggestion that any misses in the estimates could be accounted for in rate updates for RY 2024. We are concerned that this proposal would examine one input factor to hospital rate updates without considering other estimates and misses that could impact the update factor, including retained revenue. We are in support of the one year adjustment and correction moving forward. Further, we support staff's recommendation related to the adjustment of gross inflation for RY24 and do not support any additional inflation adjustments for previous years.

The Department looks forward to working closely with the Commission to preserve and evolve the Total Cost of Care waiver in order to ensure continued investments in primary care, improving population health statewide, and advancing health equity.

Thank you again for the opportunity to provide comments. If you have additional questions, please do not hesitate to contact me.

Sincerely,

Laura Herrera Scott, MD, MPH, Secretary
Maryland Department of Health

May 31, 2023

Adam Kane
Chair, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Subject: Inquiry on Update Factor and Graduate Medical Education (GME) in Maryland

Dear Chairman Kane,

As a representative of the MedChi Resident Section, I am writing to discuss a matter of great significance that directly affects the equitable compensation of residents and the funding of Graduate Medical Education (GME) programs in our state. Specifically, I would like to address the transparency and effectiveness of the update factor with regard to GME funding mechanisms employed in Maryland.

Undoubtedly, Maryland stands apart from other states by financing residents and graduate medical education through a rate-setting approach. While this methodology has facilitated the provision of essential resources, it is crucial that we ensure the citizens have transparency with regard to funding and residents are justly compensated for their services. As a Hopkins resident I recently received an out of cycle inflation index, as well as our normal yearly upgrade. While our pay is still low given our debt load, Hopkins is trying to treat us fairly, is this being done with all the other programs?

To this end, I kindly request your assistance in addressing the following inquiries:

Update Factor and Resident Compensation: Is there comprehensive data available regarding the annual increases provided by the update factor that is applied to GME? I am interested in understanding how these adjustments directly impact the compensation received by residents or the GME programs.

Comprehensive Information on GME Funding: In our pursuit of transparency and accountability, it is imperative to have access to comprehensive information on GME funding in Maryland. I kindly request any relevant reports or documentation that outlines the allocation of funds, the sources of these funds, and any applicable guidelines governing their disbursement. Such information will enable us to assess the efficacy of our current investment in GME and identify potential areas for improvement. When the State moved to GME funding through global budgets has it continued to study the number of residency slots to make sure they have increased as payments to systems who have residents increased?

Regular Reports on Value for Investments: Given the substantial investments made in GME, it is vital to establish mechanisms that continuously evaluate the value generated from these expenditures. Does the HSCRC receive regular reports that provide an overview of the outcomes, achievements, and benefits derived from the GME programs funded in Maryland. This information will assist us in further enhancing the quality and effectiveness of our investments, ultimately benefiting the residents and the overall healthcare system.

Mr. Kane, I am confident that by addressing these inquiries, we can work together to create a more transparent and accountable system that supports the well-being of our residents and bolsters the quality of healthcare in Maryland. I would like to express my sincere gratitude for your attention to this matter and your commitment to improving the healthcare landscape in our state.

Please do not hesitate to reach out to me if you require any additional information or clarification on the matters raised in this letter. I eagerly await your response and look forward to the opportunity to collaborate on these crucial issues.

Thank you for your time and consideration.

Sincerely,

Karen Dionesotes

Karen Dionesotes
Chair of MedChi Residents Section

June 1, 2023

The Honorable Adam Kane and HSCRC Commissioners

Health services Cost Review Commission

4160 Patterson Avenue

Baltimore, Maryland 21215

Re: Comments regarding Update Factor

Dear Mr. Kane,

I hope this letter finds you well. I am writing to express MedChi, the Maryland State Medical Society's support for finding a reasonable compromise to move the update factor in a positive direction. Everyone is aware that many Maryland businesses, including hospitals, are facing financial challenges related to inflation and workforce shortages. These issues have implications for Maryland's Total Cost of Care (TCOC) Model and the financial stability of Maryland hospitals. I believe it is essential to consider the following points when evaluating the inflation update and its impact on hospitals.

Hospitals are currently facing significant financial challenges and are under increasing financial strain: The healthcare industry is undergoing substantial financial pressures, stemming from rising costs, declining non-regulated reimbursements, and the ever-growing demand for healthcare services. These challenges pose a threat to the financial stability of hospitals, compromising their ability to deliver quality care and invest in vital resources and infrastructure.

Balancing hospital financial stability with the TCOC model: While recognizing and prioritizing the need to meet the TCOC Model targets, it is also crucial to prioritize hospital financial stability within the TCOC Model. The decisions made should factor in the implications on hospitals' finances and consider the long-term sustainability of the healthcare system. Striking a balance between cost control and maintaining hospitals' viability is of utmost importance. MedChi believes it is especially important to pay close attention to the needs of our world class academic hospitals as they make these decisions.

Avoiding across-the-board application of the update factor without considering significant distortions in the Model: The Health Services Cost Commission (HSCRC) should refrain from uniformly applying the update factor across all hospitals without considering notable distortions in the model. One such distortion is the impact of retained revenue, which can significantly affect hospitals' financial situation. Ignoring these distortions can lead to unfair financial implications for hospitals, potentially hampering their operations and the care provided to patients.

Correcting demographic errors and fair fund distribution: It is imperative for the HSCRC to address any demographic errors that may impact the allocation of funds to hospitals. Accurate distribution of funds ensures that hospitals receive appropriate financial support based on their patient demographics and

needs. By rectifying these errors and implementing fair fund distribution practices, we can maintain equity among hospitals and bolster their financial stability.

I urge you to carefully consider these points when making decisions and policy updates within the HSCRC. By factoring in the financial challenges faced by hospitals and ensuring fairness in the distribution of funds, we can work together to support the financial stability of our healthcare institutions and maintain the provision of quality care to our communities.

Thank you for your attention to this matter. I would greatly appreciate the opportunity to discuss these concerns further and explore potential solutions that would benefit both hospitals and the healthcare system as a whole. Please let me know if you would be available for a meeting or conversation.

Sincerely,

A handwritten signature in blue ink that reads "Gene M. Ransom III". The signature is written in a cursive style with a horizontal line under the name.

Gene M. Ransom III

CEO MedChi, The Maryland State Medical Society

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

AS OF MAY 31, 2023

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

Docket Number	Hospital Name	Date Docketed	Purpose	Analyst's Initials	File Status
2608R	Shady Grove Adventist Medical Center	7/18/2022	CAPITAL	GS	OPEN
2620T	Howard County General Hospital	4/6/2023	TEMPORARY	JS/AP	OPEN
2622N	MedStar St. Mary's Hospital	4/11/2023	OTH	WN	OPEN
2623N	MedStar St. Mary's Hospital	4/11/2023	RAT	WN	OPEN
2625A	Johns Hopkins Health System	4/19/2023	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF THE	*	COST REVIEW COMMISSION
MEDSTAR HEALTH	*	DOCKET: 2023
ST. MARY'S HOSPITAL	*	FOLIO: 2433
LEONARDTOWN, MARYLAND	*	PROCEEDING: 2623N

Staff Recommendation
June 14, 2022

Introduction

On April 7, 2023, MedStar St. Mary’s Hospital (“MSMH,” or “the Hospital”) submitted a partial-rate application requesting the creation of a new rate for Radiology – Therapeutic (RAT) services. The Hospital also requested an effective date of July 1, 2023, for the RAT services.

Staff Evaluation

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. Based on the information received, the Hospital requested a RAT rate of \$13.91. The statewide median rate is \$13.87.

<u>Service</u>	<u>Service Unit</u>	<u>Unit Rate</u>	<u>Projected Volumes</u>	<u>Approved Revenue</u>
Radiology – Therapeutic	RVUs	\$13.87	1,975	\$27,393

Recommendation

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

1. That a rate of \$13.87 be approved effective July 1, 2023 for RAT services;
2. That the RAT rate center not be rate realigned until a full year of cost data has been reported to the Commission; and
3. That no change be made to the Hospital’s Global Budget Revenue for the RAT services.

**IN RE: THE APPLICATION FOR
ALTERNATIVE METHOD OF RATE
DETERMINATION
JOHNS HOPKINS HEALTH
SYSTEM
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2023
* FOLIO: 2435
* PROCEEDING: 2625A**

Staff Recommendation

June 14, 2023

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on June 1, 2023, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) and on behalf of Johns Hopkins HealthCare, LLC (JHHC) to add nephrectomy services to the services approved in Proceeding 2613A. The approval period would be from June 1, 2023, to February 1, 2023.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found the experience under this arrangement have been slightly unfavorable for the last year, however, staff believes that the Hospitals can achieve a favorable experience under this revised arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's' application for an alternative method of rate determination to add nephrectomy services to the services approved in Proceeding 2613. The approval period would be from June 1, 2023, to February 1, 2023. 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.



maryland
health services
cost review commission

**Final Staff Recommendation for a Request to Access
HSCRC Confidential Patient Level Data from
The University of Maryland School of Medicine (UMSON)
Department of Anesthesiology.**

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

June 14, 2023

This is a final recommendation for Commission consideration at the June 14, 2023, Public Commission Meeting.

SUMMARY STATEMENT

The University of Maryland School of Medicine (UMSOM), Department of Anesthesiology, is requesting access to the Health Services Cost Review Commission (HSCRC) Confidential Inpatient and Outpatient Hospital Data (“the Data”), to evaluate the clinical and financial outcomes associated with the implementation of a statewide Critical Care Coordination Center (C4).

OBJECTIVE

Researchers aim to objectively study:

1. Efforts to address healthcare disparities throughout the state of Maryland specially for areas under-served;
2. Use of a public, safety-based, EMS agency/model to provide administrative control and direction for provision of critical care services under pandemic and non-pandemic conditions;
3. The importance of having a state-level intensive care physician who can provide medical direction for patients who are unable to be transferred from an emergency department (ED);
4. The effect of a Critical Care Coordination Center (C4) on ED crowding; and
5. How critical care, like trauma and cardiac/stroke cases, can be regionalized at a state level.

Project Investigators received approval from the Maryland Department of Health (MDH) Institutional Review Board (IRB) on September 29, 2022, and the MDH Strategic Data Initiative (SDI) office on October 28, 2022. The Data will not be used to identify individual hospitals or patients. The Data will be retained by UMSOM until June 14, 2024. 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, the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements listed 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 UMSON for the Data for Calendar Year 2020 through 2023 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.



maryland
health services
cost review commission

Changes to Relative Value Units for Physical Therapy (PTH) & Occupational Therapy (OTH) Effective July 1, 2023

Final Staff Recommendation

June 14, 2023

This document contains the final staff recommendation for changes to Relative Value Units for Physical Therapy & Occupational Therapy services effective July 1, 2023, ready for Commission discussion and vote.

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Definitions

Current Procedural Terminology (CPT) codes – describe medical, surgical, and diagnostic services.

Health Care Common Procedure Coding System (HCPCS) – codes based on the CPT to provide standardized coding when healthcare is delivered.

Relative Value Units (RVUs) – A standard unit of measure. A value or weight assigned to a specific service based on relative resources used for that service relative to other services.

Medicare Physician Fee Schedule (MPFS) – The Centers for Medicare and Medicaid Services (“CMS”) use the MPFS for reimbursement of physician services, comprised of resources costs associated with physician work, practice expense, and professional liability insurance.

Physical Therapy (PTH) - Physical therapists provide evaluation and assessments and establish plans of care that optimize a patient’s physical function, health, quality of life, and well-being across the lifespan.

Occupational Therapy (OTH) - Occupational Therapists use purposeful, everyday life activities in the evaluation and treatment of patients whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process.

Background

On January 19, 2023, the HSCRC staff convened a workgroup to review and initiate changes to the PTH & OTH RVUs and guidelines for these rate centers. The members of this workgroup included Hospitals, Maryland Hospital Association, Insurance Companies, and Hospital Consultants. These changes were initiated for the following reasons:

1. Staff is progressively standardizing RVUs for all ancillary and outpatient rate centers using national CPT code definitions and MPFS cost weights, consistent with the strategy that staff is executing over time for all services.
2. RVUs standardization using the Medicare Physician Fee Schedule weights, updating new codes, and removing inactive codes from Appendix D of the Commission’s Accounting and Budget Manual.
3. Assignment of RVUs procedures that are being reported as “By Report.”

4. The nature of the PTH/OTH visits has changed over time. These visits now focus primarily on optimizing a patient's physical function in everyday, meaningful life activities, preventing disability, and maintaining health.

The physical therapists start each episode of care with a variety of evaluative procedures and assessments that include standardized tests and measures. Based on this evaluation, the therapists develop a plan of care to meet established goals. Following the plan of care, therapists as well as qualified extenders will provide a variety of therapeutic interventions that include functional activities, therapeutic exercise, manual therapy, neuromuscular reeducation, as well as a variety of modalities all focused on the patient's goals. In addition, the therapist is an integral part of a team and consults and collaborates with other medical professionals as well as the patient and their family to maximize their functional potential. These services are provided individually or in a group setting.

Occupational therapists develop plans of care following evaluation to achieve optimal function in everyday, meaningful life activities, prevent disability, and maintain health. Specific occupational therapy services include, but are not limited to, education and training in activities of daily living (ADL) and instrumental activities of daily living (IADLs); the design, fabrication, and the application of splints; sensorimotor and developmental activities; guidance in the selection and use of adaptive equipment; therapeutic activities to enhance functional performance; prevocational evaluation and training; and consultation concerning the adaptation of physical environments. These services are provided individually or in a group setting.

Methodology

The PTH & OTH RVUs were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of the new codes in Appendix D of the Accounting and Budget Manual were obtained from the 2023 edition of the CPT manual and the 2023 edition of the HCPCS. In assigning RVUs, the group used the 2023 MPFS released November 2022, and then assigned using the following protocol.

The proposed RVUs were based on the MPFS Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there was a Technical (TC) modifier line item, that value was used. To maintain whole numbers in Appendix D, the RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5, the RVUs were rounded down and all other values were rounded up.

1. For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.

2. For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not reflect the facility resources associated with the service), the proposed RVUs were modified.
3. For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.
4. Unlisted services or services rarely performed have been designated as By Report (BR). RVUs for BR services are to be assigned based on relative RVU value of similar services.
 - a. The BR methodology for each code must be documented and readily available in the event of an audit.

Comments and Responses

The proposed changes were sent to all hospitals for comments. The comment period closed on May 17, 2023 with no comments received. Hospitals were required to calculate a conversion factor to assure no change in the hospital revenues as a result of this RVU conversion. Hospitals will begin using these revised RVUs effective July 1, 2023.

Recommendation

1. That the Commission approves the revisions to the RVU scale for the PTH & OTH Rate Centers. The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual (Attachment 1- Chart of Accounts). These revised RVUs are based on MPFS weights and were reviewed by a workgroup facilitated by the HSCRC staff;
2. That the RVU scale be updated to reflect linkages of RVUs to the CPT codes to incorporate the changes in PTH & OTH practices. The RVU scale was also updated link charging guidelines for PTH & OTH services to the national definition, consistent with the HSCRC's plan to adopt MPFS RVUs where possible (Attachment 2 – Appendix D);
3. That the new and updated RVUs be effective July 1, 2023. The conversion of the PTH & OTH RVUs be revenue neutral to the overall Hospital Global Budget Revenues; and
4. That revisions to the Chart of Account related to Observation services be effective July 1, 2023.

SECTION 200
CHART OF ACCOUNTS

7510 PHYSICAL THERAPY

Function

The Physical Therapy cost center provides treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise rather than by drugs or surgery, under the direction of a physician and/or a physical therapist. Physical therapists provide evaluation and assessments and establish plans of care. Activities include but are not limited to:

A variety of evaluative procedures and assessments that include standardized tests and measures, development of a plan of care provision by therapist and/or qualified extenders of a variety of therapeutic interventions that include functional activities, therapeutic exercise, manual therapy, neuromuscular reeducation as well as a variety of modalities.

Description

This cost center contains the direct expenses incurred in maintaining a physical therapy program. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), non-medical supplies, purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission. (See Appendix D of this manual.) Relative Value Units for unlisted modalities or for procedures should be estimated based on other comparable modalities or procedures.

Data Source

The number of Relative Value Units shall be the actual count maintained by the Physical Therapy cost center.

Reporting Schedule

Schedule D - Line D39

SECTION 200
CHART OF ACCOUNTS

7530 OCCUPATIONAL THERAPY - ACUTE/GENERAL HOSPITALS

Function

The Occupational Therapy cost center provides a form of therapy for those recuperating from physical or mental illness, which encourages rehabilitation through the performance of activities required in daily life. Following evaluations, Occupational therapists develop plans of care to achieve optimal function in everyday, meaningful life activities. Specific occupational therapy services include, but are not limited to:

Education and training in activities of daily living (ADL) and instrumental activities of daily living (IADLs); the design, fabrication, and the application of splints; sensorimotor and developmental activities; guidance in the selection and use of adaptive equipment; therapeutic activities to enhance functional performance; prevocational evaluation and training; and consultation concerning the adaptation to physical environments. These services are provided individually or in a group setting.

Description

This cost center contains the direct expenses incurred in maintaining an occupational therapy program in acute/general hospitals. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), non-medical supplies, purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be obtained from an actual count maintained by the Occupational Therapy cost center.

Reporting Schedule

Schedule D - Line D40

6750 OBSERVATION

FUNCTION

Observation services are those services furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient. Such services must be ordered and documented in writing as to time and method (FAX, telephone, etc.), given by a medical staff practitioner. Observation services may or may not be provided in a distinct area of the hospital. Notwithstanding the location of the service, all expenses, revenue, statistics, and price compliance must be included in the reporting of the Observation center. Extended recovery time for scheduled ambulatory surgery patients should be included in the reporting of the Same Day Surgery center. Additional activities include, but are not limited to the following:

Monitoring of vital life signs; collecting sputum, urine, and feces; operating of specialized equipment and assisting physicians during patient examination and treatment; changing of dressings and cleaning of wounds and incisions; observing and recording the emotional stability of patients; observing patients for reaction to drugs; administering specified medication; and infusing fluids including I.V.s and blood.

Description

This cost center contains the direct expenses incurred in providing bedside care to observation patients. Included as direct expenses are salaries and wages, employee benefits, non-physician professional fees, non-medical/surgical supplies, purchased services, and other direct expenses and transfers.

Standard Unit of Measure: Hours

Report the number of hours commencing at the time a valid order for observation is made and ending when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient or at midnight of the day before a patient is admitted. This service usually does not exceed one day. Some patients may, however, require a second day of observation services. Only in rare and exceptional circumstances should reasonable and necessary observation services span more than 48 hours. The minimum observation time is one hour; any partial hours are rounded to the nearest full hour.

Data Source

The number of hours shall be the total of the actual count of clock hours of observation services provided.

Reporting Schedule
Schedule D - Line D55

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

ACCOUNT NUMBER**COST CENTER TITLE**

7510

Physical Therapy

7530

Occupational Therapy

The Physical Therapy (PTH) and Occupational Therapy (OTH) relative value units (RVUs) were developed with the aid of the industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions in this section of Appendix D were obtained from the 2023 edition of the Current Procedural Terminology (CPT) manual, and the 2023 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2023 Medicare Physician Fee Schedule (MPFS) released December 15, 2022, and then assigned using the following protocol.

RVU Assignment Protocol

RVUs are based on the Medicare Physician Fee Schedule (MPFS) Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When the MPFS contains a Technical Component (TC) modifier line item, that value is used. To maintain whole numbers in Appendix D, RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 were rounded down and all other values were rounded up. For example, therapeutic procedure, 1 or more areas, each 15 minutes CPT of 97124 has a NON-FAC PE RVU of 0.54. $0.54 * 10 = 5.4$. 5.4 rounded = 5. 5 is the proposed RVU.

1) For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.

2) For RVUs where the calculated RVU appeared too high (for example because it included significant equipment or other overhead and non-staff costs associated with it) or too low (for example because it did not accurately reflect the facility resources associated with the service), the proposed RVU was modified as noted in the table of RVUs.

- a. 97129 Therapeutic interventions, initial 15 minutes did not seem reasonable in comparison to other codes. It was determined to mirror 97110 (Therapeutic Exercises) and 97112 (neuromuscular re-ed) which are both 4 RVUs.
- b. 97130 Therapeutic interventions, additional 15 minutes did not seem reasonable in comparison to other codes. It was determined to mirror 97110 (Therapeutic Exercises) and 97112 (neuromuscular re-ed) which are both 4 RVUs.
- c. 97605 Neg Pres Wnd Tx DME ≤ 50 SQCM it was agreed that the MPFS was too low, and it was determined that it should be weighted at 50% of CPT 97597 Debridement, open wound RVU of 22 divided by 2 = 11.
- d. 97606 Neg Pres Wnd Tx DME >50 SQCM- it was agreed that the MPFS was too low, and it was determined that it should one additional RVU than CPT 97605. $11+1=12$

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

- e. 97607 Neg Pres Wnd Tx Non DME ≤ 50 SQCM it was agreed that the MPFS was too high, and it was determined to mirror the RVUs for 97605 of 11. Supplies would be charged through MSS.
- f. 97608 Neg Pres Wnd Tx Non DME >50 SQCM it was agreed that the MPFS was too high, and it was determined to mirror the RVUs for 97606 of 12. Supplies would be charged through MSS.
- g. 97610 Low frequency, non-thermal US did not seem reasonable in comparison to other codes. It was determined to base RVU on 97035 Ultrasound each 15 minutes of 2 multiplied by 2. Supplies would be charged through MSS. $2 \times 2 = 4$

3) For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.

- a. 97545 Work hardening/conditioning initial 2 hours was based on the RVU for 97110 (Therapeutic Exercises) of 4 being multiplied by 8 because this is a 2-hour code (120 minutes) vs. 15-minute code. $4 \times 8 = 32$.
- b. 97546 Work hardening/conditioning each additional hour was based on the RVU for 97110 (Therapeutic Exercises) of 4 being multiplied by 4 because this is a 1-hour code (60 minutes) vs. 15-minute code. $4 \times 4 = 16$.

4) For RVUs converting CPT non-time-based codes time-based codes. The time increment selected was 15 minutes. The 15-minute increments used in this Appendix D are subject to the Medicare 8-minute rule. The phrase “(per HSCRC: each 15 minutes)” has been added to the CPT description for emphasis.

- a. 97150 Therapeutic procedures, group it was determined to use the MPFS RVU of 2 as the base and then double for each 15-minute increment.

Time	RVU
08-22 MINUTES	2
23-37 MINUTES	4
38-52 MINUTES	6
53-67 MINUTES	8

- b. 97161 Physical Therapy Evaluation- Low Complexity, 97162 Physical Therapy Evaluation – Moderate Complexity, 97163 Physical Therapy – High Complexity, 97165 Occupational Therapy Evaluation- Low Complexity, 97166 Occupational Therapy Evaluation – Moderate Complexity, 97167 Occupational Therapy – High Complexity: It was agreed to start with an RVU of 8 and then double for each 15-minute increment.

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Time	RVU
08-22 MINUTES	8
23-37 MINUTES	16
38-52 MINUTES	24
53-67 MINUTES	32

- c. 97164 Physical Therapy Re-evaluation, 97168 Occupational Therapy Re-evaluation: It was agreed to start with an RVU of 6 and then double for each 15-minute increment.

Time	RVU
08-22 MINUTES	6
23-37 MINUTES	12
38-52 MINUTES	18
53-67 MINUTES	24

5) Unlisted services or services rarely performed have been assigned as By Report (BR). Similar logic should be utilized to assign RVUs to any services that are not found or BR.

•If there are no MPFS RVUs for a service, their RVUs should mirror an existing code that has similar facility resources or an existing code that has similar facility resources with adjustments if needed (for example, if a BR service is slightly less resource intensive than an existing service, the RVU can be lower). The BR methodology for each code must be documented and readily available in the event of an audit.

6) Remote therapeutic monitoring codes (RTM) are new and evolving as of the publishing of this Addendum B.

Other considerations:

1. Sole use disposable supplies are separately chargeable.
2. The CPT codes reviewed account for most services provided in PTH & OTH. There are some CPT codes not listed and new codes may be added in the future. These codes should be considered as “by report” by the individual institution and use the RVU assignment protocols listed above.
 - Please note that the Athletic Training Evaluation and re-Evaluation CPTs 97169, 97170, 97171 and 97172 were intentionally excluded as they would not be performed in a hospital PTH/OTH department.
2. CPT codes are in a process of constant revision and as such providers should review their institution’s use of CPT codes and stay current with proper coding and billing procedures.

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

4. The RVU's listed in this section of Appendix D are time based. The time increments are in 15-minute multiples. HSCRC expects providers to round up/down for services, when not provided in exactly a 15-minute multiple. For example, services that are:
 - a. 08 to 22 minutes = 15 minutes,
 - b. 23 to 37 minutes = 30 minutes,
 - c. 38 to 52 minutes = 45 minutes,
 - d. 53 to 67 minutes = 60 minutes, etc.

5. Time increments used in this section of Appendix D are for direct patient time. Direct patient time is billable. Time spent for documentation of service, conference, and other non-patient contact is not billable.

6. For (Physical and Occupational Therapy services that are being performed in other areas (i.e., Wound Care Clinic) need to ensure that the revenue and expenses are appropriately re-allocated to the therapy rate centers.

7. It is expected and essential that all appropriate clinical documentation be prepared and maintained to support the services provided.

Code	Description	RVU	Category	Rationale
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	4	Non-Time Based	MPFS
20561	Needle insertion(s) without injection(s); 3 or more muscles	6	Non-Time Based	MPFS
29085	Application, cast; hand and lower forearm (gauntlet)	19	Non-Time Based	MPFS
29105	Application of long arm splint (shoulder to hand)	15	Non-Time Based	MPFS
29125	Application of short arm splint (forearm to hand); static	14	Non-Time Based	MPFS
29126	Application of short arm splint (forearm to hand); dynamic	16	Non-Time Based	MPFS
29130	Application of finger splint; static	7	Non-Time Based	MPFS
29131	Application of finger splint; dynamic	10	Non-Time Based	MPFS
29405	Application of short leg cast (below knee to toes);	15	Non-Time Based	MPFS

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Code	Description	RVU	Category	Rationale
29445	Application of rigid total contact leg cast	19	Non-Time Based	MPFS
29505	Application of long leg splint (thigh to ankle or toes)	19	Non-Time Based	MPFS
29515	Application of short leg splint (calf to foot)	13	Non-Time Based	MPFS
29540	Strapping; ankle and/or foot	4	Non-Time Based	MPFS
29580	Strapping; unna boot	13	Non-Time Based	MPFS
29581	Application of multi-layer compression system; leg (below knee), including ankle and foot	21	Non-Time Based	MPFS
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers	21	Non-Time Based	MPFS
90901	Biofeedback training by any modality	8	Non-Time Based	MPFS
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including emg and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient	15	Time-Based	MPFS
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including emg and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (list separately in addition to code for primary procedure)	4	Time-Based	MPFS
92526	Treatment of swallowing dysfunction and/or oral function for feeding	SEE SLP	Non-Time Based	See Speech Language Pathology section for RVUs.

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Code	Description	RVU	Category	Rationale
92610	Evaluation of oral and pharyngeal swallowing function	SEE SLP	Non-Time Based	See Speech Language Pathology section for RVUs.
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	BR	Non-Time Based	No current activity. MPFS RVUs are too high. Note: This CPT could be used as a base for other lymphedema measurement services in the future.
95992	Canalith repositioning procedure(s) (eg, epley maneuver, semontmaneuver), per day	5	Non-Time Based	MPFS
96110	Developmental screening (eg, developmental milestone survey, speech, and language delay screen), with scoring and documentation, per standardized instrument	SEE SLP	Non-Time Based	See Speech Language Pathology section for RVUs.
96110	Developmental screening (eg, developmental milestone survey, speech, and language delay screen), with scoring and documentation, per standardized instrument	SEE SLP	Non-Time Based	See Speech Language Pathology section for RVUs.
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	SEE SLP	Non-Time Based	See Speech Language Pathology section for RVUs.

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Code	Description	RVU	Category	Rationale
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (list separately in addition to code for primary procedure)	SEE SLP	Non-Time Based	See Speech Language Pathology section for RVUs.
97010	Application of a modality to 1 or more areas; hot or cold packs (per HSCRC: not reportable)	0	Non-Time Based	Not being reported, keep at 0.
97012	Application of a modality to 1 or more areas; traction, mechanical	2	Non-Time Based	MPFS
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	2	Non-Time Based	MPFS
97016	Application of a modality to 1 or more areas; vasopneumatic devices	2	Non-Time Based	MPFS
97018	Application of a modality to 1 or more areas; paraffin bath	1	Non-Time Based	MPFS
97022	Application of a modality to 1 or more areas; whirlpool	3	Non-Time Based	MPFS
97024	Application of a modality to 1 or more areas; diathermy (EG, microwave)	2	Non-Time Based	MPFS
97026	Application of a modality to 1 or more areas; infrared	1	Non-Time Based	MPFS
97028	Application of a modality to 1 or more areas; ultraviolet	2	Non-Time Based	MPFS
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	2	Time-Based	MPFS
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	3	Time-Based	MPFS

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Code	Description	RVU	Category	Rationale
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes	2	Time-Based	MPFS
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	2	Time-Based	MPFS
97036	Application of a modality to 1 or more areas; hubbard tank, each 15 minutes	8	Time-Based	MPFS
97039	Unlisted modality (specify type and time if constant attendance)	BR	Non-Time Based	Unlisted, By Report
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	4	Time-Based	MPFS
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	5	Time-Based	MPFS
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	6	Time-Based	MPFS
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	4	Time-Based	MPFS
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	5	Time-Based	MPFS
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	4	Time-Based	Mirrored 97110 (ther ex) and 97112 (neuromuscular re-ed) and used 4 vs. 2.

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Code	Description	RVU	Category	Rationale
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure)	4	Time-Based	Mirrored 97110 (ther ex) and 97112 (neuromuscular re-ed) and used 4 vs. 2.
97139	Unlisted therapeutic procedure (specify)	BR	Non-Time Based	Unlisted, By Report
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	4	Time-Based	MPFS
97150	Therapeutic procedure(s), group (2 or more individuals) (per HSCRC: each 15 minutes)	2	Non-Time Based	Starting with 2 and then doubling based on time
97161	Physical Therapy evaluation: low complexity (per HSCRC: each 15 minutes)	8	Non-Time Based	Starting with 8 and doubling based on time
97162	Physical Therapy evaluation: moderate complexity (per HSCRC: each 15 minutes)	8	Non-Time Based	Starting with 8 and doubling based on time
97163	Physical Therapy evaluation: high complexity (per HSCRC: each 15 minutes)	8	Non-Time Based	Starting with 8 and doubling based on time
97164	Re-evaluation of Physical Therapy established plan of care (per HSCRC: each 15 minutes)	6	Non-Time Based	Starting with 6 and doubling based on time
97165	Occupational Therapy evaluation, low complexity (per HSCRC: each 15 minutes)	8	Non-Time Based	Starting with 8 and doubling based on time
97166	Occupational Therapy evaluation, moderate complexity (per HSCRC: each 15 minutes)	8	Non-Time Based	Starting with 8 and doubling based on time
97167	Occupational Therapy evaluation, high complexity (per HSCRC: each 15 minutes)	8	Non-Time Based	Starting with 8 and doubling based on time

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Code	Description	RVU	Category	Rationale
97168	Re-evaluation of Occupational Therapy established plan of care (per HSCRC: each 15 minutes)	6	Non-Time Based	Starting with 6 and doubling based on time
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	7	Time-Based	MPFS
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct(one-on-one) patient contact, each 15 minutes	14	Time-Based	MPFS
97535	Self-care/home management training (eg, activities of daily living (adl) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	5	Time-Based	MPFS
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or workenvironment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes	5	Time-Based	MPFS
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	5	Time-Based	MPFS
97545	Work hardening/conditioning; initial 2 hours	32	Time-Based	RVU developed based on the RVU for Therapeutic exercises (CPT 97110) of 4 multiplied by 4, because this is a 2 hour/120-minute vs. 15-minute code. $4 \times 8 = 32$ RVUs

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Code	Description	RVU	Category	Rationale
97546	Work hardening/conditioning; each additional hour (list separately in addition to code for primary procedure)	16	Time-Based	RVU was developed based on the RVU for Therapeutic exercises (CPT 97110) of 4 multiplied by 4, because this is a 1-hour/60 vs. 15-minute code. $4 \times 4 = 16$ RVUs
97597	Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less	22	Non-Time Based	MPFS
97598	Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure)	8	Non-Time Based	MPFS
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session (per HSCRC: not reportable)	0	Non-Time Based	Not being reported, keep at 0.

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Code	Description	RVU	Category	Rationale
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (dme), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	11	Non-Time Based	Weighted at 50% of CPT 97597
97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (dme), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	12	Non-Time Based	One additional RVU than CPT 97605
97607	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	11	Non-Time Based	Mirrors 97605. Supplies would be charged through MSS.
97608	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	12	Non-Time Based	Mirrors 97606. Supplies would be charged through MSS.
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	4	Non-Time Based	Flat RVU based on CPT 97035 * 2 with supplies charged separately.

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Code	Description	RVU	Category	Rationale
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes (Supplemental HSCRC description: includes such tests as BTI, isokinetic tests, vision test with equipment, Etc.)	6	Time-Based	MPFS
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes	5	Time-Based	MPFS
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	9	Time-Based	MPFS
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	7	Time-Based	MPFS
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	11	Time-Based	MPFS
97799	Unlisted physical medicine/rehabilitation service or procedure	BR	Non-Time Based	Unlisted, By Report
98975	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment (NOTE: An episode of care begins when the remote therapeutic monitoring service is activated and concludes when the specific treatment goals are met)	6	Remote	MPFS (once each episode of care.)

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Code	Description	RVU	Category	Rationale
98977	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, every 30 days	15	Remote	MPFS (once per 30 days)
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days	BR	Remote	By Report, no activity (once per 30 days)
98980	Remote therapeutic monitoring treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes	8	Remote	MPFS (per month)
98981	Remote therapeutic monitoring treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes	8	Remote	Mirror MPFS of 98980 (per month)
G0129	Occupational Therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)	Based on underlying CPT	Non-Time Based	No separate RVU assigned, should mirror underlying OTH CPT.
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care	2	Non-Time Based	MPFS

**STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)**

Code	Description	RVU	Category	Rationale
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281	2	Non-Time Based	MPFS
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	2	Non-Time Based	MPFS
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	2	Non-Time Based	MPFS
G0295	Electromagnetic therapy, to one or more areas, for wound care other than described in G0329 or for other uses (per HSCRC: not reportable)	BR	Non-Time Based	By Report, no activity



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Draft Recommendation on Modifications to Efficiency Policies: Full Rate Application, Integrated Efficiency Methodology, and Capital Financing

June 14, 2023

This document contains the draft staff recommendation for modifying the Commission's efficiency policies. Written comments on this Recommendation will be accepted by HSCRC staff until close of business on June 21, 2023. Written comments should be submitted to Allan Pack at allani.pack@maryland.gov.

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Key Methodology Concepts and Definitions

1. Equivalent Casemix Adjusted Discharges (ECMADS) – ECMADS are a volume statistic that account for the relative costliness of different services and treatments, as not all admissions or visits require the same level of care and resources.
2. Inter-hospital Cost Comparison (ICC) Standard – Each hospital's ICC revenue base is built up from a peer group standard cost, with adjustments for various social goods (e.g., trauma costs, residency costs, uncompensated care mark-up) and costs beyond a hospital's control (e.g., differential labor market costs) that are not included in the peer group standard. The revenue base calculated through the ICC does not include profits. Average costs are reduced by a productivity factor of 2 percent. The term "Relative efficiency" is the difference between a hospital's actual revenue base and the ICC calculated cost base.
3. Productivity Adjustment – A percentage reduction applied to the peer group standard cost in the ICC evaluation (historically 2 percent) to ensure that hospitals do not acquire rate enhancement for merely demonstrating average cost performance and thus limited operational efficiency.
4. Volume Adjusted Inter-hospital Cost Comparison (ICC) - A version of the ICC that incorporates hospitals' reduction in potentially avoidable utilization, as defined by the Potentially Avoidable Utilization Shared Savings Program and additional proxies for avoidable utilization. Volumes from this analysis, both negative and positive, amend a hospital's final ICC calculated cost base – not the peer group cost standard - as well as the hospital's position relative to the ICC Cost Standard.
5. Efficiency Matrix – A combined ranking of a hospital's performance in the Inter-hospital Cost Comparison and Total Cost Care. Total Cost of care is measured by comparing the per capita cost of care in a hospital's service area to matched national Medicare and Commercial benchmarks on a risk-adjusted basis. Both measures are weighted equally, and hospitals are arrayed into quartiles to determine overall efficiency.
6. Total Cost of Care (TCOC) Benchmark Performance – TCOC, an assessment of part A and B Medicare expenditures and all commercial expenditures excluding retail pharmacy, is measured by comparing the per capita cost of care in a hospital's service area to matched national Medicare and Commercial benchmarks on a risk, benefit (commercial only) and demographic adjusted basis
7. Medicare Performance Adjustment (MPA) Method – An evaluation of Medicare TCOC that blends attainment and improvement by scaling the expected, cumulative improvement levels based on TCOC benchmark performance.
8. Medicare Performance Adjustment (MPA) Analog Method- An evaluation of Commercial TCOC that blends attainment and improvement by scaling the expected, cumulative improvement levels based on TCOC benchmark performance.

1. Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The GBR approach explicitly rewards hospitals by allowing them to retain revenue as volume declines. While this incentive remains fundamental to the Model, it has the potential side effect of masking hospitals that operate inefficiently.	This policy penalizes significantly inefficient hospitals and rewards significantly efficient ones by evaluating them on a normalized cost per case basis. To avoid penalizing hospitals that are effectively reinvesting savings from lower utilization in improving population health, the cost per case measure is balanced with a measure of total cost of care and a proposed efficiency buyout if a hospital invests in population health.	Hospitals that run efficiently and effectively manage total cost of care in their service areas may be entitled to additional revenue. Those that are inefficient and are not effectively managing total cost of care will lose revenue. Only clear outliers will be impacted, most hospitals will not be affected.	By incenting both efficiency and effective total cost of care management, this policy will control unit level cost inflation faced by the direct healthcare consumer, while also improving the effectiveness of the healthcare delivery for all residents.	Through this policy, hospitals are evaluated, in part, on total cost of care, thereby incentivizing hospitals to improve care coordination and non-hospital investments in their service areas. An increased focus on total cost of care can help to improve access and quality of care for residents in the hospital's service area. Additionally, allowing an efficiency buyout if a hospital invests in population health will likely improve health disparities in communities that have limited community investments.

2. Recommendations

Since 2018, staff have been working with Commissioners and stakeholders to develop and implement formulaic and transparent methodologies that:

- a) establish an absolute standard so that the Commission may reset a hospital's rate structure to align with its current services (Full Rate Application);
- b) identify and address relative efficiency performance in order to bring hospitals closer to peer average standards over time through scaled inflation (Integrated Efficiency Policy); and
- c) provide predictable rate updates for major new capital projects (Capital Financing Policy).

The efficiency policies build off traditional efficiency evaluations that the HSCRC has utilized over the course of all-payer rate setting in the State. The policies also incorporate new

evaluations of Total Cost of Care (TCOC) that better align the Commission's efficiency policies with the goals and incentives of Maryland's TCOC Model. As a result, the policies allow the Commission to adjust hospitals' permanent rate structures based on objective efficiency standards that balance hospital cost efficiency and TCOC effectiveness.

The efficiency policies have thus far been used successfully to adjudicate several full rate applications, capital rate applications, and GBR adjustments through the Integrated Efficiency policy. However, in line with the Commission's ethos to constantly refine and evolve its evaluations, staff is seeking modifications to the efficiency policies to:

- a) improve the application of TCOC evaluations,
- b) allow for Integrated Efficiency buyouts to directly incentivize population health investments,
- c) reinstitute a productivity adjustment that will ensure that only hospitals with demonstrated operational efficiency can access funding through a full rate application, and
- d) address underlying data challenges in the RY 2024 policies by making all efficiency adjustments one-time in nature.¹

Staff are presenting the following recommendations for Commission approval:

- 1) Provide TCOC Adjustments in the Full Rate Application policy based on a hospital's positive performance in attainment AND improvement.
 - a. Positive rewards for Medicare TCOC will be provided to hospitals that perform better than the Medicare Benchmark and grow slower than the average State Medicare TCOC.
 - b. Positive rewards for Commercial TCOC will be provided to hospitals that perform better than the Medicare benchmark, better than the average of top half of commercial TCOC benchmarks and are growing slower than the average State commercial TCOC.
 - c. All other existing TCOC aspects of the Full Rate Application analysis will remain the same, including capping all rewards so that a hospital does not exceed its Medicare Benchmark
- 2) Utilize a revised TCOC assessment for the Integrated Efficiency policy that considers both attainment and improvement performance.

¹ Continued data challenges specific to RY 2024 efficiency analysis includes: Casemix adjusted weights that have not been updated to a post-COVID time period; Limited scoring of hospital deregulation adjustments; Ongoing service delivery disruption due to COVID, which affects both RY 2022 hospital volumes and CY 2021 TCOC metrics; and Unrealized Demographic Adjustment funding due to census catchup, which would have increased hospital profit margins.

- a. Medicare TCOC performance will be based on the better of a benchmark attainment assessment and improvement performance captured through a metric analogous to the Medicare Performance Adjustment method (MPA)
 - b. Commercial TCOC performance will be based on the better of a benchmark attainment assessment and improvement performance captured through a Commercial TCOC assessment analogous to the Medicare MPA approach.
- 3) Amend a hospital's penalty under the Integrated Efficiency Policy to reflect the amount of eligible qualifying population health investments it makes. Qualifying population health investments should not be subject to inflationary reductions, as outlined in the Integrated Efficiency policy.
 - a. Qualifying population health investments should meet all the following (the specifics of these conditions are explained in much greater detail below and this additional detail would be used to govern admitted investments):
 - i. Non-physician community spending in the hospital's primary service area incurred outside of the regulated space and cost accounting, net of revenue generated for those services,
 - ii. Spending that meets one of three following criteria:
 1. An initiative that is intended to address an unmet health need identified on either the hospital's Community Health Needs Assessment or the Centers for Disease Control and Prevention's Health People 2030 Initiative; or
 2. Spending on primary care (as defined by the Maryland Primary Care Program), mental health, or dental providers that are located in a Medically Underserved Area (note this is an exception to item non-physician condition in (i) above); or
 3. Spending on a regional entity to improve population health.
- 4) Reinstate a productivity adjustment in the Inter-hospital Comparison (ICC) equivalent to the variance between the historical operational efficiency standard of 8 percent and the statewide regulated margin for ICC evaluated hospitals. The productivity adjustment is intended to evaluate operational efficiency in Full Rate Applications.
- 5) For RY 2024 only, all efficiency adjustments will be processed as one-time adjustments, i.e., the adjustments will be reversed out in RY 2025 and will be replaced with permanent adjustments based off of RY 2023 volumes and CY 2022 TCOC performance. This adjustment is recommended because there are continued challenges with the underlying data needed to make the RY 2024 evaluation
 - a. Hospitals eligible for a rate enhancement through the full rate application policy in RY 2024 can access funding through a streamlined process if the hospital agrees to: the value established by the methodology, all adjustments are one-time in nature, and the hospital will not file any subsequent rate request during RY 2024.

3. Introduction

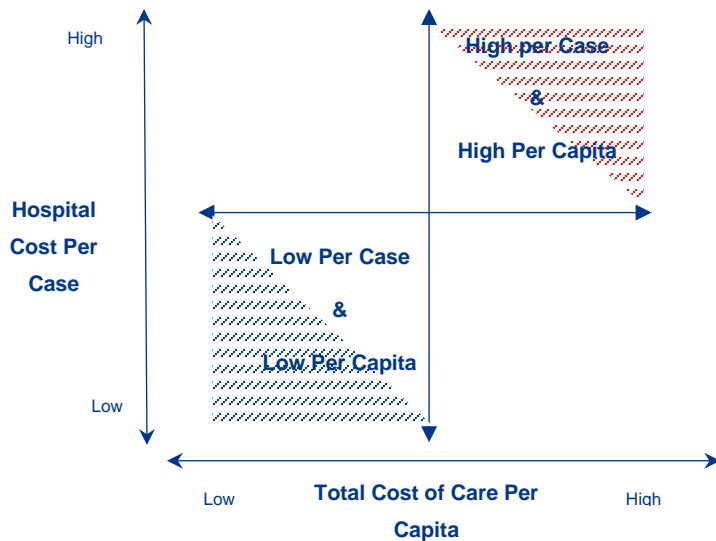
The goals of the HSCRC and the Total Cost of Care (TCOC) agreement are relatively straight forward. The Commission’s enabling statute requires that hospital costs are reasonable; that aggregate rates are set in reasonable relationship to aggregate costs; and that rates are set equitably and applied on an all-payer basis. The innovative TCOC agreement with the federal government focuses efforts on managing per capita rather than per unit costs, and to meet that focus, requires that the relative growth of per capita total health care spending in Maryland must meet certain standards.

The policies and the methodologies adopted by the Commission to achieve its goals, however, are anything but straight forward. These approaches are complex in part because the economics of health care and health services are technical and complex.

This section of the policy proposal is an attempt to describe the full rate application methodology, the integrated efficiency methodology, and the capital financing methodology, in more general language. The intent is to use this primer to paint the broad overview and to provide context to the more technical aspects of the policy.

The current efficiency policies were established by the HSCRC to simultaneously evaluate whether hospitals are “technically efficient” on a *cost per case* basis AND are effective in controlling *total cost per capita*, a hospital that is successful in both dimensions could be considered to be “Effective”. That is, they are achieve technical efficiency without sacrificing the more important per capita goals. Those hospitals identified as particularly high in both these categories are considered presumptively Ineffective (red in the 2 X 2 diagram below), while those that are low in both these categories are presumptively Effective (blue below). Presumptively Ineffective hospitals, which may have excessive retained revenue that is generating high hospital prices and bad TCOC outcomes, have restricted access to full rate and

capital rate applications and are potentially not granted access to a portion of inflation as part of the Annual Update Factor. Presumptively Effective hospitals have greater access to full rate and capital rate applications and are granted the opportunity to request slightly higher revenue through an expedited adjustment to their GBR agreement.



The simultaneous nature of this comparison is important. Controlling TCOC is essential for the waiver to succeed and per unit efficiency in the absence of per capita efficiency is of little value to healthcare payers. At the same time, controlling hospital cost per case, in a responsible way, is a valuable tool in managing cost per capita and part of the Commission’s mandate. Finding the right balance between these two

elements that tend to move in opposite directions is critical.² The remainder of this section identifies the steps taken to calculate Maryland hospitals’ values equitably along these dimensions and to establish the thresholds that determine high and low performance along both. Staff notes that the TCOC Model is an innovation focused on global budgets and not per case reimbursement and the Commission should be hesitant to implement policies that prioritize per case over per capita approaches. CMS has been reimbursing hospitals on a per case basis for many years and it has not proven effective in controlling spending on a per capita basis or addressing health equity or other community health concerns, hence the need for a global budget model.

² As hospitals volumes fall as part of improving total cost of care, hospital unit rates increase under the GBR. Conversely historically hospitals have sought increased revenue and per unit efficiency by focusing on maximizing volumes rather than on focusing on maximizing the overall health of a community.

3a. Hospital Cost per Case

The Commission has relied on the Inter-hospital Cost Comparison (ICC) methodology to evaluate an individual hospital's cost per case or technical efficiency. Although it involves complex calculations, the ICC process can be seen in three basic calculations:

- Adjusting all hospitals' permanent revenue to produce a **standard cost per case** for the comparison group.
- Adjusting this standard cost per case back up to **approved total revenue** specific to each hospital.
- The approved revenue is compared to actual revenue to calculate the **relative efficiency of the hospital**

These calculations are summarized in greater detail in Appendix A.

3b. Total Cost of Care Per Capita

The evaluation of the TCOC attributed to a hospital is likewise complex, but it involves several basic steps. These steps are separately performed against a benchmark standard for the payer categories for which the Commission has comparable information on total health care spending. Such data exists for Medicare Fee-for-Service and commercial insurance payers. It does not exist for Medicaid. The task is to find appropriate demographically similar geographic areas in the country to compare to Maryland areas; attribute the geographic data on total costs to individual hospitals; and adjust the data to make fair comparisons. Once those steps are accomplished, an aggregate TCOC comparison can be made.

- **Establish Benchmark Groups** for each Maryland geography for Medicare and Commercial populations using national data from similar locations.
- **Convert Geographic Benchmarks** into Hospital-specific Benchmarks assigning weights based on a hospital's primary service area.
- **Adjust the data for differences** in Beneficiary Risk and Demographics and compare.

These calculations are summarized in detailed tables in Appendix B. Additional detail on the benchmarking approach can be found here: [TCOC Workgroup](#)

3c. Revenue for Reform

Since 2013, most hospitals in the State that have operated under a global budget have been successful at reducing hospital utilization and therefore have generated retained revenues. While

retained revenues are indicative of a hospital following the incentives of the Model and providing more effective care to their community, they will make a hospital more inefficient on a per case basis. Since hospitals do not incur variable costs on utilization that has been avoided, the revenue retained after a reduction in utilization will increase the hospital's regulated profit. And, since regulated profit is not included in the hospital's Approved Revenue, the impact of retained revenue on hospital utilization will be to increase the hospital's charge per case without increasing the hospital's Approved Revenue. Thus, a hospital's retained revenue will make the hospital less efficient under the ICC evaluation.

This creates tension between the ICC and global budgets. Hospitals are supposed to generate retained revenues in order to invest in community and population health. But if they do so, they are considered inefficient and – under the Integrated Efficiency policy – are provided less inflation than peer institutions who may have ignored the model and made no effort to focus on community health. And perversely, a hospital that generates retained revenue and spends the entirety of that revenue on population health is considered equally inefficient as a hospital that generates retained revenue and does nothing productive with it.

The Revenue for Reform policy attempts to address this tension by allowing hospitals deemed to be inefficient to mitigate the inflationary reduction associated with the Integrated Efficiency Policy if the hospital uses the revenue to invest in community and population health. This policy proposal would mark the first direct incentive, other than grant funding, that the Commission would have to compel hospitals to invest in population health.

4. Policy Discussion

The following section discusses potential areas for improvement in the various efficiency methodologies, specifics behind each of the changes previewed above, and how each efficiency policy will be implemented.

4a. Areas for Improvement

Full Rate Application – TCOC Application & Productivity Adjustment

Over the last two years, numerous stakeholders and staff have raised concerns about the positive TCOC scaling in the FRA policy. Specifically, unlike the negative scaling in the FRA policy, a hospital only had to be better than its national benchmark geographies in order to improve its standing in a FRA; there was no consideration for improvement in TCOC. As a result, concerns were raised that TCOC “rewards” were due to geographic determinism, e.g., a hospital in a market that nationally would have had a more expensive hospital footprint and thus higher TCOC might appear more efficient, even though no improvement on TCOC had occurred in Maryland since the start of the Model.

Providing a reward to a hospital under this scenario does not represent acknowledgement of any action the hospital may have taken to advance the health of the population, reduce utilization, and improve TCOC. While the TCOC reward does not determine the final hospital approved revenue, as TCOC scales the assessment from the ICC, in certain cases the reward was quite significant. *In light of this concern, staff recommend the following changes to the TCOC algorithm:*

Exhibit 1: Proposed Changes (in bold underline) to TCOC Algorithm in Full Rate Application

Prior TCOC Performance Standard for Scaling	Proposed TCOC Performance Standard for Scaling	Reward/Penalty Modification to ICC
Better than Medicare Benchmark	Better than Medicare Benchmark <u>and better than average State TCOC growth</u>	Reward
	Better than Medicare Benchmark and worse than average State TCOC growth	No action
Better than Medicare Benchmark AND Average of Top Half of Commercial Performance	Better than Medicare Benchmark AND Average of Top Half of Commercial Performance <u>and better than average State Commercial TCOC growth</u>	Additional Reward
	Better than Medicare Benchmark AND Average of Top Half of Commercial Performance and worse than average State Commercial TCOC growth	No action

Worse than Medicare Benchmark but better than average State TCOC growth	Worse than Medicare Benchmark but better than average State TCOC growth	No action
Worse than Medicare benchmark and worse than average State TCOC growth	Worse than Medicare benchmark and worse than average State TCOC growth	Penalty
Worse than Commercial Benchmark	Worse than Commercial Benchmark	Additional Penalty
All Rewards Capped so that a Hospital Does not Exceed Medicare Benchmark		

In addition to the TCOC scaling consideration staff have brought forward, Commissioners have raised concerns about the limited emphasis on operational efficiency in the FRA policy, i.e., the degree to which hospitals demonstrate that their inputs or costs are less expensive per output or hospitalization. This is a particularly salient point when regulated margins are suppressed statewide, because as statewide margins decrease, the standard for qualifying for rate enhancements in the ICC is lowered. This occurs because the ICC is effectively equal to a hospital's operational efficiency relative to the peer group cost standard LESS the profits stripped from a hospital LESS a productivity adjustment (if there is one in place). Thus, if regulated margins decrease across the board, then the degree to which a hospital must reduce its cost per case to qualify for a permanent, higher rate structure is attenuated.

When the Full Rate Application policy was first considered for adoption, average regulated margins were greater than 8 percent and the methodology incorporated a 2 percent productivity adjustment. In effect, hospitals had to demonstrate cost per case efficiency (or operational efficiency) that was greater than 10 percent of the peer group average to qualify for a rate enhancement. As such, the Commission recommended discontinuing the productivity adjustment because having to demonstrate operational efficiency that is greater than 10 percent of the peer group standard (8 percent profit PLUS a 2 percent productivity adjustment) was considered too significant to warrant a rate enhancement.

When margins are reduced the opposite is true: having to demonstrate an operational efficiency that is less than 8 percent of the peer group standard is not stringent enough, especially compared to historical expectations of relative operational efficiency (see Exhibit 2):

Exhibit 2: Historical Minimum Operational Efficiency Standard for Enhanced Rates

Fiscal Year	Regulated Margin	Productivity Adjustment	Effective Minimum Operational Efficiency Standard
FY2004	4.61%	2%	6.61%
FY2005	4.88%	2%	6.88%
FY2006	5.16%	2%	7.16%
FY2007	5.50%	2%	7.50%
FY2008	5.44%	2%	7.44%
FY2009	6.42%	2%	8.42%
FY2010	6.44%	2%	8.44%
FY2011	7.56%	2%	9.56%
FY2012	7.07%	2%	9.07%
FY2013	4.52%	2%	6.52%
FY2018	8.81%	Discontinued	8.81%
FY2022 (Current ICC Evaluation)	6.47%	0%	6.47%
2004-2013 Average	5.76%		7.76%

Failure to reinstate a productivity adjustment in RY 2024 would result in diminishing the minimum operational efficiency standard in HSCRC policies to a point not reached in the last twenty years of rate setting (6.47 percent operational efficiency standard vs. an average of 7.76 percent). Moreover, given that the margin erosion is due to various transient costs, such as length of stay increases and nurse agency costs, increasing approximately one quarter of the industry's rate structure based on potentially temporary phenomena is not an ideal policy outcome. *Thus, staff recommend using the statewide margin erosion to calculate the productivity adjustment each year such that rate enhancements are provided only for demonstrable cost efficiency. Specifically, the productivity adjustment would be equal to the variance between 8 percent (the historical minimum operational efficiency standard) and the average regulated margin for ICC evaluated hospitals. For RY 2024 efficiency policies, this would be equal to 1.53 percent (8 percent – 6.47 percent regulated profit = 1.53 percent). In years when the regulated margin is greater than 8 percent, there would be no productivity adjustment.*

Integrated Efficiency – TCOC Application

While historical iterations of efficiency measures only considered hospital costs, under the TCOC Model any measure of efficiency should include an assessment of a hospital's total cost of care performance. The current method for scaling annual inflation through the Integrated Efficiency policy incorporates a ranking system that evaluates hospital cost per case efficiency at 50 percent, Medicare TCOC attainment performance measured against national benchmark geographies at 25 percent, and Commercial TCOC attainment performance measured against national benchmark geographies at 25 percent.

The Commission adopted a TCOC benchmarking approach because prior improvement-only analyses were unreliable and did not recognize different opportunity levels in the Model due to varying historical TCOC effectiveness that predated global budgets. While statistical reliability and consideration for TCOC effectiveness improved under the benchmarking approach, numerous stakeholders expressed concern that the incentive was still not actionable, as the wide gulf in TCOC attainment assessments could not be closed in a short time period. Thus, hospitals expressed reluctance to make investments to improve TCOC that would ultimately still result in reduced inflation through the Integrated Efficiency policy because the benefits could not possibly accrue fast enough to improve the hospitals position, i.e., the efficiency incentive was not actionable.

The Medicare Performance Adjustment (MPA) similarly wrestled with this concern and elected to blend TCOC attainment with improvement by scaling the expected, cumulative improvement levels based on TCOC benchmark performance. In effect, hospitals that were historically more expensive in terms of TCOC had to grow at a slower rate than hospitals that were less expensive. Over time (15 years in the MPA), geographies will be aligned at similar attainment levels, but in the intermediate years there are improvement rewards that reward hospitals for making investments to reduce TCOC.

Staff recommend that the same method that is incorporated in the MPA should be used in the Integrated Efficiency policy. The benefit of this approach is that hospitals that generate TCOC savings in line with the Model’s overarching incentives are not penalized with lower inflation; it is more reliable than year over year improvement assessments because it is cumulative; and, like the benchmarking analysis, it recognizes that various parts of the State do not need to improve TCOC as fast as other parts of the State due to historically good performance in TCOC. *Staff also recommend this same approach should be used for Commercial TCOC.* For a description of the calculation, see the tables below:

Exhibit 3: MPA Method for Medicare TCOC in Integrated Efficiency

Step	MPA Approach	Medicare MPA Analog for IE
A	Calculate Variance from Benchmark in 2019	Same
B	Group hospitals into roughly even 5 groups based on performance in Step A	Same
C	Assign adjustment values to each group ranging from 0 (best performing group) to 1% (weakest group). Attainment-based adjustment value is used to adjust improvement targets in Step D. As additional years elapse the adjustment is compounded.	Same
D	Calculate performance as: Hospital Growth Since 2018 – (National Growth since 20198 – Step C Adjustment)	Same
E	Cap value in Step D at +/-3% and scale to 1% to calculate MPA reward or penalty.	Rank results from Step D and blend ranking 50%/50% with ICC

Exhibit 4: MPA Analog Method for Commercial TCOC in Integrated Efficiency

Step	MPA Approach in MC IE	MPA Analog for Commercial TCOC
A	Calculate Variance from Benchmark in 2018	Same
B	Group hospitals	Same
C	Assign adjustment values to each group ranging from 0 (best performing group) to 1% (weakest group). As additional years elapse the adjustment is compounded.	Assign adjustment values to each group ranging from -0.5% (best performing group) to 0.5% (weakest group). As additional years elapse the adjustment is compounded.
D	Calculate performance as: Hospital Growth Since 2018 – (National Growth since 2018 – Step C Adjustment)	Use MD average performance instead of National as standard for being above or below target.
E	Rank results from Step D and blend ranking 50%/50% with ICC	Same

The chief variance between the two methods (the Medicare MPA analog and the Commercial MPA analog) is the former expects improvement over time, hence why the average hospital has

to perform better than the nation by 0.5 percent (halfway between 0 and 1 percent), and the latter does not expect any improvement, hence why the average hospital is expected to grow at the same rate as the statewide average. The reason for this divergence is simply because Maryland is less expensive than national peers with respect to Commercial TCOC; it is Medicare TCOC that needs to be reduced to come into line with national performance. That said, the Efficiency Workgroup that debated these proposed adjustments strongly advocated that this phenomenon is largely driven by pricing differences in the State's all-payer rate setting system, which benefit all hospitals equally, so the Commission should not elect to just focus on Medicare TCOC and should instead stick with the Commission's guiding principle of developing policies on an all-payer basis.

The final concern raised by stakeholders during the Efficiency Workgroup sessions was whether the MPA and MPA analog methods did enough in the immediate years to recognize historical TCOC effectiveness, the degree to which hospitals are less expensive than their peers at the start of the Model. While this variance is certainly recognized over time as the MPA increases the expected rate of change by 1 percent per year (e.g., a historically expensive TCOC hospital will have to beat the nation by 1 percent in year one, 2 percent in year two,³ etc., while a historical inexpensive TCOC hospital will have to just stay in line with national growth), the expected rate of change is not demonstrably different for the first few years of the MPA implementation and thus understates the variation in attainment performance. *In light of this concern and in keeping with HSCRC Quality policies that address this issue by assessing the better of a hospital's attainment or improvement performance, staff recommend that hospitals in the Integrated Efficiency policy be evaluated under TCOC benchmarking and the MPA/MPA analog approach, and that the best ranking from either assessment be utilized in determining which hospitals will have their inflation scaled.*

Revenue for Reform – Directing Retained Revenue to Population Health Investments

³ Technically the impacts are compounded over time, so year 2 = 1.01 x 1.01 -1.

Under current policy, the ICC compares a hospital's charge per case to its Hospital Approved Revenue. Since retained revenue generally results in higher regulated profits, retained revenue will make the hospital appear inefficient even if that retained revenue is being spent on productive population health investments that are in line with the purpose of the Maryland Model but not recorded in regulated cost centers (when these costs are not recorded as regulated costs they will appear as profits in the regulated entity).

Under current policy, Staff calculate the ICC for all hospitals in the State prior to the Annual Update Factor. Hospitals are ranked based on the ratio of their charges to Hospital Approved Revenue. The amount by which the hospitals are over (under) their Hospital Approved Revenue is the amount by which they are considered inefficient (efficient). For example, a hospital with \$130 million in charges and \$100 million in Hospital Approved Revenue would be considered 30 percent inefficient. Hospitals are then ranked from most efficient to least efficient. Hospitals do not receive the Medicare and Commercial portion of the Annual Update Factor if they are in the bottom quartile of hospitals.

Under the Revenue for Reform policy proposal, Staff recommend that hospitals' Integrated Efficiency penalty be reduced by the amount of qualified population spending that the hospital demonstrates. For instance, if the hospital would have received a \$10 million dollar reduction in its Annual Update Factor because of having inflation withheld but had spent \$7 million in qualified population health spending, then the hospital would receive an efficiency cut of only \$3 million (\$10 million efficiency adjustment - \$7 million in a qualifying population health safe harbor).

As discussed above, Staff recommend exempting population health spending from Integrated Efficiency adjustments. Staff recommend establishing clear criteria for what qualifies for inclusion in the Revenue for Reform policy.

Staff recommend that any spending, net of offsetting revenue for that activity, that meets the following three criteria offset a hospital's Integrated Efficiency adjustment:⁴

- 1) The investment must take place outside of the hospital itself. Activities that take place within the hospital are most likely targeted at patients currently in the hospital. These costs should be treated as part of the hospital's cost of a hospitalization and should not be safe harbored. For example, hospital-based care management programs are valuable but are part of the routine cost of a hospitalization and should be included in the evaluation of the hospital's cost per case. An intervention is considered to be 'outside of the hospital' if services are provided to beneficiaries off of the hospital's campus and recorded in unregulated or non-regulated⁵ cost centers, even if the intervention is deployed from the hospital.⁶ For example, a mobile integrated health program that treats patients at home would qualify even if the program's base of operations was in the hospital itself.
- 2) The investment must be on a non-physician cost (with the exception of the physician safe harbor below). Physician costs are obviously a critical component of many population health interventions. However, physicians are generally reimbursed for the services they provide. The reimbursement rate does not always cover the cost of providing those services, and health systems may need to invest in physician practices to develop a comprehensive strategy for managing the total cost of care. However, hospitals also spend money on physician practices for regular business reasons. Staff do not believe that there is currently an easy way to distinguish a 'business investment' from a 'population health investment.' Therefore, staff recommend excluding physician costs in this policy.

⁴ Staff recommend that all qualifying spending be included in the Revenue for Reform policy but that future policies examine the relative efficiency of the population health investments. Staff do not believe that sufficient information is available to set targets on the expected impact of the hospital's population health investments. However, it is important to ensure that hospitals are accountable for actual improvements in population health, not just monetary expenditures. Once the hospitals' population health investments are cataloged, future policies should compare the relative effectiveness of similar population investments and established outcomes targets for population health interventions.

⁵ Unregulated refers to business conducted by the regulated entity (the hospital) but not within their regulated cost structure and reported as unregulated in their HSCRC Annual Filing, non-regulated refers to business conducted by a parent or sister entity of the regulated entity which is not reported in the HSCRC Annual Filing.

⁶ Regulated safe harbors would render the Commission's ICC assessment meaningless, as revenue associated with regulated hospital costs would be earmarked as population health investments.

For this purpose, physician costs will be excluded if the physicians are billing payers for services that they provide. If the staff of a program happen to be physicians but do not bill payers for services, their costs may be included.

- 3) The investment principally must be serving people who live within the hospital's primary service area. This will ensure that the retained revenues are retained in the community itself and not just the hospital. Investments that are made in an area outside of the hospital's service area are presumably made for other purposes – such as promoting the health system in an area with a more favorable payer mix – than the health of the hospital's community.

The criteria above are intended to ensure that qualifying investments are based in the community and are not part of the hospital's routine business operations. In order to ensure that community-based investments are spent on population and community health, Staff recommends that the spending must also fall into one of the following three safe harbor categories.

- 1) Community Health Safe Harbor

In order to ensure that the hospital's interventions are intended to improve the health of its community, the intervention must be 'reasonably related' to a community health need identified on one of the following:

- a) An unmet need included on the Community Health Needs Assessment (CHNA). Hospitals are required to conduct a CHNA once every three years in which they: 1) assess the health of their community; and 2) identify the significant health needs of their community. In conducting the CHNA, hospitals must work collaboratively with members of their community and establish an implementation strategy that describes how the hospital intends to address each health need (or explains why it does not intend to address that need). Since hospitals are already required to establish an implementation plan for addressing the needs of the community, Staff believe spending on community health should be limited to needs identified on the CHNA to fall within this safe harbor.
- b) A need identified by the Centers for Disease Control and Prevention's (CDC's) Healthy People 2030 initiative. The CDC establishes national population health priorities;

essentially, this is a community health needs assessment for the entire country. Staff believe that hospitals should be allowed to invest in national health priorities, even if their local community did not explicitly address or identify a particular health need.

Staff recommend that hospitals be required to describe their interventions and justify how the intervention is intended to impact one of the community or national health needs. Staff will assess whether the intervention is reasonably related to the community health need identified by the hospital. If the Staff does not believe the intervention to be reasonably related to an identified community health need, then the costs of the intervention will not qualify. Staff recommend that only direct costs of patient care be included, but that a 25 percent overhead be included in the credit that the hospital receives.

2) Physician Spending Safe Harbor

Staff recommend that hospitals be allowed to subsidize physicians in areas that do not have sufficient access. Hospitals may invest in primary care (as defined by the Maryland Primary Care Program), mental health, or dental providers in areas that the Agency for Health Care Research and Quality (AHRQ) has identified as a Medically Underserved Area. These are areas that have fewer physicians per capita than would be expected, adjusted for the percent of the population living below the poverty rate, the percent of the population that is older than 65, and the infant mortality rate. Spending on specialists other than primary care, mental health, or dental providers would not be included in this safe harbor and spending on those specialties outside of Medically Underserved Areas would also not be included. Staff recommend that only direct costs of patient care be included, but that a 25 percent overhead be included in the credit that the hospital receives.

3) Regional Entity Safe Harbor

Staff expect the majority of the hospital's interventions to fall within one of the two safe harbors described above. However, there may be cases where it is advantageous for hospitals that have overlapping service areas and community health needs to leverage their resources and partner with other organizations to solve regional population health issues.

Staff recommend allowing hospitals to form a regional entity to develop population health partnerships, strengthen population health infrastructure, and improve community health outcomes. The regional entity will comprise multiple hospitals and one or more community partners. The community partner must be an organization that has an established presence in the region and has the capacity to implement population health interventions or to scale existing interventions. Interventions and spending are not restricted to CHNA focus areas. The community partner should also be located in the primary service area of the regional entity, demonstrate a commitment to improving population health in the region, and can attest to strong performance in improving health outcomes for the targeted populations.

Additionally, staff recommend that hospitals that contribute to a revenue entity be given credit for the additional indirect costs. Staff recommend that the hospitals safe harbor be equal to 135 percent of the direct, rather than 125 percent of the direct costs as in the other two safe harbors.

Finally, consideration should be given to statewide strategies that promote population health. To the extent possible, spending plans associated with Revenue for Reform should be made in concert with existing State and local health departments so as not to duplicate or contradict other investments in the community.

4b. Efficiency Implementation

Full Rate Application – Resetting Hospital Rates Based on Current Service Delivery

The current process for full rate applications is outlined in Maryland statute (Health-General Article §19-222 and COMAR 10.37.10.03 et seq). The process allows hospitals to file for a change in its rate schedule that will be effective based on the date that the rate application notice specifies, which must be at least 30 days after the date on which the notice is filed.⁷

The Commission, upon receiving the full rate application, must review and act on the rate application within 150 days after the notice is filed and the application is docketed, unless both parties agree to postpone this deadline. This often may occur because the hospital has introduced

⁷ The HSCRC has also historically used the full rate application methodology to enter into spend-down arrangements with hospitals, whereby the Commission reduces an inefficient hospital's rate structure over a period of years.

in its rate application a methodology consideration that deviates from the approved policy and requires additional research⁸, e.g., new funding for graduate medical education, or because there is additional data, often proprietary in nature, that requires additional staff review.

If the Commission decides to hold a public hearing, the Commission must set a place and time for the hearing within 65 days of the filing notice. In the event of a hearing, the Commission may suspend the effective date of any proposed change until 30 days after the hearing. Finally, if the Commission fails to complete the review of the rate application within 150 days, the change in rate structure will be effective to the date provided on the rate application notice.

Various stakeholders have complained that this process is potentially burdensome when a hospital qualifies for a rate enhancement under the existing Commission approved methodology, although staff believes it is necessary given the scope and permanency of adjustments. The concern about administrative burden, however, is particularly salient in a year where staff are concerned about the underlying data and thus are recommending that all efficiency rate determinations be made one-time in nature, i.e., requiring hospitals to spend time and money to file a full rate application that will have not a permanent effect on hospital rates creates unnecessary administrative costs. *As such, staff recommends that hospitals eligible for a rate enhancement through the full rate application policy in RY 2024 can access funding through a streamlined process established by the Commission. This process may involve a GBR modification. A rate enhancement under the streamlined process will only be available provided: 1) the hospital agrees to the value established by the methodology, and that all adjustments are one-time in nature; 2) no additional methodological considerations will be considered; and 3) the hospital must refrain from requesting additional funding for the entirety of RY 2024.*

Integrated Efficiency - Withholding Inflation from Outlier Hospitals

⁸ Additional considerations, either to correct a data source or to consider a different methodological approach, are referred to as a Phase II assessment.

In prior applications of the HSCRC efficiency methodologies, hospitals' revenues were reduced under spend-down agreements if they were deemed to have cost-per-case beyond a set level. In another application of efficiency measures, hospitals with favorable hospital cost-per-case positions were given higher annual updates than those hospitals with poor relative cost-per-case. However, all of these prior iterations of efficiency analyses were based on fee-for-service mechanisms and did not have to account for relative cost efficiency in a per capita system. In a per capita system, a hospital aligned with the TCOC Model will reduce utilization by improving the health of the population, retain a portion of the revenue associated with the reduced utilization, and potentially appear to be less cost efficient in a cost-per-case analysis. Moreover, hospitals can confound this analysis in the global revenue era by reducing utilization through shifting services to non-hospital providers (referred to as deregulation), eliminating services they judge to be unnecessary outright, or by simply continuing to pursue additional volume growth beyond population and demographic driven changes.

Despite these complexities, the HSCRC must still establish aggregate charges that are reasonably related to aggregate costs, which in turn should be reasonable themselves, while also properly incentivizing hospitals to reduce unnecessary utilization and total cost of care. For these reasons, staff cannot evaluate hospital cost-per-case or total cost of care analyses independently, and any combination of tools will not precisely identify hospitals' efficiency ranking, especially near the mid-range of performance. *Thus, staff continue to recommend arraying hospitals into quartiles and focusing on outliers in the fourth quartile based on a weighting system of:*

- 1. Hospital cost per case efficiency rank, as measured by the ICC, at 50 percent*
- 2. Medicare TCOC performance rank, as measured by the better of a benchmark attainment assessment and the performance captured through the Medicare Performance Adjustment analog method (MPA) at 25 percent, and*
- 3. Commercial TCOC performance rank, as measured by the better of a benchmark attainment assessment and the performance captured through a Commercial MPA analog, at 25 percent.⁹*

⁹ Medicare and Commercial performance comprise an even share of the total cost of care evaluation (25% each) as both represent approximately the same share of hospital payments statewide.

This statewide weighting approach ensures that total cost of care strongly influences the efficiency analysis and ensures that hospitals with more favorable payer mixes, i.e., more commercial purchasers, are not artificially advantaged. Focusing this policy on the worst performers, such that hospitals in the worst quartile have a portion of their Annual Update Factor withheld, ensures that hospitals are not incentivized to reclaim lost volumes at their hospitals in order to improve cost per case efficiency.

Integrated Efficiency - Global Budget Revenue Enhancements

Staff's original efficiency proposals limited the application of the policy to poor performing outlier hospitals. Positive revenue adjustments would be addressed through an additional policy on the evaluation of rate applications once total cost of care benchmarks are developed. However, concerns regarding GBR enhancement requests prompted staff to also outline a methodology for evaluating excellent performing hospitals and describe a process by which additional revenue may be requested outside of a full rate application.

Specifically, staff proposed and continues to recommend that all GBR revenue enhancements outside of a full rate application be limited to hospitals that are among the best performers in cost-per-case, as measured by a Volume Adjusted ICC, and Medicare and Commercial total cost of care. This evaluation mirrors the analysis performed for determining poor performing outliers. For hospitals to receive a GBR enhancement outside of a full rate review, they must be in the best quartile of performance as evaluated in the Efficiency Matrix and must be better than one standard deviation from average Volume Adjusted ICC performance, which indicates potential insolvency. Further, a hospital that qualifies for a GBR enhancement must submit a formal request to the HSCRC that outlines either: a) how a previous methodology disadvantaged the hospital; or b) a spending proposal that aligns with the aims of the Total Cost of Care Model. Total revenue enhancements will be capped by the funding made available by the set-aside in the Annual Update Factor approved by the Commission each year and the funding derived from withholding inflation from hospitals in the worst quartile.

This process and proposed budget cap do not restrict hospitals from submitting a formal rate application request.

Capital Financing Policy – Partial Rate Applications

To avoid a large growth in capital costs and to ensure that hospitals utilize retained revenues related to avoided utilization to finance smaller projects, the Commission adopted a policy that restricted rate enhancements to projects whose value exceeded a material percentage of a hospital’s permanent revenue base. Specifically, the policy maintains a threshold for a project to receive capital funding at 25 percent of the hospital permanent revenue for a hospital near or above the average hospital size (about \$300 million). The policy also increases the capital threshold by 0.10 percent for every million dollars that the hospital is below \$300 million. This equates to scaling from a threshold of 25 percent for a hospital with permanent revenue of \$300 million to a threshold of 50 percent for a hospital with permanent revenue of \$50 million. For example, a hospital with permanent revenue of \$200 million would have a capital threshold of 35 percent or \$70 million dollars. The table below shows the capital threshold and the threshold amounts in increments of \$50 million.

Exhibit 5: Capital Thresholds for Potential Rate Support

Permanent Revenue	Threshold for Capital Funding	Threshold Amount
> \$300,000,000	25.0%	\$75,000,000
\$250,000,000	30.0%	\$75,000,000
\$200,000,000	35.0%	\$70,000,000
\$150,000,000	40.0%	\$60,000,000
\$100,000,000	45.0%	\$45,000,000
< \$50,000,000	50.0%	\$25,000,000

Once a hospital meets the capital threshold criteria, staff recommend continuing to use the Commission’s capital financing model, which will consider: a) a hospital’s relative capital efficiency – the portion of total costs the hospital spends on capital; b) a hospital’s cost per case efficiency and TCOC effectiveness, as measured through the Integrated Efficiency policy; and c) a hospital’s level of potentially avoidable utilization and excess capacity.

Revenue For Reform – Approval Process for Hospital Safe Harbors

Staff recommend that the Revenue for Reform policy be implemented as follows:

In August of 2023, staff will release an application template for hospitals to complete. This will include a list of the hospital's interventions, which safe harbor they are applying for, and the amount of losses that they expect to incur over the following fiscal year on that intervention. By October 2023, staff will review the submissions and determine which interventions meet the requirements of the Revenue for Reform policy, described here. Interventions that meet the criteria will then be submitted to the Secretary of Health. If the Secretary or her designee deems the interventions to be a population health programs, then the cost of the approved interventions will be used to reduce any Integrated Efficiency Adjustment based on each ICC run. This will determine which hospitals are subject to the Integrated Efficiency reduction in Rate Year 2024.

In the fall of 2024, hospitals will be required to submit a cost accounting describing the costs actually incurred on their approved population health interventions. Staff anticipate start-up delays in any new community health investment, but to ensure that safe harbors are not provided erroneously, staff will penalize hospitals that take advantage of Revenue for Reform and do not spend at least 80 percent of the stated community investment, inclusive of a 25 percent indirect cost rate (35 percent for the regional partnership). Failure to reach 80 percent of the community investment will result in

- Removal of 100 percent of the variance between the actual spend and the 80 percent threshold on a permanent go forward basis.
- 105 percent of the variance between the actual spend and the 80 percent threshold on a one-time basis

In subsequent years, staff will assume safe harbors will grow by the inflation provided in the Annual Update Factor and will up the threshold for compliance to 95 percent.

5. Efficiency Assessment

In this section, staff provides the results of the Full Rate Application and Integrated Efficiency policies using RY 2023 revenue, RY 2022 volumes for the ICC, as well as results for 2021

Medicare and Commercial Total Cost of Care performance. Staff will not provide modelling on the Capital Rate Application policy, as that requires knowledge of a proposed capital project.

For the Full Rate Application policy, staff will present models that reflect the existing methodology for scaling TCOC performance and the proposed methodology that limits rewards to hospitals that have demonstrated excellent performance in attainment and improvement. Additionally, staff will reflect both models with and without a productivity adjustments in the ICC.

For Integrated Efficiency, staff will present models that array hospitals into quartiles using a weighting system of 50% ICC, 25% Medicare TCOC, and 25% Commercial TCOC. Staff will present the Integrated Efficiency models under: a) the existing methodology that does not consider TCOC improvement; b) a proposed methodology that uses the MPA Method to blend TCOC attainment and improvement for Medicare and Commercial; and c) a model that utilizes the better of attainment and MPA attainment/improvement. ***Based on this analysis and the Commission vote on the underlying methodology, staff will ultimately recommend that the hospitals in the worst quartile of performance have a portion of their Medicare and Commercial RY 2024 Update Factor withheld, effective July 1, 2023. Similar to the consideration for Full Rate Applications, staff recommends that these adjustments be one-time in nature and be made permanent if similar results occur when staff runs the efficiency models for RY 2025.***

5a. Full Rate Application Results

As noted above, staff will first provide modelling results with and without the proposed modification to TCOC scaling in the FRA. See below:

Exhibit 6: Full Rate Application Results Under Current and Proposed TCOC Scaling Methods, inclusive of 1.53 Percent Productivity Adjustment (\$ Millions)

HOSP id	Hospital Name	RY 2023 Permanent Revenue (inclusive of CY 2022 MS & RY23 DA Reversal)	GBR \$ Change Based on Hospital Approved Revenue Before TCOC Analyses	Current Methodology			Proposed Methodology		
				TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)	TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)
210001	Meritus Medical Center	\$420.9	\$41.5	-\$3.4	\$38.0	9.0%	-\$3.4	\$38.0	9.0%
210002	University of Maryland Medical Center	\$1,776.6	-\$111.1	-\$4.1	-\$115.2	-6.5%	-\$4.1	-\$115.2	-6.5%
210003	Prince Georges Hospital Center	\$369.6	-\$86.2	-\$0.6	-\$86.8	-23.5%	-\$0.6	-\$86.8	-23.5%
210004	Holy Cross Hospital	\$558.0	\$16.2	\$6.6	\$22.7	4.1%	\$0.0	\$16.2	2.9%
210005	Frederick Memorial Hospital	\$397.8	-\$42.7	\$0.0	-\$42.7	-10.7%	\$0.0	-\$42.7	-10.7%
210006	Harford Memorial Hospital	\$115.0	-\$12.7	\$0.0	-\$12.7	-11.0%	\$0.0	-\$12.7	-11.0%
210008	Mercy Medical Center	\$633.8	-\$71.0	-\$6.0	-\$76.9	-12.1%	-\$6.0	-\$76.9	-12.1%
210009	Johns Hopkins Hospital	\$2,809.8	-\$204.1	-\$4.6	-\$208.7	-7.4%	-\$4.6	-\$208.7	-7.4%
210011	St. Agnes Hospital	\$474.2	-\$69.5	-\$1.8	-\$71.4	-15.1%	-\$1.8	-\$71.4	-15.1%
210012	Sinai Hospital	\$915.4	-\$199.4	-\$9.8	-\$209.2	-22.9%	-\$9.8	-\$209.2	-22.9%
210015	MedStar Franklin Square Hospital Center	\$626.7	\$3.1	\$0.0	\$3.1	0.5%	\$0.0	\$3.1	0.5%
210016	Washington Adventist Hospital	\$339.0	-\$39.1	-\$4.6	-\$43.7	-12.9%	-\$4.6	-\$43.7	-12.9%
210017	Garrett County Memorial Hospital	\$78.0	\$9.3	\$1.2	\$10.5	13.4%	\$1.0	\$10.3	13.3%
210018	MedStar Montgomery Medical Center	\$202.1	-\$24.6	\$11.3	-\$13.3	-6.6%	\$3.4	-\$21.2	-10.5%
210019	Peninsula Regional Medical Center	\$524.1	\$27.2	\$0.0	\$27.2	5.2%	\$0.0	\$27.2	5.2%
210022	Suburban Hospital	\$392.8	-\$51.3	\$49.2	-\$2.1	-0.5%	\$0.0	-\$51.3	-13.1%
210023	Anne Arundel Medical Center	\$725.9	-\$49.8	\$22.6	-\$27.2	-3.8%	\$6.1	-\$43.8	-6.0%
210024	MedStar Union Memorial Hospital	\$474.6	-\$40.5	-\$5.8	-\$46.3	-9.7%	-\$5.8	-\$46.3	-9.7%
210027	Western Maryland Regional Medical Center	\$363.8	-\$17.8	-\$0.5	-\$18.3	-5.0%	-\$0.5	-\$18.3	-5.0%
210028	MedStar St. Mary's Hospital	\$214.1	\$6.4	\$0.0	\$6.4	3.0%	\$0.0	\$6.4	3.0%
210029	Johns Hopkins Bayview Medical Center	\$761.8	-\$109.0	-\$5.6	-\$114.5	-15.0%	-\$5.6	-\$114.5	-15.0%
210030	University of Maryland Shore Medical Center at Chestertown	\$55.5	-\$19.2	\$0.0	-\$19.2	-34.6%	\$0.0	-\$19.2	-34.5%
210032	Union Hospital of Cecil County	\$192.4	-\$26.0	-\$2.9	-\$28.9	-15.0%	-\$2.9	-\$28.9	-15.0%
210033	Carroll Hospital Center	\$267.5	-\$37.5	\$0.0	-\$37.5	-14.0%	\$0.0	-\$37.5	-14.0%
210034	MedStar Harbor Hospital Center	\$203.7	\$0.0	-\$1.2	-\$1.2	-0.6%	-\$1.2	-\$1.2	-0.6%
210035	University of Maryland Charles Regional Medical Center	\$175.2	\$0.9	\$0.0	\$0.9	0.5%	\$0.0	\$0.9	0.5%
210037	University of Maryland Shore Medical Center at Easton	\$269.4	-\$54.7	-\$0.6	-\$55.3	-20.5%	-\$0.6	-\$55.3	-20.5%
210038	University of Maryland Medical Center Midtown Campus	\$257.7	-\$48.2	-\$2.9	-\$51.1	-19.8%	-\$2.9	-\$51.1	-19.8%
210039	Calvert Memorial Hospital	\$173.5	-\$19.5	\$6.9	-\$12.6	-7.3%	\$6.6	-\$12.9	-7.4%
210040	Northwest Hospital Center	\$294.5	-\$43.9	-\$3.3	-\$47.3	-16.1%	-\$3.3	-\$47.3	-16.1%
210043	University of Maryland Baltimore Washington Medical Center	\$492.4	-\$30.2	-\$4.0	-\$34.2	-6.9%	-\$4.0	-\$34.2	-6.9%
210044	Greater Baltimore Medical Center	\$472.5	-\$44.6	\$0.0	-\$44.6	-9.4%	\$0.0	-\$44.6	-9.4%
210048	Howard County General Hospital	\$343.4	-\$2.8	\$11.1	\$8.2	2.4%	\$4.7	\$1.8	0.5%
210049	Upper Chesapeake Medical Center	\$357.3	-\$21.3	-\$2.2	-\$23.5	-6.6%	-\$2.2	-\$23.5	-6.6%
210051	Doctors Community Hospital	\$282.6	-\$21.9	\$14.0	-\$8.0	-2.8%	\$1.0	-\$21.0	-7.4%
210056	MedStar Good Samaritan Hospital	\$299.8	-\$20.9	-\$3.7	-\$24.6	-8.2%	-\$3.7	-\$24.6	-8.2%
210057	Shady Grove Adventist Hospital	\$500.0	-\$64.1	\$21.8	-\$42.3	-8.5%	\$0.0	-\$64.1	-12.8%
210058	University of Maryland Rehabilitation & Orthopaedic Institute	\$134.6	-\$32.3	-\$9.8	-\$42.1	-31.3%	\$1.0	-\$31.2	-23.2%
210060	Fort Washington Medical Center	\$64.8	-\$9.4	-\$3.7	-\$13.2	-20.3%	-\$3.7	-\$13.2	-20.3%
210061	Atlantic General Hospital	\$123.3	\$1.7	\$0.0	\$1.7	1.4%	\$0.0	\$1.7	1.4%
210062	MedStar Southern Maryland Hospital Center	\$307.0	-\$39.1	\$11.8	-\$27.3	-8.9%	\$0.1	-\$39.0	-12.7%
210063	University of Maryland St. Joseph Medical Center	\$445.9	-\$26.3	\$0.0	-\$26.3	-5.9%	\$0.0	-\$26.3	-5.9%
210065	Holy Cross Germantown	\$137.5	\$6.1	\$1.4	\$7.5	5.5%	\$0.0	\$6.1	4.4%
	Total	\$19,024.4	-\$1,578.4	\$76.7	-\$1,501.7	-7.9%	-\$47.4	-\$1,625.7	-8.5%
	Total for Rate Enhancements Only	\$3,201.1	\$109.5	\$16.8	\$126.3	3.9%	\$2.3	\$111.7	3.5%

The difference between the two methods for TCOC scaling are slight, as the overall rate enhancements for hospitals that would be eligible for funding decreases from \$126.3 million under the current methodology to \$111.7 million under the proposed methodology. The lion's share of the variance is driven by Holy Cross and Howard County General hospitals, which are both less expensive than national peers in TCOC but have not fared as well on TCOC growth

since the start of the TCOC Model. Holy Cross Hospital has grown 16.07 percent since 2018 vs. a statewide average of 14.19 percent for Medicare TCOC and 25.69 percent vs 16.74 percent for Commercial, which effectively eliminates all positive TCOC rewards. Howard County General Hospital still earned positive TCOC scaling under the proposed methodology change because it is both cheaper than national benchmark geographies and it has grown less than the statewide average. In both cases, however, the delta (12.41 percent vs a statewide average of 14.19 percent for Medicare & 15.39 vs 16.74 percent for Commercial) was less significant than the current attainment-only methodology for positive TCOC scaling.

Staff have similarly modelled the current and proposed methodology without a productivity adjustment to the ICC, as the currently policy does not include one. However, given suppressed margins impedes the ICC's ability to determine demonstrable operational efficiency, particularly if the margin erosion is transient, staff strongly urges Commissioners to consider reinstating the productivity adjustment.

Exhibit 7: Full Rate Application Results Under Current and Proposed TCOC Scaling Methods, not inclusive of Productivity Adjustment (\$ Millions)

HOSP id	Hospital Name	RY 2023 Permanent Revenue (inclusive of CY 2022 MS & RY23 DA Reversal)	GBR \$ Change Based on Hospital Approved Revenue Before TCOC Analyses	Current Methodology			Proposed Methodology		
				TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)	TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)
210001	Meritus Medical Center	\$420.9	\$46.7	-\$3.4	\$43.2	10.3%	-\$3.4	\$43.2	10.3%
210002	University of Maryland Medical Center	\$1,776.6	-\$99.6	-\$4.1	-\$103.7	-5.8%	-\$4.1	-\$103.7	-5.8%
210003	Prince Georges Hospital Center	\$369.6	-\$83.2	-\$0.6	-\$83.7	-22.7%	-\$0.6	-\$83.7	-22.7%
210004	Holy Cross Hospital	\$558.0	\$22.6	\$6.6	\$29.1	5.2%	\$0.0	\$22.6	4.0%
210005	Frederick Memorial Hospital	\$397.8	-\$38.3	\$0.0	-\$38.3	-9.6%	\$0.0	-\$38.3	-9.6%
210006	Harford Memorial Hospital	\$115.0	-\$11.6	\$0.0	-\$11.6	-10.0%	\$0.0	-\$11.6	-10.0%
210008	Mercy Medical Center	\$633.8	-\$64.4	-\$6.0	-\$70.3	-11.1%	-\$6.0	-\$70.3	-11.1%
210009	Johns Hopkins Hospital	\$2,809.8	-\$181.8	-\$4.6	-\$186.3	-6.6%	-\$4.6	-\$186.3	-6.6%
210011	St. Agnes Hospital	\$474.2	-\$65.2	-\$1.8	-\$67.0	-14.1%	-\$1.8	-\$67.0	-14.1%
210012	Sinai Hospital	\$915.4	-\$192.3	-\$9.8	-\$202.2	-22.1%	-\$9.8	-\$202.2	-22.1%
210015	MedStar Franklin Square Hospital Center	\$626.7	\$9.7	\$0.0	\$9.7	1.5%	\$0.0	\$9.7	1.5%
210016	Washington Adventist Hospital	\$339.0	-\$35.5	-\$4.6	-\$40.1	-11.8%	-\$4.6	-\$40.1	-11.8%
210017	Garrett County Memorial Hospital	\$78.0	\$10.3	\$1.2	\$11.5	14.7%	\$1.0	\$11.4	14.6%
210018	MedStar Montgomery Medical Center	\$202.1	-\$22.4	\$11.3	-\$11.1	-5.5%	\$3.4	-\$19.0	-9.4%
210019	Peninsula Regional Medical Center	\$524.1	\$33.6	\$0.0	\$33.6	6.4%	\$0.0	\$33.6	6.4%
210022	Suburban Hospital	\$392.8	-\$46.8	\$49.2	\$2.4	0.6%	\$0.0	-\$46.8	-11.9%
210023	Anne Arundel Medical Center	\$725.9	-\$41.4	\$22.6	-\$18.8	-2.6%	\$6.1	-\$35.3	-4.9%
210024	MedStar Union Memorial Hospital	\$474.6	-\$35.6	-\$5.8	-\$41.4	-8.7%	-\$5.8	-\$41.4	-8.7%
210027	Western Maryland Regional Medical Center	\$363.8	-\$13.7	-\$0.5	-\$14.2	-3.9%	-\$0.5	-\$14.2	-3.9%
210028	MedStar St. Mary's Hospital	\$214.1	\$9.0	\$0.0	\$9.0	4.2%	\$0.0	\$9.0	4.2%
210029	Johns Hopkins Bayview Medical Center	\$761.8	-\$102.6	-\$5.6	-\$108.2	-14.2%	-\$5.6	-\$108.2	-14.2%
210030	University of Maryland Shore Medical Center at Chestertown	\$55.5	-\$18.8	\$0.0	-\$18.8	-33.9%	\$0.0	-\$18.8	-33.8%
210032	Union Hospital of Cecil County	\$192.4	-\$24.1	-\$2.9	-\$27.0	-14.0%	-\$2.9	-\$27.0	-14.0%
210033	Carroll Hospital Center	\$267.5	-\$34.6	\$0.0	-\$34.6	-12.9%	\$0.0	-\$34.6	-12.9%
210034	MedStar Harbor Hospital Center	\$203.7	\$2.1	-\$1.2	\$0.9	0.4%	-\$1.2	\$0.9	0.4%
210035	University of Maryland Charles Regional Medical Center	\$175.2	\$3.0	\$0.0	\$3.0	1.7%	\$0.0	\$3.0	1.7%
210037	University of Maryland Shore Medical Center at Easton	\$269.4	-\$52.1	-\$0.6	-\$52.7	-19.6%	-\$0.6	-\$52.7	-19.6%
210038	University of Maryland Medical Center Midtown Campus	\$257.7	-\$46.3	-\$2.9	-\$49.2	-19.1%	-\$2.9	-\$49.2	-19.1%
210039	Calvert Memorial Hospital	\$173.5	-\$17.6	\$6.9	-\$10.7	-6.2%	\$6.6	-\$11.0	-6.3%
210040	Northwest Hospital Center	\$294.5	-\$41.1	-\$3.3	-\$44.4	-15.1%	-\$3.3	-\$44.4	-15.1%
210043	University of Maryland Baltimore Washington Medical Center	\$492.4	-\$24.6	-\$4.0	-\$28.6	-5.8%	-\$4.0	-\$28.6	-5.8%
210044	Greater Baltimore Medical Center	\$472.5	-\$39.1	\$0.0	-\$39.1	-8.3%	\$0.0	-\$39.1	-8.3%
210048	Howard County General Hospital	\$343.4	\$1.5	\$11.1	\$12.6	3.7%	\$4.7	\$6.2	1.8%
210049	Upper Chesapeake Medical Center	\$357.3	-\$17.0	-\$2.2	-\$19.2	-5.4%	-\$2.2	-\$19.2	-5.4%
210051	Doctors Community Hospital	\$282.6	-\$19.0	\$14.0	-\$5.1	-1.8%	\$1.0	-\$18.1	-6.4%
210056	MedStar Good Samaritan Hospital	\$299.8	-\$17.8	-\$3.7	-\$21.5	-7.2%	-\$3.7	-\$21.5	-7.2%
210057	Shady Grove Adventist Hospital	\$500.0	-\$58.7	\$21.8	-\$36.9	-7.4%	\$0.0	-\$58.7	-11.7%
210058	University of Maryland Rehabilitation & Orthopaedic Institute	\$134.6	-\$31.3	-\$9.8	-\$41.1	-30.6%	\$1.0	-\$30.3	-22.5%
210060	Fort Washington Medical Center	\$64.8	-\$8.7	-\$3.7	-\$12.5	-19.3%	-\$3.7	-\$12.5	-19.3%
210061	Atlantic General Hospital	\$123.3	\$3.3	\$0.0	\$3.3	2.7%	\$0.0	\$3.3	2.7%
210062	MedStar Southern Maryland Hospital Center	\$307.0	-\$35.9	\$11.8	-\$24.1	-7.9%	\$0.1	-\$35.8	-11.7%
210063	University of Maryland St. Joseph Medical Center	\$445.9	-\$20.8	\$0.0	-\$20.8	-4.7%	\$0.0	-\$20.8	-4.7%
210065	Holy Cross Germantown	\$137.5	\$7.9	\$1.4	\$9.3	6.8%	\$0.0	\$7.9	5.7%
Total		\$19,024.4	-\$1,392.3	\$76.7	-\$1,315.6	-6.9%	-\$47.4	-\$1,439.7	-7.6%
Total for Rate Enhancements Only		\$3,797.5	\$102.9	\$64.8	\$167.7	4.4%	\$1.1	\$150.8	4.0%

As expected, the same hospitals that were eligible for a rate enhancement under the modelling with a productivity adjustment qualify for a rate enhancement when there is not a productivity adjustment but to a larger degree. The rate enhancements for these ten hospitals increases from \$111.7 million (with a productivity adjustment and the newly proposed TCOC scaling approach) to \$150.8 million. Additionally, two hospitals that were not eligible with a productivity

adjustment qualify when it is suspended, Medstar Harbor and Suburban, albeit the latter still does not qualify under the new TCOC scaling approach.

5b. Integrated Efficiency Results

For Integrated Efficiency, staff will provide results that incorporate three TCOC modelling approaches with the ICC at 50% of the evaluation: 1) TCOC under the current TCOC benchmarking approach; 2) TCOC under the MPA analog methods; and 3) TCOC assessed by the better of option 1 and 2.¹⁰ Staff will not provide modelling with and without a productivity adjustment in the ICC, as Integrated Efficiency is a relative ranking policy and thus a straight percentage reduction to ICC Approved Revenue across all hospitals will have no impact on rankings.

Exhibit 8: Integrated Efficiency Modelling Under 3 TCOC Evaluations

Hospital	Hospital Name	Model 1: Current Methodology		Model 2: Methodology + MPA + Commercial Option 1 (MPA Analog)		Model 3: Better of Model 1 & 2 TCOC (Better of Benchmarks and MPA Approach)	
		Reduction \$	Reduction %	Reduction \$	Reduction %	Reduction \$	Reduction %
210048	Howard County General Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210065	Holy Cross Germantown	\$0	0.0%	\$0	0.0%	\$0	0.0%
210004	Holy Cross Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210062	MedStar Southern Maryland Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210051	Doctors Community Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210043	University of Maryland Baltimore Washington Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210017	Garrett County Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210035	University of Maryland Charles Regional Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210028	MedStar St. Mary's Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210019	Peninsula Regional Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210001	Meritus Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210015	MedStar Franklin Square Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210049	Upper Chesapeake Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210023	Anne Arundel Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210034	MedStar Harbor Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210027	Western Maryland Regional Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210039	Calvert Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210061	Atlantic General Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210009	Johns Hopkins Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210011	St. Agnes Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210056	MedStar Good Samaritan Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210006	Harford Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210044	Greater Baltimore Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210018	MedStar Montgomery Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210002	University of Maryland Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210033	Carroll Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210063	University of Maryland St. Joseph Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210005	Frederick Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210060	Fort Washington Medical Center	\$0	0.0%	\$505,716	0.8%	\$0	0.0%
210022	Suburban Hospital	\$0	0.0%	\$4,378,518	1.1%	\$0	0.0%
210016	Washington Adventist Hospital	\$0	0.0%	\$5,101,506	1.5%	\$2,180,607	0.6%
210057	Shady Grove Adventist Hospital	\$0	0.0%	\$5,295,541	1.1%	\$0	0.0%
210024	MedStar Union Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210003	Prince Georges Hospital Center	\$0	0.0%	\$0	0.0%	\$2,377,394	0.6%
210030	University of Maryland Shore Medical Center at Chestertown	\$644,793	1.2%	\$402,182	0.7%	\$669,458	1.2%
210058	University of Maryland Rehabilitation & Orthopaedic Institute	\$1,505,424	1.1%	\$2,400,257	1.8%	\$2,272,374	1.7%
210032	Union Hospital of Cecil County	\$2,649,272	1.4%	\$0	0.0%	\$850,970	0.4%
210008	Mercy Medical Center	\$2,999,744	0.5%	\$0	0.0%	\$2,548,218	0.4%
210038	University of Maryland Medical Center Midtown Campus	\$3,104,801	1.2%	\$3,016,596	1.2%	\$3,522,894	1.4%
210037	University of Maryland Shore Medical Center at Easton	\$3,129,138	1.2%	\$0	0.0%	\$1,841,004	0.7%
210040	Northwest Hospital Center	\$4,434,958	1.5%	\$2,133,964	0.7%	\$3,552,121	1.2%
210029	Johns Hopkins Bayview Medical Center	\$8,521,562	1.1%	\$2,122,942	0.3%	\$6,737,729	0.9%
210012	Sinai Hospital	\$22,449,385	2.5%	\$22,449,385	2.5%	\$22,449,385	2.5%
	Subtotal	\$49,439,076		\$47,806,606		\$49,002,155	

¹⁰ For results inclusive of each efficiency evaluation score, please see Appendices A through C.

While the results are fairly similar across the 3 models for various hospitals, there are some notable changes in the inflation values that will be potentially withheld. For example, Union of Cecil Hospital will incur a 1.4 percent reduction (\$2.6 million) under the current methodology that incorporates TCOC benchmarks as the only TCOC evaluation. This is driven by Cecil's Commercial TCOC attainment performance, which is the 5th worst in the State. However, under the MPA Analog Methods, Cecil does not incur a reduction because it is growing significantly slower than the Statewide average in commercial TCOC (5.2 percent from 2018-2021 versus 16.74 percent statewide; the second best in the State), and under the better of attainment and improvement, Cecil effectively reduces its inflation by two thirds. This type of improvement is exactly why staff are proposing to amend the TCOC evaluation to account for improvement over time, thus further incentivizing hospitals to reduce TCOC.

Similarly, Tidal Health Peninsula Regional Medical Center has higher Medicare TCOC relative to national benchmark peers and slightly higher than state peers (12.53 percent higher than the Medicare benchmark versus the statewide average of 9.9 percent); however, its performance in Medicare improvement since 2018 is the third best in the State, thus supporting its case to acquire increased rate enhancements through the Commission's efficiency policies.

6. Recommendations

- 1) Provide TCOC Adjustments in the Full Rate Application policy based on a hospital's positive performance in attainment AND improvement.
 - a. Positive rewards for Medicare TCOC will be provided to hospitals that perform better than the Medicare Benchmark and grow slower than the average State Medicare TCOC.
 - b. Positive rewards for Commercial TCOC will be provided to hospitals that perform better than the Medicare benchmark, better than the average of top half of commercial TCOC benchmarks and are growing slower than the average State Commercial TCOC.
 - c. All other existing TCOC aspects of the Full Rate Application analysis will remain the same, including capping all rewards so that a hospital does not exceed its Medicare Benchmark

- 2) Utilize a revised TCOC assessment for the Integrated Efficiency policy that considers both attainment and improvement performance.
 - a. Medicare TCOC performance will be based on the better of a benchmark attainment assessment and improvement performance captured through a metric analogous to the Medicare Performance Adjustment method (MPA)
 - b. Commercial TCOC performance will be based on the better of a benchmark attainment assessment and improvement performance captured through a Commercial TCOC assessment analogous to the Medicare MPA approach.

- 3) Amend a hospital's penalty under the Integrated Efficiency Policy to reflect the amount of eligible qualifying population health investments it makes. Qualifying population health investments should not be subject to inflationary reductions, as outlined in the Integrated Efficiency policy.
 - a. Qualifying population health investments should meet all of the following (the specifics of these conditions are explained in much greater detail below and this additional detail would be used to govern admitted investments):
 - i. Non-physician community spending in the hospital's primary service area incurred outside of the regulated space and cost accounting, net of revenue generated for those services,
 - ii. Spending that meets one of three following criteria:
 1. An initiative that is intended to address an unmet health need identified on either the hospital's Community Health Needs Assessment or the Centers for Disease Control and Prevention's Health People 2030 Initiative; or
 2. Spending on primary care (as defined by the Maryland Primary Care Program), mental health, or dental providers that are located in a Medically Underserved Area; (note this is an exception to item non-physician condition in i above) or
 3. Spending on a regional entity to improve population health.

- 4) Reinststate a productivity adjustment in the Inter-hospital Comparison (ICC) equivalent to the variance between the historical operational efficiency standard of 8 percent and the statewide regulated margin for ICC evaluated hospitals. The productivity adjustment is intended to evaluate operational efficiency in Full Rate Applications.

- 5) For RY 2024 only, all efficiency adjustments will be processed as one-time adjustments, i.e., the adjustments will be reversed out in RY 2025 and will be replaced with permanent adjustments based off of RY 2023 volumes and CY 2022 TCOC performance. This adjustment is recommended because there are continued challenges with the underlying data needed to make the RY 2024 evaluation
 - a. Hospitals eligible for a rate enhancement through the full rate application policy in RY 2024 can access funding through a streamlined process if the hospital agrees to: the value established by the methodology, all adjustments are one-time in nature, and the hospital will not file any subsequent rate request during RY 2024.

Appendix A. Detailed Description of Inter-Hospital Cost Comparison Methodology

Part A: Calculation of Standard Cost Per Case for Comparison Group			
Step	Efficiency Policy		Description
Step 1 Remove Items not related to the permanent Cost basis			
1a	FRA, IE, Cap	Permanent Revenue	Remove from actual revenue the impact of current one-time adjustments that are not associated with volumes in rates.
1b	FRA, IE, Cap	Markup	Remove approved markup for payer differential, uncompensated care, and other similar factors.
Step 2 Convert from Price to Cost by stripping Margins			
2a	FRA, IE, Cap	Profit	Remove hospital-specific current regulated profit in order to bring revenue to approximation of costs.
Step 3 Remove “Public Good” items for which hospitals are credited (medical education, higher wage market, more challenging socioeconomic environment)			
3a	FRA, IE, Cap	Direct Medical Education	Remove the direct expenses associated with medical education – capping the number of residents to the levels in 2011 and the costs to the statewide average cost per resident.
3b	FRA, IE, Cap	Indirect Medical Education	Adjust hospital costs for the estimated marginal impact on costs of operating a teaching program. This adjustment is separately calculated for major academic hospitals and other teaching hospitals and inflated to current year.
3c	FRA, IE, Cap	Labor Market	Adjust the portion of hospital costs associated with differences in the labor market in which the hospital operates. Use hospital wage and salary data for two groups – Montgomery and Prince George’s Counties, where wages are higher than Maryland’s average, and a second grouping of all other hospitals.
3d	FRA, IE, Cap	Make direct adjustment for impact of poverty on cost.	Directly estimate through a multi-year regression the effect on hospital costs of treating a higher share of poor patients – one of the major reasons for the peer groups.
Step 4: Convert to Standard Cost Per Case			
4a	FRA, IE, Cap	Volume	Divide by volume, which is measured by ECMADs – a statistic that incorporates the difference in the types of cases (discharges/visits) a hospital treats (case-mix adjusted) and incorporates both inpatient and outpatient activity (equivalent).

Part A: Calculation of Standard Cost Per Case for Comparison Group			
Step	Efficiency Policy		Description
4b	FRA, IE, Cap	Standard Cost Per Case	This is calculated at the individual hospital level but aggregated to create Standard Cost per Case for a comparison group. The group would either be the peer group or the statewide standard depending on the decision on the Policy Choice above. Currently there are only two peer groups, academic and non-academic

Part B: Calculation of Hospital Approved Revenue			
Step	Efficiency Policy		Description
Step 1: Establish hospital cost base at the standard cost per case			
1a	FRA, IE, Cap	Standard Cost per Case	Begin with Standard Cost per Case calculated above.
1b	FRA	Productivity Adjustment	Historically, the ICC removed a 2% uniform productivity adjustment from a hospital's Approved Revenue. This was discontinued when the Full Rate Application policy was approved by the Commission in January of 2021. Staff are proposing reinstating the Productivity Adjustment, but the value would be determined by subtracting the statewide average regulated margin from 8%, which is the historical minimum operational efficiency standard to access additional funding through a full rate application. – See pg. 10
1c	FRA	Volume	Multiply by hospital specific volume measured in ECMADs.
1d	IE, Cap	Volume (adjusted)	Multiply by hospital specific volume. In the Integrated Efficiency and Capital Financing policies, adjust hospital volume to reflect steps hospital has taken (or not) to remove potentially avoidable utilization (PAU). This step protects hospitals that have eliminated PAU (and have higher cost per case as a result) and penalizes hospitals that have added PAU (and have lower cost per case as a result). No such adjustment is made in the FRA policy because the point of that policy is to reset a hospital's rate structure to in line with its current services.
Step 2: Convert to hospital specific cost value by adding back "Public Goods"			

Part B: Calculation of Hospital Approved Revenue			
Step	Efficiency Policy		Description
2a	FRA, IE, Cap	Indirect Medical Education	Add back in hospital specific indirect medical education/ Separately calculated for major academic hospitals and other teaching hospitals and inflated to current year.
2b	FRA, IE, Cap	Labor Market	Readjust standard labor costs to the hospital-specific labor market described above.
2c	FRA, IE, Cap	Direct Medical Education	Add back the hospital specific direct expenses associated with medical education – capping the number of residents in most cases to the levels in 2011 and the costs to the statewide average cost per resident.
2d	FRA, IE, CAP	DSH	Make direct adjustment for impact of poverty on cost.
Step 3: Convert from Cost to Charges			
3a	FRA, IE, Cap	Markup	Add back hospital-specific approved markup for payer differential, uncompensated care, and other similar factors.
3b	FRA, IE, Cap	Hospital Approved Revenue	

Part C: Calculation of Hospital Relative Efficiency			
Step	Efficiency Policy		Description
Step 1: Compare Actual to Standard			
1a	FRA, IE, Cap	Actual hospital permanent revenue v. Hospital Approved Revenue from 3b in Part B	Compare actual Permanent Revenue to Hospital Approved Revenue and express as percentage above or below the standard.
Step 2: Manipulate as appropriate for applicable policy			
2a	FRA	ICC and non-ICC revenues	Various revenues not evaluated in the ICC, e.g., oncology drugs, are passed through without efficiency evaluation and added to the Hospital Approved Revenue calculated under Step 1. This revenue is then scaled using the TCOC results cited below.
2b	IE, CAP	Rank	Rank order hospitals from most to least efficient. These results will be combined with the TCOC results below to produce a composite score.

Appendix B. Detailed Description of TCOC Benchmarking Assessment Methodology

Establish Benchmarks for Medicare and Commercial Populations			
	Step		Description
Medicare	1	Claims data	Medicare TCOC claims data for Maryland is collected by county. Data is for Medicare Part A and Part B only.
	2	Data on area characteristics	Potential benchmark Medicare counties are identified for comparison based on population density, size, and other demographic factors.
	3	Identify cohorts	20 county cohorts identified for 5 largest Maryland counties using a statistical technique that finds 20 US counties that have values closest to each of the 5 largest counties and 50 county cohorts identified for remaining Maryland counties. ¹¹
	4	Calculate County Benchmark	Simple average of benchmark cohort values for Medicare TCOC per capita.
Commercial	1	Claims data	National commercial claims data is not available at the county level, but at the Metropolitan Statistical Area (MSA) level. Maryland commercial claims data is available at the county level. For comparison purposes, Maryland data is aggregated to MSA level, but excludes non-Maryland residents from the MSA.
	2	Data on area characteristics	Potential benchmark commercial MSAs are identified for comparison based on population density, size, and other demographic factors.
	3	Identify cohorts	20 MSA cohorts are identified for each Maryland MSA using a statistical technique that finds 20 US MSAs that have values closest to each of the Maryland MSAs. ²
	4	Calculate benchmark	Simple average of benchmark values.

Convert Geographic Benchmarks to Hospital Benchmarks			
	Step		Description
Medicare	1	Calculate a hospital specific TCOC	Using Maryland Medicare data by zip code, allocate costs and beneficiaries to each hospital in accordance with its primary service area. ¹² This is similar to the approach the HSCRC has used in calculating the Medicare Performance Adjustment (MPA).

¹¹ The technique is called: “K-nearest neighbor.”

¹² Shared zip codes are split among hospitals based on ECMAD share, and any unassigned zip codes are assigned to a hospital based on travel distance.

Convert Geographic Benchmarks to Hospital Benchmarks			
	Step		Description
	2	Calculate benchmark TCOC for each hospital	Using the corresponding benchmark for each county, calculate each hospital's benchmark weighted by Medicare beneficiaries allocated to its primary service area.
Commercial	1	Calculate a hospital specific TCOC	Using Maryland commercial data by zip code, allocate costs and beneficiaries to each hospital in accordance with its primary service areas. ¹³
	2	Calculate benchmark TCOC for each hospital	Using the corresponding benchmark for each county, calculate each hospital's benchmark allocated to its primary service area.

Adjust the data for differences and compare			
Step	Efficiency Policy		Description
1	FRA, IE, Cap	Medical Education	Remove estimated medical education costs from all data – Medicare and commercial, Maryland and Benchmark.
2	FRA, IE, Cap	Risk adjustment	Separately risk adjust Medicare and commercial data.
3	FRA, IE, Cap	Benefit adjustment (Commercial only)	Account for differences in commercial benefit plans by area. Richer plans result in higher utilization.
4	FRA, IE, Cap	Demographic Adjustment	Calculated separately for Medicare and commercial. Demographic factors adjusted are Median Income and Deep Poverty.
5	FRA, IE, Cap	Compare	Compare hospital to benchmark and express as % above or below
6a	FRA	Scale standardized hospital approved revenue established in the ICC	Currently, the FRA negatively scales Hospital Approved Revenue if the hospital is worse than its benchmark peers and is growing faster than statewide average TCOC growth rate. The policy also positively scales hospitals' standardized hospital approved revenue if it is better than its benchmark peers. Staff propose that the policy maintain symmetry such that TCOC rewards can only be accessed if the hospital's TCOC is better than the benchmark and growing slower than the statewide average TCOC growth rate. - See pg. 8
6b	IE, Cap	Rank	Currently, Integrated Efficiency and the Capital Financing Policy rank order hospitals on Medicare and Commercial benchmark standards. Staff are recommending supplementing the current TCOC benchmark assessment with an improvement analysis consistent with that utilized in the Medicare Performance

¹³ Ibid.

Adjust the data for differences and compare			
Step	Efficiency Policy		Description
			Adjustment (both for Medicare and Commercial). Additionally, staff are recommending that a better of attainment, as measured through the TCOC benchmarks, and improvement, as measured through the MPA method, be utilized to determine relative TCOC effectiveness. These results will be combined with the hospital efficiency results above to produce a the Effectiveness score. – See pg. 11

Appendix C. Efficiency Matrix with Existing TCOC Benchmarks

HOSP id	Hospital Name	2021 Volume Adjusted ICC Result	ICC Rank (50%)	2021 Medicare TCOC Relative to Benchmark	2021 Medicare TCOC Rank (25%)	2021 Commercial TCOC Relative to Benchmark	2021 Commercial TCOC Rank (25%)	Total Rank Points (Low Score is Better)
210048	Howard County General Hospital	1.67%	9	-3.21%	9	-24.78%	1	14
210065	Holy Cross Germantown	1.43%	11	-2.90%	10	-23.14%	4	18
210004	Holy Cross Hospital	3.78%	6	-2.15%	11	-15.91%	15	19
210035	University of Maryland Charles Regional Medical Center	1.46%	10	1.02%	13	-17.83%	12	23
210028	MedStar St. Mary's Hospital	6.18%	4	2.02%	14	-12.80%	25	24
210019	Peninsula Regional Medical Center	7.94%	3	12.53%	21	-13.57%	23	25
210017	Garrett County Memorial Hospital	14.04%	1	-5.07%	6	2.39%	42	25
210051	Doctors Community Hospital	-8.97%	22	-5.72%	4	-24.70%	2	25
210018	MedStar Montgomery Medical Center	-9.51%	24	-8.35%	2	-21.75%	7	29
210043	University of Maryland Baltimore Washington Medical Center	-6.34%	16	11.66%	20	-18.42%	11	32
210062	MedStar Southern Maryland Hospital Center	-9.85%	26	-5.27%	5	-22.01%	6	32
210001	Meritus Medical Center	10.44%	2	15.77%	26	-8.22%	35	33
210022	Suburban Hospital	-11.20%	31	-17.04%	1	-24.08%	3	33
210023	Anne Arundel Medical Center	-9.62%	25	-4.74%	8	-20.66%	9	34
210049	Upper Chesapeake Medical Center	-3.36%	12	18.01%	30	-15.47%	16	35
210057	Shady Grove Adventist Hospital	-11.92%	32	-6.73%	3	-21.53%	8	38
210002	University of Maryland Medical Center	-5.93%	15	23.70%	34	-15.33%	17	41
210015	MedStar Franklin Square Hospital Center	3.63%	7	19.81%	31	-8.16%	36	41
210034	MedStar Harbor Hospital Center	3.84%	5	26.60%	40	-11.21%	31	41
210005	Frederick Memorial Hospital	-10.04%	27	2.27%	15	-17.73%	13	41
210027	Western Maryland Regional Medical Center	-4.34%	13	13.16%	23	-10.54%	34	42
210039	Calvert Memorial Hospital	-16.28%	36	-4.77%	7	-22.35%	5	42
210061	Atlantic General Hospital	2.79%	8	24.67%	37	-10.59%	33	43
210009	Johns Hopkins Hospital	-7.96%	21	21.84%	33	-16.18%	14	45
210006	Harford Memorial Hospital	-6.85%	18	14.37%	25	-11.67%	29	45
210044	Greater Baltimore Medical Center	-6.95%	20	13.55%	24	-11.91%	28	46
210060	Fort Washington Medical Center	-10.20%	28	2.49%	16	-13.91%	20	46
210011	St. Agnes Hospital	-9.19%	23	17.44%	29	-15.04%	19	47
210063	University of Maryland St. Joseph Medical Center	-6.89%	19	15.78%	27	-11.50%	30	48
210024	MedStar Union Memorial Hospital	-6.69%	17	20.99%	32	-10.79%	32	49
210056	MedStar Good Samaritan Hospital	-4.47%	14	28.94%	42	-6.83%	37	54
210003	Prince Georges Hospital Center	-20.45%	40	6.08%	19	-19.02%	10	55
210016	Washington Adventist Hospital	-13.80%	34	2.57%	17	-13.45%	24	55
210033	Carroll Hospital Center	-12.75%	33	12.55%	22	-13.61%	21	55
210008	Mercy Medical Center	-10.42%	29	24.55%	36	-12.06%	26	60
210029	Johns Hopkins Bayview Medical Center	-13.89%	35	25.68%	38	-11.97%	27	68
210058	University of Maryland Rehabilitation & Orthopaedic Institute	-27.66%	42	23.70%	34	-15.33%	17	68
210030	University of Maryland Shore Medical Center at Chestertown	-29.33%	43	-0.05%	12	-5.67%	38	68
210037	University of Maryland Shore Medical Center at Easton	-19.50%	39	5.05%	18	-5.28%	40	68
210038	University of Maryland Medical Center Midtown Campus	-18.03%	38	26.03%	39	-13.58%	22	69
210032	Union Hospital of Cecil County	-17.82%	37	16.65%	28	-5.44%	39	71
210040	Northwest Hospital Center	-10.55%	30	29.31%	43	-2.44%	41	72
210012	Sinai Hospital	-21.61%	41	26.80%	41	3.15%	43	83

Appendix D. Efficiency Matrix with MPA and MPA Analog Method

HOSP id	Hospital Name	2021 Volume Adjusted ICC Result	ICC Rank (50%)	2021 MPA Method	2021 Medicare TCOC Rank (25%)	2021 Commercial MPA Analog Method	2021 Commercial TCOC Rank (25%)	Total Rank Points (Low Score is Better)
210017	Garrett County Memorial Hospital	14.04%	1	9.92%	6	4.65%	1	5
210019	Peninsula Regional Medical Center	7.94%	3	8.17%	3	12.79%	15	12
210028	MedStar St. Mary's Hospital	6.18%	4	12.70%	13	9.87%	8	15
210035	University of Maryland Charles Regional Medical Center	1.46%	10	7.60%	2	13.73%	20	21
210027	Western Maryland Regional Medical Center	-4.34%	13	15.68%	20	5.75%	4	25
210015	MedStar Franklin Square Hospital Center	3.63%	7	13.51%	14	15.04%	27	28
210048	Howard County General Hospital	1.67%	9	12.41%	12	14.89%	25	28
210001	Meritus Medical Center	10.44%	2	17.01%	27	14.91%	26	29
210061	Atlantic General Hospital	2.79%	8	8.63%	4	21.74%	39	30
210043	University of Maryland Baltimore Washington Medical Center	-6.34%	16	16.33%	24	11.01%	10	33
210034	MedStar Harbor Hospital Center	3.84%	5	18.89%	33	14.56%	24	34
210049	Upper Chesapeake Medical Center	-3.36%	12	16.01%	21	14.52%	23	34
210056	MedStar Good Samaritan Hospital	-4.47%	14	19.69%	35	6.42%	5	34
210063	University of Maryland St. Joseph Medical Center	-6.89%	19	14.26%	17	13.96%	21	38
210004	Holy Cross Hospital	3.78%	6	16.32%	23	25.44%	41	38
210024	MedStar Union Memorial Hospital	-6.69%	17	21.50%	36	7.13%	6	38
210044	Greater Baltimore Medical Center	-6.95%	20	14.20%	16	14.08%	22	39
210006	Harford Memorial Hospital	-6.85%	18	10.75%	9	19.63%	34	40
210009	Johns Hopkins Hospital	-7.96%	21	24.26%	40	5.43%	3	43
210039	Calvert Memorial Hospital	-16.28%	36	7.55%	1	11.83%	13	43
210011	St. Agnes Hospital	-9.19%	23	16.08%	22	13.45%	19	44
210002	University of Maryland Medical Center	-5.93%	15	24.45%	41	13.11%	17	44
210065	Holy Cross Germantown	1.43%	11	18.40%	32	20.06%	35	45
210051	Doctors Community Hospital	-8.97%	22	13.76%	15	17.28%	31	45
210023	Anne Arundel Medical Center	-9.62%	25	11.82%	10	18.64%	33	47
210033	Carroll Hospital Center	-12.75%	33	12.39%	11	12.99%	16	47
210005	Frederick Memorial Hospital	-10.04%	27	9.35%	5	20.51%	36	48
210018	MedStar Montgomery Medical Center	-9.51%	24	10.46%	8	27.40%	42	49
210008	Mercy Medical Center	-10.42%	29	22.90%	37	10.26%	9	52
210032	Union Hospital of Cecil County	-17.82%	37	17.96%	30	5.21%	2	53
210062	MedStar Southern Maryland Hospital Center	-9.85%	26	16.70%	26	16.01%	28	53
210003	Prince Georges Hospital Center	-20.45%	40	15.51%	19	11.09%	11	55
210037	University of Maryland Shore Medical Center at Easton	-19.50%	39	15.07%	18	12.66%	14	55
210029	Johns Hopkins Bayview Medical Center	-13.89%	35	23.14%	38	9.61%	7	58
210030	University of Maryland Shore Medical Center at Chestertown	-29.33%	43	10.40%	7	16.55%	30	62
210040	Northwest Hospital Center	-10.55%	30	18.35%	31	18.07%	32	62
210060	Fort Washington Medical Center	-10.20%	28	24.16%	39	16.43%	29	62
210057	Shady Grove Adventist Hospital	-11.92%	32	17.70%	28	21.33%	37	65
210022	Suburban Hospital	-11.20%	31	16.35%	25	29.27%	43	65
210038	University of Maryland Medical Center Midtown Campus	-18.03%	38	24.83%	43	11.36%	12	66
210016	Washington Adventist Hospital	-13.80%	34	17.89%	29	23.77%	40	69
210058	University of Maryland Rehabilitation & Orthopaedic Institute	-27.66%	42	24.45%	41	13.11%	17	71
210012	Sinai Hospital	-21.61%	41	19.38%	34	21.43%	38	77

Appendix E. Efficiency Matrix with Better of Benchmarks & MPA and MPA Analog Method

HOSP id	Hospital Name	2021 Volume Adjusted ICC Result	ICC Rank (50%)	2021 Medicare TCOC Rank - Better Of (25%)	2021 Commercial TCOC Rank - Better Of (25%)	Total Rank Points (Low Score is Better)
210017	Garrett County Memorial Hospital	14.04%	1	6	1	5
210019	Peninsula Regional Medical Center	7.94%	3	3	15	12
210048	Howard County General Hospital	1.67%	9	9	1	14
210028	MedStar St. Mary's Hospital	6.18%	4	13	8	15
210035	University of Maryland Charles Regional Medical Center	1.46%	10	2	12	17
210065	Holy Cross Germantown	1.43%	11	10	4	18
210004	Holy Cross Hospital	3.78%	6	11	15	19
210027	Western Maryland Regional Medical Center	-4.34%	13	20	4	25
210051	Doctors Community Hospital	-8.97%	22	4	2	25
210061	Atlantic General Hospital	2.79%	8	4	33	27
210015	MedStar Franklin Square Hospital Center	3.63%	7	14	27	28
210001	Meritus Medical Center	10.44%	2	26	26	28
210018	MedStar Montgomery Medical Center	-9.51%	24	2	7	29
210049	Upper Chesapeake Medical Center	-3.36%	12	21	16	31
210043	University of Maryland Baltimore Washington Medical Center	-6.34%	16	20	10	31
210062	MedStar Southern Maryland Hospital Center	-9.85%	26	5	6	32
210022	Suburban Hospital	-11.20%	31	1	3	33
210034	MedStar Harbor Hospital Center	3.84%	5	33	24	34
210023	Anne Arundel Medical Center	-9.62%	25	8	9	34
210056	MedStar Good Samaritan Hospital	-4.47%	14	35	5	34
210024	MedStar Union Memorial Hospital	-6.69%	17	32	6	36
210005	Frederick Memorial Hospital	-10.04%	27	5	13	36
210006	Harford Memorial Hospital	-6.85%	18	9	29	37
210057	Shady Grove Adventist Hospital	-11.92%	32	3	8	38
210063	University of Maryland St. Joseph Medical Center	-6.89%	19	17	21	38
210044	Greater Baltimore Medical Center	-6.95%	20	16	22	39
210009	Johns Hopkins Hospital	-7.96%	21	33	3	39
210039	Calvert Memorial Hospital	-16.28%	36	1	5	39
210002	University of Maryland Medical Center	-5.93%	15	34	17	41
210011	St. Agnes Hospital	-9.19%	23	22	19	44
210060	Fort Washington Medical Center	-10.20%	28	16	20	46
210033	Carroll Hospital Center	-12.75%	33	11	16	47
210008	Mercy Medical Center	-10.42%	29	36	9	52
210032	Union Hospital of Cecil County	-17.82%	37	28	2	52
210016	Washington Adventist Hospital	-13.80%	34	17	24	55
210003	Prince Georges Hospital Center	-20.45%	40	19	10	55
210037	University of Maryland Shore Medical Center at Easton	-19.50%	39	18	14	55
210029	Johns Hopkins Bayview Medical Center	-13.89%	35	38	7	58
210040	Northwest Hospital Center	-10.55%	30	31	32	62
210030	University of Maryland Shore Medical Center at Chestertown	-29.33%	43	7	30	62
210038	University of Maryland Medical Center Midtown Campus	-18.03%	38	39	12	64
210058	University of Maryland Rehabilitation & Orthopaedic Institute	-27.66%	42	34	17	68
210012	Sinai Hospital	-21.61%	41	34	38	77



maryland
health services
cost review commission

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2024 Funding

Final Recommendation

June 5, 2023

This recommendation was approved at the public Commission meeting on May 10, 2023 pending receipt of public comments. No public comments were received, thus, this recommendation is considered final and approved. The following document, that will represent the final recommendation, is identical to the draft recommendation.

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List of Abbreviations

CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
CRS	CRISP Reporting Services
eQIM	Electronic Clinical Quality Measures
FY	Fiscal year
HIE	Health information exchange
HITECH	Health Information Technology for Economic and Clinical Health Act
HSCRC	Health Services Cost Review Commission
IAPD	Implementation Advanced Planning Document
MDH	Maryland Department of Health
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan
MES	Medicaid Enterprise System
TCOC	Total Cost of Care

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
To fund and sustain a robust Health Information Exchange, CRISP, for activities related to the HSCRC and the Maryland Model.	Include an assessment in hospital rates to generate funding to support CRISP projects and operations to further the goals of the Maryland Model	Hospitals benefit from CRISP programs and pay a separate user fee. This assessment is a pass through and has no impact on hospitals.	CRISP provides vital coordination and reporting that allow hospitals and other Maryland providers to enhance the quality and cost effectiveness of the care provided.	Provider reporting supported by CRISP will collect data on social determinants of health and disparities in health outcomes in order to further the goals of improved health equity under the Model.

Summary of the Recommendation

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Total Cost of Care Model and the public interest,¹ this recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2024 to the Chesapeake Regional Information System for our Patients (CRISP):

- Direct funding and matching funds under Medicaid Enterprise System (MES) Federal Programs for Health Information Exchange (HIE) operations and infrastructure (\$2.4 million)
- Direct funding and Medicaid Enterprise System (MES) matching funds for reporting and program administration related to population health, the Total Cost of Care Model, and hospital regulatory initiatives (\$4.1 million). Staff propose using \$1.7 million of accumulated reserves to reduce the revenue generated through rates for FY2023 to \$2.3 million for this component.

Therefore, Staff recommends that the HSCRC provide funding to CRISP totaling \$4.8 million for FY 2024, consistent with FY 2023. As a result, the HSCRC will be funding approximately 15 percent of CRISP's Maryland funding, compared to budgeted 19 percent in FY 2023. The remainder of CRISP's Maryland funding is derived from user fees, federal matching funds and the Maryland Department of Health (MDH).

¹ MD. CODE ANN., Health-Gen §19-219(c).

This recommendation continues the approach used in prior years of spending down reserve funds accumulated due to a better than anticipated Federal match. Without the use of these reserves, this year's request would have been \$6.5 million, reflecting an increase of \$0.2 over the approximately \$6.3 million anticipated in FY 2023 spending; this increase primarily relates to increased investment in a system to report hospital Electronic Clinical Quality Measures (eCQMs). Currently Staff anticipates accumulated reserves will be used by FY2026 at which time the assessment amount will increase to the full amount.

Background – Past Funding

Over the past ten years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates as shown in Table 1.

Table 1. HSCRC Funding for CRISP HIE and Reporting Services, Last 10 Years

CRISP Budget: HSCRC Funds Received	
FY 2013	\$1,313,755
FY 2014	\$1,166,278
FY 2015	\$1,650,000
FY 2016	\$3,250,000
FY 2017	\$2,360,000
FY 2018	\$2,360,000
FY 2019	\$2,500,000
FY 2020	\$5,390,000
FY 2021	\$5,170,000
FY 2022	\$9,240,000
FY 2023	\$4,800,000

User fees generated by payers have historically been a small share of total CRISP revenue and remained unchanged since inception. In FY2022, the CRISP Finance Committee approved an increase of \$300,000 in payer fees, which now represents 15% of user fee revenue.

Funding Through Hospital Rates

Beginning in FY 2020, HSCRC assumed full responsibility for managing the CRISP assessment, previously shared with MHCC. CRISP-related hospital rate assessments are paid into an HSCRC fund, and the HSCRC reviews the invoices for approval of appropriate payments to CRISP. This process – which includes bi-weekly update meetings, monthly written reports, and auditing of the expenditures – has created transparency and accountability. Starting in FY 2023, CRISP's reimbursement from the HSCRC will be provided in two tranches: one relating to state match funding of core HIE operational costs and the other related to Reporting and Program Administration. This change is made to allow CRISP to recover operational reimbursement from the HSCRC in a timelier fashion.

Funding Through Federal Matching

HSCRC funding has been used to obtain federal matching funds throughout the history of the program. The federal match is obtained through the program outlined below. The HITECH IAPD program was previously the source of most federal funding, and it was terminated September 30, 2021. Funding has now moved to the MES program described below. The MES program requires 25 percent match for ongoing programs versus the 10 percent in place under IAPD

Medicaid Enterprise System (MES) Matching Funds

MES is a federal program designed to promote effective care for Medicaid beneficiaries through investments in information technology infrastructure. Medicaid benefits from CRISP's data sharing and reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer activities and for dual-eligible patients under CRISP's Medicare activities.

Activities funded under this element of the assessment include point-of-care and other provider data sharing initiatives, and CRISP reporting tools utilizing the Medicare claims and the HSCRC's hospital case mix data. Hospitals, the HSCRC, and other stakeholders use CRISP reporting from these datasets to manage and track progress under several HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

Under MES, state funds are eligible for either a 90 percent match for new reporting initiatives or a 75 percent match for ongoing reporting. The assessment funding will provide the State's portion of this match as well as the State's Fair Share amount.

Other Funding

CRISP's Maryland activities are also financed through user fees paid by hospitals and payers as well as funding received from MDH (See Table 2). Payer user fees have historically been a small share of total CRISP revenue and remained unchanged since inception. In FY2022, the CRISP Finance Committee approved an increase of \$300,000 in payer fees, which now represents 15% of user fee revenue.

Description of Activities Funded

Activities funded directly by this assessment and from earned federal matching fall into the two categories described below. The descriptions below outline, in general terms, the programs for which funds will be used. Staff will direct funding to specific programs within the general parameters described.

Category 1: HIE Operations Funding and Infrastructure

The value of an HIE rests in the premise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The General Assembly charged the MHCC and HSCRC with the designation of a statewide HIE.² In the summer of 2009, MHCC conducted a competitive selection process which resulted in awarding state designation to CRISP, and HSCRC approved up to \$10 million in startup funding over a four-year period through Maryland's unique all-payer hospital rate setting system. CRISP maintained designation through multiple renewal processes, with the most recent occurring in 2022 HSCRC's annual funding for CRISP is illustrated in Table 1 above.

The use of HIEs is a key component of health care transformation, enabling clinical data sharing among appropriately authorized and authenticated users. The ability to exchange health information electronically in a standardized format is critical to improving health care quality and safety.

Many states, along with federal policy makers, look to Maryland as a leader in HIE implementation. CRISP continues to build the infrastructure necessary to support existing and future use cases and to assist HSCRC in administering per-capita and population-based payment structures under the Total Cost of Care Model. A return on the State's investment is demonstrated through implementation of a robust technical platform that supports innovative use cases to improve care delivery, increase efficiencies in health care, and reduce health care costs. MDH made extensive use of CRISP's capabilities during the COVID crisis.

The total amount of funding recommended by Staff for FY 2023 for the HIE function is \$2.4 million.

Category 2: Reporting and Program Administration Related to Population Health, the Total Cost of Care Model, and Hospital Regulatory Initiatives

These initiatives were designed to reduce health care expenditures and improve outcomes for all Marylanders. Many of these programs focus on unmanaged high-needs Medicare patients and patients dually eligible for Medicaid and Medicare, consistent with the goals of Maryland's All-Payer Model. These initiatives encourage collaboration between and among providers, provide a platform for provider and patient engagement, and allows for confidential sharing of information among providers. To succeed under the Total Cost of Care (TCOC) Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

Based on broad program participation, including non-hospital providers, and the ability to secure federal match funds, these programs will be funded through a combination of assessments and federal matching funds. This recommendation covers three components:

² MD. CODE ANN., Health-Gen §19-143(a).

- (1) Funding for population health and cost and quality management reporting in support of HSCRC regulations and the TCOC Model;
- (2) Funding for program administration related to programs under the TCOC Model; and
- (3) Funding for innovative reporting initiatives such as enhanced data on social determinants of health and the integration of electronic health record data into statewide hospital quality measurement

The total amount recommended by Staff for FY 2024 for the activities described above is \$4.1 million.

Staff Recommendation

Staff is recommending the Commission approve a total of \$4.8 million in funding through hospital rates in FY 2023 to support the HIE and continue the investments made in the TCOC Model initiatives through both direct funding and obtaining federal MES matching funds. Staff anticipates actual CRISP spending of \$6.5 million but proposes to use \$1.7 million of prior reserves, limiting the actual assessment to \$4.8 million.

Table 2 shows the funding through hospital rates and the federal match that will be generated from the MES funding as well as the user fee and MDH funding.

Table 2. FY 2024 Recommended Rate Support for CRISP as a share of estimated total Maryland Funding

FY 2024 Project Name	Hospital Rates	Budgeted Federal Funding	User Fees	Maryland Department of Health	Maryland Total
HIE Operations	\$2,400,000	\$12,177,000	\$5,576,000	\$1,015,000	\$21,168,000
Reporting and Program Administration	\$4,100,000	\$10,133,000	\$0	\$2,245,000	\$16,678,000
Other non-HSCRC programs	\$0	\$2,490,000	\$0	\$2,540,000	\$5,030,000
Total Funding	\$6,500,000*	\$24,800,000	\$5,576,000	\$6,000,000	\$42,876,000
% Of Total	15%	58%	13%	14%	100%

*Note: Prior to reduction for use of accumulated reserves to reduce FY2024 assessment.



TO: HSCRC Commissioners
FROM: HSCRC Staff
DATE: June 14, 2023
RE: Hearing and Meeting Schedule

July 12, 2023 To be determined - GoTo Webinar

August 9, 2023 To be determined - GoTo Webinar

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

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

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