NOTICE OF WRITTEN COMMENT PERIOD

Notice is hereby given that the public and interested parties are invited to submit written comments to the Commission on the staff draft recommendation that will be presented at the May 13, 2020 Public Meeting:

1) Draft Recommendation on the Update Factor for FY 2021
2) Draft Recommendation on CRISP Funding for FY 2021
3) Draft Recommendation on Maryland Patient Safety Center for FY 2021
4) Draft Recommendation on Changes to Relative Value Units for Clinic Evaluation & Management (E&M)

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATION ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE MAY 21, 2020, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.

State of Maryland
Department of Health

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Chairman

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Vice-Chairman

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573rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
May 13, 2020

(The Commission will begin in public session at 12:00 pm for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 p.m.)

EXECUTIVE SESSION
12:00 pm

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

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

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

PUBLIC SESSION
1:00 pm

1. **Review of Minutes from Public and Closed Meetings held on**
   March 11, 2020
   March 19, 2020
   March 27, 2020
   April 2, 2020
   April 9, 2020
   April 30, 2020

2. **Docket Status – Cases Closed**

3. **Docket Status – Cases Open**
   2503R – Johns Hopkins Bayview Medical Center

4. **Recommendation on Johns Hopkins Bayview Medical Center Full Rate Application**

5. **Final Recommendation on Nurse Support Program II for FY 2021**

6. **Draft Recommendation on the Update Factor for FY 2021**

7. **Draft Recommendation on Ongoing Support of CRISP for FY 2021**
8. **Draft Recommendation on the Maryland Patient Safety Center for FY 2021**
9. **Draft Recommendation Changes to Relative Value Units for Clinic Evaluation & Management (E&M)**
10. **Policy Update and Discussion**
11. **Hearing and Meeting Schedule**

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF APRIL 28, 2020

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2503R	Johns Hopkins Bayview Medical Center	10/15/2019	3/13/2020	3/13/2020	FULL RATE	GS	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

IN RE: THE FULL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
JOHNS HOPKINS BAYVIEW	*	DOCKET: 2020
MEDICAL CENTER	*	FOLIO: 2313
BALTIMORE, MARYLAND.	*	PROCEEDING: 2503R

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STAFF RECOMMENDATION

May 13, 2020

List of Abbreviations

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

Key Methodology Concepts and Definitions

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

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

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

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

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

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

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

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

Primary Service Area (PSA): The PSA is assigned to hospitals based on geography, following an algorithm known as PSA-Plus. This methodology assigns zip codes to hospitals through three steps:

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

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

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

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

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

Overview

Johns Hopkins Bayview Medical Center ("Bayview," or "the Hospital") submitted a full rate application on July 9, 2019, requesting an increase to its permanent Global Budget Revenue (GBR) totaling $60.2 million, an 8.7 percent increase over Bayview's approved GBR that was effective for the one-year period from July 1, 2018 through June 30, 2019. The requested increase is comprised of a general revenue adjustment, to address the appropriateness of the Hospital's current rates, of $28.9 million (4.2 percent) to be effective on July 1, 2019, and a capital adjustment of $31.3 million (4.5 percent) to be effective on the date of the opening of its new inpatient building. The requested revenue increases are exclusive of HSCRC-approved adjustments, including: the update factor, market shift adjustments, demographic adjustments, quality adjustments, population health, and other routine adjustments.

Following the submission of additional required information not included with its original submission, HSCRC staff accepted Bayview's full rate application and considered it complete on October 15, 2019.

Request for General Revenue Increase

Bayview justifies the requested $28.9 million in additional operating revenue based on its objective to stabilize and increase its profit margin. Bayview states that several recent cost increases contribute to the need for additional revenue:

1. Implementation of EPIC software--$11.4 million
2. Market adjustment for clinical salaries--$6 million
3. Growth in Baltimore City medical liability costs for Obstetrics/Delivery--$4.5 million
4. Revised regulatory standards for Trauma Centers--$2 million
5. Growth in medical residents costs--$4.6 million

Request for Revenue for Increased Capital Costs

The $31.3 million requested revenue increase for capital expenses represents new depreciation and interest costs related to the Hospital's planned replacement of its inpatient facilities. The Hospital has submitted a Certificate of Need (CON) application to the MHCC requesting approval of a project to replace the current inpatient areas of the Hospital for a total cost of $468.9 million, which includes $28.3 million for an unregulated parking garage. According to the CON application, Bayview intends to finance the project with $27 million in state grants, $106 million in cash, $48 million in philanthropy, $200 million in authorized bonds, and $60 million in working capital loans.

The financial projections included in Bayview's CON application estimate first year depreciation and amortization expense of $17.3 million and interest cost of $13.0 million, for new total capital costs of $30.3 million. Bayview's rate application requests $28.5 million, or 94 percent of the total project costs, reflecting the removal of 6 percent of the project costs for the unregulated

parking garage.[1] The requested capital costs are marked up by an estimated 10 percent, to account for the payer differential and uncompensated care, to arrive at the requested revenue increase for capital of $31.3 million.

Status of CON Review and Approval

The MHCC is in the process of reviewing the CON application. The HSCRC must determine what level of funding will be provided for capital before the MHCC can determine the feasibility of the project and take action on the CON application. HSCRC staff is concerned that the inpatient volumes projected in the CON may be excessive in light of continuing declines in inpatient utilization and the expected additional reduction of utilization under the Total Cost of Care Model. The HSCRC anticipates that the MHCC will focus on the size of the project, the bed need projections, and the impact on healthcare costs as it reviews the CON application and potential feasibility. This concern will be discussed in more detail in the Analysis and Summary of Findings sections of this report.

[1] In response to completeness questions from HSCRC staff, Bayview modified the unregulated percentage to approximately 93 percent, reflecting some retail space included in the construction cost, in addition to the unregulated parking garage. HSCRC staff used the modified figures for its capital cost analysis and recommendation.

Background

Full Rate Applications

In January 2018, the Commission adopted updated regulations for full rate applications to incorporate new requirements for efficiency. The revised process is intended to encompass new measures of efficiency based on the move from volume-based payments under the charge-per-case system, employed prior to 2014, to a per capita system with value-based requirements. Under the updated requirements, the Commission will evaluate efficiency in the context of per capita costs. The evaluation contained in this recommendation addresses utilization efficiency, cost per case efficiency, and quality performance.

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

Background on Bayview

Bayview is located in southeast Baltimore and is a full-service teaching hospital with 342 acute care beds, 12 inpatient rehabilitation beds, and 76 chronic beds. Included in the 342 acute care bed count is a 20 bed burn care and wound unit for adults. The Hospital's total approved revenue cap for Fiscal Year 2019 was $691,656,049. Approximately 33 percent of its revenues came from Baltimore City residents in 2019, while 36 percent came from Baltimore County, 13 percent came from other central Maryland counties, 8 percent came from out-of-state residents, and the remaining 10 percent was derived from all other counties in Maryland.[2]

Bayview is part of the Johns Hopkins Health System (JHHS) and is located on a 130-acre campus that includes other buildings owned by the National Institutes for Health.

From Fiscal Years 2015 through 2019, Bayview had an average operating margin of 2.1 percent based on its audited financial statements. The operating margin fell to 1.4 percent on average for the three most recent fiscal years.

As part of the CON, Bayview provided projected financial statements for Fiscal Years 2020 through 2025. For Fiscal Years 2020 through 2025 Bayview projected that it would generate an average total operating margin of 3.5 percent and a total profit margin of 4 percent on all services, which are higher than historical margins or recent experience.

[2] Source: HSCRC hospital discharge data, Fiscal Year 2019

Staff Analyses

HSCRC staff has reviewed costs, financial trends, system financial statements, unregulated losses, volume trends, quality performance, and Medicare per capita trends in the primary service area, among other considerations. Recently, HSCRC staff reviewed the results of the ICC. Summaries of several of these analyses follow.

Cost to the Public of Bed Replacement at Bayview

Current trends in inpatient hospital utilization suggest continuing reductions in admissions as technology allows an increasing number of surgeries to be performed in an outpatient setting (e.g. joint replacement) and as more intensive care is delivered in home and in outpatient settings. The Total Cost of Care Model should accelerate these trends in Maryland, as chronic care management and health improvement initiatives further decrease the need for hospitalizations. Baltimore City and Baltimore County already have high levels of unused beds, and the excess bed capacity will increase as a result of current trends. These trends support the objectives of reducing avoidable costs and freeing up funds to improve care delivery and to invest in the population. However, excess capacity also means that the charge per case is higher at these facilities, making the investments in population health to improve efficiency all the more important. During the past year of discussions and evaluations, staff compared Bayview's charge per equivalent case-mix adjusted discharge ("ECMAD") to the state average and nearby competitors. For the year ended June 30, 2019, Bayview had higher charges than the state average and several of its nearby competitors. Bayview's inpatient case-mix adjusted charge per case exceeded the state average by 6 percent, or by 16 percent if Johns Hopkins Hospital (JHH) and University of Maryland Medical Center (UMMC) are removed from the averages. Bayview's inpatient charge per case exceeded all 6 nearby primary service area competitors (other than JHH and UMMC) by an average of 13 percent (Table 5). When including outpatient services, Bayview's charges are still higher, but more favorable, in part, due to the very high volume of clinic services provided at Bayview.

The implication of this comparison is that replacing beds at Bayview will increase system costs relative to using beds at other area facilities that have lower charge structures. The MHCC will need to carefully review the bed need projections and consider the financial feasibility of the proposed project in light of declining trends and the higher cost to the public of providing services at Bayview versus its local competitors.

Interhospital Cost Comparison

HSCRC staff has developed the Interhospital Cost Comparison (ICC) tool, which is used to evaluate cost-per-case efficiency in a full rate review. In the ICC, each hospital's costs per case are compared to a peer group adjusted cost-per-case. Bayview's urban teaching hospital peer group includes Mercy, Sinai, Grace Medical Center, MedStar-Union Memorial, MedStar-Harbor, UM Midtown, and UM Prince George's Hospital, in addition to Bayview. The 2019 ICC results show that Bayview's charges per ECMAD were 4 percent lower than its peer group average, but

its costs per ECMAD were 6 percent higher than the peer group average. Five out of eight of Bayview's peer hospitals had lower costs per ECMAD. The ICC removes profits and adjusts for productivity, since the average cost is not assumed to be efficient. Bayview's peer group has experienced high levels of utilization declines, and as a result, the group has a relatively large productivity adjustment to remove excess fixed costs. After making the productivity adjustment and removing profits, Bayview would receive a revenue decrease on revenues included in the ICC of 9.49 percent. To put this into perspective, Bayview can improve its profitability by 6 percent by reducing its cost to the peer group average. Although its charge per ECMAD remains below the ICC peer group average, in light of the cost variations from an efficient cost standard, Bayview is not a relatively cost-efficient hospital.

Using the 9.49 percent reduction discussed above, HSCRC staff estimates that 93 percent of Bayview's revenue ($614.7 million) included in the ICC would receive a rate decrease from a full rate review if cost-per-case were the only criterion for review, and that the rate decrease could reach up to 9.49 percent ($58.3 million).[3]

Of the revenue excluded from the ICC (7 percent or $47.9 million), $11.4 million is related to burn cases, $24.1 million is related to outpatient oncology and infusion drugs, and $12.6 million is related to chronic care patients. The HSCRC adds the estimated 340B drug costs for the excluded drugs back to the approved revenue, plus mark-up as discussed below. The HSCRC proposes to add back revenue for burn cases with no reduction. For chronic cases, Bayview's average charge per case for Fiscal Year 2019 was $59,626 versus a state-wide average charge per case of $24,173. While HSCRC staff has concerns that Bayview's chronic costs may be high, staff has not developed a case-mix methodology for evaluating chronic costs and is therefore not recommending any change in chronic revenues at this time.

To analyze drug charges, a modification to the ICC has been introduced because not all revenue is assessed by the ICC tool. As drug costs have risen, drug overhead allocations distort cost comparisons under the ICC through under-allocating overhead to other services. The ICC calculation leaves the drug overhead in the ICC and assesses the drug costs against published average purchase prices (Average Sales Price or 340B prices for eligible hospitals). Staff analysis of Bayview's drug charges, less drug overhead, indicates that Bayview has revenue for drugs modestly in excess of estimated outpatient oncology and infusion drug costs (after increasing outpatient cost for 340B discounts offset against inpatient costs). The variance between the two data sets was $1,826,558, suggesting that drug revenue excluded from the ICC tool ($24,577,580) should be decreased by this value.

The table below describes the various results of the current ICC methodology. These results do not account for hospital quality performance or Medicare total cost of care.

[3] The ICC does not at this time assess the efficiency of all hospital revenue. Revenue is excluded from the ICC for the following reasons: outpatient drugs) are not reliably case-mix adjusted using the ECMAD methodology; charges associated with chronic care beds are unique to four hospitals and, therefore, are not susceptible to statewide analyses of efficiency and charges associated with "categorical exclusions," e.g., organ transplants, research cases at academic medical centers, are not susceptible to statewide analyses of efficiency (work to obtain national benchmarks for such hospital charges is ongoing).

Table 1. Summary of Components of ICC Recommended Revenue for Bayview Hospital

ICC Methodology	Revenue Assessed	Revenue Change	ICC Recommend Revenue
ICC Efficiency Tool	$614,652,945	-$58,340,430	$556,312,515
Burn Center Revenues	$11,392,920	$0	$11,392,920
Chronic Revenues	$12,477,823	$0	$12,477,823
Drug Cost Analysis CDS-A & non CDS-A	$24,577,580	-$1,826,558	$22,751,021
Total	$663,101,268	-$60,166,988	$602,934,280

Since Bayview filed a full rate application as well as a request for a capital increase, HSCRC staff needs to make a recommendation regarding the Hospital's approved revenues. Staff proposes to look to the Integrated Efficiency policy to do this, which evaluates a 50/50 blend of a volume adjusted ICC and Medicare total cost of care performance. The Commission recently asked staff to use quartiles rather than quintiles to address relative efficiency and staff is still employing the one standard deviation rule to determine hospital eligibility for additional operating rate support, i.e. a hospital has to be better than one standard deviation of average hospital performance to qualify for additional rate support. This standard is approximately 6 percent more lenient than the full rate application standard and ensures that hospitals that are relatively efficient have a path to additional revenue, albeit a smaller amount of revenue because the funding may be capped by revenue "set aside" in the annual update factor and revenue withheld from poor performing outliers.

While Bayview did fall into the best quartile, the Hospital did not meet the standard deviation rule (Bayview was approximately 1 percent over the one standard deviation rule). Staff also conducted analyses of ICC performance using Fiscal Year 2020 revenue and Fiscal Year 2019 case-mix and while Bayview improved its performance relative to peers, it still was .80 percent over the one standard deviation. In light of the Rate Application and the evaluation of efficiency, HSCRC staff proposes that Bayview not receive any additional operating support, because the Hospital did not qualify for funding under a full rate application or the Integrated Efficiency Policy.

Utilization Efficiency

Staff evaluated the levels of potentially avoidable utilization at Bayview compared to levels of potentially avoidable utilization at all other Maryland hospitals, and Bayview's experience in reducing these volumes. As discussed below, Bayview has moderately higher rates of potentially avoidable utilization relative to the State average. Bayview has seen an increase in potentially avoidable utilization as a percentage of eligible revenue from Calendar Year 2013 to 2018.

Conversely, Bayview has reduced admissions for ambulatory-care sensitive conditions (PQIs) for its geographic service area; however, per capita PQIs have remained roughly double the statewide average.

As part of its full rate application and in response to Completeness questions, Bayview submitted 10 pages of information on population health improvement programs, behavioral health programs, and other programs to address social determinants of health. While its behavioral health programs are not new, it is important to acknowledge the significant role Bayview plays in providing these critical outpatient services.

As discussed later, Bayview is located in an area of high hospital utilization and it will need to expand its programs to reduce avoidable utilization and improve health to be successful under the Total Cost of Care Model.

Total Cost of Care Performance

Under a per capita model, a hospital's efficiency may not be adequately measured by cost per case measures. In order to consider how the cost per capita performance might alter the results from the ICC, the HSCRC also evaluates Total Cost of Care (TCOC) performance. Exceptional TCOC performance might allow for a revenue increase in the results from the ICC, while poor results might suggest reductions from the ICC results.

HSCRC staff has made progress in evaluating the TCOC data for Medicare beneficiaries at a geographical level and for attributed beneficiaries. For this analysis, staff focused on the relative growth in Medicare's TCOC per beneficiary in Bayview's primary service area relative to the Medicare TCOC growth per beneficiary statewide. HSCRC staff also present preliminary Medicare TCOC per capita cost "attainment" results relative to a national benchmark comparison.

Bayview had growth in Medicare Total Cost of Care of 6.09 percent between Calendar Years 2013 and 2018, versus a state-wide growth of 7.31 percent. This puts Bayview in 14th position out of a state-wide ranking of 46 hospitals. While Bayview performed better than the state and its peer group in Total Cost of Care growth, it does not reach a level in a full rate review to justify an increase in revenues relative to the results of the ICC efficiency tool. Since the HSCRC is nearing completion of Medicare "attainment" comparisons to selected national benchmarks, staff evaluated the Total Cost of Care per beneficiary in Bayview's primary service area to the Medicare Total Cost of Care benchmark results. While recognizing that vetting and review of the Medicare benchmarks continues, staff nevertheless reviewed those benchmarks to determine if they might affect the measured efficiency levels. Based on the review of the preliminary benchmark results, Bayview's primary service area is above its benchmark, and its relative ranking is less favorable than the growth ranking previously discussed.

Volume Funding and Volume Projections

In its rate application, Bayview indicated that it would need 100 percent capital cost funding because it had not received adequate funding to date for volume growth under its GBR revenue

cap. Additionally, as discussed in the Overview section of this report, HSCRC staff is concerned about the feasibility of the Bayview project because the volume projections in its CON application are high relative to the Hospital's own experience, and there are empty beds at lower cost hospitals nearby. This section of the staff's report addresses historical volume funding at Bayview, as well as the potential for higher utilization declines and the impact on project feasibility and cost of care.

The HSCRC uses ECMADs to calculate volume changes, when possible, because ECMADs include volumes of both inpatient and outpatient services with recognition of expected relative costs of services on a consistent scale. From Calendar Year 2013 through Calendar Year 2018, Bayview has experienced volume increases. The volume growth calculation was made more difficult by the move to ICD-10, which is used for coding diagnoses on hospital bills. This move to ICD-10 made the use of consistent inpatient DRG groupers and weights, for all years, unavailable. Lacking consistently grouped inpatient data, HSCRC staff adjusted the ECMADs for estimated changes in DRG weights, due to the changes between ICD-9 and ICD-10. Additionally, the Hospital has chronic utilization, which has longer lengths-of-stay than general acute stays. Because the HSCRC has not developed weights for chronic cases, staff developed an ECMAD measure for these cases based on charges for these services. Using this method, after including inpatient, outpatient, and chronic ECMAD changes, staff estimated a volume growth of $40.8 million between Calendar Year 2013 and Calendar Year 2018 (in current dollars) before applying any variable cost adjustment.

Bayview has been generously funded for volume changes since the inception of the GBR, having received $49.7 million in volume funding through Calendar Year 2018 (in current dollars). In the aggregate, volume funding to Bayview provided for a variable cost factor on volume growth above 100 percent, well above the 50 percent policy level used by the Commission. In addition to demographic funding, Bayview received funds relative to out-of-state volume changes, market shifts, Medicaid expansion, and burn cases. The HSCRC worked with Bayview after it opened its new oncology center and completed its emergency facility construction, and as its rehabilitation residency program at MedStar-Good Samaritan Hospital was shifted back to Bayview to ensure the market shift provided the expected funding for these programmatic changes.

Table 2. Volume Funding Provided to Bayview for Five Calendar Years 2014 through 2018 (current dollars, in millions)

Market Shift	$ 32.8
Demographic	7.8
Out-of-state	5.4
Burn case increase	2.0
Medicaid Expansion	1.7
Total	$ 49.7

While overall volumes grew at Bayview as a new oncology center and renovated emergency room facilities opened, there is a trend for declining inpatient acute care and emergency volumes at Bayview and nearby facilities.

Listed below are the total Inpatient Admissions and Outpatient Emergency Room Visits for the years ended June 30, 2017, 2018, and 2019 for Bayview, Johns Hopkins Hospital and Franklin Square:

Table 3. Inpatient Admissions for Bayview, Johns Hopkins Hospital, and Franklin Square For the Years Ended June 30, 2017, 2018, and 2019

	Inpatient Admissions			% Change
Hospital	FY 2017	FY 2018	FY 2019	FY 2017-19
Bayview	20,333	19,651	19,184	(5.7%)
Johns Hopkins Hospital	45,607	43,978	42,102	(7.7%)
Franklin Square	21,161	21,502	20,208	(4.5%)
Totals	87,101	85,131	81,494	(6.4%)

Source: HSCRC Monthly Experience Reports.

Table 4. Outpatient Emergency Room Visits for Bayview, Johns Hopkin Hospital, and Franklin Square For the Years Ended June 30, 2017, 2018, and 2019

	Outpatient Emergency Room Visits			% Change
Hospital	FY 2017	FY 2018	FY 2019	FY 2017-19
Bayview	46,269	45,694	43,583	(5.8%)
Johns Hopkins Hospital	79,332	76,137	75,755	(4.5%)
Franklin Square	71,487	69,570	63,374	(11.3%)
Totals	197,088	191,401	182,712	(7.3%)

Source: HSCRC Monthly Experience Reports.

Staff notes that Bayview's inpatient admissions in Fiscal Year 2019 have decreased by 4.6 percent over Fiscal Year 2018 compared to an assumed 0.5 percent reduction in the CON. Bayview's outpatient emergency room visits in Fiscal Year 2019 have decreased by 4.6 percent over Fiscal Year 2018 compared to an assumed 2.9 percent increase in the CON. For the first six months of Fiscal Year 2020 (through December 31, 2019), Bayview's inpatient admissions dropped 0.7 percent versus the same six months of Fiscal Year 2019, and outpatient emergency room visits decreased by 6.8 percent, continuing the decline versus the higher CON utilization projections.

The two hospitals that are located within the shortest commute to Bayview, Johns Hopkins Hospital and Franklin Square, incurred reductions in inpatient admissions in Fiscal Year 2019 of 4.3 percent and 6 percent respectively.

Staff expects continuing declines in inpatient admissions and emergency room visits under the Total Cost of Care Model and as technology improves and more services are offered in home and community settings. For example, joint replacements are being shifted to the outpatient setting, a service where Bayview has had relatively high market share. Additionally, the hospital utilization rates in Bayview's service area are well above the statewide use rates.

According to information provided by CMS, the number of Medicare discharges per 1,000 in Bayview's primary service area decreased from 455 in Calendar Year 2016 to 439 in Calendar Year 2017 and finally to 415 in Calendar Year 2018, an 8.9 percent reduction over the period and a 5.5 percent reduction in the most recent year. Despite these reductions in Medicare discharges per 1,000 in Bayview's primary service area between 2016 and 2018, the 2018 Medicare discharge rate per 1,000 for Bayview's primary service area was still 43.5 percent above the statewide average.

The expectation of continuing decreases in inpatient admissions and outpatient emergency visits combined with very high use-rates in Bayview's Primary Service Area leads the staff to believe that there may be fewer hospital beds needed than projected in the CON.

While the MHCC is the state agency that evaluates bed need, the HSCRC assists in the evaluation of financial feasibility. If there are excess beds built, this could affect the feasibility of the project and also contribute to less affordable health care in the region. HSCRC staff asked Bayview to respond in its Completeness questions to the concern of potential excess beds in light of continuing declines in inpatient admissions. In answer to the Completeness questions, Bayview responded that it projected an acute patient day decline of only 3.2 percent between 2018 and 2026 in its CON application (Completeness Table 1.6). This modest projection of utilization decline does not appear to be consistent with recent and expected trends. While Bayview's requested new medical/surgical acute licensed beds are reduced by 11 beds or 3.9 percent from the current number of beds, the projected occupancy of those beds is only 80.6 percent versus a current occupancy of 76.9 percent, and the current beds are housing approximately 5,000 observation patients. HSCRC staff calculated that there were 1,690

equivalent bed days in Fiscal Year 2018 for observations greater than 24 hours. This converts to 4.6 occupied beds (1,690 days/ 365 days per year = 4.6 occupied beds). With observations housed elsewhere and projected bed day declines, these projected occupancy rates are low for all private beds, and a reduction of only 11 beds appears inconsistent with expected utilization trends.

In its Completeness response, Bayview also argued that some hospital(s) in its service area may reduce or eliminate their acute inpatient capacity in the future. Baltimore City and Baltimore County have a very high concentration of hospitals, as well as unused bed capacity. Bayview listed 6 hospitals in Completeness Table 1.7, in addition to Johns Hopkins Hospital and University of Maryland Medical Center, which provide significant volumes of service in its primary service area. Bayview's charge per inpatient ECMAD is higher than all of these competitors. Not only would building excess beds at Bayview hurt the project feasibility, it could also contribute to higher costs. These lower cost hospitals, which are also serving Bayview's primary service area, have unused capacity, should a hospital in Bayview's service area reduce or eliminate its inpatient capacity.

Table 5: FY 2019 Inpatient Charge Per ECMAD vs Bayview Competitors

	Charge Per ECMAD	% Above Competitor
JH Bayview	$15,892	
MedStar Good Samaritan	$15,549	2.2%
MedStar Union Memorial	$15,201	4.5%
MedStar Franklin Square	$13,670	16.3%
Mercy	$13,207	20.3%
GBMC	$12,854	23.6%
UM Saint Joseph	$12,698	25.2%
Group Average	$14,062	13.0%

Source: HSCRC discharge data, excludes burns and chronic cases

Overall, the HSCRC is concerned that the use-rates in Bayview's service area are still significantly above the statewide average and there is a substantial risk that Bayview's future volumes will fall below the CON projections. There are also available beds at less expensive competitor facilities in the event of reduction in capacity of another area hospital. HSCRC staff has shared its feasibility concerns with the MHCC, which is responsible for the project review.

Potentially Avoidable Utilization

While recognizing that there is extensive unnecessary and avoidable utilization in the system, and that the HSCRC, providers, and the State have more work to do to quantify those

opportunities for reduction, the staff analyzed the utilization efficiency of Bayview with the tools it possesses. This included an analysis of Potentially Avoidable Utilization (PAU), which currently incorporates all-cause unplanned 30-day readmissions and the Agency for Healthcare Research and Quality's Prevention Quality Indicators (PQIs).[4]

Overall, Bayview's PAU revenue as a percent of eligible revenue is higher (less favorable) than the state average[5]. This percentage has grown slightly at Bayview between Calendar Year 2013 and Calendar Year 2018. In Calendar Year 2018, Bayview's share of eligible all-payer revenue associated with PAU was 20.50 percent, putting it above the State average of 17.63 percent but within the middle performing quintile in the State.

When the analysis was performed on PQIs per capita using geographic service area, Bayview was in the bottom quintile of attainment, with about 27 PQIs per 1,000 adults, compared to the average hospital per capita of 13 PQIs per 1,000 adults. Bayview's PQI per capita has decreased fairly quickly, with a PQI per capita reduction from 2013 to 2018 of -11.68 percent compared to a statewide average of -8.04 percent. This trend appears to be primarily driven by a decrease in PQI 05, chronic obstructive pulmonary disease or asthma among older adults, between 2017 and 2018.

While there is still work to do to quantify additional categories of PAU, and the PAU results are not risk-adjusted or adjusted for out-of-state admissions, Bayview has shown average rates of PAU revenue and high PQI per capita, with some success in reducing per capita PQI rates.

Quality Performance

Staff reviewed Bayview's performance on Fiscal Year 2020 quality measures for readmissions, potentially preventable complications (PPCs), and the Quality Based Reimbursement domains.

Under the HSCRC's Readmissions Reduction Improvement Program (RRIP), Bayview reduced its risk-adjusted readmissions by 6.5 percent between Calendar Year 2016 and Calendar Year 2018, which places Bayview in the 2nd quintile of statewide improvement. When this improvement is compounded with Calendar Year 2013 to Calendar Year 2016 improvement, the total Fiscal Year 2020 improvement is 13.26 percent, which is slightly less than the improvement target of 14.3 percent. Further, Bayview's readmission rate is 13.66 percent, which is worse than the attainment target of 10.70 percent and is in the 5th or bottom quintile of statewide performance. Overall, Bayview received a small RRIP penalty of approximately $366,000 for Fiscal Year 2020 based on narrowly missing the improvement target.

Under the Maryland Hospital Acquired Conditions program, Bayview had a 45 percent improvement in its case-mix adjusted Potentially Preventable Complications rate for Fiscal Year 2020, putting it in the 2nd quintile of state performance. In addition, Bayview's case-mix adjusted

[4] Using PQI v2019

[5] Eligible revenue is defined as all revenue from inpatient admissions and observation stays 23 hours or greater. This measure differs from the metric used in the PAU Savings Program, which is the percentage of PAU from total inpatient and outpatient revenue.

Potentially Preventable Complications rate for Calendar Year 2018 of 0.64 per one thousand discharges was in the 1st or top quintile of statewide performance.

Under the HSCRC's Quality Based Reimbursement (QBR) program, Bayview had a Fiscal Year 2020 total QBR score of 24.4 percent, which is in the 4th quintile of statewide performance. Specifically, for patient experience, Bayview scored 20 percent, which makes up half of the total QBR score and places them in the 3rd quintile of statewide performance. The Fiscal Year 2020 performance data shows that for the eight HCAHPS measures, Bayview performed worse than the national average on 6 measures but improved slightly on all measures except "Responsiveness of Hospital Staff." On the Mortality measure, Bayview scored 30 percent, which places them in the lowest (5th quintile) of statewide performance. For the safety measures, Bayview scored 28 percent, placing them in the 4th quintile of statewide performance.

Financial Background and Performance

Hospital Rate History

Bayview entered into a GBR agreement for Fiscal Year 2014. Under the GBR agreement, Bayview has received the following adjustments over the last five years:

Table 6. Bayview's GBR Adjustments, July 1, 2014-2018

	Year Beginning July 1,				
Component:	2014	2015	2016	2017	2018
Update Factor	2.1%	2.2%	1.8%	2.4%	1.9%
Mark Up Change	(.7)	(.9)	(.6)	(.2)	(.1)
Demographic Adjustment	.4	1.4	.4	.3	
Market Shift and other volume adjustments		.3	.1	1.3	1.7
Net Quality Adjustments	(.1)	.4	.1	(.3)	(.9)
Infrastructure	.3	.4			
Reduction in MHIP Assessments	(.3)	(.4)			
Uncompensated Care Funding		1.0	(1.0)		
Oncology Adjustments			.2		.1
Other	(.3)	.3	(.8)	.9	.5
Total	1.4%	4.7%	.2%	4.4%	3.2%

Source: Rate review work papers provided by Bayview as part of full rate application and HSCRC workpapers.

The mark up reductions resulted from changes in uncompensated care that occurred primarily as a result of Medicaid expansion under the Affordable Care Act (ACA). As uncompensated care was reduced, the HSCRC removed the uncompensated care from hospitals' rates. Also, the state

eliminated an assessment for a high-risk individual insurance product referred to as MHIP, over 2014 and 2015, as high-risk persons were able to access subsidized coverage through coverage provided under the ACA. These adjustments generally reduce hospital rates, but hospital expenses are reduced at the same time.

In 2015, the HSCRC worked with Bayview to make a temporary adjustment to uncompensated care related to undocumented residents. When this problem was fixed in the uncompensated care funding formula, the adjustment was reversed.

HSCRC staff has worked with Bayview over the last three years to address various market shift adjustments and calculations as the Hospital opened its new oncology center, expanded emergency room facilities, and moved its rehabilitation residency program from Good Samaritan Hospital to Bayview.

Revenue Growth

Bayview's HSCRC approved regulated revenues have increased by $87.9 million or 14.6 percent since Fiscal Year 2014.

Table 7. Change in Bayview Approved GBR Patient Revenue-For the 5 years Ended June 30, 2019

Year Ended June 30	Approved GBR (in 000's)	Percent Change from Prior Year
2014	$603,749	
2015	$612,219	1.4%
2016	$641,137	4.7%
2017	$642,342	0.2%
2018	$670,346	4.4%
2019	$691,656	3.2%
Change 2014 to 2019	$87,907	14.6%

Source: Bayview Full Rate Application – Exhibit 9.

According to its annual filings with the HSCRC, Bayview has averaged a profit margin of 1.4 percent on regulated services over the last five years. For all services, Bayview has averaged a profit margin of 0.9 percent over the last five years. In the last three years, Bayview's total profit margin was lower than the first two years. In addition to referencing the annual filing, the HSCRC reviewed the audited financial statements for the same period. Bayview accounts for pension expense and interest rate swaps in its audited financial statements differently than in its annual filing. In accordance with Generally Accepted Accounting Principles, gains and losses, from interest rate swaps and a portion of pension costs related to differences and changes in actuarial assumptions, are reported in non-operating income/expense. However, the Hospital has recorded these expenses as operating items in the HSCRC filing. While the audited financial statements present a somewhat different picture of annual operating income, the most recent three years show a decline relative to the first two years of results, consistent with the decline

seen in the annual reports to the HSCRC. While Bayview received a 3.2 percent revenue increase in 2019, its revenue increase for 2019 would have been 0.9 percent higher if it had not experienced a net negative quality adjustment. The Hospital can improve its profitability by addressing its cost structure, which is higher than its peer group, but also by improving its quality scores and addressing opportunities for reducing avoidable use. With these operating changes, Bayview can reach higher profitability margins.

Table 8. Bayview Regulated and Unregulated Annual Profit Margins
For the 5 Years Ended June 30, 2019

	2015	2016	2017	2018	2019
Regulated Operating Margin $	$16,999	$12,163	$2,798	$2,022	$4,428
Regulated Operating Margin %	3.3%	2.2%	0.5%	0.4%	0.8%
Unregulated Operating Margin $	($4,999)	($5,182)	($8,431)	($8,588)	($8,792)
Unregulated Operating Margin %	-8.4%	-8.6%	-15.0%	-14.8%	-14.3%
Total Operating Margin $	$12,000	$6,981	($5,633)	($6,566)	($4,364)
Total Operating Margin %	2.1%	1.2%	-0.9%	-1.0%	-0.7%
Total Net Profit Margin $	$13,875	$9,115	$3,276	$811	($788)
Total Net Profit Margin %	2.4%	1.5%	0.5%	0.1%	-0.1%

Source: Bayview HSCRC Annual Filings - Schedule RE

Total Operating Margin Per Audit $	$16,445	$20,229	$10,596	$8,405	$7,884
Total Operating Margin Per Audit %	2.9%	3.3%	1.7%	1.3%	1.2%

Source: Audited Financial Statements

Staff Review of Specific Components of Requested Revenue Increases

Capital Project Analysis

While Bayview does not qualify for a revenue adjustment under full rate review standards, HSCRC staff reviewed the Hospital's capital request under partial rate application standards. In October 2003, the Commission adopted the staff's recommendation permitting rate increases for major projects approved through a Certificate of Need (CON) under an alternative partial rate application process. The partial rate application process builds on the ICC standard methodology, but with adjustments. HSCRC staff recently updated its approach to capital requests to include evaluations of total cost of care efficiency, current levels of potentially avoidable utilization, and excess capacity, in addition to the historical analyses of capital cost efficiency and cost per case

efficiency. This updated methodology was approved at the December 11, 2019 Commission meeting.

The focus of the partial rate application is to allow a hospital that has a large capital cost increase associated with a major project to obtain some level of rate relief for the capital cost increase to the extent that the Hospital's rates are determined to be reasonable under a Commission-defined methodology.

The Hospital's rate application requests that the HSCRC grant a revenue increase equal to the total projected incremental capital costs associated with the regulated portion of the project. The CON includes projected first year interest cost of $13,000,000 and first year depreciation cost of $17,209,000 for a total of $30,209,000 in capital cost. The rate increase of $28,500,000 requested by Bayview for capital is comprised of 100 percent of the portion of the project that relates to regulated services.

The Hospital is requesting that $28,500,000 (plus mark up for uncompensated care and payer differential) in additional capital costs be added to rates at the time of the opening of the new facility.

The Hospital has assumed an interest rate of approximately 5 percent for the project. The Hospital is proposing to finance the project under the JHHS. According to the audited financial statements for JHHS for the year ended June 30, 2018, JHHS issued $500 million of bonds in Fiscal Year 2016 at an interest rate of 3.84 percent and $165 million of bonds in Fiscal Year 2017 at an interest rate of 2.31 percent. Staff believes that the actual interest rate on the debt associated with this project is less than the 5 percent assumed in the CON. Staff believes that an interest rate of 3.84 percent should be assumed for the calculation of approved debt related to the requested rate increase instead of the 5 percent assumed in the CON.

Under the HSCRC's historical capital methodology, Bayview's request would have been capped at the 50/50 blend of a hospital's capital cost share (inclusive of the new request's first year estimated depreciation and interest costs) and the peer group average capital cost share, and that value would be scaled for cost per case efficiency. Using the recently updated HSCRC capital methodology, the capital request from Bayview will continue to be capped at the 50/50 blend of the Hospital's capital cost share (inclusive of the new request's annualized estimate for depreciation and interest) and the peer group average, and that value will be scaled for cost per case efficiency, total cost of care efficiency, current levels of potentially avoidable utilization, and excess capacity.

Specifically, the regulated portion of Bayview's capital project of $438,065,232 has an annualized depreciation figure for a 25-year useful facility of $17,522,609 and an annualized interest figure of $10,012,045 on a 30-year loan with a 3.84 percent interest rate. Combined, the depreciation and interest bring Bayview's current capital cost share of 6.13 percent to 10.48 percent, an increase of 4.36 percentage points (or $34,684,188 to $62,218,842). Averaging the requested capital share of 10.48 percent to the peer group average of 8.01 percent[6] yields an

[6] Staff removed Prince George's County Hospital from the peer group average because of concerns over the data.

allowed capital cost share of 9.25 percent, which equates to a 3.12 percentage point increase in capital costs, or $17,651,023.

After this figure is derived, the new capital methodology then scales the result by the integrated efficiency of hospital cost per case and total cost of care, which is a relative ranking of hospitals that provides approximately 2 percent for each additional increase in ranking. In the case of Bayview, which is the fourth best hospital in the top quintile of performance, the hospital is entitled to 93 percent of the allowed capital cost share, or $16,474,288 (93 percent of $17,651,023).

Staff has also provided a credit to hospitals that do not have high levels of PAU, as defined by 30-day readmissions and avoidable admissions for PQIs. Bayview's reviews are in the middle quintile of performance and higher than the state average performance (21.3 percent compared to the statewide average of 18.4 percent), thus it earns no credit.

The final two steps of the methodology are to remove costs associated with excess capacity, as defined by reductions in bed days from 2010 to 2018, and to markup these cost-based figures for uncompensated care and the governmental payer differential. Bayview experienced a reduction of 1,453 bed days since 2010, so there is an adjustment for excess capacity of $1,745,638. The Hospital's markup in Fiscal Year 2019 was 1.0978; therefore, the capital allotment Bayview is eligible for is $16,168,521.

General Revenue Increase

The HSCRC's evaluation of the need for a general revenue increase is included in the analyses above. While Bayview has documented several expenditure increases — such as growth in information systems costs due to implementation of the EPIC EHR systems, wage growth, physician cost increases, malpractice expense, and additional costs for its trauma programs — these expenditures are common to other hospitals in its ICC peer group and other hospitals in the State. The HSCRC considers all of these costs in the aggregate, when it compares the cost of a hospital to its peers. As indicated above, Bayview's costs per case (ECMAD) are higher than its peers. Based on the analyses above, Bayview does not qualify for a general revenue increase for its operating costs.

Summary of Findings

HSCRC staff has reviewed the financial performance and efficiency of Bayview over the last several years. The Hospital's operating profit margin for Fiscal Year 2018 was 1.3 percent and Fiscal Year 2019 was 1.2 percent, according to the audited financial statements. While the Hospital's profit level is lower than the profits achieved by some other hospitals, Bayview's 2019 revenues were reduced due to a negative quality adjustment of 0.9 percent — and Bayview's adjusted cost per ECMAD is 6 percent higher than its ICC peer group average, even before adjusting the peer group average for inefficiencies resulting from utilization declines. The HSCRC evaluates cost efficiency of hospitals, and it does not guarantee hospital profit levels. Bayview can improve its profit level by bringing its costs into line with peer hospitals and by improving its quality performance, in addition to reducing avoidable utilization.

As outlined above, Bayview does not qualify for a rate increase under the ICC productivity standard. In fact, it would receive a revenue decrease under the ICC standard. Because Bayview has filed a full rate application, HSCRC staff needs to make a recommendation on the Hospital's approved revenues. Using the integrated efficiency policy, which is a lesser standard than the ICC productivity standard, staff determined that Bayview was in the best quartile of performance but still did not qualify for additional rate support through a GBR modification. As such, staff does not recommend adjusting the Hospital's revenues for additional operating rate support. Bayview's Total Cost of Care growth for Medicare was lower than the state-wide average growth but the preliminary measure of Medicare cost per capita "attainment" relative to a national peer benchmark is less favorable than the statewide average. The Medicare benchmarks do not warrant an adjustment to the ICC results.

As part of the rationale for the requested capital revenue increase, Bayview stated that the Hospital has not received adequate funding for the growth in volumes. Staff calculated that volume growth has been funded above 100 percent, well above the 50 percent standard level.

Bayview has moderately higher levels of potentially avoidable utilization than other Maryland hospitals. Bayview performs better than average on some quality measures and worse than average on others, and it lags behind on patient experience.

HSCRC staff is concerned that Bayview may not have projected adequate declines in utilization when it submitted its CON for bed replacement to the MHCC. Bayview's inpatient charges are relatively high compared to its competitors, and there is no rationale to build additional beds in anticipation of capacity reductions at other area hospitals. HSCRC staff has expressed these feasibility concerns to the MHCC as it undertakes its review of the Bayview CON.

Through application of the newly approved capital policy, HSCRC staff is recommending a revenue increase for a portion of Bayview's increase in capital costs of $16,168,521, which includes markup of 1.0978. These figures, if approved by the Commission, will be provided to the MHCC for its consideration in review of the Bayview CON application.

Recommendation

HSCRC staff recommends that the Commission:

Deny the general revenue increase request of $28.9 million effective July 1, 2019, because the hospital is not eligible for a revenue increase under the Interhospital Cost Comparison.

Approve a revenue increase of $16,168,521 for capital, to be effective upon the completion of the project to replace Bayview's inpatient facilities, adjusted for any changes to the markup of 1.0978 for uncompensated care and payer differential that was in effect during Fiscal Year 2019.

Nurse Support Program II
Competitive Institutional Grants Program
Review Panel Recommendations for FY 2021

May 13, 2020

Health Services Cost Review Commission

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This is a final recommendation for Commission consideration at the May 13, 2020 Public Commission Meeting.

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Introduction

This report presents recommendations for the Nurse Support Program II (NSP II) Competitive Institutional Grant Review Panel for Fiscal Year (FY) 2021. This report and recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and the Maryland Health Services Cost Review Commission (HSCRC or Commission). The FY 2021 recommendations align with both the Nurse Support Program (NSP) I and national nursing initiatives. An update is included on the status of the recommendations from the five-year program evaluation approved by HSCRC Commissioners on December 11, 2019.

Background

The HSCRC has funded programs to address the cyclical nursing workforce shortages since 1986. In July 2001, the HSCRC implemented the hospital-based Nurse Support Program I (NSP I) to address the nursing shortage impacting Maryland hospitals. Since that time, the NSP I completed three, five-year program evaluation cycles. The most recent renewal was approved on July 12, 2017 to extend the funding until June 30, 2022.

The HSCRC established the Nurse Support Program II (NSP II) on May 4, 2005, to increase Maryland's academic capacity to educate nurses [2006, chs. 221, 222]. The Commission approved funding of up to 0.1 percent of regulated gross hospital revenue to increase nursing graduates and mitigate barriers to nursing education through institutional and faculty focused initiatives. MHEC was selected by the HSCRC to administer the NSP II programs, as it is the coordinating board for all Maryland institutions of higher education. In 2012, the NSP II program was modified to include support for greater development of new and existing nursing faculty through doctoral education. At that time, revisions to the Graduate Nurse Faculty Scholarship also included renaming the nurse educator scholarship in honor of Dr. Hal Cohen and his wife Jo, a registered nurse. The Maryland All-Payer Model which launched in 2014, was an evolution of the Medicare waiver implemented successfully by the HSCRC for 36 years. At the conclusion of the first ten years of funding, in 2015, the HSCRC renewed funding for FY 2016 through June 30, 2020. In 2016, Senate Bill (SB) 108 was passed to remove the term "bedside" nurse from the statute to allow NSP I and NSP II to focus on improving the pipeline of nurses with the skills necessary to keep pace with the rapidly changing health care delivery system. In 2019, Maryland transitioned to the Total Cost of Care (TCOC) Model to bring health care provided outside the inpatient setting into the model. At the conclusion of the last funding cycle, in December 2019, the HSCRC renewed funding for another five years through June 30, 2025.

Alignment with NSP I and Institute of Medicine

In 2012, the NSP I and II initiatives were aligned with the Institute of Medicine (IOM) recommendations in its Future of Nursing report (2010). The NSP I continued core hospital initiatives and forged ahead with the Maryland Nurse Residency Collaborative. Maryland is the first state in the nation where all hospitals require a one-year residency for new graduate nurses. For NSP II, the key aims were:

- Increasing the numbers of pre-licensure graduates, and the proportion of nurses with a BSN or higher (80% BSN by 2020);
- Doubling the number of nurses with a doctoral degree (increasing preparation to 50 percent faculty with doctoral degrees by 2020);
- Recruiting and retaining faculty and promoting lifelong learning;
- Ensuring leadership opportunities for academic and practice nurses;
- Preparing faculty in clinical simulation and inter-professional education;
- Increasing the number of clinicians to serve as preceptors and clinical instructors; and
- Improving the nursing workforce infrastructure.

In 2020, the State met the IOM goal for doubling the number of doctoral prepared nurses and faculty. The proportion of BSN prepared nurses increased to 60 percent, with continued steady progress, so the goal is being raised to 80 percent BSN by 2025. Statewide programs engaged 650 nurses across education and hospital practice in formal preparation in leadership, clinical simulation, inter-professional education and preparing expert clinicians to serve as clinical faculty and preceptors. The HSCRC's investment in nursing education is recognized and appreciated across the State.

Nursing Workforce

The registered nurse (RN) workforce is the single largest group of health professionals, with more than three million nationally and estimated 53,150 employed in the State of Maryland (DLLR, 2020). A leading national nursing workforce researcher, Dr. Peter Buerhaus, and his team of economists found a near balance in supply and demand for registered nurses nationally, but advised that there are many variables that impact these figures, including nursing career decisions of the youngest nurses, the uncertainty of regional forecasts as nurses move between regions and the effects of RNs joining temporary staffing agencies (Buerhaus, et al., 2017). The Health Resources and Services Administration (HRSA) continues to explore systematic differences in state-based administrative data and analyze how each model handles entry to practice output. In fact, all researchers agree that "co-monitoring changes in RN entry is the single most important factor that affects each model and hence accuracy of its projections" (Auerbach, et al., 2017, pg. 294). Researchers are encouraging caution when using forecast models for policy and decision-making, as nursing shortages are highly sensitive to multiple variables and difficult to pinpoint beyond regional trends. (NSP II Report to HSCRC, December 11, 2019)

With this guidance, NSP II is monitoring the state-level data closely and will report on these points each year. We can access the actual number of nurse graduates in pre-licensure programs and changes in the educational skill level of the nursing workforce through the Maryland Higher Education Commission's data system. The number of newly licensed nurses entering the profession is available through the Maryland Board of Nursing's (MBON) number of first-time successful National Council Licensure Examination – Registered Nurse (NCLEX-RN) testers.

Since RN entry-to-practice is the most important factor affecting projections of the nursing workforce supply, this may be a better reflection of the number of new nurses in Maryland. Due

to several program changes, MBON first time NCLEX-RN testers trended down over the past five years, but the percent passing on the first attempt has increased (Table 1). In FY 2019, Maryland had a higher average first time pass rate than the national average for first time testers.

Table 1. Maryland's First Time NCLEX-RN Candidates FY 2015- FY 2019

Fiscal Year	Maryland BSN Programs		Maryland ADN Programs		Maryland MS Entry Programs		Total All Maryland Programs		Passing Rates	
	#Test	#Pass	#Test	#Pass	#Test	#Pass	#Test	#Pass	MD%	US%
FY 2015	1,207	930	1,658	1,355	70	64	2,935	2,349	80.03%	82.53%
FY 2016	1,158	957	1,557	1,291	44	37	2,759	2,285	82.82%	83.94%
FY 2017	961	806	1,457	1,252	163	150	2,581	2,208	85.55%	86.22%
FY 2018	773	676	1,316	1,145	261	240	2,350	2,061	87.70%	87.81%
FY 2019	867	743	1,375	1,245	305	275	2,339	2,071	88.54%	88.36%

Source: *Maryland Board of Nursing, National Council State Boards of Nursing, and Pearson Vue.*
All Maryland RN 1st time candidates who graduated from a Maryland nursing program and tested in any U.S. jurisdiction.

Candidates for licensing as a new nurse may be graduates of an Associate Degree in Nursing, Bachelor of Science in Nursing (BSN), second-degree BSN, or entry-level Master of Science (MS) in Nursing program. Last year, a third university started planning an entry-level MS in Nursing program. The first graduates from a new second-degree BSN program will be testing in FY 2020. We expect to see a trend of increased entry-level nurses over the next five years and will use this measure to report the most important factor affecting the nursing workforce projections each year to the Commission.

Advancing Nurse Faculty Excellence

The NSP II faculty-focused programs are all by nomination only. The Maryland Deans and Directors of Nursing Programs nominated 29 full-time nurse faculty who are eligible for the Academic Nurse Educator Certification (ANEC) award for FY 2020. Each faculty will receive $5,000 through their institution to fund ongoing professional development that is required to retain the credential. Nominations for each award cycle is due by March 15 every year in recognition of National Certification Month. NSP II partnered with the National League for Nursing (NLN) to host a series of Certified Nurse Educator (CNE) Workshops.

Over the past two years, 237 nurse faculty have attended one of the six CNE Workshops held in Columbia, Baltimore, and Bel Air, Maryland to prepare for the national examination. The added value of the workshops is the focus on the NLN's Nurse Educator Competencies. All participants benefit, whether an attendee is ready to test or reviewing best practices. Since inception of the ANEC award in 2019, 59 faculty achieved their CNE credential for the first time. An additional 27 renewed the CNE credential at the five-year mark. A total of 86 full-time faculty completed the requirements to be recognized as certified academic nurse educators. Maryland's CNE pass rate was 87.5 percent, compared to the national pass rate of 72 percent (NLN, March 30, 2020). There have been 13 community colleges and 10 universities with nominees for the award (83 percent participation). In order to renew, faculty must demonstrate continued excellence in the specialty practice of nursing education. This is a mark of distinction and demonstrates the

highest standards for educators charged with teaching all levels of nursing students. Maryland is leading the way in the increased proportion of nurse faculty who hold the CNE credential.

Maryland Nurse Educators

As 52 percent of experienced educators plan to retire in the next 10 years, the nurse educator workforce reflects a major shift that could be expected over the next decade for nursing overall. In the spring of 2020, 406 Maryland nurse educators in clinical and academic roles and 21 deans and directors were surveyed about MD nursing programs and the nursing workforce. The respondents were represented broadly; 40 percent representing faculty at community colleges, 13 percent were hospital nurse educators, 6 percent were nurse residency educators, and the remaining 41 percent represented faculty across the public and private universities. As nursing workforce researchers have warned of a gray tsunami with the aging of the nursing workforce, this voluntary survey confirms the wave of retirements is near. Thirty-eight percent of respondents were over age 55, 10 percent of whom were over 65 years old. This snapshot of educators underlines the importance of the NSP II nurse educator focused initiatives. The Maryland Educator Career Portal provides information for those interested in a nurse educator career, educational requirements, job openings, as well as, opportunities for the hospital or academic employers to post adjunct faculty, clinical instructors, and other nursing positions.

COVID-19 Adjustments in Nursing Education

With universities, four-year colleges, community colleges, and other schools adjusting the delivery of education due to the COVID-19 restrictions, innovation abounds. Nursing programs have moved traditional courses to online delivery through Learning Management Systems like Blackboard and Canvas. Some are using WebEx and ZOOM platforms to meet with their students. These platforms are being utilized for students to virtually join break-out rooms to preconference; use critical thinking and assessment skills; and participate in group debriefing sessions. Since March, the resources developed by NSP II over the past five years have been accessed with renewed purpose. NSP II developed virtual resources included the Video Simulation Library through Maryland Clinical Simulation Resource Consortium at Montgomery College, the Inter-professional simulation modules developed at Johns Hopkins University and the Toolkits for Leadership Development and psychiatric nursing scenarios developed at Salisbury University, along with other electronic resources for nursing programs and nurse residency programs. Over the past decade, NSP II has supported many nursing programs to redesign curriculum with the assistance of instructional designers in moving educational coursework to online delivery. Quality Matters (QM), a nonprofit that grew out of a small group of colleagues in the MarylandOnline (MOL) consortium, is an important review process that determines how to measure and guarantee the quality of an online course. Nursing online coursework benefited from the QM review processes to ensure rigor, consistency with grading rubrics, quality assurance, and evaluation. Nursing was well-positioned to be responsive to student learning needs.

In March, all of the nursing programs in Maryland donated to hospitals and public health systems their personal protective equipment (PPE) and supplies used in their Simulation Centers. Several larger schools had ventilators in their Simulation Centers that were donated for patient care. The

HSCRC and NSP II staff coordinated the donations for schools to share resources with their hospital partners. Everyone has made the necessary adjustments to protect lives and ensure we stay on course for nursing students to graduate.

Competitive Institutional Grants Program

Excellence in education and practice are the two primary overarching goals of the Nurse Support Program. Programs are directed to build educational capacity and increase the numbers of nurse educators for an adequate supply of well-prepared nurses for the hospitals and health systems. The Competitive Institutional Grants, available to nursing programs, are designed to increase the structural capacity of Maryland nursing schools through shared resources, innovative educational designs, and streamlined processes. The primary aims are to increase the number of graduates at the pre-licensure and advanced degree levels. Through providing support for preparing, recruiting, and retaining nurse faculty, the schools can ensure educational capacity to accept qualified nursing students.

Activities for funding may include the establishment of new degree programs, curriculum enhancement, redesign, and instructional technologies for online learning opportunities. These grants also contribute to the creation of a more diverse nursing faculty and workforce, as well as, preparing graduate-level nurses to serve as lecturers and/or clinical faculty at Maryland's higher education institutions. The funds are released to recipients in installments over the life of the grant which can be funded from 1-5 years, contingent upon adequate yearly progress.

Competitive institutional grants are awarded for projects addressing the following initiatives:

- Increasing nursing pre-licensure enrollments and graduates,
- Advancing academic preparation of entry-level nurses and existing nurses to meet the needs of hospitals and health systems (80 percent BSN by 2025),
- Doubling the number of nurses and nurse faculty with doctoral degrees,
- Academic/practice partnerships for hospitals and nursing programs to collaborate,
- Developing statewide resources and models for nurse educators at both hospitals and academia, and
- Cohen Scholars programs to prepare nurse educators for the future.

Implementation of Recommendations for Future Funding

The Nurse Support Program II (NSP II) Outcomes Evaluation FY 2016–FY 2020 and Final Recommendations for Future Funding was approved for five more years of funding by HSCRC Commissioners on December 11, 2019. Below is an update on the five recommendations that were approved by the Commission. Recommendations 1 through 3 have been completed, with slower progress being made on the remaining recommendations 4 and 5.

The first recommendation was renewal of funding support for NSP II going forward with the proven competitive institutional grants initiatives for a sound pipeline of new nurses and well-prepared nurse faculty. The funding was continued up to 0.1 percent of hospital regulated gross patient revenue for the next five years, FY 2021 through FY 2025.

The second recommendation was to form a Faculty Workgroup to review and revise the NSP II faculty focused programming including the New Nurse Faculty Fellowship, Nurse Educator Doctoral Grants for Practice and Dissertation Research, Academic Nurse Educator Certification and Hal and Jo Cohen Graduate Nurse Faculty Scholarship. This recommendation has also been met. The NSP II staff have worked closely with the Faculty Workgroup to make the recommended revisions to all 4 faculty-focused programs. The revisions increased the levels of support and balanced the recruitment incentives with rewards for longevity; while focusing on higher levels of education, and increased proportions of Maryland's full time nurse faculty holding the Certified Nurse Educator credential. All of the faculty focused program revisions are in place and effective with FY 2021.

One aspect of the revisions involved transitioning the Hal and Jo Cohen Graduate Nurse Faculty Scholarship program to the Competitive Institutional Grants Cohen Scholars program. NSP II staff will manage the program starting in FY 2021 in direct response to the Program Evaluation team's recommendations. The Cohen Scholars, a select group of highly competent nurse educators, will join the culture of education through relationship-based mentoring, teaching the nurses of the future as faculty in nursing programs and in hospital professional development specialist roles.

In February 2020, the Maryland Council of Deans and Directors of Nursing Programs approved the revisions and recommended a new program, the Nurse Faculty Recognition Award. This award is another tool for recognition and retention of experienced nurse faculty. It is currently under development and will launch in June. This program will be through nomination only, and it will recognize a select number of nurse faculty with notable achievements and proven impacts on students through their careers as successful educators. Nominees will be expected to have five or more years of longevity in their full-time position at a Maryland nursing program.

The third recommendation was to continue the established initiatives in the Competitive Institutional Grants program developed in 2015 at the conclusion of the first ten-year program evaluation. The FY 2021 request for applications was consistent with approved initiatives.

The fourth recommendation was to form an NSP I and NSP II Advisory Committee to address common issues. The first steps were to engage the Statewide Academic-Hospital Practice Partnership Task Force. As welcome additions, we were able to recruit engaged and knowledgeable members to focus on shared concerns in a smaller forum. The first project to complete is the standardized universal student onboarding requirement. A group of faculty and hospital leaders are working to approve a template that would standardize the process and reduce time to complete the student requirements for clinical rotations at hospitals across the State. The NSP I and II advisory committee hope to start meetings this summer.

The fifth recommendation was to support the Maryland Board of Nursing (MBON) in procuring the necessary data processing systems and work with multiple State agencies to improve the workforce data infrastructure that will better inform future recommendations. During the 2020 session of the Maryland General Assembly, Delegate Susan Krebs and colleagues introduced HB 1447 *Department of Information Technology – Study of a Common Information Technology*

Platform for Health Occupations Boards and Senator Addie Eckardt cross-filed Senate Bill 1045 with the same title. The bill's intent was to review information technology platforms across multiple health occupation boards to make recommendations on the feasibility and cost of developing common information technology platforms and report back to the General Assembly. However, due to the COVID-19 emergency, the Maryland Assembly adjourned sooner than expected and the bill never made it to a hearing. Neither bill received an unfavorable report which means they can be brought back next year. We support improved technology for the MBON. Further discussions are planned with the Maryland Nurses Association and MHEC to continue to support the MBON in the next legislative session, as the agency needs the tools to be more responsive to requests for nursing workforce data to be readily accessible to the public.

Fiscal Year 2021 Competitive Grant Process

In response to the FY 2021 request for applications (RFA), the NSP II Competitive Institutional Grant Review Panel received a total of 40 requests for funding, including 25 new competitive grant proposals for implementation, five planning grants, seven resource grants, and three continuation grant requests. The nine-member panel, comprised of former NSP II grant project directors, retired nurse leaders, hospital executives, nurse educators, licensure and policy leaders, and MHEC and HSCRC staff, reviewed the proposals. All competitive grant proposals received by the deadline were scored by the panel according to the rubric outlined in the FY 2021 RFA. The review panel convened and developed consensus around the most highly recommended proposals. For non-funded proposals, the panel provides feedback to the institutions for future proposal development and encourages them to resubmit next year.

As a result, the review panel is recommending funding for 29 of the 40 total proposals. The recommended proposals include multi-year grants for planning, full implementation of programs, continuation of programs, as well as, nursing program resource grants, totaling $29.3 million for up to five years. The FY 2021 funding includes a reallocation of $12 million from the MHEC's Office of Student Financial Assistance (OSFA) to transition the former Hal and Jo Cohen Graduate Nurse Faculty Scholarship to the NSP II Competitive Institutional Grants Cohen Scholars program. NSP II staff will work closely with future Cohen Scholars programs and all graduate nursing programs to ensure that the recipients are prepared and ready to fulfill their service obligation to teach nurses across all program levels. The transition of the program has been completed through the Faculty Workgroup, in collaboration with NSP II and OSFA.

The proposals that received the highest ratings for funding focused on nursing graduate outcomes with partnerships across community colleges, universities and hospital health systems. The funding award for one year will be $7.9 million. Table 2 lists the recommended proposals for FY 2021 funding.

Table 2. Final Recommendations for Funding for FY 2021

Proposal	Nursing Program	Project Name	Total Funding
NSP II-21-103	Carroll Community College	Academic Progression: ATB Enrollment and Collaboration	$140,484
NSP II-21-104	Cecil College	Academic Progression in Nursing Initiative	$330,923
NSP II-21-105	Coppin State University	Planning HBCU PhD./DNP Consortium	$147,663
NSP II-21-106	Frostburg State University	Planning for the future: Expanding pre-licensure capacity	$220,714
NSP II-21-107	Harford Community College	Meeting Nursing Workforce Needs: A Collaborative Approach	$2,100,663
NSP II-21-108	Johns Hopkins University	Developing Genomics Literacy in Nursing Practice (EINSTEIN Project)	$145,111
NSP II-21-110	Johns Hopkins University	DNP in Nurse Anesthesiology	$2,085,872
NSP II-21-111	Johns Hopkins University	Supporting Nursing Advanced Practice Transitions (SNAPT)	$886,378
NSP II-21-112	Johns Hopkins University	R3-Renewal, Resilience & Retention for MD Nurses	$1,228,579
NSP II-21-114	Morgan State University	Statewide Student Mentoring Initiative/Implementation of Mentoring	$146,722
NSP II-21-115	Notre Dame of Maryland University	Academic-Practice Partnership: home healthcare transition to practice	$134,244
NSP II-21-117	University of Maryland	Care Coordination Educational to Practice Scale Up	$1,343,858
NSP II-21-118	University of Maryland	Substance Use and Addictions Nursing Education Implementation	$584,484
NSP II-21-120	University of Maryland	Entry Level BSN Expansion: UMSON @ Shady Grove	$1,081,606
NSP II-21-122	University of Maryland	Head Start Partnership to Expand Pediatric Clinical Opportunities	$918,069
NSP II-21-201	Frostburg State University	Nurse Educator Cohen Scholars	$490,836
NSP II-21-202	Johns Hopkins University	Cohen Scholars Faculty Cohort	$3,487,944
NSP II-21-203	Notre Dame of Maryland University	NDMU Cohen Scholars	$1,688,783
NSP II-21-204	Stevenson University	Cohen Scholars Model	$1,599,738
NSP II-21-205	Salisbury University	Cohen Scholars Cohort Model	$979,319
NSP II-21-206	University of Maryland	Advancing Nurse Educator Skills to Meet the Needs of Tomorrow	$3,987,694
NSP II-21-207	Montgomery College	Maryland Clinical Simulation Resources Consortium	$1,164,017
NSP II-21-208	Salisbury University	Faculty Academy and Mentorship Initiative of Maryland (FAMI-MD)	$2,490,851
NSP II-21-209	University of Maryland	Nurse Leadership Institute	$1,718,866
NSP II-21-125	Allegany College of Maryland	Resource grant for ACEN reaccreditation	$5,485
NSP II-21-126	Carroll Community College	Resource grant faculty development	$52,000
NSP II-21-128	Prince George's Community College	Resource grant for faculty development	$14,230
NSP II-21-129	Morgan State University	Resource grant for faculty development	$7,000
NSP II-21-130	Stevenson University	Resource grant for electronic testing	$80,265
TOTAL			**$29,262,397**

Recommendations

HSCRC and MHEC staff recommend the 29 proposals presented in Table 2 for the FY 2021 NSP II Competitive Institutional Grants Program. This final recommendation specifies the panel recommendations for Commission approval. The most highly recommended proposals include:

- Expanding enrollments for 77 additional Associate Degree Nursing graduates at Harford Community College with 286 BSN completions in partnership with Towson University and UM Upper Chesapeake Health.
- Planning a BSN program to expand pre-licensure capacity at Frostburg State University.
- Implementing a new Certified Registered Nurse Anesthetist (CRNA) program at Johns Hopkins University in partnership with Johns Hopkins Healthcare System (JHHS).
- Continuing the Faculty Academy and Mentoring Initiative (FAMI), at Salisbury University to include advanced curriculums and expanded partners at schools and hospitals across the state to prepare 500 clinical instructors.
- Implementing Care Coordination Education to Practice programs at the University of Maryland with University of Maryland Medical Center (UMMC) and UM Midtown hospitals.
- Implementing the R3- Renewal, Resilience and Retention program at Johns Hopkins University for nurses, nurse residents, educators, and faculty at four universities, two

community colleges and six hospital partners including Anne Arundel Medical Center, the Johns Hopkins Hospital, UMMC, Peninsula Regional Medical Center, and Atlantic General Hospital.

- Expanding enrollments and entry-level BSN graduates at the University of Maryland at Shady Grove with 180 additional BSN graduates projected over five years.
- Planning a Historically Black College and Universities (HBCU) Consortium to develop dual PhD and DNP program opportunities at Coppin State University.
- Supporting academic progression initiatives to expedite the completion of the BSN at two nursing programs: Cecil College and Carroll Community College.

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Draft Recommendation for the Update Factors for Rate Year 2021

May 13, 2020

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This document contains the draft staff recommendation for the RY 2021 Update Factors. Please submit comments on this draft to the Commission by May 21, 2020 to hscrc.payment@maryland.gov

Table of Contents

List of Abbreviations

ACA	Affordable Care Act
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
HSCRC	Health Services Cost Review Commission
MPA	Medicare Performance Adjustment
PAU	Potentially avoidable utilization
QBR	Quality Based Reimbursement
RY	Rate year, which is July1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care

Summary

The following report includes a draft recommendation for the Update Factor for Rate Year (RY) 2021. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness, both during and after the COVID-19 response, and to keep healthcare affordable in the State of Maryland.

This update factor generally follows approaches established in prior years for setting the update factors. Staff recognizes that the COVID-19 crisis has created significant uncertainty and will likely drive large short and long-term changes in the healthcare industry. However, in order to maintain simplicity and stability during the crisis this policy reflects approaches established prior to the COVID-19 crisis and does not explicitly address COVID-19 specific challenges. Staff plans to continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis.

At this time, the staff requests that Commissioners consider the following draft recommendations:

a) Provide an overall increase of 3.50 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.33 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.

b) Provide an overall increase of 2.37 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

c) Continue to work with all stakeholders to address specific COVID-19 issues such as anticipated hospital undercharges, the challenge of maintaining affordability in a time of economic crisis and the need to ensure sufficient ongoing health system liquidity.

d) The Total Cost of Care Contract and the Commission's mandate both assume that hospital rate increases maintain the affordability of care for all Marylanders. This responsibility has been acknowledged through a cumulative test against a static historic average Gross State Product (GSP) in the Total Cost of Care contract, and more recently through a comparison to recent GSP in the FY20 and FY21 Update Factor Recommendations and the acknowledgement of maintaining growth below GSP in the MPA Framework and Capital Policies approved by the Commission. However, none of these policies create an active, defined method for evaluating and enforcing the affordability of hospital rates against GSP, when setting the update factor. In addition there are inconsistencies in the calculations required under the guardrail tests in the Medicare Total Cost of Care contract and the Commission's approach to rate setting. To address these issues the Commission should task staff with:

    i) Developing, by December 31st 2020, in conjunction with industry, a recommendation for evaluating future update factors against GSP, over the most recent 1 to 5 years, as a proxy for affordability. The recommendation should include both (1) a method of evaluation and (2) concrete policies for adjusting the update factor should the inflation provided not meet the affordability standard in future years.

ii) Preparing in the same time frame, in conjunction with industry, a report discussing how Maryland hospital rates relate to the premiums paid for commercial insurance as maintaining the affordability of healthcare for Marylanders also requires that hospital rates are translated into affordable premiums.

iii) Working with CMS to assess the feasibility of converting the Medicare guardrail test to a Fiscal Year basis and utilizing retrospective Medicare growth rates in Medicare tests in a way that recognizes multiple years of results.

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 extraordinary circumstances of the COVID-19 response in the development of the update factor. Specifically, while staff will implement any and all adjustments that had a performance period prior to the onset of COVID-19 pandemic in the United States (e.g. CY 2019 Market Shift, RY 2021 Readmissions Reduction Incentive Program), staff will not reduce inflation or anticipated utilization growth (related to general population growth) due to total cost of care performance, for either the annual savings rate test or the annual total cost of care guardrail test.

Staff recognizes that this approach will result in projected dissavings to Medicare in CY 2020 of 0.34%, and staff also acknowledges that this is at odds with the direction taken in recent update factors to ensure Maryland Medicare cost growth does not exceed prior year national Medicare growth. However, given Maryland's overall Medicare savings in the Total Cost of Care contract to date ($335 million annual savings relative to a contractually obligated value of $300 million by 2023), and Maryland's positive performance in the total cost of care guardrail the last two years (1.3% below the nation in 2018, 0.3% below in 2019), staff believes the proposed update factor will provide greater certainty to an industry in the midst of a pandemic while not jeopardizing the continuance of the Total Cost of Care Model.

Moreover, the estimated dissavings of 0.34% likely will not violate the total cost of care guardrail tests, assuming Maryland and the nation experience volume fluctuations and regulatory financing responses related to COVID-19 in a similar fashion, because it is still below growth of 1% relative to the nation and it will not represent two consecutive years of growth in excess of the nation (due to the aforementioned positive performance the past two years). If the 1% guardrail threshold is triggered, the reason is likely due to the extraordinary circumstances of COVID-19, which will necessitate invoking the exogenous factor clause in the Total Cost of Care contract. Finally, staff would note that while the proposed test of assessing projected Maryland total cost of care growth to prior year national growth reduces many uncertainties in the annual update factor formulation, it has a potential flaw if multiple years of unforeseen positive performance relative to national Medicare compound, and then this accumulation of savings relative to the nation is not accounted for in future update factors. As such, staff proposes to convene a workgroup to establish a more permanent benchmark for assessing Medicare total cost of care growth that complies with the tenets of the Total Cost of Care contract and responsibly credits hospitals

for continued Medicare savings. Staff will also endeavor to create a defined method for assessing the affordability of healthcare in Maryland, one that creates an active, defined method for evaluating and enforcing the affordability of hospital rates against GSP, in accordance with the contractual requirement to limit the growth in hospital costs in line with economic growth.

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 2023 ("the Medicare TCOC Savings Requirement"), continue quality improvements, and improve the health of the population. 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 ensure that the RY 2021 annual update is in line with these Model requirements is outlined in this report, but as mentioned, is not considered in the final development of the RY 2021 Update Factor because of the extraordinary circumstances of the COVID-19 pandemic and due to the fact that Maryland has already met the five year goal for Medicare total cost of savings rate and maintained healthcare inflation below GSP growth.

Update Factors are Revenue Updates

It is important to note that the proposed update factor 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.

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.

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 on the basis of those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital.

This recommendation proposes Rate Year (RY) 2021 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Draft Update Factors Recommendations

For RY 2021, HSCRC staff is proposing an update of 3.33 percent per capita for global revenues and an update of 2.37 percent for non-global 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 Fourth Quarter 2019 market basket growth estimate with a capital growth estimate. For RY 2021, HSCRC staff combined 91.20 percent of Global Insight's Fourth Quarter 2019 market basket growth of 2.90 percent with 8.80 percent of the capital growth estimate of 1.40 percent, calculating the gross blended amount as a 2.77 percent inflation adjustment.

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 FFY 2021 Inpatient Psychiatric Facilities Medicare productivity reduction of 0.40 percent to the inflation adjustment. When subtracting the 0.40 percent productivity adjustment from the gross blended inflation adjustment of 2.77 percent growth, this results in a proposed update of 2.37 percent. Additionally, HSCRC staff note that these hospitals receive a volume adjustment, rather than a population adjustment. HSCRC staff continues to work toward implementing quality measures for these hospitals in future rate years.

Table 1

	Global Revenues	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	2.77%	2.77%
Productivity Adjustment		-0.40%
Proposed Update	2.77%	2.37%

Update Factor Recommendation for Global Budget Revenue Hospitals

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

- Meeting the requirements of the TCOC Model agreement;
- 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 TCOC Model; and
- Incorporating quality performance programs.

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 3.47 percent and per capita growth of 3.30 percent for RY 2021. After accounting for changes in uncompensated care and assessments, the HSCRC estimates net revenue growth at 3.50 percent with a corresponding per capita growth of 3.33 percent for RY 2021.

Staff needs to split the annual Rate Year revenue into six month targets to calculate financial tests, which are performed on Calendar Year (CY) results. Consistent with the past several years, the staff will 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 2021 estimated revenue used to evaluate the Rate Year year-end target. Of note, there are a few hospitals that do not follow this seasonal pattern, particularly Atlantic General Hospital. Thus, HSCRC staff will adjust the revenue split to accommodate their normal seasonality.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC staff's draft 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 2021			
Components of Revenue Change Linked to Hospital Cost Drivers/Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 3.10% for compensation)			2.64%
- Rising **Cost of Outpatient Oncology Drugs**			**0.13%**
Gross Inflation Allowance	**A**		**2.77%**
Care Coordination/Population Health			
- Regional Partnership Grant			0.19%
Total Care Coordination/Population Health	**B**		**0.19%**
Adjustment for Volume			
-Demographic /Population			0.16%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**0.16%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		**0.25%**
- Low Efficiency Outliers	E		**0.00%**
- Capital Funding	F		**0.03%**
- Complexity & Innovation	G		**0.10%**
-Reversal of one-time adjustments for drugs	H		**-0.03%**
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.34%**
Quality and PAU Savings			
-PAU Savings	J		**-0.28%**
-Reversal of prior year quality incentives	K		**0.19%**
-QBR, MHAC, Readmissions			
-Current Year Quality Incentives	L		**0.41%**
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**0.32%**
Total Update First Half of Rate Year 21			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**3.79%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1+0.16%)	**3.62%**
Adjustments in Second Half of Rate Year 21			
-Oncology Drug Adjustment	P		**0.00%**
-QBR	Q		**-0.32%**
Total Adjustments in Second Half of Rate Year 21	**R =**	P + Q	**-0.32%**
Total Update Full Fiscal Year 21			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**3.47%**
Per Capita Fiscal Year	**T =**	(1+S)/(1+0.16%)	**3.30%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		**0.12%**
-Deficit Assessment	V		**-0.09%**
Net decreases	**W =**	U + V	**0.03%**
Total Update First Half of Rate Year 21			
Revenue growth, net of offsets	**X =**	N + W	**3.82%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1+0.16%)	**3.65%**
Total Update Full Rate Year 21			
Revenue growth, net of offsets	**Z =**	S + W	**3.50%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1+0.16%)	**3.33%**

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

HSCRC staff accounted for a number of 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 2.77 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's Fourth Quarter 2019 market basket growth of 2.90 percent with 8.80 percent of the capital growth index change of 1.40 percent. The adjustment for inflation includes 3.10 percent for compensation. A portion of the 2.77 inflation allowance (0.13 percent) will be allocated to hospitals in order to more accurately provide revenues for increases in outpatient oncology drugs. This drug cost adjustment is further discussed below.

- **Rising Cost of New Outpatient Drugs:** The rising cost of drugs, particularly of new physician-administered outpatient infusion and oncology drugs in the outpatient setting, continues to be a concern among hospitals, payers, and consumers. Not all hospitals provide these services and some hospitals have a much larger proportion of costs allocated. To address this situation, staff began allocating a specific part of the inflation adjustment to fund increases in the cost of drugs in RY 2016, based on the portion of each hospital's total costs that were comprised of drug costs. In RY 2020 this was refined to focus increases on the hospitals with the high-cost, outpatient infusion and oncology drugs that drive the overall drug inflation.

  In addition to the drug inflation allowance, in RY 2017, HSCRC initiated a utilization adjustment for changes in use of high cost oncology and infusion drugs. The adjustment for change in use is made utilizing information from the HSCRC's Casemix dataset and a supplemental report provided by the hospitals for a list of specified outpatient medications. 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.

  For 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.

- **Care Coordination / Population Health:** In January 2020, The Commission approved $25.3 million which was 0.25 percent in RY2020 hospital rates for funding streams that focus on Diabetes & Management and Behavioral Health Crisis Program. The 0.25 percent will be reduced by 0.06 percent due to unspent funds from prior rate years, which ultimately reduces the amount included in RY 21 rates to 0.19 percent.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2020 is 0.16 percent. For RY 2021, the staff are proposing recognizing the full value of the 0.16 percent growth for the Demographic Adjustment to hospitals in keeping with prior year norms.

- **Set-Aside for Unforeseen Adjustment:** Staff recommends a 0.25 percent set-aside for unforeseen adjustments during RY 2021.
- **Capital Funding:** Suburban Hospital received approval in 2015 for a Certificate of Need (CON) totaling $200 million to replace and renovate the Hospital facility. The Commission approved a $7.7 million capital adjustment as part of Suburban's Full Rate Application in RY2020. The hospital received $2.6 million for this adjustment in RY2020. The remaining $5.1 million of the capital adjustment is included in RY2021. To account for the remaining capital adjustment, 0.03 percent is included in the update factor for RY2021.
- **Complexity and Innovation (previously known as 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. Based on this analysis, staff concluded that the historical average growth rate was 0.43 percent, which equates to a combined State impact of 0.10 percent for the RY 2021 Update Factor.
- **Quality Scaling Adjustments:** The RY 2020 adjustments have been restored in the base for the Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement (QBR) adjustment. New adjustments are reflected in staff's recommendation. The amount for RRIP and MHAC, which will be adjusted for in the first half of the rate year, is 0.41 percent of total permanent revenue. CMS provides data for the Quality Based Reimbursement (QBR) adjustment. Due to the data delivery schedule, HSCRC does not have the final data available to calculate the QBR adjustment at this time. HSCRC expects the QBR adjustment to be approximately -0.32 percent of total permanent revenue, based on the changes in Commission policy and preliminary modeling. HSCRC staff will include the QBR adjustment in the second half of RY 2021.
- **PAU Savings Reduction:** The statewide RY 2021 PAU savings adjustment is now calculated based on update factor inflation and demographic adjustment applied to CY 2019 PAU revenue. RY 2021 PAU savings adjustment represents the change between RY 2020 and RY 2021. Previous years of PAU savings adjustments are not reversed out.

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 neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2021 will be 0.12 percent. The amount in rates was 4.26 percent in RY 2020, and the proposed amount for RY 2021 is 4.38 percent.
- **Deficit Assessment:** The legislature reduced the deficit assessment by $15 million in RY 2021, and as a result, this line item is -0.09 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 is included in the Update Factor Recommendation; however, a PAU measurement report was presented separately to the Commission in March.

Starting in RY 2020, the incremental amount of statewide PAU Savings reductions is determined formulaically using inflation and demographic adjustment applied to the amount of PAU revenue (see Table 3). This will result in a RY 2021 PAU savings reduction of -0.28 percent statewide, or $49,415,935. Hospital performance on avoidable admissions per capita and sending readmissions estimated revenue determines each hospital's specific PAU savings reduction.

Table 3

Statewide PAU Reduction		**Value**
RY 2020 Total Estimated Permanent Revenue	A	17,648,548,348
RY 2020 Inflation Factor (preliminary)	B	2.72%
Total RY20 PAU $	C	$1,844,766,206
RY 2020 Revenue Adjustment $	D=B*C	-$50,177,641
Ry 2020 Revenue Adjustment %	E=round(D/A)	-0.28%
RY 2020 Revenue Adjustment $ - Rounded	F = E*A	$49,415,9354

*Does not include revenue from Grace, UM-Laurel, or free standing EDs.

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. Additionally, based on staff calculations, the proposed update falls within the financial parameters of the TCOC Model agreement requirements. The staff's considerations in regards to the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

Based on the staff's calculations, the proposed update keeps Maryland within the constraints of the TCOC Model's Medicare savings 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 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 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 added up to determine the total *hospital* savings. The TCOC Model requires that the State reach *annual* 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 over time to meet the new TCOC Medicare Savings Requirements. The new TCOC Model contains specific annual Medicare Savings Requirements for each year. Based on the CY 2019 performance, staff calculates that Maryland hospitals have exceeded the TCOC Model's annual Savings Requirement of $120 million for performance year one (CY 2019), reaching $335 million in savings. However, similar to the All-Payer Model, there is a second financial test on the TCOC growth guardrails. Maryland's Medicare TCOC growth may not exceed the national Medicare TCOC growth rate in any two successive years and Maryland may not exceed the national growth rate by more than one percent in any year. Corrective actions are required if these limits are exceeded.

The growth in Medicare expenditures in Maryland outside of hospitals continues to exceed the national growth rate. Under the All-Payer Model, the HSCRC built a conservative approach to estimating variations in hospital cost growth. For the Total Cost of Care Model, HSCRC staff proposes to extend this approach to evaluating variations in Total Cost of Care performance. This revised approach will be discussed in the following section.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In order to ensure Model savings and guardrails are being met, staff compared Medicare growth estimates to the all-payer spending limits. Because the actual revenue resulting from updates in RY 2020 affect the CY 2020 results, staff must convert the recommended RY 2021 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2020 to assist in estimating the impact of the recommended update factor together with the projected RY 2019 results. The overall increase from the bottom of this table is used in Table 5a.

Table 4

Estimated Position on Medicare Target		
Actual Revenue CY 2019		17,895,385,316
Adjust for MU Change 1/31/19-6/30/19		106,559,120
Adjusted Actual Revenue CY 2019		18,001,944,436
Step 1:		
Estimated Approved GBR RY 2020		18,383,120,012
Actual Revenue 7/1/19-12/31/19		9,015,458,624
Approved Revenue 1/1/20-6/30/20	**A**	**9,367,661,388**
Step 2:		
Estimated Approved GBR RY 2021		19,084,932,442
Permanent Update		3.82%
Step 3:		
Estimated Revenue 7/1/20-12/31/20(after 49.73% & seasonality)		9,490,936,903
Estimated Undercharge Percentage**		(101,553,025)
Projected Revenue 7/1/20-12/30/20	**B**	**9,389,383,878**
Step 4:		
Estimated Revenue CY 2020	**A+B**	**18,757,045,266**
Increase over CY 2019 Revenue		4.19%

Steps to explain Table 4 are described as below:
The worksheet begins with actual revenue for CY 2019. This revenue is adjusted for the impact of the "Differential Adjustment" that was made on July 1, 2019 and not included in the first six months of actual revenue from January 1, 2019 to June 30, 2019.

· Step 1: The table uses estimated global revenue for RY 2020 and actual revenue for the last six months for CY 2019 to calculate the projected revenue for the first six months of CY 2020 (i.e. the last six months of RY 2020).

· Step 2: This step shows the estimated RY 2021 global budget revenue based on the information that staff have available to date. The permanent update over RY 2019 of 3.82 percent represents the portion of the RY 2021 update provided during the calendar year 2020, as shown in Table 2.
· Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2021 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2021 and estimated undercharge adjustment.
· Step 4: This step shows the resulting estimated revenue for CY 2020 and then calculates the increase over actual CY 2019 Revenue.

For the past five updates, Maryland obtained calendar year Medicare fee-for-service growth estimates from the CMS Office of the Actuary. The projected per capita amount for Medicare Parts A and B for CY 2020 is 4.28 percent. Due to the variability in the estimates from actual performance, particularly with estimates beyond the current year, staff is proposing using actual national Medicare FFS total cost of care growth from the previous calendar year moving forward in our guardrail and savings test, absent large policy changes that would suggest significantly different growth estimates. National Medicare FFS total cost of care growth for CY 2019 was 3.84 percent, shown in line A of Table 5a and 5b.

During CY 2014-CY 2019, all-payer growth outpaced Medicare growth on a per capita basis and in the updates staff adjusted the all-payer growth limit using the difference in Medicare and all-payer per capita growth to estimate the implied limit for Medicare.

For the purposes of evaluating the maximum all-payer spending growth that will allow Maryland to meet the per capita Medicare FFS target, the Medicare target must be translated to an all-payer growth limit. There are several ways to calculate the difference between Medicare FFS and all-payer growth rates using recent data trends. A consultant to CareFirst developed a “conservative difference statistic" that reflected the historical increase in Medicare per capita spending in Maryland relative to all-payer per capita spending growth. This conservative statistic has been updated each year using data provided by HSCRC. For the RY 2021 update, CareFirst and HSCRC staff calculated a difference of 0.95 percent, which used a five-year average difference between Maryland Medicare and all-payer claims reduced by the average annual absolute variance.

Maryland Medicare total cost of care cannot exceed national Medicare total cost of care growth by one percent in any single year and cannot exceed the national growth by any amount in two consecutive years; these are known as ‘total cost of care guardrails.’ In an effort to ensure that Maryland does not exceed the national Medicare growth rate in CY 2020, staff modeled the impact of excess non-hospital growth on the maximum hospital update that could be provided. This calculation assesses Medicare growth in unregulated settings and factors this excess growth into allowable hospital rate increases for RY 2021. Staff modeled non-hospital excess growth, inclusive of a conservative factor of -1.10 percent, which was calculated by taking a six year average of non-hospital excess growth and additionally accounting for the absolute average variance to provide conservatism.

In prior years the staff has included a 0.50 percent reduction in the Medicare Growth target to ensure the State achieves savings under the All-Payer Model. This year we omitted that adjustment in both tables 5a and 5b. Starting with Fiscal 2020 this target adjustment is no longer necessary, as the Commission

approved the MPA Framework in the fall of 2019. The MPA Framework provides a vehicle for achieving savings on a Medicare-only basis if needed to meet contract targets.

The first scenario, shown in Table 5a calculates savings using the calendar year growth calculated in Table 4. The second scenario, shown in Table 5b calculates savings using the full rate year growth projection from lines AA & Z on Table 2.

Table 5a – Using Calendar Year Growth Estimate

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare TCOC Growth (CY2019 3.84%)	A	3.84%		
Savings Goal for FY 2021	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	3.84%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer *with conservatism*		0.95%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation *with conservatism*		-1.10%		
Net Difference Statistic Related to Total Cost of Care	D	-0.15%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**3.68%**	**4.03%**	**-0.34%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.16%)-1	F	**3.85%**	**4.19%**	**-0.34%**

Table 5b – Using Rate Year Growth Estimate

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare TCOC Growth (CY 2019 3.84%)	A	3.84%		
Savings Goal for RY 2021	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	3.84%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer *with conservatism*		0.95%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation *with conservatism*		-1.10%		
Net Difference Statistic Related to Total Cost of Care	D	-0.15%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**3.68%**	**2.87%**	**0.81%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.16%)-1	F	**3.85%**	**3.04%**	**0.81%**

Staff also modeled the growth and compared it to economic growth in Maryland as measured by the State Gross Domestic Product (State GDP, which was previously called the Gross State Product (GSP)). The purpose of this modeling is to ensure that healthcare remains affordable in the state. Staff calculated the compounded annual growth rate (CAGR) for three years using the most updated State GDP numbers available. (CY16-CY19). The 3-year CAGR calculation shows a per capita amount of 3.39 percent. Staff compared that number to the calendar year increase shown in Table 6 to ensure that the update provided in this draft recommendation would maintain growth in line with economic growth. The chart below shows this comparison. The proposed update factor, on a calendar year basis, shows growth above the 3-year CAGR calculation for State GDP. Last year the update factor was 0.4% below the GDP. Staff believes that the proposed update factor will provide greater certainty to an industry in the midst of a

pandemic. The draft recommendation contained in this report suggest that work be conducted, with stakeholders, to produce a more nuanced method to evaluate affordability and to create additional policies for adjusting the update factor should the inflation provided not meet the affordability standard in future years.

Table 6 – Using Calendar Year Growth Estimate

Maximum Increase that Maintains Affordability				
State Gross Domestic Product per Capita (3 year CAGR 3.39%)	A	3.39%	Recommendation:	Savings:
Savings Goal for FY 2021	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	**3.39%**	**4.03%**	**-0.64%**
Conversion to total All-Payer revenue growth (1+C)*(1+0.16%)-1	D	**3.56%**	**4.19%**	**-0.64%**

Medicare's Proposed National Rate Update for FFY 2021

Traditionally CMS provides published proposed updates to the federal Medicare inpatient rates for FFY 2021 in the Federal Register. These updates haven't been provided at this time. Staff will continually monitor CMS websites for updates.

Stakeholder Comments

HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2021 update. HSCRC staff will update this section when the official stakeholder comment period has closed.

Recommendations

Based on the currently available data and the staff's analyses to date, the HSCRC staff provides the following draft recommendations for the RY 2020 update factors.

a) Provide an overall increase of 3.50 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.33 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.

b) Provide an overall increase of 2.37 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

c) Continue to work with all stakeholders to address specific COVID-19 issues such as anticipated hospital undercharges, the challenge of maintaining affordability in a time of economic crisis and the need to ensure sufficient ongoing health system liquidity.

d) The Total Cost of Care Contract and the Commission's mandate both assume that hospital rate increases maintain the affordability of care for all Marylanders. This responsibility has been acknowledged through a cumulative test against a static historic average Gross State Product (GSP) in the Total Cost of Care contract, and more recently through a comparison to recent GSP in the FY20 and FY21 Update Factor Recommendations and the acknowledgement of maintaining growth below GSP in the MPA Framework and Capital Policies approved by the Commission. However, none of these policies create an active, defined method for evaluating and enforcing the affordability of hospital rates against GSP, when setting the update factor. In addition there are inconsistencies in the calculations required under the guardrail tests in the Medicare Total Cost of Care contract and the Commission's approach to rate setting. To address these issues the Commission should task staff with:

   i) Developing, by December 31st 2020, in conjunction with industry, a recommendation for evaluating future update factors against GSP, over the most recent 1 to 5 years, as a proxy for affordability. The recommendation should include both (1) a method of evaluation and (2) concrete policies for adjusting the update factor should the inflation provided not meet the affordability standard in future years.

   ii) Preparing in the same time frame, in conjunction with industry, a report discussing how Maryland hospital rates relate to the premiums paid for commercial insurance as maintaining the affordability of healthcare for Marylanders also requires that hospital rates are translated into affordable premiums,

   iii) Working with CMS to assess the feasibility of converting the Medicare guard rails to a Fiscal Year basis and utilizing retrospective Medicare growth rates in Medicare tests in a way that recognizes multiple years of results.

Draft Recommendation: Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2021 Funding to Support HIE Operations, CRISP Reporting Services and the ICN Project

May 13, 2020

Health Services Cost Review Commission

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This document contains the draft staff recommendations for the Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2021 Funding to Support HIE Operations, CRISP Reporting Services and the ICN Project. Comments on the draft policy may be submitted by email to william.henderson@maryland.gov and are due by May 21, 2020.

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LIST OF ABBREVIATIONS

BRFA	Budget Reconciliation and Financing Act
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
CRP	Care Redesign Program
CRS	CRISP Reporting Services
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
ICN	Integrated Care Network
MDH	Maryland Department of Health
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan
MMIS	Medicaid Management Information Systems
PDMP	Prescription Drug Monitoring Program

OVERVIEW AND 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 draft recommendation identifies the following amounts of State funding support for fiscal year (FY) 2021 to the Chesapeake Regional Information System for our Patients (CRISP):

- Health Information Exchange (HIE) operations ($1,500,000)
- Implementation Advanced Planning Document (IAPD) matching funds ($1,000,000)
- Integrated Care Network (ICN) Program Support ($1,110,000)
- Medicaid Management Information System (MMIS) matching funds ($1,560,000)

Therefore the recommendation is that the HSCRC provide total funding of $5,170,000 to CRISP. This reflects a decrease of $220,000 from FY 2020 funding of $5,390,000.

This funding represents approximately 24 percent of CRISP's Maryland funding, excluding the Prescription Drug Monitoring Program which has its own funding source. The remainder of CRISP's Maryland funding is from user fees and Federal matching funds. This equivalent value was 23 percent in the prior year. The HSCRC assessment request is 14 percent of total CRISP funding for FY 2021, when funding from other states is included.

While this assessment declined slightly, overall CRISP activities will continue to expand because ongoing operating costs for HIE services continue the planned shift to user fees resulting in an overall increase in CRISP operating capacity. CRISP, in partnership with Medicaid, also continues to leverage federal funding through IAPD and MMIS matching grants.

However, the HITECH IAPD funding used to drive much of the CRISP project development is terminating September 30, 2021. Sustainable operations funding for these activities is available through the Federal MMIS program with an increase in State matching from 10 percent to 25 percent. As a result, the total funds requested for matching has increased for FY 2021 and is likely to continue to increase in FY 2022.

In recognition of this future funding change, CRISP is focusing FY 2021 on achieving operational efficiencies with a goal of maximizing current investments.

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

BACKGROUND – PAST FUNDING

Over the past nine 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, FYs 2010-2019

CRISP Budget: HSCRC Funds Received	
FY 2010	$4,650,000
FY 2011	No funds received
FY 2012	$2,869,967
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

In December 2013, the Commission authorized staff to provide continued funding support for CRISP for FYs 2015 through 2019 without further Commission approval as long as the amount does not exceed $2.5 million in any year. Since FY 2020, when Maryland Health Insurance Plan (MHIP) funding terminated, requests have exceed that amount and require Commission approval.

FY 2020 FUNDING THROUGH HOSPITAL RATES

Beginning in FY 2020, when MHIP funding was no longer available, HSCRC assumed full responsibility for managing the CRISP assessment where it was 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. The remaining section details the infrastructure and support that will be funded in FY 2021 through the hospital rate setting system.

HIE Operations Funding

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 2019. 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.

The total amount of funding recommended by staff for FY 2021 for the HIE function is $1,500,000.

Implementation Advanced Planning Document (IAPD) Matching Funds

In addition to its role in HIE among providers, CRISP is also involved in health care transformation activities related to HSCRC, MHCC, and the Maryland Department of Health (MDH). In its collaboration with the Medicaid program, uniform and broad-based funding through hospital rates can also be used to leverage federal financial participation under the Health Information Technology for Economic and Clinical Health (HITECH) Act, known as IAPD funding. Under the HITECH Act, the Centers for Medicare & Medicaid Services (CMS) may approve states for Medicaid Electronic Health Record Incentive Program funding, and states receive a 90 percent federal financial participation match for expanding HIE through September, 2021. This request will enable CRISP (working with MDH) to obtain federal funding. IAPD funding allows CRISP (working with MDH) to qualify for funding to implement use cases that complement ICN activities.

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

In FY 2021, the State's match of $1.0 million will leverage $9.0 million in federal funds for a variety of initiatives. Activities enabled through IAPD that enhance the point of care delivery include encounter notification services, practice-level advanced-implementation support, ambulatory integration, hospital integration, and image exchange. Common infrastructure activities include data routing and consent management, technical infrastructure and operations expense, and data architecture. Finally, there are a number of public health reporting initiatives as well, including public health use case management, electronic lab reporting, MDH interface development and validation, and CMS Clinical Quality Measures reporting.

The total amount of funding recommended by staff to obtain IAPD matching funds for FY 2021 is $1,000,000. As discussed above, this funding source will end after FY 2021 and CRISP anticipates moving this funding to the MMIS grant described below.

ICN Project Support

The ICN initiatives were designed to reduce health care expenditures and improve outcomes for unmanaged high-needs Medicare patients and patients dually eligible for Medicaid and Medicare, consistent with the goals of Maryland's All-Payer Model. The ICN initiative encourages collaboration between and among providers, provides a platform for provider and patient engagement, and allows for confidential sharing of information among providers. To succeed under the new Total Cost of Care Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

The initial intent was to transition funding for the administration of ICN projects to user fees, a process that began in FY 2019. Operating the core HIE infrastructure built as a result of the ICN project will transition as planned. However, based on broad program participation, including non-hospital providers, and the ability to secure federal match funds, program administration will be funded through a combination of assessments and federal matching funds. This recommendation covers three components that are not currently funded by user fees: (1) funding of operations for ICN-related HIE services remaining to transition to user fee funding, (2) funding for enhancements to current administrative processes, and (3) funding for ICN-related reporting that is broadly supporting transformation under the Total Cost of Care Model. The existing programs recommended for funding are:

- Point of care tools for providers and care managers. Funding for these tools is scheduled to transfer to 100 percent CRISP user fee funding by FY 2022.
- Program Administration and ICN-related reporting for initiatives related to care redesign under the Total Cost of Care Model.

The enhancements recommended for funding include developing and implementing streamlined administrative procedures and support for enhanced knowledge sharing tools in support of existing and future care redesign programs.

Starting in FY 2021 CRISP intends to offer hospitals a discount on user fees in return for meeting defined standards for submission of data to CRISP. CRISP and HSCRC believe full

hospital compliance with these requirements drives significant value to the healthcare system. This FY 2021 proposal anticipates some user fee collection reductions as a result of this program.

If CRISP is unable to meet compliance goals through fee reduction incentives in FY 2021, staff recommend that, in the future, the Commission consider assessing non-compliance penalties under the Commission's regulatory authority because even limited non-compliance erodes the value of the data collected and the investment made by the rest of the system.

Last year's request included transitional funding for the period prior to anticipated MMIS matching funds on October 1, 2019. The MMIS funds were approved as expected, at which point eligible reporting was funded under the MMIS section of this recommendation.

The total amount of funding recommended by staff for FY 2021 for ICN Project Support is $1,110,000. Approximately $300,000 of the funding is for remaining activities already scheduled to transition to user fee funding in future fiscal years.

Medicaid Management Information Systems (MMIS) Matching Funds

A major component of the ICN project is the reporting provided by CRISP to hospitals, the HSCRC and other system stakeholders from both Medicare and All-Payer sources. In FY 2020 CRISP transitioned funding for this reporting, previously funded by MHIP dollars, to matching grants under the Federal MMIS program. MMIS is a Federal program designed to promote effective care for Medicaid beneficiaries through investments in information technology infrastructure. Medicaid benefits from CRISP's reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer reporting and for dual-eligible patients under CRISP's Medicare reporting.

Reporting funded under this element of the assessment includes CRISP reporting tools utilizing the Medicare claims and the HSCRC's hospital Casemix data set. CRISP reporting from these datasets are used by hospitals, the HSCRC and other stakeholders to manage and track progress under a number of HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

In FY 2020 CRISP was able to transition funding to the MMIS grant faster than anticipated in the FY 2020 assessment request. In addition, the implementation of certain reporting initiatives was delayed as a result of the COVID crisis and other program changes. As a result of these two factors, there was a balance remaining from the FY 2020 funding, which will be retained by the HSCRC and disbursed to CRISP as relevant projects are completed.

Under MMIS, 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. Approximately $640,000 relates to maintaining existing reporting infrastructure and is therefore eligible for a 75 percent match. Approximately $170,000, relates to new reporting initiatives, which are eligible for a 90 percent match. In addition, as HITECH

IAPD funds are matched at the higher rate, as projects shift from IAPD to MMIS, additional funding is required from the state. Therefore, approximately $750,000 is required to maintain the core HIE infrastructure upon which the reporting relies, such as the master person index.

The total amount of funding recommended by staff for FY 2020 for to obtain Federal MMIS matching funds is $1,560,000.

RECOMMENDATION

Staff is recommending the Commission approve a total of $5,170,000 in funding through hospital rates in FY 2021 to support the HIE and IAPD initiative activities and continue the investments made in the ICN initiatives through both direct funding and obtaining Federal MMIS matching funds.

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

Table 2. FY 2021 Recommended Rate Support for CRISP as a share of total non-PDMP related Maryland Funding

FY 2021 Project Name	Hospital Rates	Federal Budgeted Funding	User Fees	Total
HIE Operations	$1,500,000	$0	$4,380,000	$5,880,000
IAPD Match	$1,000,000	$9,000,000	$0	$10,000,000
ICN Project Support	$1,110,000	$0	$0	$1,110,000
MMIS Match	$1,560,000*	$3,204,000**	$0	$4,764,000
Total Funding	**$5,170,000**	**$12,204,000**	**$4,380,000**	**$21,754,000**
% of Total	**24%**	**56%**	**20%**	**100%**

*Includes match funds for population health reporting and non-reporting operations

**Only includes MMIS operations funding related to population health reporting

Draft Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2021

May 13, 2020

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

This is a draft recommendation. Written comments should be submitted to Dianne.feeney@maryland.gov no later than May 21, 2020.

Table of Contents

LIST OF ABREVIATIONS

Delmarva	Delmarva Foundation for Medical Care
FY	Fiscal Year
HQI	Hospital Quality Initiative
HSCRC	Health Services Cost Review Commission
LTC	Long Term Care
MAPSO	Mid-Atlantic Patient Safety Organization
MDH	Maryland Department of Health
MHA	Maryland Hospital Association
MHCC	Maryland Health Care Commission
MPSC	Maryland Patient Safety Center
NAS	Neonatal Abstinence Syndrome
OHCQ	Office of Health Care Quality
RFP	Request for Proposals
TCOC	Total Cost of Care

INTRODUCTION

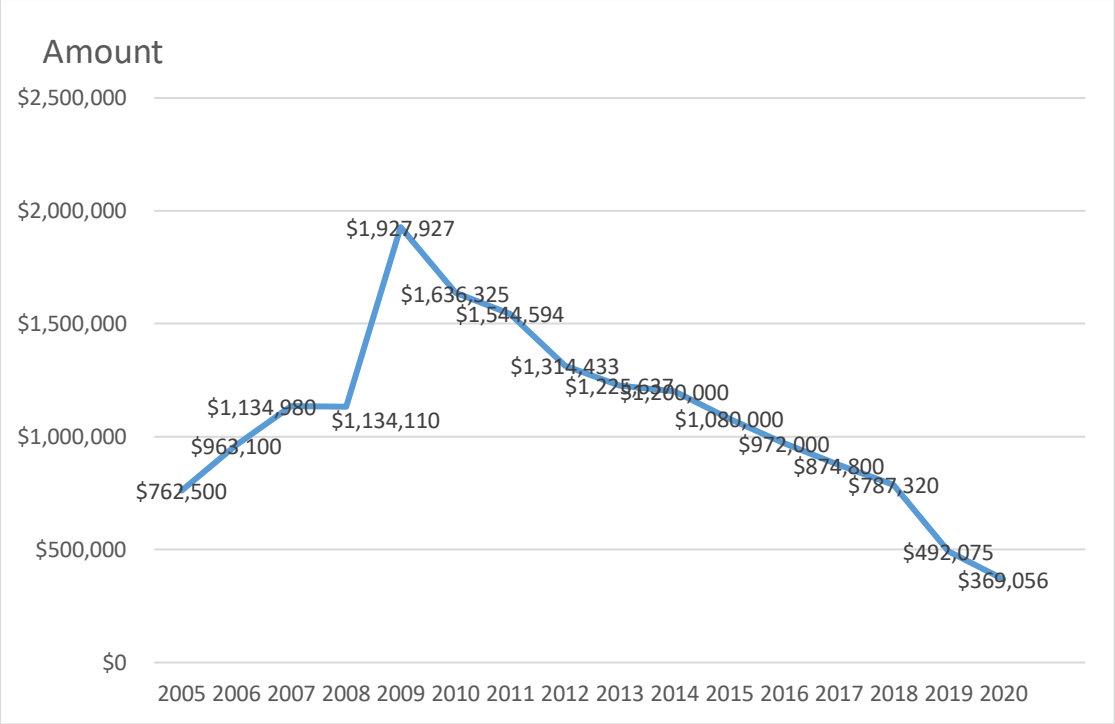
In 2004, the Maryland Health Services Cost Review Commission (HSCRC or Commission) adopted recommendations to provide seed funding for the Maryland Patient Safety Center (MPSC) through hospital rates. The initial recommendations funded 50 percent of the reasonable budgeted costs of the MPSC. In FY 2020, HSCRC-dedicated funds accounted for 20 percent of MPSC's total budget. The proposed support for MPSC in FY 2021 represents 14.5 percent of the total budget. The HSCRC collaborates with MPSC on projects as appropriate, receives an annual briefing and documentation on the progress of the MPSC in meeting its goals, as well as an estimate of expected expenditures and revenues for the upcoming fiscal year. Based on the annual budget item information provided by the MPSC and staff experience, staff makes recommendations to the Commission regarding the continued financial support of the MPSC.

Under the Total Cost of Care Model (TCOC Model), it is increasingly important that safety and quality is improved across all care settings. The key stakeholders that are involved with the MPSC include hospitals, patients, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the TCOC Model. To achieve mutual healthcare goals for these stakeholders, MPSC notes that it is critical (and should be prioritized) that the Center also collaborates with Maryland's key health policy agencies including the Maryland Department of Health (MDH), the Maryland Health Care Commission (MHCC), HSCRC and the Office of Health Care Quality (OHCQ). The MPSC is in a unique position in the State to develop and share best practices among these key stakeholders. It is also favorably positioned to act as a convener for hospital and non-hospital providers in Maryland to support provider sharing of best practices and disseminate data that will help them succeed under the TCOC Model.

As noted in the MPSC December 2019 report to MHCC, without the centralization of activities from a trusted patient safety center, Maryland healthcare facilities would be left to experiment and duplicate efforts in their patient safety strategies. This added cost is avoided through regular communication with patient safety officers across the state to share best practices, resources and consultation and coaching from the MPSC.

Over the past 16 years, the HSCRC included an adjustment to the rates of eight Maryland hospitals to provide funding to cover the costs of the MPSC. Funds are transferred biannually, by October 31 and March 31 of each year. Although funding increased between FY 2005 and FY 2009, the level of HSCRC support has declined each year since FY 2009, consistent with the original intent to scale back State-funded support. **Figure 1** below shows the funding level the HSCRC's in support of the MPSC.

Figure 1. HSCRC Unrestricted Funds Supporting MPSC FY2005-FY2020



In April 2020, the HSCRC received the MPSC program plan update for FY 2021. The MPSC is requesting a total of $246,056 in funding support from the HSCRC for FY 2021, a 50 percent decrease over the FY 2019 budget, consistent with the Commission's intent to reduce State funds over time and encourage a sustainable business model for the MPSC.

BACKGROUND

The 2001 General Assembly passed the Patients' Safety Act of 2001,[1] charging the Maryland Health Care Commission (MHCC)—in consultation with the Maryland Department of Health (MDH)—with studying the feasibility of developing a system for reducing the number of preventable adverse medical events in Maryland, including a system of reporting such incidences. The MHCC subsequently recommended the establishment of the MPSC to improve patient safety in Maryland.

In 2003, the General Assembly endorsed this concept by including a provision in legislation to allow the MPSC to have medical review committee status, thereby making the proceedings, records, and files of the MPSC confidential and not discoverable or admissible as evidence in any civil action.[2]

[1] Chapter 318, 2001 Md. Laws.
[2] MD. **CODE**. ANN., Health-Gen. § 1-401(b)(14);(d)(1).

The MHCC selected the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva) through the State's Request for Proposals (RFP) procurement process to establish and operate the MPSC in 2004, with an agreement that the two organizations would collaborate in their efforts. MHA and Delmarva jointly operated the MPSC from 2004 to 2009. The MPSC was then reorganized as an independent entity and was re-designated by the MHCC as the State's patient safety center starting in 2010 for two additional five-year periods with an expiration in April 2020, following an extension from the December 2019 date. An RFP process was conducted by MHCC in the first quarter of 2020, and MHCC again selected and re-designated MPSC as the State's patient safety center for a five-year period through 2025.

ASSESSMENT

Strategic Priorities and Partnerships

The MPSC's vision is to be a center of patient safety innovation, convening healthcare providers to accelerate understanding of, and implement evidence-based solutions for preventing avoidable harm. Its mission is to make healthcare in Maryland the safest in the nation.

The MPSC's goals are to:

- Eliminate preventable harm for every patient, with every touch, every time;
- Develop a shared culture of safety among patient care providers; and,
- Be a model for safety innovation in other states.

To accomplish its vision, mission, and goals, the MPSC established and continues to build new strategic partnerships with an array of key private and public organizations. The organizations represent a broad array of interests and expertise, including policymakers and providers across the continuum of healthcare quality, safety, and learning and education.

MPSC Members and Partnerships

As of fiscal year ending 2020, MPSC has 45 paid member facilities (increased from 42 from last year), including 43 hospitals, one long-term care facility, one rehabilitation hospital; membership fees provide the largest portion of MPSC's FY20 annual revenue. Paid membership provides member organizations with unlimited staff participation at education sessions and conferences free of charge or at a reduced rate (Six Sigma and Lean for Healthcare). Patients and family participation in MPSC initiatives is actively sought. Patients and families are represented by two board members and patients and/or family members are sought to provide their perspective to MPSC collaboratives and projects.

With regard to expanding membership to non-hospital entities, MPSC notes that they actively seek membership from non-hospital organizations by offering in-person educational programs and webinars free of charge[3]. MPSC has recently begun negotiating with Federally Qualified

[3] In 2019 these efforts included Patient Safety Foundations for Long Term Care and Patient Safety Principles to Implement QAPI, and RCA for LTC webinar.

Health Centers regarding potential membership. Through their efforts to engage non-hospital members, MPSC notes that:

- Non-hospital budgets are limited for participation in quality and patient safety programs.
- Financial incentives are different for non-hospital organizations, presenting additional challenges in engaging participation.

The **Mid-Atlantic Patient Safety Organization (MAPSO)**, a component of the MPSC, includes **43 members** representing hospitals and long-term care facilities. **Membership is separate from MPSC and is free of charge.** The primary activities of the MAPSO are to improve patient safety and healthcare quality by collecting adverse event reports and holding Safe Tables for members. Safe Tables are a forum conducted under the federal law establishing Patient Safety Organizations (PSOs), such as MAPSO, at which healthcare professionals convene and have open dialogues about patient safety and quality issues. Frank and transparent discussions are encouraged in these legally and privileged settings held for MAPSO member organizations only. MAPSO has held one Safe Table in October 2019, and due to the pandemic cancelled the second for April 2020. To assure confidentiality of discussion these are not held virtually or via conference call. MAPSO has collected, analyzed and trended over 23,000 adverse events from 13 facilities in the last 12 months.

The MPSC identifies 15 strategic partners in FY 2020:

- **Qlarant** – Maryland QIO
- **Alliance for Innovation in Maternal Health -** National alliance promoting maternal and infant health
- **Health Facilities Association of Maryland -** A leader and advocate for Maryland's long-term care provider community
- **Maryland Healthcare Education Institute** – The educational affiliate of the Maryland Hospital Association
- **Maryland Hospital Association** - The advocate for Maryland's hospitals, health systems, communities, and patients before legislative and regulatory bodies
- **MedChi -** Statewide professional association for licensed physicians
- **CRISP -** Regional health information exchange (HIE) serving Maryland and the District of Columbia
- **Society to Improve Diagnosis in Medicine -** National non-profit that catalyzes and leads change to improve diagnosis and eliminate harm
- **Maryland Ambulatory Surgical Association -** The state membership association that represents ambulatory surgery centers (ASCs) and provides advocacy and resources to assist ASCs in delivering high quality, cost-effective ambulatory surgery to the patients they serve
- **Johns Hopkins School of Medicine / The Armstrong Institute for Patient Safety and Quality** – The patient safety center within Johns Hopkins Medicine
- **MedStar Health**

- **MD RxALI**
- **Johns Hopkins Bloomberg School of Public Health**
- **Lifespan**
- **State entities** - HSCRC, MHCC, MDH, OHCQ

Educational Programs and Conferences

Safety Tools Education

Customized educational programs for MPSC members are driven by changing needs of members and the healthcare industry. In FY 2020 the following educational programs were offered, however the COVID-19 pandemic forced the postponement or cancellation of nearly all of the spring 2020 programs. Some have been postponed until June 2020, while others have been cancelled for spring but are planned to be offered again in the fall of 2020. This year as a result of the pandemic attendance dropped from over 500 registrants for educational programs in FY 2019 to 246 registrants for FY 2021. Educational programs offered included:

- Root Cause Analysis (RCA)
- Failure Modes and Effects Analysis (FMEA)
- Patient Safety Foundations
- TeamSTEPPS® Train the Trainer
- Six Sigma for Healthcare
- Lean for Healthcare
- Appreciative Inquiry
- Human Factors Engineering
- Patient Safety Principles for QAPI Implementation (Free for LTCs)
- Treatment of Opioid Use Disorder: A Buprenorphine Waiver Qualifying Course (offered in partnership with the American College of Gynecologists and the American Association of Addiction Medicine)

Safety Conferences

The **Annual Patient Safety Conference** has grown from 1,200 to 1,500 registrants annually.

- Participants from acute care hospitals, long term care, rehabilitation hospitals, ambulatory surgery centers, state agencies, quality improvement organizations
- Continuing education credits are provided for multiple specialties.
- The spring 2020 conference was postponed due to the COVID-19 pandemic and rescheduled to September 9, 2020 with over 1400 already registered. MPSC will also hold the planned FY 2021 conference as usual in the spring of 2021.

The **Medication Safety Conference draws** 200 to 500 registrants annually and is held in the fall. There were 242 in attendance at the October 30, 2019 conference.

- Participants include medication safety officers, pharmacists, quality improvement professionals, other disciplines
- Continuing education credits are provided.
- MPSC plans to hold the FY 2021 conference in November 2020

FY 2020 Maryland Patient Safety Center Activities, Accomplishments, Initiatives and Outcomes

MPSC initiatives have engaged providers in hospitals, long-term care facilities, and ambulatory care facilities, as well as patients and consumers. MPSC uses a collaborative model to bring together providers from across the care spectrum to learn best practices to improve care and outcomes. MPSC uses the Berkley Research Group to verify and analyze data collected from hospitals and other providers participating in MPSC initiatives as well as to provide return on investment figures. Highlights from FY 2020 are provided below

Collaborative Sustainability and Return on Investments

Reducing First Time Cesarean Sections – A two- year collaborative conducted from June 2016 to June 2018 with sustainability data collected for 18 months following the completion of the collaborative through December of 2019. Thirty-one of Maryland's thirty-two birthing hospitals participated and achieved an aggregate decrease of primary c-sections of 5.1% during the collaborative period with an estimated cost savings of $1,294,936. During the period of sustainability there was an additional reduction of 2.5% from the last quarter of the collaborative, resulting in a post collaborative cost savings of $1,375,582.
Total savings for this collaborative is $2,670,518 (Source: BRG).

Improving Care to Improve Outcomes: Neonatal Abstinence Syndrome Collaborative-
A two-year collaborative conducted from October 2016 to September 2018 with a sustainability period post collaborative from October 2018 to September 2019. During the collaborative period three metrics were assessed:

1. ***LOS for all newborns with a diagnosis of NAS (ICD10 96.1)-***
   The LOS of stay for all infants did not show a statistically significant reduction during the collaborative, however, the LOS for infants treated in NICUs pharmacologically did decrease by 3 days with a cost savings of $3,427,373 during the collaborative period. MPSC has received two quarters of data from MDH for the sustainability period, but that reflects a further savings of $1,765,242 for a total thus far of $5,192,615.
2. ***Rate of transfers out of the birth hospital for newborns with NAS (ICD10 96.1)-***
   Transfers of newborns with NAS decreased by 57% during the collaborative period demonstrating efforts by the birth hospitals to employ the best practice of keeping the mother baby dyad together. This provides an estimated cost savings in ground transport fees of $87,472. In the first two quarters of the four quarter sustainability periods transfers decreased another 5% for an estimated cost savings of $36, 878 in ground ambulance transport for a total of $124,350.
3. ***Readmissions of infants age 3 days to 30 days for NAS (ICD 10 96.1)-***
   There were not enough infants readmitted with a diagnosis of NAS to provide data.

Total estimated cost savings for this collaborative is $5,316,965 (Source: BRG).

MPSC notes that the Perinatal and Neonatal list servs established under the above collaboratives remain very active as a resource to the maternal infant health community and are utilized extensively to share information, resources and best practices.

Additional FY 2020 Initiatives and Activities

In addition to the above collaboratives, MPSC engaged in the following activities and initiatives in FY 2020:

Opioid Education for Consumers – In response to the statewide opioid addiction epidemic, the MPSC partnered with MHA and MedChi in 2018 to conduct a patient-centered statewide public awareness education for consumers on opioid use. In FY 2020 MPSC also joined with the Rx Abuse Leadership Initiative (RALI) of Maryland, an alliance of more than 20 local, state and national organizations committed to finding solutions to end the opioid crisis in Maryland. MPSC has continued to provide this consumer education in FY 2020, however COVID-19 has also impacted this effort. Plans are now underway to make this education available virtually.

Diagnostic Errors: A study group exploring the role of MPSC in the emerging work on diagnostic errors has been convening quarterly. As a result, MPSC has taken on a consulting role with MedStar, which was awarded an AHRQ grant to develop a new TeamSTEPPS® module to improve communication among the healthcare team in ambulatory settings to improve diagnosis. This consultative invitation is a result of Maryland's long history of provision of TeamSTEPPS® training and early work convening experts in improving diagnosis. In addition, MPSC was one of the earliest organizational members of the Society to Improve Diagnosis in Medicine (SIDM).

HRSA Maryland Maternal Health Innovation Grant: MPSC was named as a sub-awardee in the Johns Hopkins Bloomberg School of Public Health $10.3 million five year HRSA grant to improve maternal health in Maryland. The project is known as MDMOM (www.mdmom.org). MPSC, through its strong relationships with the Maryland hospitals, and the birthing hospitals especially, will leverage those relationships to facilitate implicit bias training, training on stigma associated with opioid use disorder in pregnancy and quality improvement training for hospital maternal units. In FY 2020 MPSC conducted a needs assessment survey with a 100% return rate from the birthing hospitals related to the previously mentioned topics. With this information work is now in progress to select models and /or vendors and develop an implementation plan to start training in the second grant year beginning October 1, 2020.

Patient Safety Officer Forums and PSO list serv: MPSC convene quarterly forums for patient safety officers, quality improvement staff, risk managers and any others interested in patient safety across the state. The forums are two hours in length and provide the opportunity for topic driven exchange of issues of interest to this group. Offered as an in- person meeting but a conference call line is established as well. The MPSC manages a PSO list serv that supports this group and is an active means for quick exchange of best practices, ideas and concerns across the state. Participants are from acute care, long term care, specialty hospitals and state entities such as OHCQ.

Care Alerts Collaborative– This grant between MPSC and CRISP is in its final year. In FY 2020, the role of MPSC was to review activities and quality of alerts by those making entries. These were analyzed, reviewed and action recommendations made and provided to CRISP quarterly.

Caring for the Caregiver – MPSC has implemented the Caring for the Caregiver program, a partnership with the Armstrong Institute, in 42 organizations across the country. The Caring for the Caregiver program provides training to organizations that assists them in establishing a peer responder program to provide immediate, confidential, "psychological first aid" and emotional support to "second victims" following work-related traumatic events. MPSC expects to close FY 2020 with $392,000 in gross sales, of which MPSC will receive $110,000.

Patient Safety Certification and Organization Specific Education– MPSC implemented the Patient Safety Certification Education in one long term care facility this past fiscal year. MPSC provided patient safety champion training at the organization in three 5- week sessions for a total of 78 staff at the facility. The organization reports that as result they have implemented an adverse event reporting system, created a Patient Safety Committee, begun patient safety leadership rounds, implemented a "Good Catch" program and plan to do a culture of safety survey. This resulted in $14,000 in gross sales in FY 2020.

Patient and Family Advisory Councils for Quality and Safety (PFACQS) – MPSC and MedStar Health have engaged in a partnership to provide consultation and education to organizations to assist them in the creation of councils that embody partnership and open communication with diverse patient populations and patient families to improve quality and safety. This partnership was kicked off in January 2020.

Activities initiated FY 2020 in Response to COVID-19 Pandemic

In an effort to provide the healthcare community with support and resources related to the COVID-19 pandemic MPSC has initiated the following:

Caring for the Caregiver– Through this program MPSC is assisting organizations and healthcare peers to respond to caregivers in distress by sharing a series of interventions on social media from the internationally recognized Caring for the Caregiver: Implementing RISE program. Additionally, MPSC is providing a FREE copy of the full training manual for the program to organizations upon request.

PFACQS – MPSC recognizes that as a result of COVID-19 some patients are anxious, ill, and possibly facing death while separated from their loved ones. This has resulted in healthcare providers engaging in tough conversations with families in untraditional ways. Strategies for successful decision-making, communication, and patient experience have been challenged. MPSC in collaboration with the MedStar Institute for Quality and Safety is presenting a one-hour live webinar discussion on ideas and resources to effectively engage patients, families and the patient and family advisory council during these difficult times.

FY 2021 Projected Budget

MPSC expects to continue the work of the following initiatives, programs, education, and conferences in FY 2021 with the requested $246,056:

- Mid-Atlantic PSO
- Safety Tools Education
- Safety Conferences
- Opioid Education for Consumers
- Diagnostic Errors
- Maryland Maternal Health Innovation program- implicit bias, etc training
- PFACQS
- Patient Safety Officer Forums
- Patient Safety Certification
- Caring for the Caregiver

MPSC anticipates increased revenue from membership, and sales of the Caring for the Caregiver Program. Program sales for PFACQS are projected and some grant funding has been obtained. These amounts are reflected in the FY 2021 proposed budget Version A outlined in Figure 2 below, including potential funds from the HSCRC. Consistent with FY 2020, the majority of the revenue anticipated in FY 2021 is derived from membership dues and conference revenue. In FY 2010, HSCRC funding accounted for 20 percent of its operating expenses. If approved, the FY 2020 HSCRC funding will account for approximately 14.5% percent of the total MPSC expenses.

MPSC notes that the HSCRC funds in addition to the other revenue currently identified would not support other important projects MPSC is ready and able to do in FY 2021 that targets Safety in Long Term Care (LTC) facilities in the state; these new projects are described following Figure 2 below.

Continuing to diversify the revenue stream for MPSC is crucial to the long-term sustainability of the Center in order to create stability in fiscal planning and to move away from the reliance on rate setting funds.

Figure 2. Proposed MPSC Revenue and Expenses Version A

Maryland Patient Safety Center, Inc.		
Statement of Income and Expenses		
Working Copy for FY 2021 (Version A)		
		DRAFT
		Rev. 05-01-20
	FY 2020	**FY 2021**
Description	**Budget**	**Budget**
Beginning Restricted Fund Balance as of July 1	-	**-**
Restricted Grant Revenue-MDH	200,000	**-**
Restricted Grant Revenue-Care First	159,500	**-**
Restricted Grant Revenue-HRSA	-	**36,600**
Net Assets Released from Restriction-Care First	(156,167)	**-**
Net Assets Released from Restriction-MDH	(200,000)	**-**
Net Assets Released from Restriction-HRSA		**(36,600)**
Change in Restricted Net Assets	3,333	**-**
Ending Restricted Fund Balance as of June 30	3,333	**-**
Unrestricted Funds as of July 1		
Board-Designated Operating Reserve	174,344	**174,344**
Unrestricted Net Assets	1,552,078	**1,576,700**
Total Unrestricted Funds as of July 1	1,726,422	**1,751,044**
Revenue		
HSCRC Funding	369,056	**246,056**
Membership Dues	400,000	**503,650**
Education Session Revenue	19,750	**18,800**
Annual Patient Safety Conference Revenue	200,000	**175,500**
Medsafe Revenue	10,000	**24,000**
Caring for HC/Rise Program Sales	175,000	**392,000**
Sales - Patient Safety Certification	100,000	**-**
Sales - Team STEPPS	125,000	**-**
Sales - Lean Daily Management	25,000	**-**
Care Alerts Collaborative Revenue	8,494	**-**
Net Assets Released from Restriction	356,167	**36,600**
Total Revenue	1,788,467	**1,396,606**
Expenses		
Administration	409,646	**447,780**
Education Sessions	32,750	**27,400**
Patient Safety	287,500	**418,700**
Medication Safety	21,500	**139,400**
Caring for HC	158,457	**347,579**
Safe Sleep	156,167	**-**
Certification	90,733	**55,300**
Team STEPPS	130,191	**-**
Lean Daily Management	33,908	**-**
MidAtlantic PSO	34,500	**96,800**
Perinatal/Neonatal Collaboratives	200,000	**-**
OB Hemmorrhage	58,000	**-**
Care Alerts	8,494	**-**
PFAQS	-	**52,033**
Joy & Meaning	15,000	**-**
Diagnosis Errors	66,900	**47,900**
Maternal Health	-	**38,900**
Opioid Safety	60,100	**35,400**
Total Expenses	1,763,846	**1,707,192**
Change in Unrestricted Net Assets	24,622	**(310,586)**
Restricted Funds as of June 30	3,333	**-**
Board-Designated Operating Reserve as of June 30	174,344	**174,344**
Unrestricted Fund Balance as of June 30	1,576,700	**1,266,114**
Total Ending Fund Balances	1,754,377	**1,440,458**

FY 2021 Additional Budget Requests/Proposals

In consideration of the tremendous patient safety needs identified with the COVID-19 pandemic, MPSC is proposing the new initiatives described below and requesting the additional funding amounts identified to implement them.

Clean Collaborative for Long Term Care: Over the past decade, substantial scientific evidence has accumulated indicating that contamination of environmental surfaces plays a key role in the transmission of several healthcare-associated pathogens. Figure 3 below provides the findings of a study confirming that the SARS-CoV-2 virus can live on surfaces for hours to 3 days. In light of the current SARS-CoV-2 challenges surrounding the high rates of infection and death in LTC, by providing LTC with tools to establish cleaning and disinfection procedures and access to technologies to substantiate validation of cleanliness, this time is now.

Figure 3. SARS CoV Surfaces Life

Media	SARS-CoV-1	SARS-CoV-2
Aerosols	3 hours	3 hours
Plastic	72 hours	72 hours
Stainless Steel	48 hours	48 hours
Cardboard	8 hours	24 hours
Copper	8 hours	4 hours

Gamble, A., Williamson, B.N., et al. (2020) Aerosol and surface stability of SARS-CoV-2 as compared with SARS-CoV-1. New England Journal of Medicine, Correspondence nejm.org.

Leaping off the successes of Clean Collaborative Phases 1 and 2 MPSC previously conducted, the Clean Collaborative for LTC will focus the scope of the collaborative specifically to the needs of long-term care. The purpose of the collaborative is to: (1) identify best practices for cleaning and disinfecting hard and soft surface areas throughout the facility (specifically a concern in the current COVID-19 pandemic) and (2) to educate and promote best management practices via webinars, collaborative calls, face to face meetings and onsite consultation and evaluation. Through collection of quantitative data on a monthly basis each facility will be able to respond to and evaluate changes in products, frequency and cleaning practices in their facility. The long- term benefits expected are a decrease in HAIs, implementation of best practices in the facility, decreases in hospital admissions for HAI, and prevention of, and rapid response to, possible future infection outbreaks. In addition, per the collaborative participant agreement, all participating facilities will be able keep the validation technology, following the collaborative, a key component of a comprehensive cleaning validation program.

To assist LTCs to have the greatest impact on infection prevention related to cleaning and disinfecting healthcare surface areas, MPSC is proposing to facilitate an 18-month collaborative. MPSC will provide a subject matter experts and experienced infection preventionists to consult and evaluate through site visits with participating facilities. Estimated collaborative cost: $275,000 Year 1; $150,000 Year 2 (FY 2022).

Total additional request for FY 2021: $275,000

Decreasing racial disparities in healthcare collaborative: The experience of the COVID-19 pandemic has vividly highlighted the racial disparities in healthcare. MPSC proposes implementing a two-year collaborative pilot that will enroll ten hospitals to participate in selection of a diagnosis to explore, noting disparity in clinical outcomes. MPSC will provide developed Implicit Bias training and obtain, analyze and report back to facilities their data and analysis compared to the pilot aggregate with the intended goal of improving the disparity outcomes for that specific diagnosis and population. Costs would include staff time, cost of online training, development of data portal for reporting and generation of reports, development of tools and subject matter expert consultation. Expected total cost for the planning, development implementation of the project: Year 1 (planning): $125,000; Year 2 (Implementation): $250,000; Year 3 (Implementation and close out): $175,000.

Total additional request FY 2021: $125,000

Caring for the Healthcare Provider in LTC: MPSC is proposing development of a program specifically designed for LTC staff who have suffered tremendous stress in the COVID-19 environment. MPSC would like to convene focus groups to identify the support LTC staff need, challenges to leadership, and identification of solutions to support, empower and heal. Year 1 cost: $50,000

Total additional FY 2021 request: $50,000

Figure 4 below presents revised revenues and expenses with the optional projects outlined above included.

Figure 4. Proposed Revised MPSC Revenue and Expenses with Optional Projects Version B

Maryland Patient Safety Center, Inc.		
Statement of Income and Expenses		
Working Copy for FY 2021 (Version B)		**DRAFT Rev. 05-01-20**
Description	**FY 2020 Budget**	**FY 2021 Budget**
Beginning Restricted Fund Balance as of July 1	-	**-**
Restricted Grant Revenue-MDH	200,000	**-**
Restricted Grant Revenue-Care First	159,500	**-**
Restricted Grant Revenue-HRSA	-	**36,600**
Restricted HSCRC Funding-Clean Collaborative		**275,000**
Restricted HSCRC Funding-Racial Disparities		**125,000**
Restricted HSCRC Funding-Caring for Long Term Care		**50,000**
Net Assets Released from Restriction-Care First	(156,167)	**-**
Net Assets Released from Restriction-MDH	(200,000)	**-**
Net Assets Released from Restriction-HRSA		**(36,600)**
Net Assets Released from Restriction-Clean Collaborative		**(275,000)**
Net Assets Released from Restriction-Racial Disparities		**(125,000)**
Net Assets Released from Restriction-Caring for Long Term Care		**(50,000)**

Maryland Patient Safety Center, Inc.		
Statement of Income and Expenses		
Working Copy for FY 2021 (Version B)		**DRAFT Rev. 05-01-20**
Description	**FY 2020 Budget**	**FY 2021 Budget**
Change in Restricted Net Assets	3,333	**-**
	-	**-**
Ending Restricted Fund Balance as of June 30	3,333	**-**
Unrestricted Funds as of July 1		
Board-Designated Operating Reserve	174,344	**174,344**
Unrestricted Net Assets	1,552,078	**1,576,700**
Total Unrestricted Funds as of July 1	1,726,422	**1,751,044**
	-	**-**
Revenue		
HSCRC Funding	369,056	**246,056**
Membership Dues	400,000	**503,650**
Education Session Revenue	19,750	**18,800**
Annual Patient Safety Conference Revenue	200,000	**175,500**
Medsafe Revenue	10,000	**24,000**
Caring for HC/Rise Program Sales	175,000	**392,000**
Sales - Patient Safety Certification	100,000	**-**
Sales - Team STEPPS	125,000	**-**
Sales - Lean Daily Management	25,000	**-**
Care Alerts Collaborative Revenue	8,494	**-**
Net Assets Released from Restriction	356,167	**486,600**
	-	**-**
Total Revenue	1,788,467	**1,846,606**
Expenses		
Administration	409,646	**410,880**
Education Sessions	32,750	**27,400**
Patient Safety	287,500	**406,500**
Medication Safety	21,500	**114,900**
Caring for HC	158,457	**347,579**
COVID19-Clean Collaborative	-	**275,000**
COVID19-Racial Disparities	-	**125,000**
COVID19-Caring for LTC	-	**50,000**
Safe Sleep	156,167	**-**
Certification	90,733	**54,000**
Team STEPPS	130,191	**-**
Lean Daily Management	33,908	**-**
MidAtlantic PSO	34,500	**81,500**
Perinatal/Neonatal Collaboratives	200,000	**-**
OB Hemmorrhage	58,000	**-**

Maryland Patient Safety Center, Inc.		
Statement of Income and Expenses		
Working Copy for FY 2021 (Version B)		**DRAFT Rev. 05-01-20**
Description	**FY 2020 Budget**	**FY 2021 Budget**
Care Alerts	8,494	**-**
PFAQS	-	**48,633**
Joy & Meaning	15,000	**-**
Diagnosis Errors	66,900	**47,900**
Maternal Health	-	**38,900**
Opioid Safety	60,100	**35,400**
	-	**-**
Total Expenses	1,763,846	**2,063,592**
Change in Unrestricted Net Assets	24,622	**(216,986)**
	-	**-**
Restricted Funds as of June 30	3,333	**-**
Board-Designated Operating Reserve as of June 30	174,344	**174,344**
Unrestricted Fund Balance as of June 30	1,576,700	**1,359,714**
Total Ending Fund Balances	1,754,377	**1,534,058**

MPSC Return on Investment

As noted in the last several Commission recommendations, the HSCRC provides funding for the MPSC with the expectation that there will be both short- and long-term reductions in Maryland healthcare costs, particularly related to such outcomes as reduced mortality rates, lengths of stay, patient acuity, and malpractice insurance costs. Working with BRG this past year, as noted above, the MPSC has demonstrated estimated cost avoidance/ savings for the neonatal and perinatal collaboratives conducted 2016-2019 of $7,987,143.

Additional data on all of the MPSC's programs is needed to ensure that the limited dollars available for MPSC funding creates meaningful improvements in quality and outcomes at facilities in Maryland to achieve the goals of the Total Cost of Care Model. The MPSC should continue to report results from its initiatives to HSCRC staff.

RECOMMENDATIONS

Quality and safety improvements are the primary drivers to achieve the goals of reduced potentially avoidable utilization and reduced complications in acute care settings under the TCOC Model. For these reasons, it is important to continue to support hospitals in identifying and sharing best practices to improve patient quality and outcomes. Individual hospitals across the State are experimenting with strategies to improve care coordination, enhance processes for better care, and advance systems and data sharing to maximize the efficiency and effectiveness of care; the MPSC is in a unique position to convene healthcare providers and share best practices that have been identified through multi-provider collaborative testing and change. The

key stakeholders that are involved with the MPSC include hospitals, patients, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the Total Cost of Care Model. The MPSC is in a favorable position in the State to develop and share best practices among this group of key stakeholders. To support the overall mission of the State, the MPSC should align initiatives with the broader statewide plan and activities for patient safety.

In light of the information presented above, HSCRC staff provides the following draft recommendations for the MPSC funding support policy for FY 2021:

1. Consistent with the prior Commission recommendations, the HSCRC should reduce the amount of **unrestricted** funding support for the MPSC in FY 2021 by 25 percent from the FY 2019 HSCRC unrestricted grant amount of $492,075. The result is an adjustment to hospital rates in the amount of $246,056.
2. In order to receive future funding from the hospital rate setting system, the MPSC should continue to report twice annually on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.
3. Going forward, the HSCRC should decrease the amount of **unrestricted** support by 25 percent per year from the RY 2019 amount of $492,075 in order to achieve the goal of independent sustainability for MPSC.
4. MPSC may request annually needed funding from HSCRC that will be **restricted for targeted projects** that align with statewide TCOC Model and quality and safety goals which the Commission will consider on a case by case basis.
    a. For FY 2021, HSCRC should fund an additional $275,000 for the Clean Collaborative for Long Term Care project through hospital rates.
5. The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs.

Draft Recommendation

Changes to Relative Value Units for Clinic Evaluation & Management (E&M) Effective July 1, 2020

May 13, 2020

Health Services Cost Review Commission

4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX (410) 358-6217

This is a draft recommendation for Commission consideration at the May 13, 2020 Public Commission Meeting. Please submit comments on this draft to the Commission by Thursday, May 21, 2020, via hard copy mail or email to William Hoff, William.Hoff@maryland.gov

Definitions

- Current Procedural Terminology (CPT) codes – The medical service and procedure code used to bill for hospital outpatient services. The primary CPT codes used for billing Clinical Evaluation & Management codes are 99201-99205, 99211-99215, and G0463.

- These codes provide the progressive levels of care for billing of Clinic services, based on the use of hospitals' resources in diagnosis and treatment of these patients.

- 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.

Introduction & Background

The Health Services Cost Review Commission (HSCRC) is revising the Clinic Evaluation and Management (E&M) services charge structure. As a result of patient complaints, State legislators have contacted the HSCRC to evaluate the Clinic rate and its underlying components. In light of the concerns raised, the HSCRC has agreed to review and modify the rate structure. In the short term, staff will revise the Relative Value Unit (RVU) scale. In the future, staff will assess overhead allocations to Clinic and other rate centers.

Staff has determined that a significant reason for high Clinic E&M charges is that the rate setting methodology does not fully reflect the less intensive nature of Clinic services versus other hospital services. Additionally, the RVU range of the five E&M Visit Levels is too wide. Modifications to the methodology used to allocated overhead expenses is a long term undertaking; therefore, staff has decided that for Fiscal Year (FY) 2021, narrowing the range of the Visit Level RVUs, similar to Medicare's E&M RVU scale, coupled with a reduction in the amount of overhead allocated to Clinics, would result in a significant lowering of E&M RVUs.

	Current RVUs	**New RVUs (eff July 1, 2020)**
99201	2	2
99202	4	3
99203	7	4
99204	15	5
99205	18	6
99211	2	2
99212	4	3
99213	7	4
99214	15	5

99215	18	6
G0463	4	3

Historically, this would be done in a revenue neutral fashion within a given rate center, i.e. increasing the unit rate as RVUs decline. The HSCRC plans to reallocate the revenues associated with the Clinic RVU reductions from the resulting compression to other rate centers. These adjustments **will be revenue neutral to the overall GBR** and will be reflected in each hospital's FY 2021 rate order, effective July 1, 2020.

Recommendation

1. The Commission staff recommends revisions to the Relative Value Unit (RVU) Scale for Clinic Evaluation & Management Current Procedural Terminology (CPT) codes;

2. The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual;

3. Effective July 1, 2020, hospitals will need to change their RVUs on the 11 E&M codes listed in this recommendation; and

4. The Clinic E&M reset will be revenue neutral to the overall GBR and will be reallocated in the other rate centers.

Policy Update Report and Discussion

Staff will present materials at the Commission Meeting.

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Department of Health

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TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **May 13, 2020**

RE: **Hearing and Meeting Schedule**

June 10, 2020	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
July 8, 2020	To be determined – 4160 Patterson Avenue HSCRC/MHCC Conference Room

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday 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.