maryland
health services
cost review commission

595th Meeting of the Health Services Cost Review Commission
May 11, 2022

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

EXECUTIVE SESSION
11:30 am

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

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

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on April 13, 2022

2. Docket Status – Cases Closed
   2590A – Johns Hopkins Health System
   2591A – Johns Hopkins Health System
   2592A – Johns Hopkins Health System
   2593A – University of Maryland Medical Center

3. Docket Status – Cases Open
   2587R – Tidal Health Peninsula Regional
   2588R – Carroll Hospital
   2589R – Shady Grove Medical Center
   2594A – Johns Hopkins Medical System
   2595R – Johns Hopkins Hospital

4. PRMC Full Rate Review Update

5. Final Hospital Payment Plan Guidelines

6. Proposed Amendments – Medical Debt Regulations

7. FY 2021 Hospital Financial Condition Report Presentation

8. Draft Recommendation on the Update Factor for FY 2023

9. Nursing Workforce Support Initiative
   a. Final Recommendation on the Nurse Support Program II for FY 2023
   b. Draft Recommendation on Nurse Support Program I Renewal

10. Draft Recommendation on Ongoing Support of CRISP in FY 2023

11. Draft Recommendation on Revisions and Updates to Clinic Relative Value Units

12. Policy Update and Discussion

    a. Model Monitoring
    b. Workgroup Update

13. Hearing and Meeting Schedule

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MINUTES OF THE
594th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
April 13, 2022

Vice Chairman Joseph Antos, PhD called the public meeting to order at 11:03 a.m. Commissioners Stacia Cohen, James Elliott, M.D., Maulik Joshi, DrPH, and Sam Malhotra were also in attendance. Upon motion made by Commissioner Cohen and seconded by Commissioner Elliot, the meeting was moved to Closed Session. Vice Chairman Antos reconvened the public meeting at 1:10 p.m.

REPORT OF APRIL 13, 2022 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the April 13, 2022, Closed Session.

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

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

ITEM II
CASES CLOSED

2582R- Johns Hopkins Health System
2583A- Johns Hopkins Health System
2584N- Brooks Lane Hospital
2585A- Johns Hopkins Health System
2586A- Johns Hopkins Health System

ITEM III
OPEN CASES

2587R- Tidal Health Peninsula Regional

Mr. Allan Pack, Principal Director, Population Based Methodologies, presented Staff's Recommendation on the TidalHealth Peninsula Regional Center full rate application.

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

PRMC is an acute care hospital in Salisbury, Maryland with 266 licensed acute beds that provides the only trauma center coverage on the Eastern Shore.

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

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

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

4. New Adolescent Behavioral Health Program (Year 1) - $3.2 million
5. five percent margin- $23 million

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

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

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

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

Staff recommends removing $11.9 million of McCready Memorial Hospital associated revenue from the PRMC Fiscal Year 2020 ICC evaluation. This modification reduces the baseline revenue write-down, as outlined in Exhibit 9, from $19.8 million to $14.7 million.

PRMC notes the ICC accounts for the regulated and "...incremental costs associated with the [trauma] program by allowing a "direct strip" of allowed trauma costs. These incremental costs

only account for on-call costs and limited administrative costs associated with maintaining trauma program requirements. However, the on-call costs are a small component of the cost of meeting the stringent requirements for maintaining a Level III trauma center in the State. These costs are eclipsed by the need to hire physicians to be available for care, along with the premium required to attract the appropriate professionals to a rural market." In recognition of "...the social costs of meeting the state's requirements for providing Level III Trauma care," PRMC requests that a direct cost strip of $25.9 million ($25.5 million attributable to unregulated physician subsidies and on-call pay) be removed from PRMC's cost per case assessment and then passed through the ICC without qualification. The Hospital also asserts that a similar cost strip should be provided to the state's other trauma centers, but in the absence of physician contracts for each trauma center, it suggests the cost strip should be equal to the percentage of the PRMC cost strip relative to its total permanent revenue (6 percent).

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

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

1. HSCRC does not have jurisdiction over physician services per statute, and since 93 percent of costs put forward by PRMC as "Trauma Fixed Costs" are unregulated physician subsidies, the proposed cost strip would extend HSCRC's regulatory jurisdiction beyond its statutory authority. The remaining 7 percent of costs put forward by PRMC is already covered by the existing regulated standby cost strip in the ICC.

2. In response to the staff's completeness question: "If these [physician] subsidies will continue in the event that PRMC ceases trauma services, please outline the extent of the subsidies," the Hospital noted the following: "TidalHealth Peninsula Regional has evaluated existing physician subsidies including on-call pay to determine the amount if any that would remain if TidalHealth Peninsula Regional eliminated trauma services. Based on projected volumes and required physician coverage, it is estimated that the

$25,473,440 in physician costs would be reduced to $8,424,224." In effect, PRMC is noting that approximately one third of the proposed cost strip that is needed to support trauma fixed costs would continue if trauma services were discontinued, and thus the proposed cost strip, if allowed, would need to be reduced to $17,458,078 or 4 percent of revenue.

3. The Commission is unable to determine if the subsidies provided to trauma physicians are reasonable, nor does it know whether the assumption that all other trauma facilities have a similar level of costs for trauma coverage is sound; therefore, the Commission would have no basis on which to adjust other Trauma centers should such an allowance be made for PRMC. PRMC has not provided sufficient evidence to assuage these concerns.

4. During the development of the full rate application policy, staff demonstrated that there was no statistically significant relationship between various hospital characteristics and ICC performance. In effect, there were no variables, such as number of medical residents that had an alarming explanatory power on the outcome of a hospital's ICC assessment. One characteristic that was assessed was the presence of a trauma program, both as a categorical and continuous variable, and in both instances, there was not a statistically significant relationship, indicating that the Commission's assessment of a hospital's performance under the ICC is not negatively affected by having a trauma program.

5. Unregulated costs are purposefully not reflected in HSCRC efficiency methodologies, and the consideration to include one particular type of unregulated cost due to the argument that it is a social good fail to recognize that similar arguments could be made for other service lines, e.g., labor and delivery, open heart surgery, pediatric oncology, etc. Thus, unless all unregulated costs deemed a social good are allowed in an HSCRC efficiency methodology, contingent on expanded regulatory authority, the handpicking of a select few would disadvantage all other hospitals with a different service array.

Considering these concerns, Staff do not recommend approving the Trauma methodology consideration put forth by PRMC.

PRMC suggests that: the benchmarking methodology for Medicare may not be representative of actual total cost of care (TCOC), because it is based on a 5 percent sample of National Medicare beneficiaries; the benchmarking methodology for Commercial has potential data inconsistencies because in the Maryland All Payer Claims Database (APCD) - the source for the Commercial TCOC assessment - CareFirst data are 28 percent lower than reported in the National Association of Insurance Commissioners (NAIC), and there is inconsistent membership identification for United HealthCare; neither the Medicare nor the Commercial benchmarking methodologies

directly account for differences in wages levels; and the regression model used for both the Medicare and Commercial TCOC assessments yields higher coefficients for median income than deep poverty, thus "increasing disparities for populations in counties with higher levels of poverty." Due to these concerns, PRMC requests that negative TCOC adjustment be removed from the full rate determination.

To be responsive to industry concerns on the benchmarking methodology, HSCRC staff worked with its contractor to develop an approach to look at variation in TCOC outcomes across 20 different iterations of the benchmarking analysis. Specifically, the different models used alternative metric sets for peer selection and regression, including three different wage measures to both replace and supplement median income. The alternatives all yielded remarkably comparable results to the selected approach, especially in terms of rankings. Moreover, in no model did PRMC's attributed TCOC perform better than its benchmark peers, suggesting that in all cases the Hospital would incur a TCOC penalty under the TCOC algorithm that first tests if a hospital is worse than its benchmark before clawing back excess growth.

Thus, staff do not recommend approving PRMC's request to not consider its TCOC performance under the existing TCOC algorithm.

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

Staff are supportive of the request to provide additional funding for child and adolescent psychiatric services in Salisbury, MD, as there are no pediatric inpatient services available on the Eastern Shore. Moreover, this request was approved by MHCC through the CON process in May 2019. Staff notes, however, that in keeping with prior volume policies for new regulated services (e.g., open heart surgery program at Anne Arundel Medical Center), the funding should be limited to a 50 percent variable cost factor.

Staff recommend reducing PRMC's request from $3,249,853 to $1,624,927. The 50 percent variable cost factor will be applied to growth in the adolescent behavioral health program until it reaches maturity in Fiscal Year 2025. All prospective adjustments for volume will be subject to retrospective review and settlement, including an accounting of volume funding received from the market shift methodology. In tandem with the McCready methodology consideration, this modification reduces the baseline revenue write down from $19.8 million to $13 million.

PRMC intends to establish a graduate medical education (GME) program and seeks direct and indirect medical education ($244 thousand per resident per year) for 10 residents in year 1 ($2.4 million). PRMC also notes that it anticipates to expanding its GME program to a forecasted resident population of 65 over a five-year period and would ask that it receive the same direct and indirect medical education credit of $244 thousand per resident per year ($15.9 million) in line with the national Medicare policy on funding new GME programs. The current rate request only reflects the initial 10 residents.

Based on staff analyses, Maryland's GME spending per Medicare and Medicare Advantage beneficiary is $35.9 million more than the national experience. Moreover, for the nation to have a similar level of investment in GME, it would need to add 13,508 residents at its current rate of funding for direct and indirect medical education. While Congress is considering a proposal that would provide 14,000 GME slots over seven years, approved legislation in 2020 only approved 1,000 slots over 5 years.

Given Maryland's existing level of GME funding relative to the nation and the State's required savings per the TCOC contract, HSCRC staff recommend Commissioners consider a standard by which additional GME slots could be funded in the State. Specifically, until national funding of GME per Medicare and Medicare Advantage beneficiaries reach levels equivalent to Maryland, no additional funding for new GME slots, including PRMC's request, should be provided in hospital rates.

PRMC requests $16 million to provide market adjustments to maintain competitive wages, and $23 million to generate a five percent total operating margin to support population health initiatives.

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

Because PRMC has filed a full rate application, staff needs to make a recommendation on the Hospital's approved revenues. As such, staff recommends adjusting the hospital's rate structure for a $13,043,455 revenue write-down or -2.82 percent, contingent on the Commission's determination that no additional funding should be provided to PRMC for a graduate medical education program. If the Commission elects to approve new residency slots at PRMC, staff

recommend implementing a revenue write-down of $10,597,952 million or -2.29 percent to recognize the intended resident count (10) for the first year of the GME program and potentially restore that reduction after 5 years once the program has reached maturity to fund an additional 43 residents. In effect, this would allow PRMC to fund 53 residents or 82 percent of its projected program. Should the Commission determine that a new residency program at PRMC be funded through hospital rates, staff recommend that mandatory reviews occur. Specifically, the Hospital must attest to providing the same residency specialty mix as outlined in the full rate application and must provide data on the retention of trained residents within the State of Maryland. If the specialty mix changes by more than 50 percent for any one category or if the retention rate falls below 50 percent, staff would recommend that the Hospital forfeit any funding provided in rates for the GME program.

HSCRC staff recommend that the Commission:

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

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

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

Staff also proposed an alternative recommendation as follows:

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

a. PRMC's technical consideration to reduce McCready Hospital's revenue from its ICC evaluation
b. A 50 percent variable cost factor for growth in the adolescent behavioral health program until it reaches maturity in Fiscal Year 2025.

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

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

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

Dr. Steven Leonard, President/CEO TidalHealth Peninsula Medical Center addressed the Commission concerning the Staff Recommendation for PMRC full rate application.

Dr. Leonard state that PRMC is the most advanced hospital in the Delmarva area providing tertiary and trauma services to a rural and underserved area. Dr. Leonard reported PRMC Medicare/Medicaid population is at 70%; its rate structure is the fifth lowest in the State and its ADI (Area Deprivation Index) is comparable to Baltimore City.

Dr. Leonard noted that PRMC is the only trauma center on the Eastern Shore and not only serves the 9 counties located on the Eastern Shore but also Sussex County in Delaware and Accomack County in Virginia.

PRMC also serves as the Regional Referral Center on the Eastern Shore with over 800 transfers from other acute care facilities in both FY 2020 and 2021. Inpatient transfers come from Atlantic General, Easton, Dorchester, Shore Memorial, Nanticoke, and other facilities. Reasons for the transfers include:

1. Access to specialized cardiac and stroke care
2. Lack of capacity at other facilities
3. Trauma Services
4. Extreme age and weight
5. Other specialize care

Dr. Leonard stated that PRMC's last full rate application was in 1998 and opened dialogue with the HSCRC regarding rate relief in May 2017 when the Hospital was facing financial pressures due to rising physician costs, trauma and tertiary services, coupled with inadequate inflation updates.

Dr. Leonard stated that those financial pressures remain and are worsening due to:

1. Projecting a significant operating loss in FY2022 and beyond
    - Cost pressures related to COVID
    - Overdue market adjustments
    - Elimination of COVID related funding
2. Margin pressures and decline in days cash on hand equals negative outlook on PRMC bond rating.
3. System operating loss attributable to PRMC should be considered
    - Population Health/Total Cost of Care initiative
    - Trauma Program

Finally, Dr. Leonard stated that as a low cost, rural, tertiary, regional referral center and trauma center, the $15 million rate reduction recommended by Staff does not address the unique needs of PRMC and the Eastern Shore Community that its serves.

The Commission directed Staff and PRMC to work together and try to agree on a resolution agreement. The Hospital agreed to waive the 65-day requirement that the Commission call for a public hearing until the May meeting

ITEM IV
REPORT ON THE READMISSION REDUCTION INCENTIVE PROGRAM FOR RATE YEAR 2024

Dr. Alyson Schuster, Deputy Director, Quality Methodologies, presented a report for the Readmission Reduction Incentive Program (RRIP) for Rate Year 2024 (see "Report Extending the Readmission Reduction Incentive Program for Rate Year 2024" available on the HSCRC website).

With the commencement of the Total Cost of Care (TCOC) Model Agreement on January 1, 2019, the performance standards, and targets in HSCRC's portfolio of quality and value-based payment programs have been reviewed and updated. In CY 2019, staff focused on the rate year (RY) 2022 RRIP program and convened a subgroup with clinical and measurement experts who made recommendations that were then further evaluated by the Performance Measurement Workgroup (PMWG). The RRIP subgroup and PMWG considered updated approaches for reducing readmissions in Maryland to support the goals of the TCOC Model. Specifically, the workgroup evaluated Maryland hospital performance relative to various opportunity analyses, including external national benchmarks, and developed a 5-year improvement target (2018-2023). In addition, the staff developed a within-hospital disparities metric for readmissions, which was linked with a Statewide Integrated Health Improvement Strategy (SIHIS) goal to have half of hospitals improve disparities by 50 percent.
The RY 2023 final recommendation, in general, maintained the measure updates and methodology determinations that were developed and approved for RY 2022. Thus, for RY 2024 staff intends to extend the RY 2023 policy with no significant changes.

ITEM V
DRAFT GUIDELINES FOR HOSPITAL PAYMENT PLANS

Ms. Megan Renfrew, Associate Director of External Affairs, presented the Staff's draft guidelines for Hospital Payment Plans (see "Draft Hospital Payment Plan Guidelines" available on the HSCRC website),

Since 2009, Maryland law has required each hospital to have a policy on the collection of debts owed by patients (Maryland Code, Health General §19-214.2, Maryland Code). This law contains protections for patients (including the prohibition of interest on certain debt owed by self-pay patients, a prohibition on hospitals selling debt, and a requirement that the hospital's policy clearly describe the hospital's procedures for collecting a debt). Chapter 770 of 2021 made a number of statutory changes to Health General §19-214, Maryland Code, related to hospital collection of medical debt, including adding a requirement that hospital payment plans for patients must meet guidelines developed by the HSCRC. Chapter 770 required that the HSCRC seek input from stakeholders in drafting these guidelines. Accordingly, the HSCRC formed a Workgroup on Hospital Payment Plan Guidelines, which met three times between January and February of 2022 to review guidelines originally drafted by HSCRC staff, in collaboration with staff from the Office of the Commissioner of Financial Regulation (OCFR). Workgroup members and members of the public were also invited to submit written comments on the draft guidelines.

HSCRC and OCFR staff revised the guidelines based on feedback from the workgroup and members of the public. HSCRC staff are working on additional documents to provide further

guidance for hospitals on implementation of Chapter 770, including updates to COMAR 10.37.10.26 and a Frequently Asked Questions document, which is being developed in conjunction with OCFR. In addition, HSCRC staff plan to update the Special Audit Procedures to reflect the new requirements in Chapter 770.

In developing these guidelines, HSCRC staff balanced a number of different policy goals. In general, HSCRC sought to focus on the requirements of Health General §19-214.2, as amended by Chapter 770 (2021). This contained the potential scope of the guidelines.

Under the law, income-based payment plans are now required to be offered to all patients, regardless of income. In developing these guidelines, HSCRC staff sought to balance providing protections to the low- and moderate-income patients who will most benefit from these protections, while trying to minimize the burden on other patients.

HSCRC staff also worked to ensure that the guidelines provide patients with all the protections required by law while continuing to require that hospitals seek payment from patients who can pay their bills. This balance is intended to avoid unnecessary increases in uncompensated care costs.

The proposed guidelines address a number of topics related to hospital payment plans, including:

- Notice requirements
- Monthly payment amounts not to exceed 5% of a patient's income
- Duration of payment plans
- A cap on interest rates
- Treatments of prepayments, missed payments, and late payment, and
- Modification of payment plan.

These guidelines will be incorporated by reference into COMAR 10.37.10.26. Written comments on the draft guidelines will be accepted by the public through April 20, 2022. Final guidelines will be presented for approval at the May monthly Commission meeting.

Vice Chairman Antos asked what criteria were used to ensure that the monthly payment will not exceed 5 percent of income.

Ms. Renfrew stated that it will be based on the family household income and the number of family members.

Vice Chairman Antos also asked whether there is a penalty if families wanted to pay off their hospital debt ahead of schedule.

Ms. Renfrew stated that there would be no penalty assessed patients who pay their bills off ahead of schedule.

Commissioner Cohen asked if the new medical payment plan would increase hospital administrative costs and if the increase in costs would cause a hospital rate increase.

Ms. Renfrew did not know the impact the new medical payment plan would have on administrative costs. She said that this would be brought up with the workgroup.

Commissioner Elliot asked how the 5 percent income guidelines would be affected for families with multiple payment plans.

Ms. Renfrew stated that health systems need to coordinate this to ensure that the 5 percent guideline is followed. She also said that she will get back to the workgroup for further discussion.

ITEM VI
POLICY UPDATE AND DISCUSSION

Model Monitoring

Ms. Caitlin Cooksey, Deputy Director of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 12 months ending December 2021. Maryland's Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Cooksey noted that Medicare Nonhospital spending per-capita was trending unfavorably for both Part A and Part B when compared to the nation. Ms. Cooksey noted that Medicare Total Cost of Care (TCOC) spending per-capita was unfavorable when compared to the nation. Ms. Cooksey noted that the Medicare TCOC guardrail position is .80% above the nation through December. Ms. Cooksey noted that Maryland Medicare hospital and non-hospital growth through December shows a run rate erosion of $89,945,000.

Legislative Update

Ms. Hannah Friedman-Bell, Analyst, Payment Reform and Stakeholder Alignment, presented the Legislative Update (see "Legislative Update" available on the HSCRC website).

Ms. Bell noted that the following bills were approved and waiting Governor approval:

- HB 300/ SB 290 - Budget Bill for FY 2023 (The Governor's Budget)

a) The Budget Bill now includes $50 million to MDH
b) The money will be distributed based on a plan developed by the HSCRC

- HB 510/SB 917 - Health Care Facilities- Health Services Cost Review Commission- User Fee Assessment

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

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

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

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

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

    a) Seeks to codify Medicaid regulations re: funding doulas

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

    a) Provides for the establishment of unregulated hospital-adjacent urgent care centers.
    b) HSCRC amendment focuses on the definition of hospital-adjacent urgent care center.
    c) Bill failed to crossover by the deadline

Staff Update

Ms. Katie Wunderlich, Executive Director, introduced, Anwesha Majumder as the new Chief, Population Health for Population-Based Methodologies.

Workgroup Update

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

- Performance Measurement Workgroup

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

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

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

ITEM V
HEARING AND MEETING SCHEDULE

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

June 8, 2022 Times to be determined - Go to Webinar

There being no further business, the meeting was adjourned at 2:52 pm.

Closed Session Minutes
of the
Health Services Cost Review Commission

April 13, 2022

Upon motion made in public session,

Vice-Chairman Antos called for adjournment into closed session to discuss the following items:

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

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

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

The Closed Session was called to order at 11:03 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

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

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

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

Item One

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

Item Two

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

Item Three

Ms. Wunderlich updated the Commission on progress on the development of the annual compounded savings targets, as well as the areas in the TCOC Model where Maryland must demonstrate progress.

Item Four

Ms. Wunderlich updated the Commission on the process in preparing for negotiations for the next phase of the Model. In addition, the Commission discussed potential topic areas for the next phase of the Model.

The Closed Session was adjourned at 12:48 p.m.

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF May 2, 2022

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

Docket Number	Hospital Name	Date Docketed	Purpose	Analyst's Initials	File Status
2587R	Tidal Health Pennisula Regional	2/25/2022	FULL	JS/AP	OPEN
2588R	Carroll Hospital	3/14/2022	DEF/MSG	WN	OPEN
2589R	Shady Grove Adventist Medical Center	3/16/2022	CAPITAL	JS/AP	OPEN
2594A	Johns Hopkins Health System	4/6/2022	DNP	DNP	OPEN
2595R	Johns Hopkins Hospital	4/6/2022	CL/PDC	WH	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2404**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2594A**

Staff Recommendation

May 11, 2022

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on April 6, 2022, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement for bariatric surgery, bladder cancer surgery, anal and rectal cancer surgery, cardiovascular services, joint replacement surgery, pancreatic cancer surgery, spine surgery, and thyroid and parathyroid surgery with BridgeHealth Medical, Inc. for a period of one year beginning June 1, 2022.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the

Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that there was no experience under this arrangement for the last year. However, Staff believes that the Hospitals can achieve favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for bariatric surgery, bladder cancer surgery, anal and rectal cancer surgery, cardiovascular services, joint replacement surgery, pancreatic cancer surgery, spine surgery, and thyroid and parathyroid surgery for a one-year period commencing June 1, 2022. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*	**COST REVIEW COMMISSION**	
JOHNS HOPKINS BAYVIEW	*	**DOCKET:**	**2022**
MEDICAL CENTER	*	**FOLIO:**	**2405**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2595R**

Staff Recommendation
May 11, 2022

Introduction

On April 6, 2022, Johns Hopkins Bayview Medical Center ("JHBMC," or "the Hospital") submitted a partial rate application to the Commission requesting its Partial Day Clinic (PDC) rate center be combined with the Clinic (CL) rate center effective July 1, 2022.

Background

The Intensive Outpatient Program (IOP) of JHBMC's Center for Addiction and Pregnancy (CAP) is the only PDC service currently being provided. However, over time the Hospital has restructured the CAP IOP so that the services provided no longer meet the definition of PDC as defined in the Accounting and Budget Manual. The remaining CAP IOP services being provided now meet the definition of CL services as defined in the Accounting and Budget Manual. The Hospital conducted a time study to convert the PDC visits to CL RVUs.

Staff Evaluation

This request is revenue neutral and will not result in any additional revenue for the Hospital. The consolidation of these clinics will provide consistency in billing and reporting. The Hospital's currently approved rates and the new proposed rate are as follows:

	Volumes	**Revenues**	**Unit Rates**
Partial Day Clinic (PDC)	19,620	$1,652,440	$84.22
Clinic (CL)	2,198,952	$72,262,344	$32.86
Combined Rate (CL)	2,218,572	$73,914,784	$33.32

Recommendation

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

1. That the Hospital be allowed to collapse its PDC rate center into its CL rate center;
2. That a CL rate of $33.32 per RVU be approved effective July 1, 2022; and
3. That no change be made to the Hospital's Global Budget Revenue for CL services.

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Partial Rate Application Staff Recommendation

Proceeding 2595R

Proceeding 2595R Johns Hopkins Bayview Medical Center

On April 6, 2022, Johns Hopkins Bayview Medical Center ("JHBMC," or "the Hospital") submitted a partial rate application to the Commission requesting its Partial Day Clinic (PDC) rate center be combined with the Clinic (CL) rate center effective July 1, 2022. The Hospital restructured the Center for Addiction and Pregnancy Intensive Outpatient Program to meet the definition of CL services as defined in the Accounting and Budget Manual. The Hospital also conducted a time study to convert the PDC visits to CL RVUs. This request is revenue neutral and will not result in any additional revenue for the Hospital.

Recommendation

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

1. That the Hospital be allowed to collapse its PDC rate center into its CL rate center;

2. That a CL rate of $33.32 per RVU be approved effective July 1, 2022; and

3. That no change be made to the Hospital's Global Budget Revenue for CL services.

Final Hospital Payment Plan Guidelines

- **Legal Requirement:** Chapter 770 of 2021 law amended hospital-based medical debt consumer protections and required HSCRC to develop guidelines for income-based payment plans offered by hospitals.

- **Process for guidelines development**
  - Staff from HSCRC and the Office of the Commissioner of Financial Regulation (OCFR) worked together to develop a first draft of the guidelines.
  - HSCRC convened a workgroup, in accordance with the law, that met three times to review and discuss the guidelines.
  - HSCRC presented draft guidelines in April meeting with a public comment period

Final Hospital Payment Plan Contents

These guidelines address topics related to hospital payment plans, including:

- notice requirements,
- monthly payment amounts may not exceed 5% of a patient's income;
- duration of payment plans,
- a cap on interest rates,
- treatment of prepayments, missed payments, and late payments, and
- modifications of payment plans.

Recommendation and Next Steps

- Staff recommends adopting the hospital payment plan guidelines
- These guidelines will be incorporated by reference into COMAR 10.37.10.26, also presented at this meeting
- Future work:
  - FAQ document developed in collaboration with Office of the Commissioner of Financial Regulations
  - Amend Special Audit Procedure to track compliance with the guidelines

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Final Guidelines for Hospital Payment Plans, per Chapter 770 of 2021

May 11, 2022

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Table of Contents

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
Md. Code Health General §19-214 requires that hospitals provide financial assistance to low-income patients and follow rules around medical debt collection that are designed to protect patients. In 2021, the legislature changed the medical debt requirements, including a requirement that HSCRC develop guidelines for hospitals that require that payment plans be income based (Chapter 770, 2021).	The hospital payment plan guidelines meet the requirements of the statute. These guidelines were developed with input from a stakeholder workgroup.	Hospitals must follow these guidelines for any patient payment plans. These guidelines will likely cause some payment plans to have longer durations, which may negatively impact the amount collected. In addition, hospitals may need to update their online payment portals to meet the requirements of these guidelines. Those IT changes should be a one-time expense.	These guidelines provide additional protections for consumers, including by limiting the amount due under payment plans to five percent of the patient's income and prohibiting the collection of interest for patients who are eligible for financial assistance, in addition to providing other protections for patients.	To the extent that income-based payment plans are most beneficial to lower-income patients, this policy will help improve equity for this group, which includes a disproportionate share of racial and ethnic minorities.

Commission Action

Staff are presenting the Final "Guidelines for Hospital Payment Plans", in order to meet the requirements of Health General §19-214.2, as amended by Chapter 770 of 2021, Maryland Code. The final guidelines are in Appendix I. A description of the changes made to the Guidelines between April and May, including responses to comments received in the April 6 - April 20 public comment period is in Appendix II. These guidelines will be incorporated by reference into COMAR 10.37.10.26, which will also be presented in this meeting.

Introduction

Since 2009, Maryland law has required each hospital to have a policy on the collection of debts owed by patients (Health General §19-214.2, Maryland Code). This law contains protections for patients (including

the prohibition of interest on certain debt owed by self-pay patients, a prohibition on hospitals selling debt, and a requirement that the hospital's policy clearly describe the hospital's procedures for collecting a debt).[1] Chapter 770 of 2021 made a number of statutory changes to Health General §19-214.2, Maryland Code, related to hospital collection of medical debt, including adding a requirement that hospital payment plans for patients must meet guidelines developed by the Commission.

Chapter 770 required that the HSCRC seek input from stakeholders in drafting these guidelines. Accordingly, the HSCRC formed a Workgroup on Hospital Payment Plan Guidelines, which met three times between January and February of 2022 to review guidelines originally drafted by HSCRC staff, in collaboration with staff from the Office of the Commissioner of Financial Regulation (OCFR). [2] Workgroup members and members of the public were also invited to submit written comments on the draft guidelines. In April, staff presented draft guidelines to the Commission and solicited public comments. HSCRC and OCFR staff revised the draft guidelines presented based on the comments received in April and the discussion in the April Commission meeting.

HSCRC staff are working on additional documents to provide further guidance for hospitals on implementation of Chapter 770, including a Frequently Asked Questions document, which is being developed in conjunction with OCFR. In addition, HSCRC staff plan to update the Special Audit Procedures to reflect the new requirements in Chapter 770.

Background

Chapter 770 of 2021

In addition to updating hospital debt collection requirements under Health General §19-214, Chapter 770 of 2021 required HSCRC to develop guidelines for hospital income-based payment plans with input from stakeholders. Chapter 770 requires that these guidelines include:

(1) the amount of medical debt owed to the hospital;

(2) the duration of the payment plan based on a patient's annual gross income;

(3) guidelines for requiring appropriate documentation of income level;

(4) guidelines for the payment amount, that:

[1] Maryland law also requires that hospital provide financial assistance to lower income patients (Health General §19-214.1, Maryland Code).

[2] OCFR is Maryland's consumer financial protection agency and financial services regulator. Among other things, the Office is responsible for licensing and supervising state-licensed financial institutions including consumer debt collection agencies, consumer lenders, installment lenders, credit services businesses, debt management companies to ensure compliance with the laws and regulations of Maryland.

(i) may not exceed 5% of the individual patient's federal or State adjusted gross monthly income; and

(ii) shall consider financial hardship, as defined in § 19–214.1(a) of the Health – General Article;

(5) guidelines for:

(i) the determination of possible interest payments for patients who do not qualify for free or reduced–cost care, which may not begin before 180 days after the due date of the first payment; and

(ii) a prohibition on interest payments for patients who qualify for free or reduced–cost care;

(6) guidelines for modification of a repayment plan that does not create a greater financial burden on the patient; and

(7) a prohibition on penalties or fees for prepayment or early payment.

Chapter 770 required that, in drafting the income-based payment plan guidelines, HSCRC seek input from stakeholders, including the Maryland Hospital Association, Maryland Insurance Administration, Office of the Attorney General, labor unions that represent the health care sector, a statewide nonprofit consumer rights group; patients' rights organizations, legal service providers who work with patients who have experienced medical debt; and patients who have experienced medical debt.

Hospitals must demonstrate that they attempted in good faith to meet the requirements of the guidelines before either filing an action to collect a debt owed on a hospital bill by a patient or delegating collection activity to a debt collector for a debt owed on a hospital bill by a patient.[3]

The effective date for Chapter 770 was January 1, 2022. On December 7, 2021, Kathryn Rowe, the Assistant Attorney General for the General Assembly, issued an opinion that the provision of Chapter 770 relating to the guidelines "could be given partial effect until such time as the guidelines are in place. All other provisions in the bill can be given full effect on the January 1, 2022, effective date".[4] Ms. Rowe further stated, "some of the provisions that have to be included in the hospitals' income-based payment plans are clearly stated in the law itself, even before the Commission has issued its final guidelines", so that hospitals could comply with those provisions until the Commission guidelines were in place.

[3] Health General §19–214.2 (e)(5), Maryland Code
[4] Kathyn M. Rowe, Letter to the Honorable Lorig Charkoudian regarding Chapter 770 of 2021, December 7, 2021.

Policy Goals

In developing these guidelines, HSCRC staff balanced a number of different policy goals. In general, HSCRC sought to focus on the requirements of Health General §19-214.2, as amended by Chapter 770 (2021). This contained the potential scope of the guidelines.

Under the law, income-based payment plans are now required for all patients, regardless of income. In developing these guidelines, HSCRC staff sought to balance providing protections to the low- and moderate-income patients who will most benefit from these protections, while trying to minimize the burden on other patients.

HSCRC staff also worked to ensure that the guidelines provide patients with all the protections required by law while continuing to require that hospitals seek payment from patients who can pay their bills. This balance is intended to avoid unnecessary increases in uncompensated care costs.

Process for Soliciting Stakeholder Input

To meet the requirements in Chapter 770 of 2021 for developing the payment plan guidelines, HSCRC formed a Workgroup on Hospital Payment Plan Guidelines. This group reviewed a draft of the guidelines written by HSCRC staff in conjunction with staff from the Office of the Commissioner of Financial Regulation (OCFR). The workgroup met three times:

1. 6:30 – 8:30pm on Monday, January 24, 2022
2. 9:00 – 11:00am on Friday, February 11, 2022
3. 3:00 – 5:00pm on Monday, February 28, 2022

HSCRC publicized this workgroup on its website[5] and also sent workgroup notifications to a group of interested stakeholders. Each workgroup meeting included time for public comment from non-workgroup members. In addition to receiving input through workgroup discussion, HSCRC also asked workgroup members and other interested stakeholders to provide written comments. HSCRC staff considered both the verbal comments from workgroup discussion and the written comments received from stakeholders when writing the draft of the guidelines presented to the Commission in April. See Appendix III for the full list of workgroup members.

Staff presented the draft guidelines in the April Commission meeting and solicited public comments. Staff informed the workgroup members and members of the public who had attended workgroup meetings of the public comment period. HSCRC and OCFR staff revised the guidelines based on comments received in April and the discussion in the April Commission meeting.

[5] See https://hscrc.maryland.gov/Pages/Workgroup-on-Hospital-Payment-Plan-Guidelines.aspx

Additional Documents

In addition to these guidelines presented in this recommendation, HSCRC staff are presenting updates to regulations to align COMAR 10.27.10.26 with the changes that Chapter 770, 2021, made to Health General §§ 19–214.1 and 19–214.2 in the May meeting. This update to COMAR incorporates the payment plan guidelines by reference.

HSCRC staff are also working with staff from OCFR on a “Frequently Asked Questions” document to provide additional clarity on Chapter 770 for hospitals and debt collectors.

Finally, HSCRC plans to update its Special Audit Procedures to ensure hospitals are complying with Chapter 770.

Appendix I: Final Guidelines

1) **Definitions:**
   a) In these guidelines, the following terms have the meanings indicated.
   b) Terms defined.
      i) **Financial Hardship:** "Financial hardship" has the same meaning as in COMAR 10.37.10.26.
      ii) **Written:** "Written" has the same meaning as in COMAR 10.37.10.26.
2) **Scope:**
   a) **In general:** These guidelines apply to any payment plans offered by hospitals to patients to pay for medically necessary hospital services after the services are provided.
   b) **Prepayment plans**: These guidelines do not apply to arrangements to make payments prior to the provision of a hospital service. Nothing in these guidelines prevents a hospital from offering patients arrangements to make payments prior to service, provided that–
      i) A hospital may not require or steer a patient to enter into such an arrangement solely to avoid the application of these guidelines; and
      ii) Such an arrangement terminates once the hospital service is rendered.
   c) **Unregulated services:** These guidelines apply only to hospital services that are regulated by the HSCRC. These guidelines do not apply to services that are not regulated by the HSCRC, including physician services.
   d) **Limitation of guidelines:** These guidelines do not prevent hospitals from extending payment plans for services or at times that are outside the parameters of these guidelines. Except as otherwise required by law or regulation, payment plans that are outside the parameters of these guidelines are not subject to these guidelines.
3) **Access to payment plans:**
   a) **Available to all Maryland residents:** Maryland hospitals must make payment plans available to all patients who are Maryland residents, including people temporarily residing in Maryland due to work or school, irrespective of their:
      i) Insurance status;
      ii) Citizenship status;
      iii) Immigration status; or
      iv) Eligibility for reduced cost care, including reduced cost care due to financial hardship, under COMAR 10.37.10.26.
   b) **Treatment of non-residents:** These guidelines do not prevent hospitals from extending payment plans to patients who are not described in subsection (a). Except as otherwise required by law or

regulation, payment plans for patients who are not described in subsection (a) are not subject to these guidelines.

4) **Notice requirements:**
   a) **Notice of availability of payment plans***:*
      i) **Posted notice:** A notice shall be posted in conspicuous places throughout the hospital including the billing office informing patients of the availability of a payment plan and whom to contact at the hospital for additional information.
      ii) **Information sheet:** A written notice of availability of payment plans is contained in the information sheet required under COMAR 10.37.10.26.
      iii) **Before prepayment plan:** A hospital shall provide a written notice of the availability of payment plans to a patient before a patient enters into a prepayment plan described in guideline 2 for a medically necessary hospital service.
   b) **Notice of terms before execution:** Hospitals shall provide written notice of the terms of a payment plan to a patient before the patient agrees to enter the payment plan. The terms of the payment plan must include:
      i) The amount of medical debt owed to the hospital;
      ii) The interest rate applied to the payment plan and the total amount of interest expected to be paid by the patient under the payment plan;
      iii) The amount of each periodic payment expected from the patient under the payment plan;
      iv) The number of periodic payments expected from the patient under the payment plan.
      v) The expected due dates for each payment from the patient;
      vi) The expected date by which the account will be paid off in full;
      vii) The treatment of any missed payments (including missed payments under guideline 10) and default;
      viii) There are no penalties for early payments; and
      ix) If the hospital plans to apply a periodic recalculation of monthly payment amounts under guideline 10, the process for such recalculation.
   c) **Notice of plan after execution:** A hospital shall promptly provide a written payment plan, including items listed in subsection (b), to the patient following execution by all parties. The payment plan shall be provided to the patient at least 20 days before the due date of the patient's first payment under the payment plan.
5) **Payment plans are income-based:**
   a) **Financial assistance:** Before entering a payment plan with a patient, a hospital shall evaluate if the patient is eligible for financial assistance (including free care, reduced-cost care, and reduced-cost care due to financial hardship) in accordance with COMAR 10.37.10.26. The hospital will apply the financial assistance reduction prior to entering into a payment plan with a patient.

b) **Monthly payment amounts are limited to 5% of income:** Under a payment plan subject to these guidelines, a hospital shall not require a patient to make total payments in a month that exceed 5% of the lessor of the individual patient's federal or State adjusted gross monthly income. This applies to total amounts due under the plan, including both principal and interest.

c) **Calculation of income:** A hospital shall calculate a patient's income by taking the following steps:
   i) **Determining the income amount:** Determining the lessor of the patient's federal or state adjusted gross income. If the patient has not provided their tax returns, the hospital shall use available information, including information provided by the patient, to approximate the patient's adjusted gross income. Income that is not taxable, such as certain gifts, should not be treated as income for purposes of determining the income limitation under this guideline.
   ii) **Determining the number of filers and dependents:** The hospital shall determine the number of tax filers and dependents listed on the tax return provided by the patient. For example, if a married couple files jointly and has three dependents, the number of tax filers and dependents would equal five. If a patient files as an individual and the patient is not a dependent and has no dependents, the number of tax filers would equal one. If the patient has not provided a tax return, the hospital shall ask the patient to provide the number of tax filers and dependents.
   iii) **Determining the patient's pro-rata share of income:** The hospital shall divide the income amount determined under paragraph (i) by the number of tax filers and dependents under paragraph (ii). This is the individual patient's income for purposes of determining the 5% limit on the income-based payment plans under these guidelines.

d) **Income documentation:**
   i) Hospitals shall accept generally acceptable forms of documentation that verify income, such as tax returns, pay stubs, and W2s.
   ii) Hospitals may accept patient attestation of the patient's monthly or annual income and the number of filers and dependents on their tax return without documentation. Such an attestation must include the patient's income and the number of filers and dependents on their tax return.

e) **Expenses:** A hospital shall consider information provided by a patient about household expenses in determining the amount of the monthly payment due under a payment plan.

f) **Application to multiple payment plans:**
   i) **Hospitals:** A hospital must ensure that the total monthly payment amount for all payment plans provided to a patient by such hospital, when added up collectively, may not exceed the income limitation under subsection (b).
   ii) **Hospital system:** A hospital system must ensure that the total monthly payment amount for all payment plans provided to a patient by all hospitals in the hospital system, when added up collectively, may not exceed the income limitation under subsection (b).

6) **Duration of payment plan:** The duration of a payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitation that no monthly payment may exceed 5% of the patients income as calculated under guideline (5).
7) **Interest and fees:**
    a) **No interest for patients eligible for charity care:** A hospital shall not charge and collect interest on the medical debt amount owed under a payment plan for patients who qualify for free or reduced-cost care, including reduced cost care due to financial hardship, under COMAR 10.37.10.26.
    b) **No Interest for self-pay patients:** A hospital may not charge interest on bills incurred by self-pay patients in a payment plan.
    c) **Interest allowed:** A hospital may charge interest under a payment plan for a patient who is not described in subsection (a) or (b). A hospital is not required to charge interest for a payment plan.
    d) **Interest rate.** A payment plan may not provide for interest in excess of an effective rate of simple interest of 6 percent per annum on the unpaid principal balance of the payment plan. A hospital may not set an interest rate that results in negative amortization.
    e) **Timing:** Interest may not begin before 180 days after the due date of the first payment.
    f) **Late payments:** A hospital may not charge additional fees or interest for late payments.
8) **Early payment:**
    a) **Prepayment allowed:** Patients may, on a voluntary basis, pre-pay, in whole or in part, any amounts owed under a payment plan. Any prepayment made under this provision is not subject to guideline (5)(b).
    b) **No fees or penalties:** A hospital shall not assess fees or otherwise penalize early payment of a payment plan provided by a patient.
    c) **Solicitation of early payments prohibited:** Hospitals may not solicit, steer, or mandate patients to pay an amount in excess of the monthly payment amount provided for in a payment plan.
9) **Limited Modifications of Payment Plans:**
    a) **Limitations on payment plan modifications:** A hospital may only modify a payment plan in the following ways:
        i) **Limitation on payment amount:** A hospital shall not modify a payment plan in a way that requires a patient to make a monthly payment that exceeds the percent of the patient's income used to set the monthly payment amount under the initial payment plan as provided for in guideline (5).
        ii) **No increase in interest rate:** A hospital may not increase the interest rate on a payment plan when making a modification under this guideline.

iii) **Change in duration:** The duration of a modified payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitations under guideline (5) and section (d) of this guideline.

b) **Process for modifying a payment plan:**

i) **Prompt response to patient request:** If a patient requests a modification to the terms of the payment plan, the hospital must respond in a timely manner and may not not refer the outstanding balance owed to a collection agency or for legal action until 30 days after providing a written response to the patient's request for a modification of the payment plan.

ii) **Reconsideration for financial assistance:** If a patient makes a request for modification of a payment plan, the hospital shall consider if such patient is eligible for financial assistance (including free care, reduced-cost care, and reduced-cost care due to financial hardship under COMAR 10.37.10.26). The hospital will apply the financial assistance reduction in its modification of the payment plan.

iii) **Change in income:** If a patient notifies a hospital that the patient's income has changed, as calculated under guideline (5), then the hospital shall offer to modify the payment plan to meet the requirement of subsection (a)(i) of this guideline.

iv) **Expenses:** A hospital shall consider information provided by a patient about changes in household expenses in considering a patient request to modify a payment plan.

v) **Mutual agreement:** A hospital shall not modify a payment plan without mutual agreement between the hospital and the patient before the changes are made.

vi) **Notice of terms:** The hospital must provide the patient with a written notice of all payment plan terms, consistent with the requirements of guideline (4), upon modifying a payment plan under this guideline.

10) **Hospital-initiated changes to payment plans based on changes to patient income:**

a) **Recalculation allowed:** A hospital may, in the terms of an initial payment plan that exceeds 3 years in length, provide for periodic recalculations to the amount of the monthly payments and the duration of the payment plan based on changes in the patient's income as subject to and calculated under guideline (5).

b) **Notice included in initial payment plan:** The hospital may only recalculate payment amounts under this guideline if the hospital included the process for such recalculation in the notice provided to the patient before they entered into the payment plan, per guideline 4(b)(ix). The patient's agreement to enter into the payment plan after receiving that notice constitutes consent to the payment recalculations allowed under this subsection.

c) **Limitations on modification apply:** Guideline 9(a) and paragraphs (i), (ii), (iii), (iv), and (vi) of Guideline 9(b) apply to payment recalculations under this subsection.

d) **Frequency of recalculation:** A hospital may not seek a recalculation of the monthly payment amount, as provided for under this subsection more often than once every 3 years.

e) **Treatment of missing information:** If a patient does not provide income information on the request of the hospital seeking to make a change to a payment plan under this subsection and the patient is in good standing on the patient's payments under the payment plan the hospital shall not change the monthly payment amounts under the payment plan.

11) **Treatment of missed payments:**

a) **First Missed Payment:**

i) A hospital may not deem a patient to be noncompliant with a payment plan if the patient makes at least 11 scheduled monthly payments within a 12-month period.

ii) The hospital shall permit the patient to repay the missed payment amount at any time, as determined by the patient, including through a set of partial payments.

iii) The hospital may consider a patient to be in default on the payment plan if the missed payment is not repaid in full by the end of the 12-month period that begins on the date of the missed payment under paragraph (i).

b) **Additional missed payments:**

i) A hospital may forbear the amount of any additional missed payments that occur in a 12-month period.

ii) If a hospital forbears the amount of any additional missed payments that occurs in a 12-month period, the hospital shall allow the patient to continue to participate in the income-based payment plan.

iii) If a hospital forbears the amount of any additional missed payments that occur in a 12-month period, the hospital may not refer the outstanding balance owed to a collection agency or for legal action.

iv) The hospital shall recapitalize the amount of any missed payments that were subject to forbearance under this subsection as additional payments at the end of the payment plan, thereby extending the length of the payment plan.

v) The hospital shall provide written notice to the patient of the treatment of the missed payments, including any extension of the length of the payment plan.

12) **Treatment of loans and extension of credit:** After a hospital service is provided to the patient, a hospital, hospital affiliate, or a third-party in partnership with a hospital may not make any loan or extension of credit to the patient that is inconsistent with these guidelines for medical debt resulting from that service.

13) **Application of Credit Provisions of Maryland Commercial Code:** A payment plan is an extension of credit subject to Maryland credit regulations under the Annotated Code of Maryland, Commercial Law Article, Title 12. Accordingly, hospitals must elect or otherwise enter into an income-based payment

plan under one of the subtitles thereunder. Pursuant to CL § 11-302(b)(6), if a hospital is making an extension of credit through a payment plan for hospital services rendered under Subtitles 1, 9, or 10 of the Commercial Law Article, and is otherwise not making loans or acting as a loan broker, then an Installment License issued by the Commissioner of Financial Regulation may not be required to engage in such activity.

14) **Books and Records:** A hospital must retain books and records on payment plans for at least 3 years after the payment plan is closed.
15) **Default:** If a patient defaults on a payment plan and the parties are not able to agree to a modification, then the hospital must follow the provisions of its collection and write-off policy for the collection of debt established in accordance with COMAR 10.37.10.26, before a hospital may write this debt off as bad debt.

Appendix II: Staff Description of Changes to the Guidelines, including Responses to Public Comments Received through the April Public Comment Period

This appendix contains a description of the changes made to the Guidelines presented in the April Commission meeting, including HSCRC staff responses to comments received in the April 6 - April 20 public comment period. These HSCRC staff responses are in addition to the discussion in the "Staff Explanation for Guidelines for Hospital Payment Plans" included in the April Meeting materials.

Guideline 1: Definitions: A commenter urged the HSCRC to change the definition of "written" under Guideline 1(b) to include that communication must be delivered both in paper form and electronically. Another commenter expressed support for allowing notification through either paper or electronic means. HSCRC believes that either electronic or written notice is sufficient. The language specifically allows patients to opt-out of electronic notices if they would prefer paper, giving patients choice over the document format. After review, HSCRC has decided to move this definition into the proposed regulations and cross reference it in these guidelines.

Guideline 2: Scope: The draft guideline 2 in April focused on distinguishing between payment plans that occur after a debt is incurred, rather than before a service is provided.

A commenter urged the Commission to reconsider applying the Guidelines to prepayment plans or include a requirement that hospitals give patients notice at the time an appointment is made that payment plans would be available to patients making prepayments after services are provided. Another commenter noted that it is not feasible to apply these guidelines to prepayment arrangements because it may be impossible to determine whether patients owe any outstanding balance until they receive the service and their insurance claim is adjudicated. As HSCRC noted in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April, HSCRC does not believe that the statute directed HSCRC to apply the guidelines to prepayment plans. In addition, not all of these guidelines would be appropriate for prepayment plans. HSCRC has added a requirement to guideline 4 that hospitals must provide notice to patients of the availability of payment plans before entering into a pre-payment plan.

Another commenter suggested striking all language about pre-payment arrangements due to the concern that these arrangements are entirely outside of the scope of these guidelines. HSCRC mentions prepayment plans in this guideline to clarify that these guidelines do not apply to pre-payment plans. HSCRC believes this clarity is important for hospitals and debt collectors who must operationalize this bill.

Another commenter suggested that HSCRC clarify that these payment plan guidelines are limited to hospital bills and not physician expenses. HSCRC has added language to guideline 2 that clarifies that these guidelines only apply to HSCRC regulated hospital services.

HSCRC added language to make clear that hospitals can provide payment plans for situations that are out-of-scope of these guidelines and those payment plans are not subject to these guidelines.

Guideline 3: Access to payment plans: No changes were made to this guideline.

Guideline 4: Notice requirements

Guideline 4(a): Notice of availability of payment plans: In April, this guideline only contained language about hospitals posting notices in the hospital about the availability of payment plans. One commenter suggested that, in addition to conspicuous notices, hospitals should also provide "paper" notice before discharge from the hospital. As is outlined in HSCRC's proposed updates to COMAR 10.37.10.26, this information will be included in the information sheet, which is provided before discharge. HSCRC added language to the guidelines to clarify that notice of payment plans is included in the information sheet. In addition, HSCRC added a provision to require notice of the existence of payment plans before a hospital and patient enter into a prepayment plan that is out-of-scope of these guidelines.

Guideline 4(b): Notice of terms before execution: One commenter suggested removing this subsection over concern that it would be administratively burdensome for hospitals and delay the start of payment plans. HSCRC continues to agree with feedback received from other commenters that this requirement is necessary to ensure consumers know the terms of the payment plan before they agree to enter into the payment plan.

Another commenter proposed adding the interest rate and the total amount of interest due under the payment plan to the notice requirements under 4(b). HSCRC has added that language to the guideline.

In the April meeting, a Commissioner asked how patients would be made aware of the option to make early payments under a prepayment plan. Staff have added language to this notice requirement to require notice that there is no penalty for early payments.

The commenter also recommended adding a requirement that hospitals outline the good faith requirement from Chapter 770 into the notice so that patients have know that they can make complaints based on lack of good faith requirements when applicable. More specifically, they proposed adding to the list under 4(b) "The requirement that a hospital shall demonstrate that it attempted in good faith to meet the requirements of the medical debt statute and the Commission's Guidelines before filing an action to collect a debt owed on a hospital bill by a patient or delegating collection activity to a debt collector." HSCRC and OCFR focused on providing the terms of the prepayment plan in this notice. The good faith requirement is not a term of the payment plan. HSCRC does not think that this guideline is the appropriate place to address this topic. HSCRC

understands the concerns that advocates have about how the "good faith" language in Chapter 770 will be applied. HSCRC has included some language related to this topic in the proposed regulations.

Guideline 4(c): Notice of plan after execution: One commenter expressed concern that requiring hospitals to provide the payment plan to the patient at least 10 days before the due date of the patient's first payment may not give patients sufficient time if a hospital sends the payment plan by mail. For this reason, HSCRC is proposing to update Guideline 4(c) to provide for a 20 day period.

Guideline 5: Payment plans are income-based:

Guideline 5(a): Financial assistance: A commenter requested an edit to guideline 5a to clarify that any reduction in the amount due based on financial assistance should be applied prior to entering into the payment plan. HSCRC agreed that the new second sentence in this guideline adds clarity and accepted this change.

Guideline 5(b): Monthly payment amounts are limited to 5% of income: HSCRC staff have not changed this guideline.

Several commenters encouraged the Commission to allow patients to pay more than 5% if the patient chose to do so. Some commenters urged the Commission to alter the draft guidelines to allow patients to self-select the plan that best suits their financial needs if hospitals disclose that payment plans cannot by law exceed 5% of adjusted gross monthly income, without requiring hospitals to determine if the monthly payment about does exceed 5% of the patient's monthly income. One commenter asserted that the Commission could read the requirement in Health General § 19-214.2 that the installment payment amount may not exceed 5% of gross monthly income, along with the statutory prohibition of penalties or fees for prepayment or early payment to allow this approach. Some of these commenters are concerned about the length of payment plans that may arise due to the 5% income restriction. Commission staff do not agree that this approach would meet either the letter or the intent of the law. Staff believe that a monthly billing statement that contains an "amount due" that the hospital knows is greater than 5% of the adjusted gross monthly income amounts to a solicitation of a payment amount in excess of 5% of monthly income, which is prohibited by the law. HSCRC considers any amount in excess of 5% of monthly income (with the exception of a missed payment under guideline 10(a)) to be an early payment. Guideline 8 specifically prohibits the solicitation of early payments. A hospital cannot avoid this obligation by purposely failing to ask for the patient's income (such as by using a checkbox to have the patient certify that the monthly payment amount does not exceed 5% of their income -see additional discussion of this topic under guideline 5(d)).

At least one commenter asked HSCRC to clarify that hospitals may not solicit payments above 5% of monthly income. As stated above, HSCRC considers any amount in excess of 5% of monthly income (with the exception of a missed payment under guideline 10(a)) to be an early payment and guideline 8 specifically prohibits the solicitation of early payments.

Guideline 5(c): Calculation of income: HSCRC staff have not changed this guideline.

One commenter noted that the use of individual income for payment plans in Health General § 19-214.2 does not align with the use of family income for the determination of eligibility for hospital financial assistance in Health General § 19-214.1 and asked HSCRC to use family income in the payment plan guidelines. HSCRC agrees that these statutory differences lead to inconsistencies in how the payment plan policies and financial assistance policies will be applied and increase administrative challenges for hospitals and patients, who will have to make two different income determinations, one for financial assistance and one for payment plans. As noted in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April:

> "The meaning of "individual patient" was discussed in the workgroup and in a number of written comments. Staff had …concerns about the use of individual income to determine the income limitation for hospital payment plans…. [T]he use of individual income could result in unintended outcomes. For example, a non-working spouse or child in a high income household could have an individual income of zero dollars, resulting in an income repayment plan with monthly payments that cannot exceed $0, despite that household's ability to pay for hospital charges. Conversely, a sole wage owner in a family with many dependents would end up with a higher payment plan income limit if their dependents were not taken into account. Several approaches were suggested to staff to address this issue. Ultimately, staff decided that using a pro-rata share of the adjusted gross income for all filers and dependents was the best approach."

Commenters stated their belief that using the "pro-rata" approach, rather than "family income", would be complex and confusing for both hospitals and consumers. Staff continue to believe that the pro-rata approach is the appropriate approach given the constraints of the statutory language. A statutory change to use the term "family income" in Health General § 19-214.2 would allow for greater consistency between the financial assistance and payment plan policies and reduce administrative burden for patients and hospitals.

Guideline 5(d): Income documentation: One commenter requested that HSCRC allow patients to self-attest that the payment plan they select will result in monthly payments that are no more than 5% of GMI. The commenter felt that this approach would make entering a payment plan easier for patients by minimizing the amount of information that the patient needs to provide the hospital.

HSCRC staff discussed the request to use the attestation described in this comment in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April.

> "Some stakeholders requested that the guidelines allow hospitals to request patient attestations that the payment plan is under 5% of income (for example, through a check box and signature) rather than collecting income information from the patient. HSCRC staff do not think this approach satisfies the legal requirement that payment plans be income-based. Hospitals may not accept such an attestation in lieu of collecting information about the patient's income and calculating the 5% limitation on the monthly payment amount based on the income information provided by the patient."

A commenter asserted that the process in this guideline would push "hospitals to require more verification as the number of dependents directly affects the monthly amount the hospital can collect from the patient." Guideline 5(d) allows hospitals to accept attestation of patient income. HSCRC has edited this guideline to clarify that the attestation can also include the number of filers and dependents. Staff do not think that hospitals would require more verification given that patient attestation of this information is allowed. As noted in Guideline 5(d), an attestation of the patients income and the number of filers and dependents is sufficient documentation of income.

Guideline 5(e) Expenses: HSCRC staff have not changed this guideline.

Some commenters requested striking this language due to concerns that it is burdensome for hospitals. Other commenters requested that each hospital develop and report to the HSCRC on a process for documenting how they incorporate expenses into the payment plan. As noted in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April, we included this guideline in response to commenters noting that various expenses other than medical debt may affect a patient's ability to pay for hospital services. Medical debt is addressed through reduced cost care with financial hardship under the statutory requirements for financial assistance. Staff continue to believe that this guideline, which encourages but does not require hospitals to consider expenses, appropriately balances different viewpoints on this issue.

At least one commenter asked that we include a definition of "household expenses". Given that the consideration of these expenses is not required, HSCRC does not feel that including a definition is necessary.

Guideline 5(f): Limitation of payment amount across hospitals. HSCRC staff have not changed this guideline.

Several commentators (and a Commissioner) asked HSCRC to consider a guideline that limited all payment plans across all hospital systems to the 5% monthly income limit. In the "Staff Explanation

for Guidelines for Hospital Payment Plans" in April, "HSCRC staff determined that operationalizing such an approach was not operationally feasible at this time." Staff continue to believe that the operational complexity of this topic would prevent effective implementation. In addition, HSCRC does not read the language of the law to require this coordination.

Guideline 6: Duration of payment plan: HSCRC staff have not changed this guideline.

Guideline 7: Interest and Fees: HSCRC staff have not changed this guideline.

One commenter stated that the interest rate should not be capped at 6%, but rather tied to market indicators. This commenter noted that this would recognize the additional carrying costs of the longer payment plans that will result from these guidelines. As noted in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April, 6% is the constitutional rate of interest in Maryland, which is the default interest rate in Maryland law when no interest rate is provided in statute.[6] This interest rate is half of the interest rate cap that HSCRC applies to hospital accounts receivable under COMAR 10.37.10.26 (B)(3). Additional discussion of the selection of this interest rate is in the "Staff Explanation for Guidelines for Hospital Payment Plans" from April. Staff continue to believe this is an appropriate interest rate.

Guideline 8: Early payment: HSCRC staff have not changed this guideline.

In the April meeting, a Commissioner asked how patients would be made aware of the option to make early payments. HSCRC staff made a change to guideline 4 to include notice that there is no prepayment penalties in the information that the patient receives before entering into a payment plan under these guidelines.

Guideline 9: Limited Modifications of Payment Plans

The heading of this guideline was changed to reflect the narrower scope of the guideline (see the discussion of the new guideline 10 below for more information).

Guideline 9(a): Limitations on payment plan modifications: HSCRC staff have not changed this guideline.

Guideline 9(b): Process for modifying a payment plan: Commenters asked that HSCRC change Guideline 9(b)(i) so that hospitals may not refer the outstanding balance owed to a collection agency or for legal action until 180 days after providing a written response to the patient's request for a modification of the payment plan. As stated in the April "Staff Explanation for Guidelines for Hospital Payment Plans", staff "decided that 30 days was appropriate given the many other protections against referral for collections or legal action in Health General §19-214.2."

[6] Article 3, §57 of the Maryland Constitution states that "the legal rate of interest shall be six per cent per annum; unless otherwise provided by the General Assembly ".

In guideline 9(b)(ii), HSCRC added a sentence to clarify that any reduction in the amount due based on financial assistance should be applied prior to entering into the payment plan. This is similar to a change made in guideline 5(a).

Another commenter requested the HSCRC change Guideline 9(b)(iii) to allow hospitals to modify a payment plan if a patient's income has changed, not just when the income decreased. HSCRC staff made this change in the guideline.

Guideline 10 (former Guideline 9(c)): Hospital-initiated changes to payment plans based on changes to patient income: HSCRC staff moved this provision from a subsection in guideline 9 to it's own guideline, to make clear that the process contemplated in this guideline is different than the modifications discussed in guideline 9.

A commenter requested that HSCRC amend this guideline so that the recalculation period is not limited to once every 3 years. Instead, the commenter recommended that HSCRC allow for hospital discretion to identify when recalculation may be appropriate. As stated in the April "Staff Explanation for Guidelines for Hospital Payment Plans", HSCRC staff believe it is important for hospitals to have the option to change monthly payment amounts under payment plans based on changes in patient income. This is particularly important given that staff expect that payment plans will be longer under this new regulatory regime than they have been in the past. However, this must be balanced with protections for consumers so that they are not subject to constant attempts by hospitals to recalculate payment plan amounts. Staff believe 3 years is the right balance.

Another commenter suggested removing this guideline, with the belief that the guideline allowing patients to modify their payment plan suffices. HSCRC staff continue to believe that this guideline, which gives hospitals the option to recalculate payment amounts but does require hospitals to do so, is important given the significant change that is expected in the length of payment plans under these guidelines.

Another commenter suggested that Guideline 10(b) could be clarified. Staff added language to this guideline in response to this comment.

Guideline 11 (former guideline 10): Treatment of Missed Payments: HSCRC staff have not changed this guideline.

Guideline 12 (former guideline 11) : Treatment of Loans and Extension of Credit: HSCRC has simplified the language in the guideline based on feedback from commentators.

One commenter urged HSCRC to strike this language due to the belief that this creates unnecessary confusion regarding third-party financing options that are available to patients. HSCRC continues to believe that this language is necessary to ensure that hospitals comply with these guidelines regardless of the type of arrangement (payment plan, loan, other extension of credit) that exists between the hospital and the

patient. This guideline only applies to loans and extensions of credit offered by the hospital or by a third party in partnership with the hospital. In the "Staff Explanation for Guidelines for Hospital Payment Plans" in April, staff noted that-

> "HSCRC does not intend these guidelines to apply to loans or other forms of consumer credit (such as credit cards) that are offered to patients by entities that do not have an agreement with the hospital. These forms of credit are outside of the scope of Health General §19-214.2 and are subject to Federal and State law related to consumer protection for financial products."

HSCRC believes that striking this language would not succeed in clarifying this issue, but would instead create an opportunity for use of loans and extensions of credit that violate these guidelines.

Former Guideline 12: Debt Collectors: Commenters suggested that HSCRC provide further detail in this guideline. On further consideration of this feedback and the law, HSCRC has moved the text of this guideline to the proposed regulations.

In addition, commenters urged HSCRC to clarify the auditing and compliance process to enforce these guidelines and to clarify the consumer complaint process. HSCRC does not think the guidelines are the appropriate document to use to address these concerns. HSCRC plans to update audit procedures to reflect the requirements of Chapter 770.

Guideline (13): Application of Credit Provisions of Maryland Commercial Code: HSCRC staff have not changed this guideline.

Guideline (14): Books and Records: Commenters requested that this guideline be changed to make the minimum document retention 3 years after the payment plan is closed or "*for the period of time required to retain medical records under federal or state laws, whichever is later."*

As stated in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April, this guideline was drafted to allow sufficient time for the purposes of HSCRC's audit requirements and for compliance activities. This guideline does not supersede any other record retention requirements under law. The HSCRC does not feel it is necessary to mention other federal and state laws in this provision, but rather simply state the time period that is necessary for compliance with these guidelines.

Guideline 15: Default: HSCRC staff have not changed this guideline.

A commenter encouraged the HSCRC to update its audit procedures to ensure these guidelines are followed. HSCRC plans to update the special audit procedures, which is a separate document, to add auditing requirements related to Chapter 770, 2021. The HSCRC does not believe that these guidelines are the best place to address this concern.

Uncompensated Care and Bad Debt. One commenter "strongly encourage[d] the Commission to balance the proposed payment plan guidelines to safeguard reasonable rates for all payers, including out-of-pocket costs for all patients." HSCRC staff is not clear what specific changes the commenter is requesting to the guidelines, if any. HSCRC staff have worked throughout this process to meet the letter of the law and ensure consumer protections, while remaining mindful of the operational impacts of these guidelines on both hospitals and consumers.

HSCRC staff agree that the move to income-based guidelines will likely lengthen individual payment plans and this may have an impact on bad debt and uncompensated care HSCRC acknowledges that other commenters think these guidelines will reduce bad debt by increasing adoption of payment plans. HSCRC does not have data on current payment plan use or the rate of collections from those payment plans. HSCRC does not have a current reporting process to collect this data. As a result, it will be difficult, if not impossible, to isolate the impact of this change in policy on UCC and administrative costs. HSCRC will, as always, consider uncompensated care in setting future hospital rates.

Appendix III: Workgroup Members

1. Brett McCone, *Maryland Hospital Association*
2. Lakmini Kidder, *Johns Hopkins Health System*
3. Mark Norby, *University of Maryland Medical System*
4. Sue Whitecotton, *Medstar Health*
5. Cheryl Nottingham, *Atlantic General Hospital*
6. Bradley Boban, *Maryland Insurance Administration*
7. Pat O'Connor, *Health Education and Advocacy Unit of the Maryland Attorney General's Office*
8. Girume Ashenafi, *1199 SEIU United Healthcare Workers East*
9. Marceline White, *Maryland Consumer Rights Coalition*
10. Anna Palmisano, *Marylanders for Patient Rights*
11. Amy Hennen, *Maryland Volunteer Lawyers Service*
12. Tori Nefflen, *Patient Representative*
13. Godlee Davis, *DECO Recovery Management*
14. Leslie Bender, *Clark Hill Law Firm*
15. Neal Karkhanis, *League of Life and Health*
16. Kenneth Krach, *Office of the Commissioner of Financial Regulation*
17. Jedd Bellman, *Office of the Commissioner of Financial Regulation*
18. Megan Renfrew, *HSCRC*
19. Dennis Phelps, *HSCRC*
20. Stan Lustman, *HSCRC*

Appendix IV: Chapter 770, 2021

See Next Page

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April 20, 2022

Via email: hannah.friedman-bell@maryland.gov

Katie Wunderlich, Executive Director
Hannah Friedman-Bell, Analyst
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Public comments on Draft Guidelines for Hospital Payment Plans

Dear Ms. Wunderlich and Ms. Friedman-Bell,

The Health Education and Advocacy Unit (the HEAU) submits the following informal comments on the Commission's proposed draft Guidelines for Hospital Payment Plans which are scheduled for a vote at the May Meeting. Today's comments incorporate comments previously submitted by the HEAU as a member of the Stakeholder Workgroup that has been providing input, along with members of the public, on the draft Guidelines since January.

We wish to thank the Commission's staff for adopting many of the HEAU's previous suggestions and for addressing many of the HEAU's previously stated concerns. As a result, the current draft Guidelines promise to achieve the remedial intent of Chapter 770 of 2021. We remain concerned, however, that the current draft Guidelines (1) would not apply to prepayments demanded by some hospitals, and (2) lack express notice to patients of the good faith effort requirement under the new remedial scheme, i.e., that a hospital "shall demonstrate that it attempted in good faith [to meet the requirements of the medical debt statute and the Commission's Guidelines]" before filing an action to collect a debt owed on a hospital bill by a patient or delegating collection activity to a debt collector. The HEAU interprets this to mean a hospital must prove it made good faith efforts *under the circumstances of each case* to continue a payment plan before filing an action to collect a debt owed on a hospital bill by a patient or delegating collection activity to a debt collector.

The term "medical debt" encompasses obligations to pay for medical services, whether those payments are made after the fact or as prepayments demanded by hospitals to obtain services. Any more limited definition of the term, which excludes efforts to obtain prepayment, contravenes the purpose of the statute and the protections that it affords. We would welcome staff's reconsideration of the applicability of the Guidelines to prepayments.

However, if the Commission limits the application of the Guidelines to payments made after a procedure, we request that Guideline 2, Scope, be amended as set forth below. The HEAU is concerned that prepayment is requested from those patients most likely to need the remedial protections of income-based payment plans and submits those patients, at a minimum, should be given timely notice that the plans would be available to them if they did not prepay for services. With timely notice, a patient may seek the services from a hospital that does not demand prepayment and would provide the patient a payment plan.

2) Scope:

a) These guidelines apply to any payment plans offered by hospitals to patients to pay for hospital services after the services are provided.

b) These guidelines do not apply to arrangements to make payments prior to the provision of a hospital service provided that-

i) the hospital notifies the patient orally and in writing that payment plans are available to patients who pay for services after they are provided;

ii) explains the payment plans orally and in writing to the patient; and

iii) provides the notice and explanation required by subparts (i) and (ii) at the time the appointment is made.

c) Nothing in these guidelines prevents a hospital that has complied with subpart (b)(i)-(iii) from offering patients arrangements to make payments prior to service, provided that–

i) A hospital may not require or steer a patient to enter into such an arrangement ~~solely~~ to avoid the application of these guidelines; and

ii) Such an arrangement terminates once the hospital service is rendered.

The HEAU also proposes amending Guideline 4(b), Notice Requirements, to include interest related information and to provide patients express notice of the good faith effort requirement under the new remedial scheme so that patients may file complaints based on lack of good faith efforts when appropriate. We suggest that the interest rate, if applicable, and the total amount of interest to be paid be added to the terms of the payment plan in 4(b) and that the following also be added to the terms of the payment plan, "(viii) The requirement that a hospital shall demonstrate that it attempted in good faith to meet the requirements of the medical debt statute and the Commission's Guidelines before filing an action to collect a debt owed on a hospital bill by a patient or delegating collection activity to a debt collector."

Finally, we suggest that Guideline 14, Books and Records, be amended by the adding the following, ", or for the period of time required to retain medical records under federal or state laws, whichever is later."

The HEAU thanks staff and the Commission for considering our comments.

Sincerely,

/s/

Patricia F. O'Connor
Assistant Attorney General
Deputy Director
Health Education and Advocacy Unit

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

April 20, 2022

Comments on Draft Guidelines for Hospital Payment Plans

On behalf of the Maryland Consumer Rights Coalition, thank you for the opportunity to submit these comments on the proposed Hospital Payment Policy Guidelines per chapter 770 of 2021. We appreciate the work of HSCRC staff in convening and facilitating the workgroup session and developing these proposed guidelines.

1. **Guideline. Definitions.**

Guideline (1) (b) (i)
Recommendation: We recommend that the income-based payment plans be offered to all patients and that we eliminate use of financial hardship in determining who is eligible for the payment plans. The definition of financial hardship in 19.214.1 is a high bar to meet for many families who are already struggling to meet basic needs prior to seeking medical care and holding hospital medical debt. As our reseach found, the average amount of medical debt sought by Maryland hospitals in lawsuits was $944. This indicates that many patients who may earn just above the reduced-cost care threshold struggle to pay an unexpected expense of less than $1000. For middle-class households, a family that earns $100,000 annually would have to accrue more than $25,000 in medical debt to be eligible for a payment plan. While $100,000 is above the median income of $87,063 in Maryland, assuming the household pays a mortgage, a car, auto insurance, utilities, and basic needs, that amount shrinks rapidly. For this payment plan to be meaningful, it should be available to **all** Maryland patients.

Guideline (1) (b) (ii)
Recommendation: While we largely agree with the definition of written as proposed, we recommend that written communication should be delivered **both** in paper form as well as electronically.

Many patients struggle with side effects from medicine, fatigue, and may be living in pain while trying to heal which means that as a precautionary measure, it is important to use multiple means of communication. Moreover, in our workgroup, the patient representative reported

problems that she and other cancer survivors experienced receiving notification and billing via patient portals. Finally, for older adults, many struggle to manage multiple forms of electronic communication so it is not a suitable way to deliver information to many older adults as well as those in urban and rural communities that lack broadband service or only have spotty, unreliable internet service.

2. **Scope.**

We agree with the proposed scope of the regulations.

3. **Access to Payment Plans.**

We agree that the payment plans should be accessible to all Maryland residents irrespective of their citizenship, immigration, or insurance status, or their eligibility for free or reduced cost care.

4. Notice Requirements.

a) **Notice of Availability.**

Recommendation: In addition to conspicuously posting a notice of the availability of payment plans, we recommend that patients also receive a paper notice before discharge from the hospital.

b) **Notice of Terms.** We agree with the proposed notice of terms.

c) **Notice of Plan**. We agree with the proposed notice of plan after execution.

5) Payment Plans Are Income-Based

a) Financial Assistance.

Recommendation: We agree patients should be considered for free and reduced-cost care and for those that quality, that the hospital apply the discount to the medical bill prior to entering a payment plan with the patient. The rationale for this is that some patients may qualify for free care so will not need a payment plan while others will have a smaller amount due if the reduced cost care discount is applied before creating the plan. This reduces the individual's debt and increases the likelihood that the hospital will be repaid over a shorter period of time.

b) Monthly Payments are Limited to 5% of Income.

Recommendation: We agree that this guideline reflects the statutory requirement. If it is not included elsewhere, we recommend including additional language stating that hospitals may not steer patients toward making monthly payments that exceed 5% of their federal or state gross monthly income.

c) **Calculation of Income.** We agree with the proposed guidelines to calculate income using a pro-rata share of the adjusted gross income of all filers and dependents.

d) **Income Documentation.** We support the proposal for income documentation.

e) **Expenses.**

Recommendation: We agree that hospitals should consider household expenses when developing a payment plan. However we believe that each hospital should develop a process documenting how they will review and incorporate these expenses into the development of the payment plan. Furthermore, the process each hospital develops should be reported and approved by HSCRC.

f) Application to Multiple Payment Plans.

(i) Hospitals. We agree with this proposed guideline.

(ii) Hospital Systems. We agree with this proposed guideline

(iii) **Recommendation:** We recommend that hospitals and hospital systems throughout the state coordinate across systems to ensure that all payment plans a patient may be enrolled in do not exceed 5% income limitation on payment plans.

6) Duration of Payment Plans. We agree with the proposed guidelines in this section.

7) Interest and Fees. We agree with the proposed guidelines in this section.

8) Early Prepayment. We agree with the proposed guidelines in this section.

9) Limited Modifications of Payment Plans and Recalculation of Payment Amounts

a) Limitations on payment plan modifications. We agree with proposed guidelines (9) (a) (i-iii).

b) Process for modifying a payment.

(i) Prompt response to patient request.

Recommendation: We recommend that the hospital must wait **180** days before referring the outstanding balance to a collection agency or filing a lawsuit. This is consistent with other areas of Maryland law and provides reasonable time for an individual to respond or plan accordingly.

(ii-vi) We agree with the proposed guidelines in these subsections.

c) Hospital initiated changes to payment plans based on changes to patient income

(i) Recalculation allowed. We support the proposed guidelines in this subsection.

(ii) Term included in initial payment plan. Language is confusing and unclear. We recommend that this guideline should be redrafted for clarity.

(iii)-(v) We support the proposed guidelines in these subsections.

10) Treatment of Missed Payments

a) First Missed Payment. We agree with the proposed guidelines in this subsection.
b) Additional Missed Payments. We agree with the proposed guidelines in this subsection.

11) Treatment of Loans and Extension of Credit. We agree with the proposed guidelines in this section.

12) Debt Collectors.

Recommendation: We recommend that this section be more fully fleshed out with greater specificity. Robust implementation of these guidelines is critical to expand protections for patients in accordance with the legislative intent of HB 565. There should be no ambiguity regarding every hospital's obligation to fully conform with HB 565, whether hospital staff or contractors are engaging in covered activities. It remains unclear how hospitals will ensure that staff or contractors are following these guidelines, how HSCRC will use its authority to guarantee that the regulations are followed and how these regulations and oversight harmonize with the Commissioner of Financial Regulation's office. Moreover, the HEAU unit in the Office of the Attorney General may play a critical role in redressing complaints, providing guidance, and enforcement but as drafted these guidelines fall short of providing clarity in terms of delineating clear roles and responsibilities among multiple agencies. After multiple emails with HSCRC, the role of auditing in supporting implementation and enforcement of regulations remains opaque and vague. Meaningful enforcement and accountability are critical to ensuring that the law is followed, yet conversations in the workgroup among stakeholders repeatedly referred to allowing patients to pay more than the legal limit on payment plans, contemplated very short timelines for payment plans, and seemingly did not fully account for these meaningful changes in law.

13) Application of credit provisions of Maryland commercial code. We agree with the proposed guidelines in this section.

14) Books and Records. We agree with the proposed guidelines in this section.

15) Default.

Recommendation: We recommend that auditing and other processes be amended so that the remedial statutory scheme for payment plans is not undermined. We remain concerned that

the hospital representatives spoke repeatedly about the patients who self-selected into plans with high payments and of short duration (under 1 year). It remains unclear how hospitals will comply with the good faith effort requirement under the new remedial scheme, i.e., that a hospital prove it made good faith efforts under the circumstances of each case to continue a payment plan before filing an action to collect a debt owed on a hospital bill by a patient or delegating collection activity to a debt collector. Auditing regulations and processes require updating to harmonize with the remedial payment plan provisions. We also think more discussion of existing processes (e.g., how, when and why charity care is treated as uncompensated care like bad debt and factored into the hospital rates that are payable by all payers) is necessary.

Thank you for your consideration of these comments. Please don't hesitate to contact me with any questions or additional comments.

Best,

Marceline White
Executive Director

Cc: Denis Phelps
Megan Renfrew
Hannah Friedman-Bell

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

April 20, 2022

1199SEIU Comments on Draft Guidelines for Hospital Payment Plans

We the members and leadership of 1199SEIU United Healthcare Workers East, would like to thank you for the opportunity to submit these comments on the proposed Hospital Payment Plan Guidelines compiled by HSCRC staff. We appreciate the work of HSCRC staff in convening the workgroup sessions as well as developing these proposed guidelines.

Guideline 1: Definitions

We agree with this guideline as written.

Guidelines 2: Scope

We agree with this guideline as written.

Guideline 3: Access to Payment Plans

Recommendation: We generally agree with this guideline as written but would also like to highlight that we strongly believe that payment plans need to be made available to **all** Marylanders regardless of any other circumstances, financial or otherwise.

Guideline 4: Notice of Requirements

Recommendation: In addition to conspicuously posting notice of the availability of payment plans, we recommend that patients receive digital as well as paper notification about the availability of payment plans after receiving care.

Guideline 5: Payment Plans are Income-Based

Recommendation: We mostly agree with this guideline as written but have a few recommended changes. Our first change is that the guideline should explicitly state that even though patients may opt to exceed the 5% income limit in their monthly payments, hospitals may not steer patients toward doing so.

Secondly, we believe the language around hospitals considering household expenses when developing a payment plan is a bit vague. We would support hospitals developing a process for documenting how they will incorporate household expenses into a patient's payment plan. Thirdly, we believe that some type of mechanism should be developed to ensure that patients with payment plans across multiple health systems do not exceed the 5% income threshold across all payment plans. We believe that anything short of this type of mechanism would become burdensome on patients having to keep track of multiple payment plans across multiple health systems.

Guideline 6: Duration of Payment Plans

We agree with this guideline as written.

Guideline 7: Interest and Fees

We agree with this guideline as written.

Guideline 8: Early Prepayment

We agree with this guideline a written.

Guideline 9: Limited Modifications of Payment Plans and Recalculation of Payment Amounts

Recommendation: We generally agree with this guideline as written but would recommend that hospitals must wait 180 days before referring an outstanding balance to debt collection or pursuing legal action. We believe this to be consistent with other areas of law.

Guideline 10: Treatment of Missed Payments

We agree with this guideline as written.

Guideline 11: Treatment of Loans and Extension of Credit

We agree with this guideline as written.

Guideline 12: Debt Collectors

Recommendation: We believe that this guideline is rather vague and needs further attention. We believe that there needs to be some additional oversight of debt collectors by an entity other than hospitals. Whether that entity is HSCRC or HEAU-OAG, we strongly believe that allowing hospitals alone to oversee the compliance with the law of debt collectors is not a tenable solution in the long run.

Guideline 13: Application of Credit Provisions of Maryland Commercial Code

We agree with this guideline as written.

Guideline 14: Books and Records

We agree with this guideline as written.

Guideline 15: Default

Recommendation: We generally agree with this guideline as written but remain highly concerned about hospitals making a good faith effort on a case-by-case basis to continue a payment plan before referring outstanding balances to debt collection. We believe that there needs to be tighter oversight and auditing of payment plan cases, by HSCRC or otherwise, before cases are referred to debt collection. We believe debt collection should be an extreme last resort only used when all other reasonable or good faith efforts have been exhausted.

Thank you for your consideration of our comments. Please do not hesitate to reach out with any questions or comments.

Girume Ashenafi
1199SEIU-UHE Representative to the HSCRC Payment Plan Workgroup

April 20, 2022

Megan Renfrew
Associate Director of External Affairs
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Comments on Workgroup on Hospital Payment Plan Guidelines

Dear Ms. Renfrew:

On behalf of the Johns Hopkins Health System (JHHS), we appreciate the opportunity to comment on the items discussed in the Workgroup on Hospital Payment Plan Guidelines. JHHS has long-recognized that some of our patients need support and guidance managing their medical bills. This need has increased as more patients find themselves with high co-pay and deductible insurance plans. Payment plans are an essential mechanism to balance patient affordability and uncompensated care. This is particularly true in Maryland, where uncompensated care is a burden shared by all patients and payers. As the Health Services and Cost Review Commission (HSCRC) develops policies on payment plans, we urge staff and commissioners to consider the best practices of institutions that have been implementing payment plans for many years.

In 2021, through our established processes to support our patients, JHHS provided 79,000 payment plans to over 18,000 unique patients. Our established processes work well for these 18,000 patients, as our data shows that 75% of these payment plans were established by patients who successfully navigated the process without requiring additional intervention by hospitals. As proposed, the guidelines have the unintended consequence of disrupting patients' payment plan processes where the process is already working successfully.

The hospital industry appreciates that the HSCRC's guidelines must be developed within the confines of the legislative directive. However, there is enough flexibility within the legislation to adopt payment plan policies that address the concerns of both hospitals and consumers. Our specific concerns and comments are addressed below.

Impact on the Maryland Model

It is critical to note that Commissioners raised concerns with the payment plan guidelines during the April 13, 2022 Commission meeting, where staff repeatedly noted that certain guidelines requirements were outlined in law. This imbalance of what is required under law and what is appropriate within the

confines of Maryland's All-Payer system highlights the critical role of HSCRC staff and commissioners in engaging with legislators on policy issues that impact the model. The payment plan policies outlined under HB 565 have the unintended consequence of increasing uncompensated care without appropriately distinguishing between those who need financial assistance and those who do not. Increased uncompensated care for those who simply choose not to pay, or to delay payment could impact the success of the Maryland Model.

New Jersey's previous all-payer system offers crucial insight into the potential consequences of the addition of inappropriate uncompensated care costs to the model. As increasing uncompensated care costs were added to the New Jersey model, the model became unsustainable. An analysis of the New Jersey system demonstrated that "the presence of uncompensated care trust funds may discourage the purchase of private insurance," as care was provided to the uninsured at no cost[1]. Additionally, because patients were not accountable for hospital-based care costs, "the uninsured used higher-cost hospital-based services rather than lower-cost community-based care."[2] The experience in New Jersey illustrates that this policy may incent individuals to opt out of insurance to avoid a large medical bill, or drive patients to seek routine care in hospitals, as there would be limited concern about a hospital bill. While well-intentioned, this policy undermines the objectives the model aims to achieve. JHHS urges the HSCRC staff and commissioners to leverage their expertise to engage with legislators on any bills that may also undermine model objectives in the future.

Documentation of Income Level

JHHS agrees with consumer advocates' suggestion to accept patient attestations as "appropriate documentation of income level." The attestation is a vital tool in making payment plans easy and accessible for all patients. In order for the attestation to be most effective, JHHS recommends the attestation appear before and after a payment plan is proposed by the hospital. The proposed payment plan could be formulated using known historical payment patterns of the patient when available. The attestation of income would then become available to create an alternative payment plan, if desired (see Appendix A). This process allows both patients and hospitals the flexibility required to come to reasonable agreements regarding payment plans. However, if the duration and approach to payment plans does not provide this needed flexibility, then hospitals will have no choice but to implement income verification processes impacting the large patient population that successfully uses the current payment plan process without such verifications.

Duration of Payment Plans

The proposed guidelines note that installment payments are capped at 5% of the patient's household gross adjusted income. Given that some patients may wish to pay their bill earlier, we urge the HSCRC to ensure ample flexibility for hospitals to offer patients the option to pay installments of more than 5% of their household gross adjusted income if desired. This approach provides patients the ability to structure their plan and payment timelines as needed, and also allows hospitals to close accounts according to the patient's ability to pay. It is not the hospital field's intention to steer patients to higher installment amounts; rather, hospitals aim to give patients choices regarding how to best structure their own finances.

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[1] Volpp K.G. & Siefel, B, 1993. "New Jersey: Long-Term Experience with All-Payer State Rate Setting." *Health Affairs.* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.12.2.59

[2] Volpp K.G. & Siefel, B, 1993. "New Jersey: Long-Term Experience with All-Payer State Rate Setting." *Health Affairs.* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.12.2.59

Additionally, in order to maintain the integrity of the health care system, it is crucial that the payment plan guidelines allow for timely recoupment of funds. Hospitals are unable to provide unlimited loans for services rendered. In our experience, patients of all income levels enter payment plans for a myriad of reasons; our current processes ensure that patients only pay what they can afford and there are many options for assistance if they cannot afford their bill.

Interest
JHHS currently does not charge interest. However, hospitals may be forced to begin charging interest to both maintain the integrity of the payment plan and encourage patients to pay in a timely fashion. The current payment plan process effectively balances the needs of both patients and hospitals. If policies are enacted that change this balance, other mechanisms including charging interest may need to be implemented.

Reasonable Attempts to Collect Requirement
As discussed during the workgroup meeting, the HSCRC requires that hospitals make a "reasonable collection effort" before writing charges off to bad debt. These efforts are necessary to preserve usage of the uncompensated care fund for patients who are eligible for financial assistance. Additionally, federal regulations at 26 CFR § 1.501(r) require hospitals to engage in presumptive eligibility screening and notify the patient of available financial assistance prior to engaging in certain collection activities.

Prepayment Plans
While HB 565 does not distinguish based on when the payment plan is created, we agree with the HSCRC's assessment that these guidelines should not apply to prepayment plans. The legislative intent was to protect patients who incurred medical debt, rather than patients who want to prepay for scheduled services. In fact, for many patients with insurance, it may be impossible to determine whether the patient owes any outstanding balance until the patient receives the service and their insurance claim is adjudicated.

Access to Payment Plans
The HSCRC's proposal is in line with existing hospital field practices.

Notice of Availability of Payment Plan
HB 565 requires hospitals to include information about the availability of payment plans to patients at the following times: before the patient is discharged; within the hospital bill; upon request; and in each written communication to the patient regarding collection of hospital debt. We urge the HSCRC not to stipulate how this information must be provided (e.g. included as part of the financial assistance information sheet required by COMAR 10.37.10.26(A) or as a separate sheet). Instead, we hope the HSCRC will grant hospitals flexibility to comply with this statutory requirement in the most efficient manner for their patients, whether as part of the medical bill, on the information sheet, or as an electronic notice. For JHHS, this information is already readily available. Information on payment plans is available online, during phone calls, posted through the facilities and on every statement.

Notice of Payment Plan Terms
We appreciate the HSCRC's intent in setting forth this guideline to ensure patients have ample notice before their first payment is due. If the HSCRC requires notice of payment plan terms, we urge the HSCRC to allow both written and electronic delivery, particularly if the patient has self-selected a payment plan through electronic means.

Payment Amount
We agree with the HSCRC's focus on the patient's family (or household) income for charity care. In most instances, family or household income is the most accurate and easily documented representation of a patient's financial circumstances.

Financial Hardship
Consumer advocates have noted that HB 565 was intended to first check for patient eligibility for financial assistance, then allow enrollment in a payment plan if there is a remaining balance the patient cannot afford at that time. JHHS agrees with this intent. However, we strongly urge the HSCRC to remove the provision regarding periodic adjustments to the payment plan. This is an unnecessary intrusion into a patient's finances, and HB 565 already has language permitting patients to seek modification of their payment plans at any time.

Patient-Centered Billing Practices
In order to provide a complete picture of services received, JHHS currently bills patients for all services together – inclusive of physician fees, home health services, pharmacy charges and hospital charges. This allows patients to develop payment plans for both hospital and physician charges. If the payment plan guidelines become unreasonable, there will be one payment plan process for hospital charges and another process for physician charges. By driving a process for only hospital-based services and regulated clinics, hospitals risk driving disconnected and conflicting expectations for patients as they seek to understand the services received and amounts owed. The law is limited to only hospital fees, so JHHS urges the HSCRC to make every effort to establish guidelines that support the aligned processes that are in place today.

We appreciate the HSCRC's dedication to ensuring patients receive flexibility in paying for medically necessary services when needed, while balancing the need for hospitals to collect payments from those who can afford to pay. Although we recognize the close relationship between payment plans and financial assistance, we urge the HSCRC to maintain the focus of this workgroup on the provisions within HB 565 and table discussions on other hospital requirements. We appreciate your consideration of our comments and look forward to our continued collaboration.

Sincerely,

Lakmini Kidder

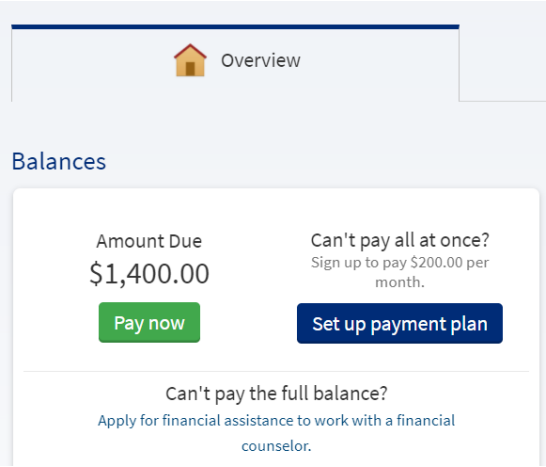
Lakmini Kidder
Vice President, Revenue Cycle Management
Johns Hopkins Health System

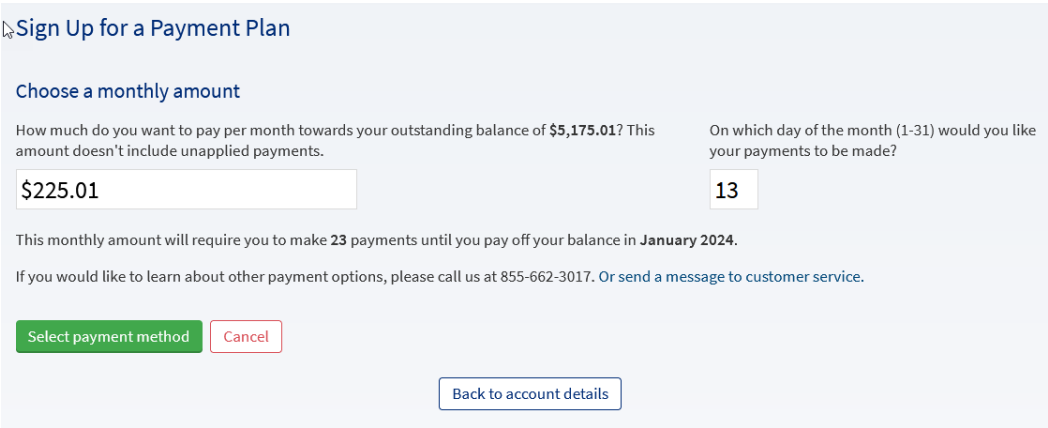
Appendix A: Current & Future Payment Plan Process Examples

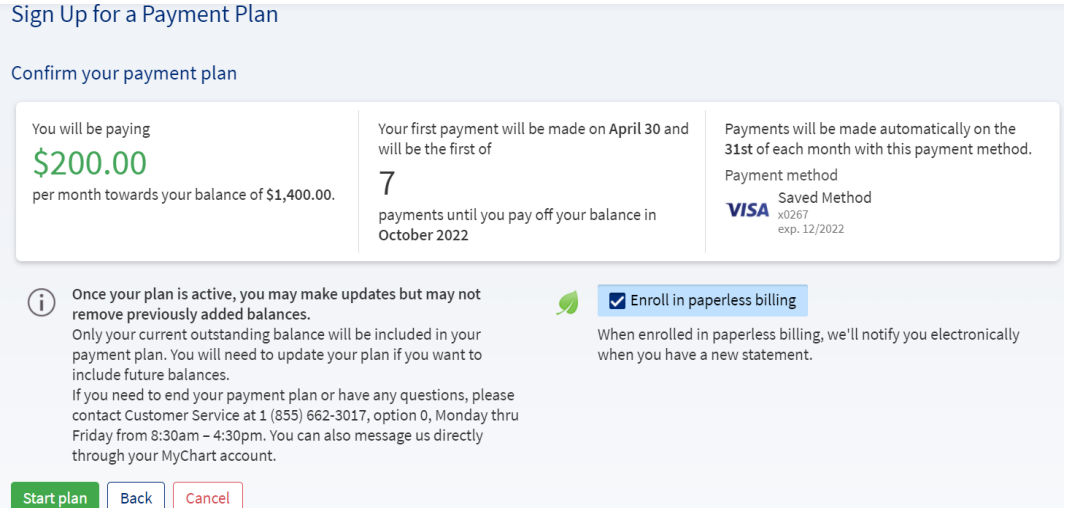
Current Payment Plan Process

The below figures illustrate the current payment plan interface from the patient perspective.

Enroll in payment plan



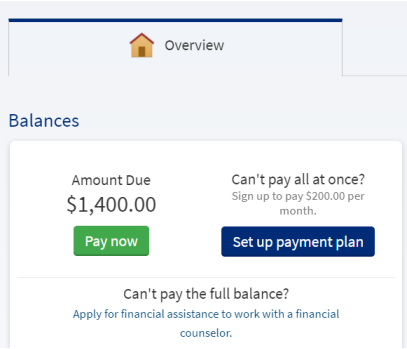


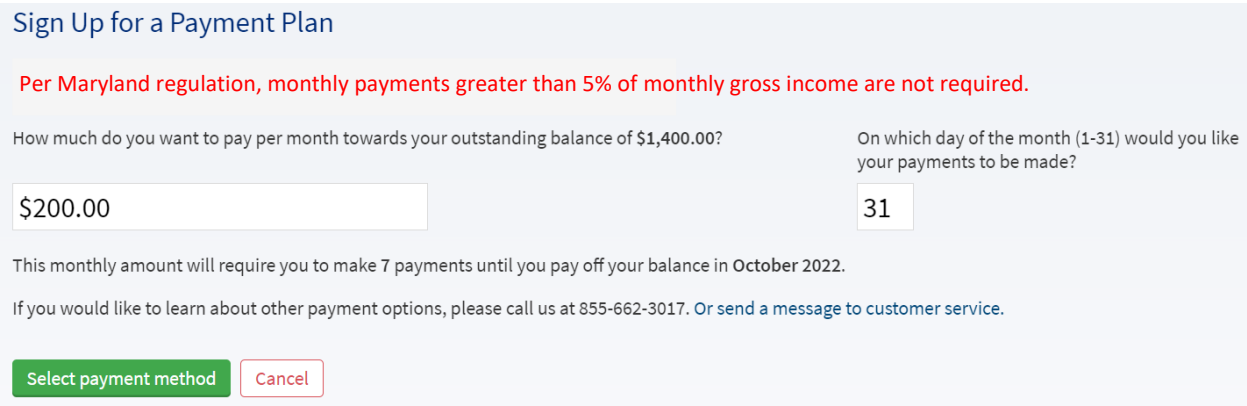


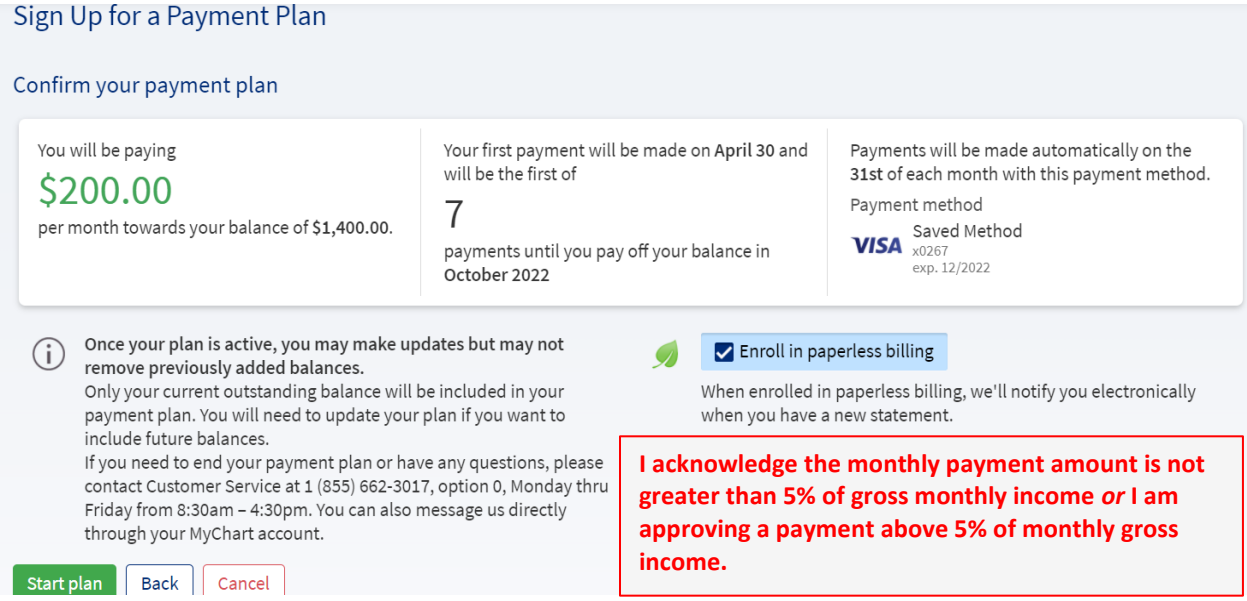
Future Payment Plan Process

The below figures illustrate potential changes to a future payment plan interface. This additional proposed language is *draft* and may change pending review by legal counsel.

Enroll in payment plan







Maryland
Hospital Association

April 20, 2022

Hannah Friedman-Bell
Analyst, Payment Reform and Stakeholder Alignment
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Comments on Draft Guidelines for Hospital Payment Plans

Dear Ms. Friedman-Bell:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft guidelines for hospital payment plans. These guidelines have undergone significant revisions since the first iteration in December 2021.

As a result, **MHA is concerned these guidelines pose a significant risk to the success of the Total Cost of Care Model (Model) and the future of uncompensated care in Maryland.**

I. Impact on the Maryland's Total Cost of Care Model (Model)

MHA shares concerns voiced by Commissioners at the April 13 public meeting about the unknown impact of these new guidelines on Maryland's Model. The Model hinges on the delicate balance of funding uncompensated care in hospital rates and the need to collect from patients who are ineligible for financial assistance. Lower uncompensated care means lower hospital prices for all Marylanders, and charity care is available for patients who need it.

HSCRC requires hospitals to make a "reasonable collection effort" before writing off charges. Prolonged payment plans mean hospitals will record the open balance (i.e., the amount the patient owes) as long as it remains. General accounting standards require hospitals to reserve a larger portion as the balance ages. A clear conclusion of the proposed guidelines is that outstanding balances will be carried over a longer period, requiring larger amounts to be reserved against expected payment. **As a result, uncompensated care reported on the income statement will rise, ultimately raising hospital rates.**

Beyond immediate hospital rate impacts, continued growth of health plans with higher patient cost shares creates a future conundrum. Health plan structures are a result of the market. While we are not commenting on this root cause issue, hospitals are ultimately left trying to collect patient balances in a fair and reasonable way. If the guidelines force hospitals to accept minimal

payments, rising deductibles, and co-payments will simply compound this issue when only minimal payment amounts are required.

II. Administrative Cost to Administer Payment Plans

Commissioners also commented on the expected rise in administrative costs to comply with the proposed guidelines. Beyond reserving for aged accounts due to longer payment periods from the proposed 5% income cap, hospitals will need to invest significant resources to overhaul their payment plan processes. Current processes offer an array of options to the patient, and if none of the options suit the patient's financial needs, hospitals work with the patient to find one that does. **We strongly urge HSCRC to allow hospitals to continue offering different options for patients, without requiring patient income input, so long as the patient is clearly informed that hospitals cannot require installment payments that are more than 5% of their adjusted gross monthly income (GMI).**

III. Family vs. Individual GMI

The initial guidelines proposed using family income, aligning with HSCRC's financial assistance policy requirements. MHA agreed with this approach. However, the draft guidelines now propose a new pro rata scheme to allocate individual income within a family. This approach is inconsistent with existing policy, and if implemented, will place greater burdens on patients and hospitals.

The proposed guidelines require a completely new process to determine a patient's income. Even if patients self-attest to their income, the hospital and patient must work to determine how much of a patient's income can apply toward their repayment, after accounting for other family members. **This proposed approach will create an incredibly complex and confusing process for hospitals and patients,** potentially discouraging patients from following up with the hospital, resulting in more bad debt and collection efforts. Moreover, this will compound the administrative burdens and costs on hospital billing departments to ask for, calculate, and maintain additional personal patient information. **MHA suggests HSCRC revert to its original provision, which uses family income as the basis for payment plan installments.**

IV. Specific Provisions

MHA also recommends the following changes for specific provisions in the draft guidelines:

- In Section 2 ("Scope"), we urge HSCRC to strike all language about pre-payment arrangements. This was not contemplated by the legislature and exceeds the scope of the statute. During work group discussions, HSCRC staff agreed that these provisions applied to post-service payment plans. The language requiring termination of any pre-payment arrangements after the health care service has been rendered is not consistent with this conclusion.

- In Section 5 ("Payment Plans Are Income-Based"), subsection (e), we strongly recommend striking the requirement for hospitals to consider household expenses in

setting up payment plans. This is not contemplated in the statute, and instead creates confusion for patients and hospitals alike in identifying what may or may not be counted as a household expense. This language should also be struck at Section 9(b)(iv).

- Also in Section 5, subsection (f), we suggest HSCRC clarify that these payment plan guidelines are limited to hospital bills, and not physician expenses.

- Regarding Section 7 ("Interest and Fees"), subsection (d), we disagree with the proposed 6% interest rate. Instead, we urge HSCRC to consider using market indicators to identify the appropriate interest rate. As proposed, the guidelines will force hospitals to carry outstanding balances for much longer periods than previously experienced, requiring HSCRC to recognize the additional carrying costs.

- In Section 9 ("Limited Modifications of Payment Plans and Recalculations of Payment Amounts"), subsection (b)(iii), we urge HSCRC to include language allowing hospitals to offer modification of a payment plan if a patient's income has changed (i.e., either decreased or increased).

- Also in Section 9, subsection (c), we disagree with HSCRC's proposed recalculation period of three years. Instead, we urge HSCRC to allow hospitals discretion to identify when recalculation—including verification of income, if necessary—may be appropriate.

- Regarding Section 11 ("Treatment of Loans and Extension of Credit"), we urge HSCRC to strike this language as it creates unnecessary confusion regarding third-party financing options that are available to patients.

MHA appreciates HSCRC's continued dedication to hospitals and their patients. Thank you for your consideration of our comments

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

CC: Adam Kane, Esq., Chairman
Joseph Antos, PhD, Vice Chairman
Victoria W. Bayless
James Elliott, M.D.
Maulik Joshi, DrPH
Stacia Cohen, RN, MPA
Sam Malhotra

Katie Wunderlich, Executive Director, HSCRC
Megan Renfrew, HSCRC
Dennis Phelps, HSCRC
Stan Lustman, HSCRC

GBMC

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

RE: Proposed Hospital Payment Plan Guidelines

Dear Ms. Wunderlich:

On behalf of Greater Baltimore Medical Center (GBMC), we are commenting on proposed guidelines for hospital payment plans. Under Chapter 770 of the 2021 Laws of Maryland (formerly House Bill 565 and Senate Bill 514), the Health Services Cost Review Commission (HSCRC) is charged with forming guidelines for payment plans hospitals offer to patients who are not eligible for medically necessary free care. GBMC remains concerned proposed revisions will increase uncompensated care, causing hospital prices to rise for patients.

Family vs. Individual Gross Monthly Income

Family income is used to determine financial assistance and under the proposed guidelines for payment plans, individual income is to be used. Although hospital financial assistance policies are separate from payment plans, using different calculations will cause additional administrative burden and confusion on the part of the patients. The most effective way to prevent this inconsistency is to use family income in the guidelines. Making a second determination of income may discourage patient from following up with the hospital resulting in more bad debt and collection efforts. We should be simplifying the process not further complicating the process.

Proposed 5% Cap on Payment Plans

Chapter 770 requires HSCRC to create guidelines for the installment payment amount that may not exceed 5% of GMI. However, Chapter 770 also prohibits penalties or fees for prepayment or early payment. Hospitals have not routinely charged fees, interest or penalties on payment plans. We ask the Commission to require hospitals to disclose that payment plans cannot by law exceed 5% of GMI but allow patients to determine the plan that best suits their financial needs. Patients should not be forced into payment plan terms due to these proposed guidelines.

Prolonged payment plans

These guidelines will result in prolonged payment plans. Hospital will continue to record the open balance for the duration of the payment plan. General accounting standards require hospitals to reserve a larger portion as the balance ages. As a result, uncompensated cared reported on the income statement will increase which will ultimately raise hospital rates. The concern is the recommended guidelines will cause bad debts to rise which results in higher prices for all Marylanders.

Consideration of Expenses

Consideration of household expenses should be removed from the proposed guidelines. The term household expenses is undefined and can be quite broad in interpretation.

Notice of Terms before Execution

The required notice of terms prior to execution is another added administrative burden on the hospitals and should be removed. Hospitals have utilized their systems to allow patients to set up payment plans electronically. In this process, the patient is provided with the information outlined in the notice requirement. Requiring a written notice and a delay in initial payment adds an additional burden on the hospital.

GBMC appreciates your consideration of our comments.

Kind Regards,

Laurie R. Beyer, MBA, CPA
Executive Vice President and Chief Financial Officer
GBMC HealthCare Systems, Inc.

Maryland

Megan Renfrew -MDH- <megan.renfrew1@maryland.gov>

Updates on Hospital Payment Plan Guidelines and Regulations

Palmscience <palmscience@verizon.net> Tue, Apr 19, 2022 at 3:24 PM
To: Hannah Friedman-Bell -MDH- <hannah.friedman-bell@maryland.gov>
Cc: Megan Renfrew -MDH- <megan.renfrew1@maryland.gov>

Hi Hannah,
Thank you for providing the hospital payment plan draft recommendations. I have a concern about Section 4.c. "The payment plan shall be provided to the patient at least 10 days before the due date of the patient's first payment under the payment plan."

For those who are using the paper (versus electronic) option which is allowed in Section 1.a.ii. ("Written" includes communications in paper form), I don't think the 10 day minimum is a realistic turnaround time. Most of the paper bills I receive have a due day of 24 to 28 days after the billing date.

I see under the explanation of the guidelines that the 10 day minimum was an HSCRC Staff decision. Their postal service must be more efficient than mine! I strongly recommend a minimum of 30 days to allow patients using the paper option to receive notification by mail, review the notification, mail payment, and have the payment received by the appropriate person in the billing department.

Thank you and your colleagues for all your hard work on these important guidelines.

Sincerely,
Anna Palmisano

--
Anna Palmisano, Ph.D.
Marylanders for Patient Rights
www.marylandpatientrights.org
palmscience@verizon.net
301-230-9327
301-529-0946 cell

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Chapter 770

(House Bill 565)

AN ACT concerning

Health Facilities – Hospitals – Medical Debt Protection

FOR the purpose of specifying the method for calculating family income to be used for certain purposes under a certain hospital financial assistance policy; requiring that the description of a hospital's financial assistance policy that is included on a certain information sheet include a certain section; requiring a hospital to submit annually a certain report to the Health Services Cost Review Commission at a certain time; requiring the Health Services Cost Review Commission to post certain information on its website; altering the required contents of a hospital's policy on the collection of debts owed by patients; ~~requiring a hospital to provide a refund of certain amounts collected from a patient or the guarantor of a patient who was found eligible for reduced–cost care on the date of service; establishing certain prohibitions on hospitals that charge interest fees on hospital bills;~~ prohibiting a hospital from charging interest or fees on certain debts incurred by certain patients; requiring a hospital to provide in writing to certain patients information about the availability of a certain installment payment plan; requiring a hospital to provide certain information to a patient, the patient's family, an authorized representative, or the patient's legal guardian at certain times; ~~prohibiting a certain payment plan from requiring a patient to make certain monthly payments and imposing certain penalties; requiring a hospital to determine certain adjusted monthly income in a certain manner under certain circumstances; requiring a certain payment plan to have a certain repayment period;~~ requiring the Health Services Cost Review Commission to develop certain guidelines, with input from stakeholders, for an income–based payment plan; prohibiting a hospital from seeking legal action against a patient on a debt owed until the hospital has implemented a certain payment plan; establishing that certain patients are deemed to be compliant with a certain payment plan under certain circumstances; requiring a patient to contact the health care facility and identify a certain plan under certain circumstances; authorizing a health care facility to waive certain payments required in a payment plan under certain circumstances; providing that a health care facility may not be required to waive certain payments; requiring a hospital to demonstrate that it attempted in good faith to meet certain requirements and guidelines before the hospital takes certain actions; providing that certain provisions of this Act do not prohibit a hospital from using a certain vendor for a certain purpose; altering and specifying certain time periods during which and the circumstances under which a hospital is prohibited from taking a certain action; prohibiting a hospital from reporting certain information about certain patients to a consumer reporting agency; prohibiting a hospital from taking certain actions against certain patients under certain circumstances; requiring a hospital to provide certain instructions to a consumer reporting agency under certain circumstances; repealing a certain authorization for a hospital to hold a certain lien; prohibiting a hospital from requesting a certain lien

in a certain action; prohibiting a hospital from filing an action or giving a certain notice to a patient for nonpayment of debt until after a certain time period; prohibiting a hospital from taking certain actions if the hospital files a certain action; prohibiting a hospital from requesting a certain writ to garnish certain wages or filing a certain action under certain circumstances; ~~prohibiting a hospital from filing a certain action if a certain debt is below a certain amount;~~ prohibiting a hospital from making a certain claim against an estate of a deceased patient under certain circumstances; authorizing a hospital to offer the family of a certain patient the ability to apply for financial assistance; prohibiting a hospital from filing a certain action ~~against a certain patient or~~ until certain conditions are met; ~~prohibiting a hospital from delegating certain collection activity to a debt collector to collect a certain amount of debt;~~ prohibiting certain individuals from being held liable for a certain debt; authorizing a certain individual to consent to assume a certain liability under certain circumstances; requiring a hospital to send a certain written notice of intent at least a certain period of time before filing a certain action; providing for the manner of delivery, content, and structure of a certain notice of intent; requiring a certain complaint to include a certain affidavit and be accompanied by certain documents; requiring that a hospital require a debt collector to have certain responsibility for meeting certain requirements under certain circumstances; requiring the Health Services Cost Review Commission, on or before a certain date, to compile certain information and prepare a certain ~~annual~~ report; requiring that a certain report be made available to the public in a certain manner and submitted to certain committees of the General Assembly; altering certain references by changing "outside collection agency" to "debt collector"; making conforming changes; requiring the Health Services Cost Review Commission, on or before a certain date and with input from certain stakeholders, to develop certain guidelines; requiring the Health Services Cost Review Commission, on or before a certain date, to report to certain committees of the General Assembly on certain guidelines; requiring the Health Services Cost Review Commission to conduct a certain study on uncompensated care; requiring the Maryland Health Care Commission to examine the feasibility of using the State–designated Health Information Exchange for a certain purpose and to make a certain report to certain committees of the General Assembly on or before a certain date; providing for a delayed effective date; and generally relating to hospital debt collection policies.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 19–214.1(b)(1)
Annotated Code of Maryland
(2019 Replacement Volume and 2020 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–214.1(b)(2)(i) and (ii) and (f)(1)(i) and 19–214.2
Annotated Code of Maryland
(2019 Replacement Volume and 2020 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19–214.1.

(b) (1) The Commission shall require each acute care hospital and each chronic care hospital in the State under the jurisdiction of the Commission to develop a financial assistance policy for providing free and reduced–cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill.

(2) The financial assistance policy shall provide, at a minimum:

(i) Free medically necessary care to patients with family income at or below 200% of the federal poverty level**, CALCULATED AT THE TIME OF SERVICE OR UPDATED, AS APPROPRIATE, TO ACCOUNT FOR ANY CHANGE IN FINANCIAL CIRCUMSTANCES OF THE PATIENT THAT OCCURS WITHIN 240 DAYS AFTER THE INITIAL HOSPITAL BILL IS PROVIDED**;

(ii) Reduced–cost medically necessary care to low–income patients with family income above 200% of the federal poverty level, **CALCULATED AT THE TIME OF SERVICE OR UPDATED, AS APPROPRIATE, TO ACCOUNT FOR ANY CHANGE IN FINANCIAL CIRCUMSTANCES OF THE PATIENT THAT OCCURS WITHIN 240 DAYS AFTER THE INITIAL HOSPITAL BILL IS PROVIDED,** in accordance with the mission and service area of the hospital;

(f) (1) Each hospital shall develop an information sheet that:

(i) Describes the hospital's financial assistance policy **AND INCLUDES A SECTION THAT ALLOWS FOR A PATIENT TO INITIAL THAT THE PATIENT HAS BEEN MADE AWARE OF THE FINANCIAL ASSISTANCE POLICY**;

19–214.2.

(a) **(1)** Each hospital **ANNUALLY** shall submit to the Commission**[**, at**]:**

(I) AT times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients**; AND**

(II) A REPORT INCLUDING:

1. THE TOTAL NUMBER OF PATIENTS BY RACE OR ETHNICITY, GENDER, AND ZIP CODE OF RESIDENCE AGAINST WHOM THE HOSPITAL,

OR A DEBT COLLECTOR USED BY THE HOSPITAL, FILED AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL;

2. THE TOTAL NUMBER OF PATIENTS BY RACE OR ETHNICITY, GENDER, AND ZIP CODE OF RESIDENCE WITH RESPECT TO WHOM THE HOSPITAL HAS AND HAS NOT REPORTED OR CLASSIFIED A BAD DEBT; AND

3. THE TOTAL DOLLAR AMOUNT OF THE ~~COSTS OF~~ CHARGES FOR HOSPITAL SERVICES PROVIDED TO PATIENTS BUT NOT COLLECTED BY THE HOSPITAL FOR PATIENTS COVERED BY INSURANCE, INCLUDING THE OUT–OF–POCKET COSTS FOR PATIENTS COVERED BY INSURANCE, AND PATIENTS WITHOUT INSURANCE.

(2) THE COMMISSION SHALL POST THE INFORMATION SUBMITTED UNDER PARAGRAPH (1) OF THIS SUBSECTION ON ITS WEBSITE.

(b) The policy **SUBMITTED UNDER SUBSECTION (A)(1) OF THIS SECTION** shall:

(1) Provide for active oversight by the hospital of any contract for collection of debts on behalf of the hospital;

(2) Prohibit the hospital from selling any debt;

(3) Prohibit the charging of interest on bills incurred by self–pay patients before a court judgment is obtained;

(4) Describe in detail the consideration by the hospital of patient income, assets, and other criteria;

(5) PROHIBIT THE HOSPITAL FROM REPORTING TO A CONSUMER REPORTING AGENCY OR FILING A CIVIL ACTION TO COLLECT A DEBT WITHIN 180 DAYS AFTER THE INITIAL BILL IS PROVIDED;

[(5)**] (6)** Describe the hospital's procedures for collecting a debt;

[(6)**] (7)** Describe the circumstances in which the hospital will seek a judgment against a patient;

[(7)**] (8)** In accordance with subsection (c) of this section, provide for a refund of amounts collected from a patient or the guarantor of a patient who was ~~[~~later~~]~~ found to be eligible for free ~~OR REDUCED–COST~~ care **[**on the date of service**]** ~~MORE THAN 240 DAYS AFTER THE FIRST POSTDISCHARGE~~ **WITHIN 240 DAYS AFTER THE INITIAL BILL WAS PROVIDED**;

[(8)**]** **(9)** If the hospital has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who ~~[~~later~~]~~ was found to be eligible for free ~~OR REDUCED–COST~~ care **[**on the date of the service**]** ~~MORE THAN 180 DAYS AFTER THE FIRST POSTDISCHARGE~~ **WITHIN 240 DAYS AFTER THE INITIAL BILL WAS PROVIDED** for which the judgment was awarded or the adverse information was reported, require the hospital to seek to vacate the judgment or strike the adverse information; **[**and**]**

[(9)**]** **(10)** Provide a mechanism for a patient to:

(i) Request the hospital to reconsider the denial of free or reduced–cost care; **[**and**]**

(ii) File with the hospital a complaint against the hospital or **[**an outside collection agency**]** **A DEBT COLLECTOR** used by the hospital regarding the handling of the patient's bill**; AND**

(III) ALLOW THE PATIENT AND THE HOSPITAL TO MUTUALLY AGREE TO MODIFY THE TERMS OF A PAYMENT PLAN OFFERED UNDER SUBSECTION (E) OF THIS SECTION OR ENTERED INTO WITH THE PATIENT; AND

(11) PROHIBIT THE HOSPITAL FROM COLLECTING ADDITIONAL FEES IN AN AMOUNT THAT EXCEEDS THE ~~COST OF THE HOSPITAL SERVICE~~ APPROVED CHARGE FOR THE HOSPITAL SERVICE AS ESTABLISHED BY THE COMMISSION FOR WHICH THE MEDICAL DEBT IS OWED ON A BILL FOR A PATIENT WHO IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY.

(c) (1) Beginning October 1, 2010, a hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who, within a 2–year period after the date of service, was found to be eligible for free ~~OR REDUCED–COST~~ care on the date of service.

(2) A hospital may reduce the 2–year period under paragraph (1) of this subsection to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for free ~~OR REDUCED–COST~~ care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the requested information.

(3) If a patient is enrolled in a means–tested government health care plan that requires the patient to pay out–of–pocket for hospital services, a hospital's refund policy shall provide for a refund that complies with the terms of the patient's plan.

(D) ~~**IF A HOSPITAL CHARGES INTEREST FEES ON A HOSPITAL BILL, THE HOSPITAL MAY NOT:**~~

~~**(1) CHARGE INTEREST IN EXCESS OF AN EFFECTIVE RATE OF SIMPLE INTEREST OF 1.5% PER ANNUM ON THE UNPAID PORTION OF A HOSPITAL BILL;**~~

~~**(2) CHARGE**~~ **A HOSPITAL MAY NOT CHARGE INTEREST OR FEES ON ANY DEBT INCURRED ON OR AFTER THE DATE OF SERVICE BY A PATIENT WHO IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE**~~**; OR**~~

~~**(3) BEGIN ACCRUAL OF INTEREST OR LATE PAYMENT CHARGES UNTIL 180 DAYS AFTER THE DATE OF THE LATER OF:**~~

~~**(I) THE END OF EACH REGULAR BILLING PERIOD; OR**~~

~~**(II) THE PATIENT'S DISCHARGE**~~**.**

(E) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A HOSPITAL SHALL PROVIDE IN WRITING TO EACH PATIENT WHO INCURS MEDICAL DEBT INFORMATION ABOUT THE AVAILABILITY OF AN INSTALLMENT PAYMENT PLAN FOR THE DEBT.

(2) A HOSPITAL SHALL PROVIDE THE INFORMATION UNDER PARAGRAPH (1) OF THIS SUBSECTION TO THE PATIENT, THE PATIENT'S FAMILY, THE PATIENT'S AUTHORIZED REPRESENTATIVE, OR THE PATIENT'S LEGAL GUARDIAN:

(I) BEFORE THE PATIENT IS DISCHARGED;

(II) WITH THE HOSPITAL BILL;

(III) ON REQUEST; AND

(IV) IN EACH WRITTEN COMMUNICATION TO THE PATIENT REGARDING COLLECTION OF HOSPITAL DEBT.

~~**(3) (I) A PAYMENT PLAN OFFERED UNDER THIS SUBSECTION MAY NOT:**~~

~~**1. REQUIRE THE PATIENT TO MAKE MONTHLY PAYMENTS THAT EXCEED 5% OF THE INDIVIDUAL PATIENT'S FEDERAL OR STATE ADJUSTED GROSS MONTHLY INCOME; OR**~~

~~2. IMPOSE PENALTIES OR FEES FOR PREPAYMENT OR EARLY PAYMENT.~~

~~(II) IF THE PATIENT DOES NOT SUBMIT TAX DOCUMENTATION TO BE USED FOR DETERMINING A PAYMENT PLAN, A HOSPITAL SHALL DETERMINE A PATIENT'S ADJUSTED GROSS MONTHLY INCOME BY FOLLOWING STANDARDS FOR THE DETERMINATION OF INCOME THAT ARE DEVELOPED BY THE COMMISSION IN REGULATIONS.~~

~~(4) A PAYMENT PLAN UNDER THIS SUBSECTION SHALL HAVE A REPAYMENT PERIOD THAT IS NOT LESS THAN THE LONGER OF:~~

~~(I) 36 MONTHS; OR~~

~~(II) A TIME PERIOD THAT WOULD ENSURE THAT PAYMENTS ARE GREATER THAN ACCRUED INTEREST.~~

(3) (I) THE COMMISSION SHALL DEVELOP GUIDELINES, WITH INPUT FROM STAKEHOLDERS, FOR AN INCOME–BASED PAYMENT PLAN OFFERED UNDER THIS SUBSECTION THAT INCLUDES:

1. THE AMOUNT OF MEDICAL DEBT OWED TO THE HOSPITAL;

2. THE DURATION OF THE PAYMENT PLAN BASED ON A PATIENT'S ANNUAL GROSS INCOME;

3. GUIDELINES FOR REQUIRING APPROPRIATE DOCUMENTATION OF INCOME LEVEL;

4. GUIDELINES FOR THE PAYMENT AMOUNT THAT:

A. MAY NOT EXCEED 5% OF THE INDIVIDUAL PATIENT'S FEDERAL OR STATE ADJUSTED GROSS MONTHLY INCOME; AND

B. SHALL CONSIDER FINANCIAL HARDSHIP, AS DEFINED IN § 19–214.1(A) OF THIS SUBTITLE;

5. GUIDELINES FOR:

A. THE DETERMINATION OF POSSIBLE INTEREST PAYMENTS FOR PATIENTS WHO DO NOT QUALIFY FOR FREE OR REDUCED–COST CARE, WHICH MAY NOT BEGIN BEFORE 180 DAYS AFTER THE DUE DATE OF THE FIRST PAYMENT; AND

B. A PROHIBITION ON INTEREST PAYMENTS FOR PATIENTS WHO QUALIFY FOR FREE OR REDUCED–COST CARE;

6. GUIDELINES FOR MODIFICATION OF A PAYMENT PLAN THAT DOES NOT CREATE A GREATER FINANCIAL BURDEN ON THE PATIENT; AND

7. A PROHIBITION ON PENALTIES OR FEES FOR PREPAYMENT OR EARLY PAYMENT.

(II) A HOSPITAL MAY NOT SEEK LEGAL ACTION AGAINST A PATIENT ON A DEBT OWED UNTIL THE HOSPITAL HAS ESTABLISHED AND IMPLEMENTED A PAYMENT PLAN POLICY THAT COMPLIES WITH THE GUIDELINES DEVELOPED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.

~~(5)~~ (4) (I) A PATIENT SHALL BE DEEMED TO BE COMPLIANT WITH A PAYMENT PLAN IF THE PATIENT MAKES AT LEAST 11 SCHEDULED MONTHLY PAYMENTS WITHIN A 12–MONTH PERIOD.

(II) IF A PATIENT MISSES A SCHEDULED MONTHLY PAYMENT, THE PATIENT SHALL CONTACT THE HEALTH CARE FACILITY AND IDENTIFY A PLAN TO MAKE UP THE MISSED PAYMENT WITHIN 1 YEAR AFTER THE DATE OF THE MISSED PAYMENT.

(III) THE HEALTH CARE FACILITY MAY, BUT MAY NOT BE REQUIRED TO, WAIVE ANY ADDITIONAL MISSED PAYMENTS THAT OCCUR WITHIN A 12–MONTH PERIOD AND ALLOW THE PATIENT TO CONTINUE TO PARTICIPATE IN THE INCOME–BASED PAYMENT PLAN AND NOT REFER THE OUTSTANDING BALANCE OWED TO A COLLECTION AGENCY OR FOR LEGAL ACTION.

~~(6)~~ (5) (I) A HOSPITAL SHALL DEMONSTRATE THAT IT ATTEMPTED IN GOOD FAITH TO MEET THE REQUIREMENTS OF THIS SUBSECTION AND THE GUIDELINES DEVELOPED BY THE COMMISSION UNDER PARAGRAPH (3) OF THIS SUBSECTION BEFORE THE HOSPITAL:

~~(I)~~ 1. FILES AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL BY A PATIENT; OR

~~(II)~~ 2. DELEGATES COLLECTION ACTIVITY TO A DEBT COLLECTOR FOR A DEBT OWED ON A HOSPITAL BILL BY A PATIENT.

(II) SUBPARAGRAPH (I) OF THIS PARAGRAPH DOES NOT PROHIBIT A HOSPITAL FROM USING AN ELIGIBILITY VENDOR TO PROVIDE OUTREACH TO A PATIENT FOR PURPOSES OF ASSISTING THE PATIENT IN QUALIFYING FOR FINANCIAL ASSISTANCE.

[(d)**] (F)** (1) For at least **[**120**] 180** days after ~~[~~issuing an initial patient bill~~]~~ ~~THE FIRST POSTDISCHARGE BILL WAS PROVIDED~~, a hospital may not report adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment **[**unless the hospital documents the lack of cooperation of the patient or the guarantor of the patient in providing information needed to determine the patient's obligation with regard to the hospital bill**]**.

(2) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient.

(3) A HOSPITAL MAY NOT REPORT ADVERSE INFORMATION TO A CONSUMER REPORTING AGENCY REGARDING A PATIENT WHO AT THE TIME OF SERVICE WAS UNINSURED OR ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE.

(4) A HOSPITAL MAY NOT REPORT ADVERSE INFORMATION ABOUT A PATIENT TO A CONSUMER REPORTING AGENCY, COMMENCE A CIVIL ACTION AGAINST A PATIENT FOR NONPAYMENT, OR DELEGATE COLLECTION ACTIVITY TO A DEBT COLLECTOR:

(I) IF THE HOSPITAL WAS ~~INFORMED~~ NOTIFIED IN ACCORDANCE WITH FEDERAL LAW BY THE PATIENT OR THE INSURANCE CARRIER THAT AN APPEAL OR A REVIEW OF A HEALTH INSURANCE DECISION IS PENDING~~, AND UNTIL 60 DAYS AFTER THE APPEAL IS COMPLETE~~ WITHIN THE IMMEDIATELY PRECEDING 60 DAYS; OR

(II) ~~UNTIL 60 DAYS AFTER~~ IF THE HOSPITAL HAS COMPLETED A REQUESTED RECONSIDERATION OF THE DENIAL OF FREE OR REDUCED–COST CARE THAT WAS APPROPRIATELY COMPLETED BY THE PATIENT WITHIN THE IMMEDIATELY PRECEDING 60 DAYS.

(5) IF A HOSPITAL HAS REPORTED ADVERSE INFORMATION ABOUT A PATIENT TO A CONSUMER REPORTING AGENCY, THE HOSPITAL SHALL INSTRUCT THE CONSUMER REPORTING AGENCY TO DELETE THE ADVERSE INFORMATION ABOUT THE PATIENT:

(I) IF THE HOSPITAL WAS INFORMED BY THE PATIENT OR THE INSURANCE CARRIER THAT AN APPEAL OR A REVIEW OF A HEALTH INSURANCE DECISION IS PENDING, AND UNTIL 60 DAYS AFTER THE APPEAL IS COMPLETE; OR

(II) UNTIL 60 DAYS AFTER THE HOSPITAL HAS COMPLETED A REQUESTED RECONSIDERATION OF THE DENIAL OF FREE OR REDUCED–COST CARE.

[(e)**] (G)** (1) A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill.

(2) **[**If a hospital holds a lien on a patient's primary residence, the hospital may maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt**] A HOSPITAL MAY NOT REQUEST A LIEN AGAINST A PATIENT'S PRIMARY RESIDENCE IN AN ACTION TO COLLECT DEBT OWED ON A HOSPITAL BILL**.

(3) (I) A HOSPITAL MAY NOT FILE AN ACTION AGAINST A PATIENT TO COLLECT A DEBT OWED ON A HOSPITAL BILL OR GIVE NOTICE TO A PATIENT UNDER SUBSECTION (I) OF THIS SECTION UNTIL AFTER 180 DAYS AFTER THE ~~FIRST POSTDISCHARGE~~ INITIAL BILL WAS PROVIDED.

(II) IF A HOSPITAL FILES AN ACTION TO COLLECT THE DEBT OWED ON A HOSPITAL BILL, THE HOSPITAL MAY NOT REQUEST THE ISSUANCE OF OR OTHERWISE KNOWINGLY TAKE ACTION THAT WOULD CAUSE A COURT TO ISSUE:

1. A BODY ATTACHMENT AGAINST A PATIENT; OR

2. AN ARREST WARRANT AGAINST A PATIENT.

(4) A HOSPITAL MAY NOT REQUEST A WRIT OF GARNISHMENT OF WAGES OR FILE AN ACTION THAT WOULD RESULT IN AN ATTACHMENT OF WAGES AGAINST A PATIENT TO COLLECT DEBT OWED ON A HOSPITAL BILL IF THE PATIENT IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE.

~~**(5) A HOSPITAL MAY NOT FILE AN ACTION AGAINST A PATIENT TO COLLECT A DEBT OWED ON A HOSPITAL BILL IN AN AMOUNT OF $1,000 OR LESS.**~~

~~**(6)**~~ **(5) (I) A HOSPITAL MAY NOT MAKE A CLAIM AGAINST THE ESTATE OF A DECEASED PATIENT TO COLLECT A DEBT OWED ON A HOSPITAL BILL IF THE DECEASED PATIENT WAS KNOWN BY THE HOSPITAL TO BE ELIGIBLE FOR FREE CARE UNDER § 19–214.1 OF THIS SUBTITLE OR IF THE VALUE OF THE ESTATE AFTER TAX OBLIGATIONS ARE FULFILLED IS LESS THAN HALF OF THE DEBT OWED.**

(II) A HOSPITAL MAY OFFER THE FAMILY OF THE DECEASED PATIENT THE ABILITY TO APPLY FOR FINANCIAL ASSISTANCE.

~~(7)~~ (6) A HOSPITAL MAY NOT FILE AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL BY A PATIENT:

~~(I) WHO WAS UNINSURED AT THE TIME SERVICE WAS PROVIDED; OR~~

~~(II)~~ ~~UNTIL~~ UNTIL THE HOSPITAL DETERMINES WHETHER THE PATIENT IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE.

~~(8) A HOSPITAL MAY NOT DELEGATE COLLECTION ACTIVITY TO A DEBT COLLECTOR FOR DEBT OWED ON A HOSPITAL BILL BY A PATIENT THAT IS $1,000 OR LESS.~~

(H) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, A SPOUSE OR ANOTHER INDIVIDUAL MAY NOT BE HELD LIABLE FOR THE DEBT OWED ON A HOSPITAL BILL OF AN INDIVIDUAL WHO IS AT LEAST 18 YEARS OLD.

(2) AN INDIVIDUAL MAY VOLUNTARILY CONSENT TO ASSUME LIABILITY FOR THE DEBT OWED ON A HOSPITAL BILL OF ANY OTHER INDIVIDUAL IF THE CONSENT IS:

(I) MADE ON A SEPARATE DOCUMENT SIGNED BY THE INDIVIDUAL;

(II) NOT SOLICITED IN AN EMERGENCY ROOM OR DURING AN EMERGENCY SITUATION; AND

(III) NOT REQUIRED AS A CONDITION OF PROVIDING ANY EMERGENCY OR NONEMERGENCY HEALTH CARE SERVICES.

(I) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, AT LEAST 45 DAYS BEFORE FILING AN ACTION AGAINST A PATIENT TO COLLECT ON THE DEBT OWED ON A HOSPITAL BILL, A HOSPITAL SHALL SEND WRITTEN NOTICE OF THE INTENT TO FILE AN ACTION TO THE PATIENT.

(2) THE NOTICE REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:

(I) BE SENT TO THE PATIENT BY CERTIFIED MAIL AND FIRST–CLASS MAIL;

(II) BE IN SIMPLIFIED LANGUAGE ~~AS DETERMINED IN REGULATIONS ADOPTED BY THE COMMISSION~~ AND IN AT LEAST 10 POINT TYPE;

(III) INCLUDE:

1. THE NAME AND TELEPHONE NUMBER OF:

A. THE HOSPITAL;

B. IF APPLICABLE, THE DEBT COLLECTOR; AND

C. AN AGENT OF THE HOSPITAL AUTHORIZED TO MODIFY THE TERMS OF THE PAYMENT PLAN, IF ANY;

2. THE AMOUNT REQUIRED TO CURE THE NONPAYMENT OF DEBT, INCLUDING PAST DUE PAYMENTS, PENALTIES, AND FEES;

3. A STATEMENT RECOMMENDING THAT THE PATIENT SEEK DEBT COUNSELING SERVICES;

4. TELEPHONE NUMBERS AND INTERNET ADDRESSES OF ~~NONPROFIT AND GOVERNMENT RESOURCES, INCLUDING~~ THE HEALTH EDUCATION ADVOCACY UNIT IN THE OFFICE OF THE ATTORNEY GENERAL, AVAILABLE TO ASSIST PATIENTS EXPERIENCING MEDICAL DEBT;

5. AN EXPLANATION OF THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY; AND

~~6. AN EXPLANATION OF THE STATE MEDICAL DEBT COLLECTION PROCESS AND TIMELINE;~~

~~7. AN EXPLANATION OF THE PATIENT'S RIGHT TO APPEAL TO THE PATIENT'S INSURANCE CARRIER, THE MARYLAND INSURANCE ADMINISTRATION, OR THE HOSPITAL FOR ANY DENIED REIMBURSEMENT OR ACCESS TO FREE OR REDUCED-COST CARE, AND THE NEED TO INFORM THE HOSPITAL IF AN APPEAL IS IN PROCESS; AND~~

~~8.~~ 6. ANY OTHER RELEVANT INFORMATION PRESCRIBED BY THE COMMISSION; AND

(IV) BE PROVIDED IN THE PATIENT'S PREFERRED LANGUAGE OR, IF NO PREFERRED LANGUAGE IS SPECIFIED, EACH LANGUAGE SPOKEN BY A LIMITED ENGLISH PROFICIENT POPULATION THAT CONSTITUTES 5% OF THE

POPULATION WITHIN THE JURISDICTION IN WHICH THE HOSPITAL IS LOCATED AS MEASURED BY THE MOST RECENT FEDERAL CENSUS.

(3) THE NOTICE REQUIRED UNDER THIS SUBSECTION SHALL BE ACCOMPANIED BY:

(I) AN APPLICATION FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, ALONG WITH INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR FINANCIAL ASSISTANCE, AND THE TELEPHONE NUMBER TO CALL TO CONFIRM RECEIPT OF THE APPLICATION;

(II) THE AVAILABILITY OF A PAYMENT PLAN TO SATISFY THE MEDICAL DEBT THAT IS THE SUBJECT OF THE HOSPITAL DEBT COLLECTION ACTION; AND

(III) THE INFORMATION SHEET REQUIRED UNDER § 19–214.1(F) OF THIS SUBTITLE.

(J) A COMPLAINT BY A HOSPITAL IN AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL BY A PATIENT SHALL:

(1) INCLUDE AN AFFIDAVIT STATING:

(I) THE DATE ON WHICH THE 180–DAY PERIOD REQUIRED UNDER SUBSECTION (G)(3) OF THIS SECTION ELAPSED AND THE NATURE OF THE NONPAYMENT;

(II) THAT A NOTICE OF INTENT TO FILE AN ACTION UNDER SUBSECTION (I) OF THIS SECTION:

1. WAS SENT TO THE PATIENT AND THE DATE ON WHICH THE NOTICE WAS SENT; AND

2. ACCURATELY REFLECTED THE CONTENTS REQUIRED TO BE INCLUDED IN THE NOTICE;

(III) THAT THE HOSPITAL PROVIDED:

1. THE PATIENT WITH A COPY OF THE INFORMATION SHEET ON THE FINANCIAL ASSISTANCE POLICY IN ACCORDANCE WITH SUBSECTION (I)(3)(II) OF THIS SECTION; AND

2. ~~ORAL NOTICE~~ NOTICE OF THE FINANCIAL ASSISTANCE POLICY AS DOCUMENTED UNDER § 19–214.1(F) OF THIS SUBTITLE;

(IV) THAT THE HOSPITAL MADE A DETERMINATION REGARDING WHETHER THE PATIENT IS ELIGIBLE FOR THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY IN ACCORDANCE WITH § 19–214.1 OF THIS SUBTITLE; AND

(V) THAT THE HOSPITAL MADE A GOOD–FAITH EFFORT TO MEET THE REQUIREMENTS OF SUBSECTION (E) OF THIS SECTION; AND

(2) BE ACCOMPANIED BY:

(I) THE ORIGINAL OR A CERTIFIED COPY OF THE HOSPITAL BILL;

(II) A STATEMENT OF THE REMAINING DUE AND PAYABLE DEBT SUPPORTED BY AN AFFIDAVIT OF THE PLAINTIFF, THE HOSPITAL, OR THE AGENT OR ATTORNEY OF THE PLAINTIFF OR HOSPITAL;

(III) A COPY OF THE MOST RECENT HOSPITAL BILL SENT TO THE PATIENT;

(IV) IF THE DEFENDANT IS ELIGIBLE FOR FEDERAL SERVICE MEMBERS CIVIL RELIEF ACT BENEFITS, AN AFFIDAVIT THAT THE HOSPITAL IS IN COMPLIANCE WITH THE ACT;

(V) A COPY OF THE NOTICE OF INTENT TO FILE AN ACTION ON A HOSPITAL BILL; AND

~~**(VI) DOCUMENTATION THAT THE PATIENT HAS ACKNOWLEDGED RECEIPT OF A COPY OF THE INFORMATION REQUIRED TO BE PROVIDED BY THE HOSPITAL UNDER SUBSECTION (I)(3) OF THIS SECTION; AND**~~

~~**(VII) DOCUMENTATION THAT THE HOSPITAL HAS PROVIDED WRITTEN AND ORAL NOTICE OF THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY TO THE PATIENT.**~~

(VI) A COPY OF THE PATIENT'S SIGNED CERTIFIED MAIL ACKNOWLEDGMENT OF RECEIPT OF THE WRITTEN NOTICE OF INTENT TO FILE AN ACTION, IF RECEIVED BY THE HOSPITAL.

[(f)**] (K)** If a hospital delegates collection activity to **[**an outside collection agency**] A DEBT COLLECTOR**, the hospital shall:

(1) Specify the collection activity to be performed by the **[**outside collection agency**]** **DEBT COLLECTOR** through an explicit authorization or contract;

(2) Require the **[**outside collection agency**]** **DEBT COLLECTOR** to abide by the hospital's credit and collection policy;

(3) Specify procedures the **[**outside collection agency**]** **DEBT COLLECTOR** must follow if a patient appears to qualify for financial assistance; and

(4) Require the **[**outside collection agency**]** **DEBT COLLECTOR** to:

(i) In accordance with the hospital's policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the **[**outside collection agency**]** **DEBT COLLECTOR** regarding the handling of the patient's bill; **[**and**]**

(ii) Forward the complaint to the hospital if a patient files a complaint with the **[**collection agency**]** **DEBT COLLECTOR; AND**

(III) ALONG WITH THE HOSPITAL, BE JOINTLY AND SEVERALLY RESPONSIBLE FOR MEETING THE REQUIREMENTS OF THIS SECTION.

[(g)**]** **(L)** (1) The board of directors of each hospital shall review and approve the financial assistance and debt collection policies of the hospital at least every 2 years.

(2) A hospital may not alter its financial assistance or debt collection policies without approval by the board of directors.

[(h)**]** **(M)** The Commission shall review each hospital's implementation of and compliance with the hospital's policies and the requirements of this section.

(N) (1) ~~**THE**~~ **ON OR BEFORE FEBRUARY 1 EACH YEAR, BEGINNING IN 2023, THE COMMISSION SHALL** ~~**PREPARE AN ANNUAL MEDICAL DEBT COLLECTION REPORT THAT IS BASED ON SPECIAL AUDIT PROCEDURE REQUIREMENTS FOR HOSPITALS RELATED TO MEDICAL DEBT**~~ **COMPILE THE INFORMATION REQUIRED UNDER SUBSECTION (A) OF THIS SECTION AND PREPARE A MEDICAL DEBT COLLECTION REPORT BASED ON THE COMPILED INFORMATION.**

(2) THE REPORT REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE:

(I) MADE AVAILABLE TO THE PUBLIC FREE OF CHARGE; AND

(II) SUBMITTED TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE IN ACCORDANCE WITH § 2–1257 OF THE STATE GOVERNMENT ARTICLE.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) On or before January 1, 2022, the Commission shall develop guidelines, with input from stakeholders, for an income–based payment plan offered under this subsection that includes:

(1) the amount of medical debt owed to the hospital;

(2) the duration of the payment plan based on a patient's annual gross income;

(3) guidelines for requiring appropriate documentation of income level;

(4) guidelines for the payment amount, that:

(i) may not exceed 5% of the individual patient's federal or State adjusted gross monthly income; and

(ii) shall consider financial hardship, as defined in § 19–214.1(a) of the Health – General Article;

(5) guidelines for:

(i) the determination of possible interest payments for patients who do not qualify for free or reduced–cost care, which may not begin before 180 days after the due date of the first payment; and

(ii) a prohibition on interest payments for patients who qualify for free or reduced–cost care;

(6) guidelines for modification of a repayment plan that does not create a greater financial burden on the patient; and

(7) a prohibition on penalties or fees for prepayment or early payment.

(b) In developing the payment plan guidelines required under subsection (a) of this section, the Health Services Cost Review Commission shall seek input from stakeholders, including the Maryland Hospital Association, Maryland Insurance Administration, Office of the Attorney General, labor unions that represent the health care sector, a statewide nonprofit consumer rights group; patients' rights organizations, legal service providers who work with patients who have experienced medical debt; and patients who have experienced medical debt.

(c) On or before January 1, 2022, the Commission shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on the guidelines required under subsection (a) of this section.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The Health Services Cost Review Commission shall study the impact on uncompensated care of:

(1) providing for a refund of amounts collected from patients or guarantors of patients who were later found by the hospital to be eligible for reduced–cost care; and

(2) requiring a hospital to forgive a judgment or strike adverse information if a hospital obtains a judgment against, or reports adverse information to a consumer reporting agency about patients who were later found by the hospital to be eligible for reduced–cost care.

(b) (1) In conducting the study required under subsection (a) of this section, if the Health Services Cost Review Commission determines that additional hospital data is required, the Commission shall notify the hospital of the data that is required.

(2) Not later than 30 days after receiving notification from the Commission under paragraph (1) of this subsection, a hospital shall submit the required data to the Commission.

(c) On or before January 1, 2022, the Health Services Cost Review Commission shall report the findings of the study required under subsection (a) of this section to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article.

SECTION 4. AND BE IT FURTHER ENACTED, That the Maryland Health Care Commission shall:

(1) examine the feasibility of using the State–designated Health Information Exchange to support the determination of financial status for purposes of determining eligibility for free or reduced–cost care or for an income–based payment plan; and

(2) on or before December 1, 2021, report the findings from the examination required under item (1) of this section to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article.

SECTION ~~2.~~ 5. AND BE IT FURTHER ENACTED, That ~~this Act shall take effect October 1, 2021~~ Sections 2, 3, and 4 of this Act shall take effect June 1, 2021.

SECTION 6. AND BE IT FURTHER ENACTED, That, except as provided in Section 5 of this Act, this Act shall take effect January 1, 2022.

Enacted under Article II, § 17(c) of the Maryland Constitution, May 30, 2021.

Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207, 19-214.1 and 19-214.2, Annotated Code of Maryland

.26 Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies.

A. Definitions. In this regulation, the following terms have the meanings indicated:

(1) Debt Collector.

(a) "Debt collector" means a person who engages directly or indirectly in the business of:

(i) Collecting for, or soliciting from another, a debt owed on a hospital bill by a patient;

(ii) Giving, selling, attempting to give or sell to another, or using, for collection of a debt owed on a hospital bill by a patient, a series or system of forms or letters that indicates directly or indirectly that a person other than the hospital is asserting the debt owed on a hospital bill by a patient; or

(ii) Employing the services of an individual or business to solicit or sell a collection system to be used for collection of a debt owed on a hospital bill by a patient.

(b) "Debt collector" includes a collection agency, as defined in Business Regulation Article, §7-101, Annotated Code of Maryland.

(2) "Financial hardship" means medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

(3) "Initial bill" means the first billing statement provided to an individual by a hospital after the care, whether inpatient or outpatient, is provided and the individual has left the hospital facility.

(4) "Medical debt" means out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by a hospital.

(5) "Payment plan" means a payment plan offered by a hospital that meets the requirements of Health-General Article, §19-214.2, Annotated Code of Maryland.

(6) Written Communications.

(a) "Written communications" include in paper form and delivered electronically, including through electronic mail and through a secure web or mobile based application such as a patient portal.

(b) "Written communications" does not include oral communications, including communications delivered by phone. A patient may opt out of electronic communications by informing the hospital or debt collector orally or through written communication.

[A.**]** *B.* Hospital Information Sheet.

(1) Each hospital shall develop an information sheet that:

(a) Describes the hospital's financial assistance policy *as required in §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland*;

(b) (text unchanged)

(c) Provides contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

(i)—(ii) (text unchanged)

(iii) How to apply for **[**free and reduced-cost care**]** *financial assistance*; **[**and**]**

(iv) How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill; *and*

(v) How to apply for a payment plan;

(d)—(h) (text unchanged)

(i) Provides the patient with the contact information for filing the complaint**[**.**]***;*

(j) Includes a section that allows the patient to initial that the patient has been made aware of the financial assistance policy; and

(k) Includes language explaining the availability of a payment plan.

(2) (text unchanged)

(3) The information sheet shall be provided *in writing* to the patient, the patient's family, **[**or**]** the patient's authorized representative*, or the patient's legal guardian*:

(a)—(e) (text unchanged)

(4)—(5) (text unchanged)

[A-1.**]** *B-1.* Hospital Credit and Collection **[**Policies**]** *Responsibilities.*

(1) (text unchanged)

(2) The policy shall:

(a) (text unchanged)

(b) Prohibit the charging of interest or fees on any debt owed on a hospital bill that is incurred on or after the date of service by a patient who is eligible for free or reduced-cost care under §B-2 of this regulation and Health-General Article, §19–214.1, Annotated Code of Maryland;

[(b)**]** *(c)*—**[**(d)**]** *(e)* (text unchanged)

[(e)**]** *(f)* Provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free care **[**on the date of service, in accordance §A-1(3) of this regulation**]**, *in accordance with §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland, within 240 days after the initial bill was provided;*

[(f)] *(g)* If the hospital**[,]** has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free *medically necessary* care **[**on the date of the service for which the judgment was awarded or the adverse information was reported**]**, *in accordance with §B-2 of this regulation and Health-General Article, §19-214.2, Annotated Code of Maryland, within 240 days after the initial bill was provided,* require the hospital to seek to **[**vacated**]** *vacate* the judgment or strike the adverse information;

[(g)] *(h)* (text unchanged)

[(h)] *(i)* Provide detailed procedures for the following actions:

(i)—(iii) (text unchanged)

(iv) When a lien on a patient's or patient guarantor's personal residence*, excluding a primary resident in accordance with §B-1(9)(b) of this regulation and Health-General Article, §19-214.2(g)(2), Annotated Code of Maryland,* or motor vehicle may be placed;

(j) Prohibit the hospital from collecting additional fees in an amount that exceeds the approved charge for the hospital service as established by the Commission for which medical debt is owed on a hospital bill for a patient who is eligible for free or reduced-cost medically necessary care, in accordance with §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland.

(k) Establish a process for making payment plans available to all patients in accordance with "Guidelines for Hospital Payment Plans" ("the Guidelines"), which is hereby incorporated by reference. These guidelines shall

represent the Commission's official interpretation of hospital payment plan procedural requirements in accordance with Health-General Article, §19-214.2(e)(3), Annotated Code of Maryland.

(3) Consistent with Health-General Article, §19-214.2(e)(5), Annotated Code of Maryland, a hospital shall demonstrate that it attempted in good faith to meet the requirements of Health-General Article, §19-214.2(e), Annotated Code of Maryland and the Guidelines before the hospital:

(a) Files an action to collect a debt owed on a hospital bill by a patient; or

(b) Delegates collection activity to a debt collector for a debt owed on a hospital bill by a patient.

(4) The hospital shall be deemed to have acted in good faith under Health-General Article, §19-214.2(e)(5)(i)(2), Annotated Code of Maryland and §B-1(3)(b) of this regulation if, before delegating collection of a debt owed by a patient on a hospital bill to a debt collector, the hospital:

(a) Provides the information sheet before the patient receives scheduled medical services and before discharge in accordance with Health-General Article, §19-214.2(e)(1) and (2), Annotated Code of Maryland, and §B(3)(a) and (b) of this regulation; and

(b) Establishes a process for making payment plans available to all patients in accordance with Health-General Article, §19-214.2(e)(5), Annotated Code of Maryland, and §B-1(2)(j) of this regulation.

(5) In delegating any or all collection to a debt collector for a debt owed on a hospital bill by a patient, the hospital may rely on a debt collector to engage in various activities, including:

(a) Facilitating and servicing payment plans in accordance with the Guidelines, including receiving and forwarding any payments received under a payment plan approved by the hospital; and

(b) Such other activities as the hospital may direct in collecting and forwarding payments under a payment plan.

(6) A hospital may not seek legal action to collect a debt owed on a hospital bill by a patient until the hospital has established and implemented a payment plan policy that complies with the Guidelines.

[(3)**]** *(7)* Beginning October 1, 2010, as provided by Health-General Article, §19-214.2(c):

(a) A hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who, within a 2-year period after the date of service, was found to be eligible for free *medically necessary* care on the date of service;

(b) A hospital may reduce the 2-year period under §**[**A-1(3)(a)**]***B-1(7)(a)* of this regulation to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for free *medically necessary* care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the required information; and

(c) (text unchanged)

[(4)**]** *(d)* For at least **[**120**]** *180* days after issuing an initial **[**patient] bill, *a hospital may not*:

(i) **[**a hospital may not report**]** *Report* adverse information about a patient to a consumer reporting agency against a patient for nonpayment;

(ii) A Commence civil action against a patient for nonpayment; and

(iii) Give notice of civil action to a patient under §B-1(11) of this regulation and Health-General Article, §19-214.2(g)(3), Annotated Code of Maryland.

(e) A hospital may not report adverse information to a consumer reporting agency regarding a patient who, at the time of the service, was uninsured or eligible for free or reduced-cost medically necessary care, in accordance with §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland.

(f) A hospital may not report adverse information about a patient to a consumer reporting agency, commence civil action against a patient for nonpayment, or delegate collection activity to a debt collector, if the hospital:

(i) Was notified in accordance with federal law by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days; or

(ii) Has completed a requested reconsideration of the denial of free or reduced-cost medically necessary care under §B-2(1)(a)(v) of this regulation and Health-General Article, §19-214.1(b)(4), Annotated Code of Maryland, that was appropriately completed by the patient within the immediately preceding 60 days.

[(5)**]** *(8) Consumer Reporting.*

(*a*) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient.

(b) If a hospital has reported adverse information about a patient to a consumer reporting agency, the hospital shall instruct the consumer reporting agency to delete the adverse information about the patient:

(i) If the hospital was informed by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending, and until 60 days after the appeal is complete; or

(ii) Until 60 days after the hospital has completed a requested reconsideration of the denial of free or reduced-cost medically necessary care, in accordance with §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland,.

[(6)**]** *(9) Primary Residences.*

(a) A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill. **[**If a hospital holds a lien on a patient's primary residence, the hospital may maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt.**]**

(b) A hospital may not request a lien against a patient's primary residence in an action to collect debt owed on a hospital bill.

(10) If the hospital files an action to collect the debt owed on a hospital bill, the hospital may not request the issuance of or otherwise knowingly take action that would cause a court to issue:

(a) A body attachment against a patient; or

(b) An arrest warrant against a patient.

(11) A hospital may not request a writ of garnishment of wages or file an action that would result in an attachment of wages against a patient to collect debt owed on a hospital bill if the patient is eligible for free or reduced-cost medically necessary care, in accordance with §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland.

(*12) Deceased patients.*

(a) A hospital may not make a claim against the estate of a deceased patient to collect a debt owed on a hospital bill if the deceased patient was known by the hospital to be eligible for free medically necessary care, in accordance with §B-2 of this regulation and Health-General article, §19-214.1, Annotated Code of Maryland, or if the value of the estate after tax obligations are fulfilled is less than half of the debt owed.

(b) A hospital may offer the family of the deceased patient the ability to apply for financial assistance.

(13) A hospital may not file an action to collect a debt owed on a hospital bill by a patient until the hospital determines whether the patient is eligible for free or reduced-cost medically necessary care under §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland.

(14) At least 45 days before filing an action against a patient to collect on the debt owed on a hospital bill, a hospital shall send written notice of the intent to file an action to the patient. The notice shall:

(a) Be sent to the patient by certified mail or first class mail;

(b) Be in simplified language and in at least 10 point type;

(c) Include:

(i) The name and telephone number of the hospital, the debt collector (if applicable), and an agent of the hospital authorized to modify the terms of the payment plan (if any);

(ii) The amount required to cure the nonpayment of debt owed on a hospital bill, including past due payments, penalties, and fees;

(iii) A statement recommending that the patient seek debt counseling services;

(iv) Telephone numbers and internet addresses of the Health Education Advocacy Unit of the Office of the Attorney General, available to assist patients experiencing medical debt; and

(v) An explanation of the hospital's financial assistance policy;

(d) Be provided in the patient's preferred language or, if no preferred language is specified, English and each language spoken by a limited English proficient population that constitutes 5 percent of the population within the jurisdiction in which the hospital is located as measured by the most recent federal census; and

(e) Be accompanied by:

(i) An application for financial assistance under the hospital's financial assistance policy, along with instructions for completing the application for financial assistance and the telephone number to call to confirm receipt of the application;

(ii) Language explaining the availability of a payment plan to satisfy the medical debt that is the subject of the hospital debt collection action; and

(iii) The information sheet required under §B of this regulation and Health-General Article, §19-214.1(f), Annotated Code of Maryland.

[(7)**]** *(15)* If a hospital delegates collection activity to **[**an outside collection agency**]** *a debt collector*, the hospital shall:

(a) Specify the collection activity to be performed by the **[**outside collection agency**]** *debt collector* through an explicit authorization or contract;

(b) Require the debt collector to abide by the hospital's credit and collection policy;

[(b)**]** *(c)* Specify procedures the **[**outside collection agency**]** *debt collector* must follow if a patient appears to qualify for financial assistance *under §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland;* and

[(c)**]** *(d)* Require the **[**outside collection agency**]** *debt collector* to:

(i) In accordance with the hospital's policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the **[**outside collection agency**]** *debt collector* regarding the handling of patient's bill; **[**and**]**

(ii) If a patient files a complaint with the **[**collection agency**]** *debt collector*, forward the complaint to the hospital; *and*

(iii) Along with the hospital, be jointly and severally responsible for meeting the requirements of §B-1 of this regulation and Health-General Article, §19-214.2, Annotated Code of Maryland,, including the requirements enumerated in the Guidelines.

(16) A spouse or another individual may not be held liable for the debt owed on a hospital bill of an individual 18 years old or older unless the individual voluntarily consents to assume liability for the debt owed on the hospital bill. The consent shall be:

(a) Made on a separate document signed by the individual;

(b) Not solicited in an emergency room or during an emergency situation; and

(c) Not required as a condition of providing emergency or nonemergency health care services.

[(8)**]** *(17)* (text unchanged)

[(9)**]** *(18)* The Commission shall review each hospital's implementation of and compliance with the hospital's policy and the requirements of §**[**A-1(2)**]***B-1(3)* of this regulation.

(19) Reporting Requirements.

(a) Each hospital shall annually submit to the Commission within 120 days after the end of each hospital's fiscal year a report including:

(i) The total number of patients by race or ethnicity, gender, and zip code of residence against whom the hospital or a debt collector used by the hospital, filed an action to collect a debt owed on a hospital bill;

(ii) The total number of patients by race or ethnicity, gender, and zip code of residence with respect to whom the hospital has and has not reported or classified a bad debt; and

(iii) The total dollar amount of charges for hospital services provided to patients but not collected by the hospital for patients covered by insurance, including the out-of-pocket costs for patients covered by insurance, and patients without insurance.

(b) The Commission shall post the information submitted under §B-1(19)(a) of this regulation on its website.

[A-2.**]** *B-2.* Hospital Financial Assistance Responsibilities.

[(1) Definitions

(a) In this regulation, the following terms have the meanings indicated.

(b) Terms Defined.

(i) "Financial hardship" means medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

(ii) "Medical debt" means out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by a hospital.**]**

[(2)**]** *(1)* Financial Assistance Policy.

(a) On or before June 1, 2009, each hospital and on or before October 1, 2010, each chronic care hospital under the jurisdiction of the Commission shall develop a written financial assistance policy for providing free and reduced-cost *medically necessary* care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill. A hospital shall provide notice of the hospital's financial assistance policy to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the hospital bill. The financial assistance policy shall provide at a minimum:

(i) (text unchanged)

(ii) Reduced-cost**[**,**]** medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level, in accordance with the mission and service area of the hospital;

(iii) A maximum patient payment for reduced-cost *medically necessary* care not to exceed the charges minus the hospital mark-up;

(iv) A payment plan available to *all* patients **[**irrespective of their insurance status with family income between 200 and 500 percent of the federal poverty level who request assistance**]** *in accordance with the Guidelines*; and

(v) A mechanism for a patient, irrespective of that patient's insurance status, to request the hospital to reconsider the denial of free or **[**reduced**]** *reduced-cost medically necessary* care, including the address, phone number, facsimile number, email address, mailing address, and website of the Health Education and Advocacy Unit, which can assist the patient or patient's authorized representative in filing and mediating a reconsideration request.

(b) The financial assistance policy shall calculate a patient's eligibility for free medically necessary care under §B-2(1)(a)(i) of this regulation and Health-General Article, §19-214.1(b)(2)(i), Annotated Code of Maryland or reduced-cost medically necessary care under §B-2(1)(a)(ii) of this regulation and Health-General Article, §19-214.1(b)(2)(i), Annotated Code of Maryland at the date of service or updated, as appropriate, to account for any change in the financial circumstances of the patient that occurs within 240 days after the initial bill is provided.

[(b)**]** *(c)* A hospital whose financial assistance policy as of May 8, 2009, provides for free or reduced-cost medical*ly necessary* care to a patient at an income threshold higher than those set forth above may not reduce that income threshold.

[(c)**]** *(d)* Presumptive Eligibility for Free *Medically Necessary* Care. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the following means-tested social services programs are deemed eligible for free *medically necessary* care**[**, provided that the patient submits proof of enrollment within 30 days unless the patient or the patient's representative requests an additional 30 days**]**:

(i)—(v) (text unchanged)

(vi) Other means-tested social services programs deemed eligible for hospital free *medically necessary* care policies by the Maryland Department of Health and the HSCRC, consistent with **[**HSCRC regulation COMAR 10.37.10.26**]** *this regulation*.

[(d)**]** *(e)*—**[**(f)**]** *(g)* (text unchanged)

[(3)**]** *(2)* Each hospital shall submit to the Commission within **[**60**]** *120* days after the end of each hospital's fiscal year:

(a) (text unchanged)

(b) An annual report on the hospital's financial assistance policy that includes:

(i) (text unchanged)

(ii) The total number of inpatients and outpatients who received free *medically necessary* care during the immediately preceding year and reduced-cost *medically necessary* care for the prior year;

(iii)—(iv) (text unchanged)

(v) The total cost of hospital services provided to patients who received free *medically necessary* care; and

(vi) The **[**totalcost**]** *total cost* of hospital services provided to patients who received reduced-cost *medically necessary* care that was covered by the hospital as financial assistance or that the hospital charged to the patient.

(3) Financial Hardship Policy.

(a) Subject to §**[**A-2(b) and (c)**]***B-2(3)* of this regulation, the financial assistance policy required under *§B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland,* shall provide reduced-cost**[**,**]** medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship.

(b) A hospital may seek and the Commission may approve a family income threshold that is different than the family income threshold under §**[**A**]***B*-2(1)*(a)***[**(c)(1)**]** of this regulation.

(c) (text unchanged)

(d) If a patient has received reduced-cost**[**,**]** [JG1][HFB2]medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

(i) Shall remain eligible for reduced-cost**[**,**]** medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost**[**,**]** medically necessary care was initially received; and

(ii) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost**[**,**]** medically necessary care.

[(5)**]** *(4)* If a patient is eligible for reduced-cost medical*ly necessary* care under a hospital's financial assistance policy or financial hardship policy, the hospital shall apply the reduction in charges that is most favorable to the patient.

[(6)**]** *(5)*—**[**(7)**]** *(6)*(text unchanged)

[(8)**]** *(7)* Each hospital shall use a Uniform Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost *medically necessary* care.

[(9)**]** *(8)*—**[**10)**]** *(9)* (text unchanged)

[(11)**]** *(10)* Monetary assets excluded from the determination of eligibility for free and reduced-cost *medically necessary* care under these provisions shall be adjusted annually for inflation in accordance with the Consumer Price Index.

[(12)**]** *(11)*—**[**(13)**]** *(12)* (text unchanged)

[A-3.**]** *B-3.* (text unchanged)

[B.**]** *C.* Working Capital Differentials — Payment of Charges.

(1) (text unchanged)

(2) The third-party payer shall promptly provide the Commission with a verified record of the detailed calculation of the current financing and of each recalculated balance as adjustments are made. The detailed calculations shall become a part of the public record. The Commission may, at any time, evaluate the amount of current financing monies provided to a hospital to assure that it meets the discount of requirements specified in §**[**B**]***C*(1) of this regulation. If the Commission finds that the amount of current financing is inconsistent with the requirements of §[B]*C*(1), the Commission may, at its sole discretion, require an adjustment to the working capital advance or to the discount.

(3) A payer or self-paying patient, who does not provide current financing under §**[**B**]***C*(1)(a)—(e) of this regulation, shall receive a 2-percent discount if payment is made at the earlier of the end of each regular billing period or upon discharge from the hospital. Payment within 30 days of the earlier of the end of each regular billing period or discharge entitles a payer or self-pay patient to a 1-percent discount. For those payers not subject to Insurance Article, §15-1005, Annotated Code of Maryland, after 60 days from the date of the earlier of the end of each regular billing period or discharge, interest or late payment charges may accrue on any unpaid charges at a simple rate of 1 percent per month. The interest or late payment charges may be added to the charge on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that. *For patients that have entered into a hospital payment plan, the interest rate shall be established in accordance with the Guidelines.*

(4) (text unchanged)

(5) [JG3][HFB4]Hospital Written Estimate.

(a)—(c) (text unchanged)

(d) The provisions set forth in §**[**B**]***C*(5)(a)—(c) of this regulation do not apply to emergency services.

[C.**]** *D.* (text unchanged)

Adam Kane, Chair

Health Services Cost Review Commission

Update on Maryland Hospital Financial Condition Report FY 2021

- Report posted to HSCRC website - April 24, 2022.
- Covers cost reports based on FY 2021 for fiscal year hospitals and CY 2020 for hospitals reporting on a calendar year cycle and compared to two previous years.

	FY 2019	FY 2020	FY 2021
Gross Regulated Revenue	$17,455,591,502	$17,260,040,507	$18,821,795,017
Net Regulated Patient Revenue	$14,813,607,135	$14,483,050,744	$15,878,368,394
Profits on Regulated Operating Activities	$1,216,831,316	$1,172,542,968	$1,602,630,043
Profits on Total Operations	$353,853,731	$344,720,894	$748,116,936
Total Profit Margin (from operating and non-operating business)	$541,070,061	$292,688,181	$2,175,928,697
Margin on Regulated Operating Activities %	8.09%	7.76%	9.70%
Margin on Total Operations %	2.10%	2.01%	4.01%
Total Profit Margin %	3.16%	1.70%	10.83%

maryland
health services
cost review commission

Draft Recommendation on the RY 2023 Update Factors

May 11, 2022

Update Factor Recommendation for Non-Global Budget Revenue

	Global Revenues	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.66%	3.66%
Productivity Adjustment	N/A	SUSPENDED
Proposed Inflation Update	3.66%	3.66%

Table 1: Page 5 of Draft Recommendation

Table 2: Page 7 of Recommendation

Balanced Update Model for RY 2023

Components of Revenue Change Link to Hospital Cost Drivers /Performance

			Weighted Allowance
Adjustment for Inflation (this includes 4.50% for wages and compensation)			3.64%
- Outpatient Oncology Drugs			0.02%
Gross Inflation Allowance	**A**		**3.66%**
Care Coordination/Population Health			
- Reversal of One-Time Grants			-0.22%
- Regional Partnership Grant Funding RY23			0.20%
Total Care Coordination/Population Health	**B**		**-0.03%**
Adjustment for Volume			
-Demographic /Population			-0.12%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**-0.12%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.00%
- Low Efficiency Outliers	E		0.00%
- Capital Funding: GBMC	F		0.01%
- Complexity & Innovation	G		0.14%
-Reversal of one-time adjustments for drugs	H		-0.04%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.11%**
Quality and PAU Savings			
-PAU Savings	J		-0.32%
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	K		-0.11%
-Current Year Quality Incentives	L		0.00%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.43%**
Total Update First Half of Rate Year 23			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**3.19%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1-0.12%)	**3.32%**
Adjustments in Second Half of Rate Year 23			
-Oncology Drug Adjustment	P		0.00%
-Current Year Quality Incentives	Q		TBD
Total Adjustments in Second Half of Rate Year 23	**R =**	P + Q	**0.00%**
Total Update Full Fiscal Year 23			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**3.19%**
Per Capita Fiscal Year	**T =**	(1+S)/(1-0.12%)	**3.32%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		-0.43%
-Deficit Assessment	V		0.00%
Net decreases	**W =**	U + V	**-0.43%**
Total Update First Half of Rate Year 23			
Revenue growth, net of offsets	**X =**	N + W	**2.76%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1-0.12%)	**2.89%**
Total Update Full Rate Year 23			
Revenue growth, net of offsets	**Z =**	S + W	**2.76%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1-0.12%)	**2.89%**

HSCRC Update Factor Evaluation

CY22 Revenue Growth Estimate

Estimated Position on Medicare Test		
Actual Revenue CY 2021		18,951,788,063
Step 1:		
Approved GBR RY 2022		19,638,102,984
Actual Revenue 7/1/21-12/31/21		9,501,433,932
Approved Revenue 1/1/22-6/30/22		10,136,669,052
FY22 Undercharge in First Half of CY22		(178,000,000)
Anticipated Revenue 1/1/22-6/30/22	**A**	**9,958,669,052**
Step 2:		
Approved GBR RY 2022		19,638,102,984
Reverse One Time Extraodinary Adjustments:		(189,274,421)
Adjusted GBR RY 2022		19,448,828,563
Projected Approved GBR RY 2023		19,986,207,313
Permanent Update RY 2023		2.76%
Adjusted Change from GBR RY 2022		1.77%
Step 3:		
Estimated Revenue 7/1/22-12/31/22 (after 49.73% & seasonality)		9,939,140,897
CARES Act $ Payback		-
FY23 Inflation Advance Payback		(98,505,808)
FY21 Undercharge Release in Second Half of CY22		95,754,888
Projected Revenue 7/1/22-12/30/22	**B**	**9,936,389,977**
Step 4:		
Estimated Revenue CY 2022	**A+B**	**19,895,059,029**
Increase over CY 2021 Revenue		4.98%

Table 7: Page 13 of Recommendation

CY 2022 Test Approach

- National Approach
  - Scenario 1 (Same as Last Year but updated Base Year):
    - Calculate average trend 2017 to 2019
    - Trend 2021 forward at that rate to calculate 2022 estimate
    - Separately for Part A and Part B, Hospital and Non-Hospital (4 buckets)
  - Scenario 2 (Increase Number of Years Assessed to Create More Stable Statistic):
    - Calculate average trend 2015 to 2019
    - Trend 2021 forward at that rate to calculate 2022 estimate
    - Separately for Part A and Part B Hospital and Non-Hospital (4 buckets)
  - Scenario 3:
    - Utilizes OACT projected FFS TCOC growth for CY 22*

- Compared to Maryland Approach:
  - Maryland non-hospital estimated using the same approach for Scenarios 1, Scenario 2, and Scenario 3 (utilizes non-hospital OACT projection)
    - HSCRC considering specifically adjusting for MDPCP fees
  - Plus: Maryland hospital trended from 2021 to 2022 based on HSCRC data and proposed HSCRC all-payer update factor
    - Assumes Medicare trend = All-payer trend
    - Factors in estimated remaining release of remaining undercharge for FY21, take back of FY23 advanced inflation funding, anticipated FY22 undercharge, and other Maryland-specific factors

*hospital stakeholders suggested using the US Per Capita Cost trends used to project Medicare Advantage increase. This methodology estimates a 9 percent growth for the nation for CY22. Staff have concerns about differing from the estimate provided by OACT used for FFS.

CY 22 Guardrail Scenarios

CY 2022 Predicted Guardrail: Scenario 1			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,706	$11,974	Predicted Variance
YOY Growth	4.73%	3.88%	**0.85%**

CY 2022 Predicted Guardrail: Scenario 2			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,661	$11,850	Predicted Variance
YOY Growth	4.38%	2.80%	**1.57%**

CY 2022 Predicted Guardrail: Scenario 3			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,705	$12,103	Predicted Variance
YOY Growth	4.72%	5.00%	**-0.28%**

Tables 5a, 5b, & 5c: Pages 14-15 of Draft Recommendation

TCOC Savings Test Using Scenarios

CY 2022 Predicted Guardrail (Scenario 1)	
	Maryland
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$81 M
2022 Savings (Run Rate)	$257 M

CY 2022 Predicted Guardrail (Scenario 2)	
	Maryland
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$163 M
2022 Savings (Run Rate)	$175 M

CY 2022 Predicted Guardrail (Scenario 3)	
	Maryland
2021 Savings (Run Rate)	$338 M
2022 Annual Savings	$29 M
2022 Savings (Run Rate)	$367 M

Tables 6a, 6b, & 6c: Page 16 & 17 of Draft Recommendation

Gross State Product (GSP) Review

- Staff calculated a 3-year CAGR of Maryland GSP for 2018 – 2021
- Compared it to a 3-year CAGR of Maryland Acute Hospital Charges for 2019-2022 (staff is able to project 2022 using the Update Factor)

GSP (2018-2021)	Maryland Hospital Charges (2019-2022)	Variance
2.22%	3.59%	1.38%

- Comparing 3 years GSP to 3 year of charges provides more reliability of variance and a better projection of affordability
- While unfavorable, staff would note that given the volatility in the economy over the past few years and the extraordinary actions the Commission and the Federal government took to provide more funding to hospitals during the COVID public health emergency, this analysis should be considered with caution.

Table 7: Page 17 of Draft Recommendation

Inflation Review

	RY13	RY14	RY15	RY16	RY17	RY18	RY19	RY20	RY21	RY22	RY23	Cumulative Growth
Funded Inflation		1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	3.66%	23.87%
Actual Inflation		1.85%	1.93%	1.84%	2.29%	2.38%	2.59%	2.31%	2.01%	4.42%		23.79%
Difference		-0.20%	0.46%	0.55%	-0.36%	0.29%	-0.26%	0.64%	0.75%	**-1.77%**		**0.07%**
Infrastructure		0.33%	0.33%	0.40%								1.06%
PAU Savings		0.00%	-0.40%	-0.20%	-0.65%	-0.20%	-0.30%	-0.35%	-0.28%	-0.22%		-2.58%
Infrastructure/PAU Difference		0.33%	-0.08%	0.20%	-0.65%	-0.20%	-0.30%	-0.35%	-0.28%	-0.22%		-1.54%
Funded Inflation + Infrastructure/PAU		1.98%	2.33%	2.60%	1.27%	2.48%	2.02%	2.61%	2.49%	2.35%		22.01%
Actual Inflation		1.85%	1.93%	1.84%	2.29%	2.38%	2.59%	2.31%	2.01%	4.42%		23.79%
Total Difference		0.13%	0.39%	0.75%	-1.00%	0.10%	-0.56%	0.29%	0.47%	-1.98%		**-1.44%**
Regulated Margin	**4.59%**	**7.23%**	**8.42%**	**8.59%**	**8.05%**	**8.98%**	**8.09%**	**7.80%**	**9.70%**			

Inflation Review - Policy Considerations

- Between RY14 and RY22, the Commission has cumulatively funded above actual cost inflation by 0.07 percentage points (23.87% funded vs. 23.79% actual)
- However, policy decisions by the Commission that permanently adjust rates could also be taken into consideration
  - Infrastructure Funding - Intended to provide revenue to hospitals in the early years of switching to a population-based reimbursement system
  - Ongoing PAU Savings Reductions - Intended to reinforce the incentives to reduce potentially avoidable utilization, as it is a central tenet of the Model
  - These additional policy decisions result in lower overall funded inflation below that of actual cost inflation by -1.44 percentage points (22.01% funded vs. 23.79% actual)
- Because inflation is applied to revenue and volumes have declined under the Model, regulated margins have improved despite any underfunding of cost inflation and continued PAU reductions.

Inflation Reconciliation Proposal

- The annual update factor relies on an estimate of the inflation for the future period being funded. As a result, the approved Update Factor could over- or under-fund inflation for a given period versus the actual experience for that period.
- Hospital stakeholders have argued that because the inflation estimate used in the RY 2022 update factor was a significant underestimate of actual inflation, the Commission should depart from historic practice and provide additional inflation, a “catch-up”, in RY 2023, in order to fund full inflation on a permanent basis.
- Staff recommend that the Commission direct staff to convene a stakeholder workgroup and report back to the Commission in November 2022 on
  - (a) a policy for addressing differences between actual and estimated inflation in future update factors within the parameters outlined below (or that such a policy is not required)
    - any policy is two-sided and would apply to both over and underestimates of inflation
    - any policy look at cumulative inflation funding since 2013 (including a discussion of policy considerations of PAU, infrastructure, and other permanent inflation funding)
    - any policy would have a materiality provision that would only apply when cumulative funding reached a specific threshold (i.e. 0.75 percent)
  - (b) a recommendation to the Commission for a reconciliation inflation adjustment for experience through RY 2022 to be applied to hospital rates on January 1, 2023, consistent with the policy developed under item
  - (c) and with the State’s savings position and other factors considered in the typical annual update factor process

Recommendations

For Global Revenues:

(a) Provide an overall increase of 2.76 percent for revenue (including a net change to uncompensated care) and 2.89 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target.

Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

(b) Provide all hospitals a base inflation increase of 3.66 percent and apply 0.02 percent of this total inflation allowance based on each hospital's proportion of drug cost to total cost, thereby adjusting hospitals' budgets more equitably for increases in drug prices and high-cost drugs.

(c) Staff be tasked with developing, by November 2022, in accordance with the parameters outlined in this recommendation, a new recommendation to the Commission containing a general policy for adjusting for variations between the actual inflation and estimated inflation in future update factors or determining such a policy is not needed. In addition, if applicable, the recommendation will include a specific adjustment for cumulative variances from RY 2014 to RY 2022, based on the newly developed general policy, to be implemented in rates on 1/1/2023.

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

(a) Provide an overall update of 3.66 percent for inflation.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Appendix

Adjustments to CY22 Revenue Estimate

- Assumes undercharge at 12/31/21 is recovered in first half of CY22 but that additional undercharges will be accrued in the remainder of FY22
  - Staff are not anticipating guaranteeing FY22 Undercharge other than the inflation advance
  - Therefore, estimated CY22 revenue will be reduced by the anticipated amount of undercharge penalties as of 6/30/22 in evaluating spending tests
    - Amount is hard to estimate, hospitals should strive to submit accurate charging projections when they submit March experience data next month
    - Currently, as a placeholder, HSCRC is assuming that 178M will be undercharged at FYE
    - Staff will refine this estimate as we move toward a final update factor

- No assumptions have been made about COVID surge revenue for FY22 or COVID expense reimbursement for FY20 and FY21. Staff anticipates finalizing a position on these items in the coming months and including them in the final update factor. The exact terms of these approaches are still tbd but likely include:
  - Consideration of only incremental expenses
  - A more restrictive COVID surge policy than that instituted previously
  - That any expense and surge awards and remaining FY21 undercharge will be offset against additional CARES Phase 4 revenue and potentially previously unused CARES revenue.

ANNUAL PAYMENT UPDATE

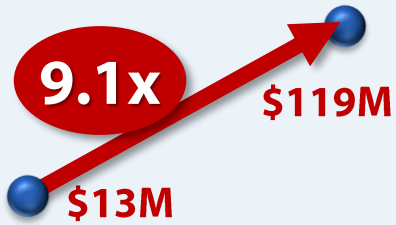
HSCRC Public Meeting

May 11, 2022

Maryland
Hospital Association

HOSPITAL COST PRESSURES MOUNT, WILL PERSIST

Contract Labor Monthly Spend



Early '20 Early '22

Hourly RN Wage

Mar '21 Mar '22

Drug Cost Per Patient

2019 2021

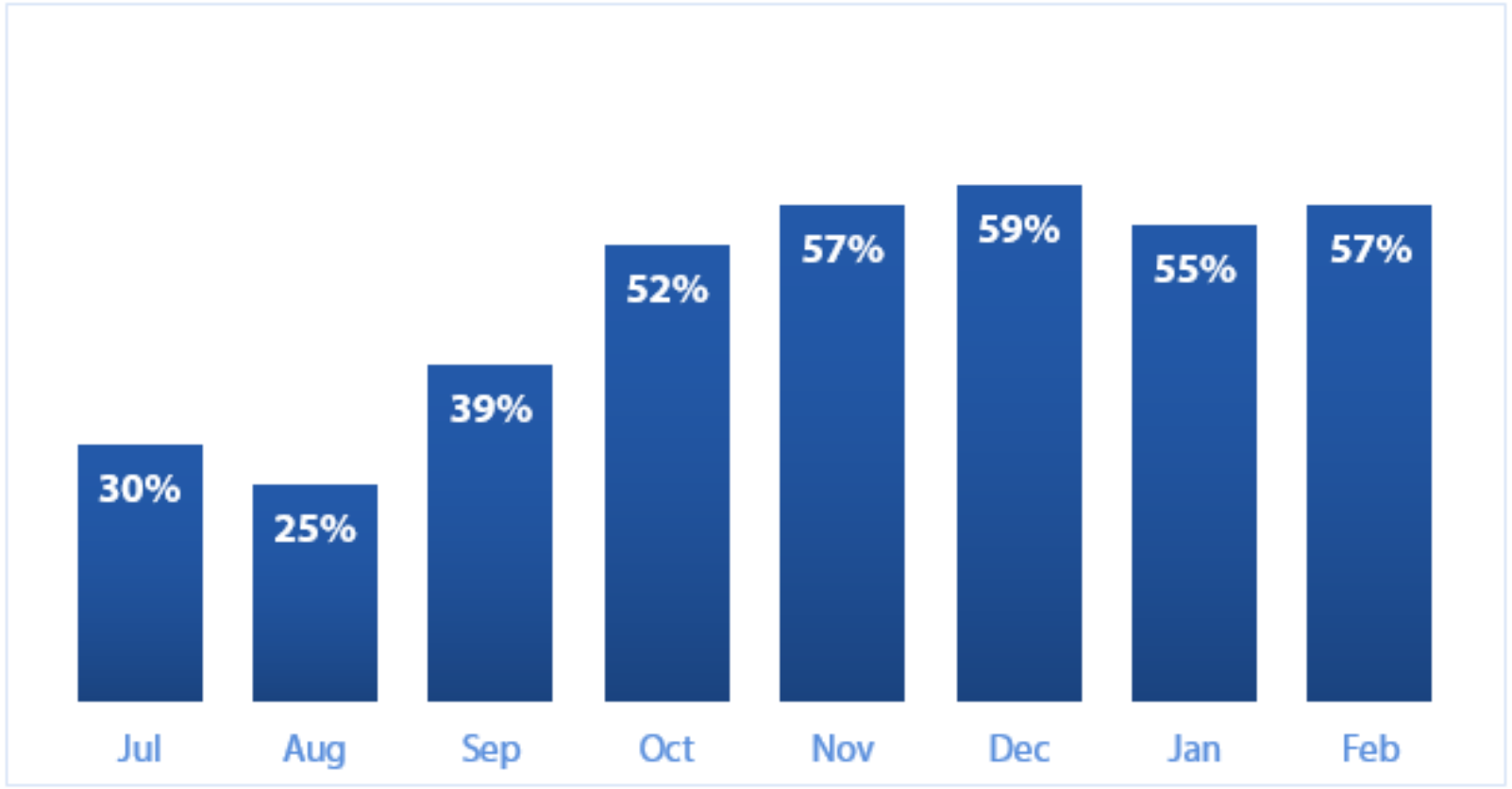
Total Cost Per Patient Day

Feb '20 Feb '22

Sources: Drug spend, January 2022 Kaufman Hall National Hospital Flash Report; all other, MHA member surveys

Total Cost Per Patient Day is expense per equivalent inpatient day (EIPD)

PERCENTAGE OF MARYLAND HOSPITALS WITH NEGATIVE OPERATING MARGINS IN RY2022



MHA POSITION – RATE YEAR 2023 REQUESTS

1. Fully fund FY2023 inflation – *3.66%*
2. Make the $100 million (0.5%) advance funding permanent and require no repayment
3. Modify PAU savings adjustment to reduce takeaway
4. Limit uncompensated care funding reduction
5. Monitor inflation and Model performance; **add funding Jan. 1, 2023**

\+ *If needed, apply MPA savings adjustment to muffle one-time adjustments*

Category	MHA Proposal	HSCRC Draft
2023 Base Inflation (New IHS Q1 2022 forecast)	3.66%	3.66%
Make 2022 $100m advanced funding permanent	0.50%	-
Subtotal	**4.16%**	**3.66%**
PAU savings offset	-0.16%	-0.32%
Quality policies (defer action until Jan. 1)	-0.11%	-0.11%
Other (net)	-0.05%	-0.05%
Uncompensated Care (UCC)	-0.22%	-0.43%
Total Revenue Growth	**3.62%**	**2.76%**
Total Per Capita Growth*	**3.75%**	**2.89%**

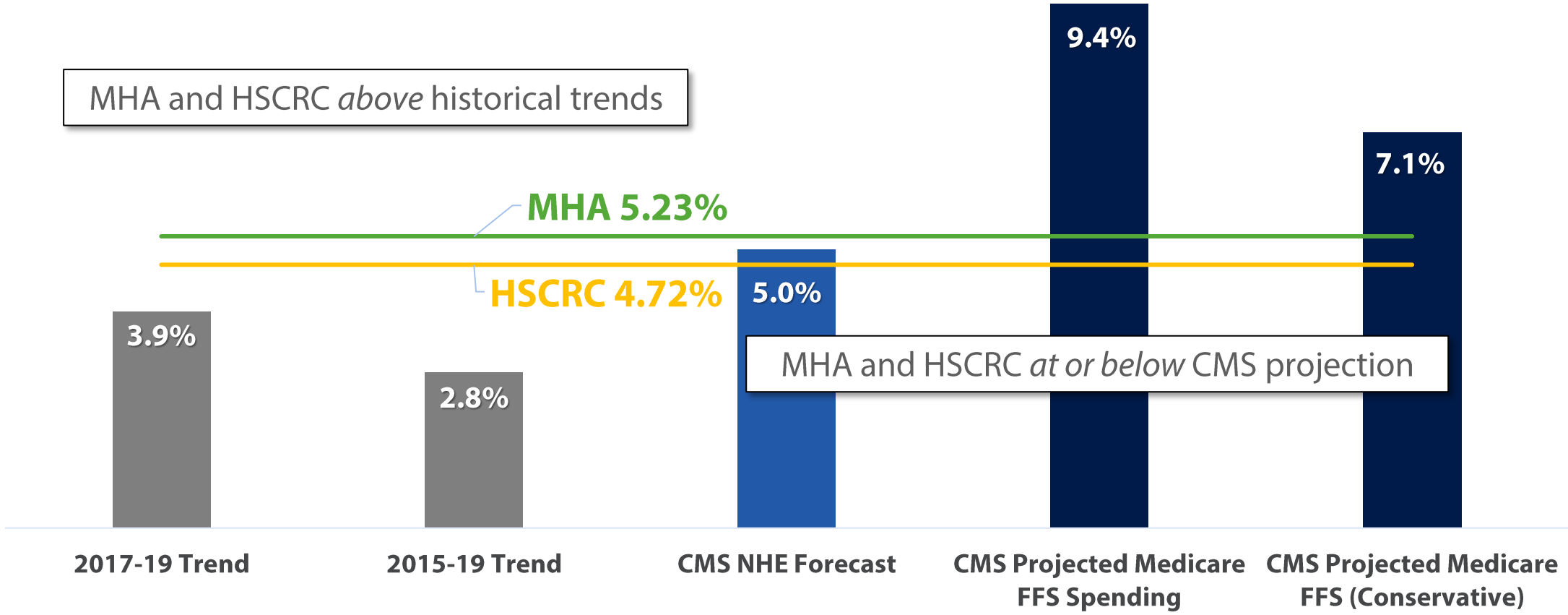
PAU = Potentially avoidable utilization *Population change –0.12%

PROJECTED CY2022 REVENUE GROWTH

Category	MHA	HSCRC
RY2023 Rate Growth	**3.75%**	**2.89%**
Net one-time adjustments and price leveling to CY022, incl 2017-2019 trend for MD non-hosp. (MHA = no payback of $100m advance; ½ year)	1.48%	1.83%
CY2022 Revenue Growth	**5.23%**	**4.72%**

MHA used the 2017-2019 annual average to project non-hospital growth, resulting in a single projection. HSCRC's April 28 document reflects multiple projections of Maryland total cost of care growth using different non-hospital growth assumptions paired with the 2023 hospital payment update.

CMS ACTUARY'S FORECAST GIVES HEADROOM



maryland
health services
cost review commission

Draft Recommendation for the Update Factors for Rate Year 2023

May 11, 2022

Please submit all comments to hscrc.payment@maryland.gov by COB May 18, 2022.

Table of Contents

List of Abbreviations

ACA	Affordable Care Act
CAGR	Compounded Annual Growth Rate
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year, refers to the period of October 1 through September 30
FY	Fiscal year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital Acquired Conditions
MPA	Medicare Performance Adjustment
MPA-SC	Medicare Performance Adjustment - Saving Component
OACT	Office of the Actuary
PAU	Potentially avoidable utilization
QBR	Quality Based Reimbursement
RRIP	Readmission Reduction Incentive Program
RY	Rate year, which is July1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.	The draft recommendation provides an annual update factor of 2.89 percent per capita, a revenue increase of 2.76 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 3.66 percent for hospitals not under Global Budgets which includes psych hospitals and Mt. Washington Pediatrics.	The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2023. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, uncompensated care, and others as deemed necessary.	One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Total Cost of Care Agreement.	The annual update factor contains the growth of costs for all payers and also reflects ongoing investments in population health and health equity through the Regional Partnership programs. The update factor also reflects quality measures, including within hospital disparities, that aim to improve health disparities across the State.

Summary

The following report includes a draft recommendation for the Update Factor for Rate Year (RY) 2023. 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 recommendation generally follows approaches established in prior years for setting the update factors. Staff recognizes that the COVID-19 crisis continues to create significant uncertainty and will likely drive large, short and long-term changes in the healthcare industry. Staff plans to continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis and its lingering effects on healthcare in the State of Maryland. As with all HSCRC policies, the aim is equity and fairness for all hospitals and payers that balances the need to provide sufficient resources for operational readiness and necessary investment, while simultaneously ensuring affordability and slowing the growth of healthcare costs.

Staff requests that Commissioners consider the following draft recommendations:

For Global Revenues:

(a) Provide an overall increase of 2.76 percent for revenue (including a net change to uncompensated care) and 2.89 percent per capita for hospitals under Global Budgets, as shown in

Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target.

Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

(b) Provide all hospitals a base inflation increase of 3.66 percent and apply 0.02 percent of this total inflation allowance based on each hospital's proportion of drug cost to total cost, thereby adjusting hospitals' budgets more equitably for increases in drug prices and high-cost drugs.

(c) Staff be tasked with developing, by November 2022, in accordance with the parameters outlined in this recommendation, a new recommendation to the Commission containing a general policy for adjusting for variations between the actual inflation and estimated inflation in future update factors or determining such a policy is not needed. In addition, if applicable, the recommendation may include a specific adjustment for cumulative variances from RY 2014 to RY 2022, based on the newly developed general policy, to be implemented in rates on 1/1/2023.

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

(a) Provide an overall update of 3.66 percent for inflation.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Introduction & Background

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

In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. Under the new TCOC Model, the State committed to continue to limit the growth in hospital costs in line with economic growth, reach an annual Medicare total cost of care savings rate of $300 million by 2023 ("the Medicare TCOC Savings Requirement"), continue quality improvements, and improve the health of the population. It is worth mentioning that Maryland has already

met the 5-year total cost of care savings requirement under the Total Cost of Care Agreement, but this progress must be sustained through 2023 as the savings requirement is not a cumulative test.

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 develop the RY 2023 annual update is outlined in this report, as well as staff's estimates on calendar year Model tests.

Hospital Revenue Types Included in this Recommendation

There are two categories of hospital revenue:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority. The proposed update factor for hospitals under Global Budget Revenues is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.

2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals is strictly related to price, not volume.

This recommendation proposes Rate Year (RY) 2023 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Draft Update Factors Recommendations

For RY 2023, HSCRC staff is proposing an update of 2.89 percent per capita for global budget revenues and an update of 3.66 percent for non-global budget revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's First Quarter 2022 market basket growth estimate with a capital growth estimate. For RY 2023, HSCRC staff combined 91.20 percent of Global Insight's First Quarter 2022 market basket growth of 3.80 percent with 8.80 percent of the capital growth estimate of 2.20 percent, calculating the gross blended amount as a 3.66 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 inflation adjustment of 3.66 percent. The pandemic's effect on hospitals continues to result in historically low volumes. For this reason, HSCRC staff propose to withhold the productivity adjustment from this year's gross blended inflation amount. It is important to note that these hospitals receive an adjustment based on their actual volume change, rather than a population adjustment. HSCRC staff continues to include these non-global budget hospitals in readmission calculations for global budget hospitals and may implement quality measures for these hospitals in future rate years

Table 1

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.66	3.66%
Productivity Adjustment	N/A	SUSPENDED
Proposed Inflation Update	3.66%	3.66%

Update Factor Recommendation for Global Budget Revenue Hospitals

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

- Meeting the requirements of the Total Cost of Care Model agreement;
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model;
- Incorporating quality performance programs; and
- Ensuring that healthcare remains affordable for all Marylanders.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates net revenue growth (before accounting for changes in uncompensated care and assessments) of 3.19 percent and per capita growth of 3.32 percent for RY 2023. After accounting for changes in uncompensated care and assessments, the HSCRC estimates net revenue growth at 2.76 percent with a corresponding per capita growth of 2.89 percent for RY 2023.

To measure the proposed update against financial tests, which are performed on Calendar Year results, staff split the annual Rate Year revenue into six-month targets. Staff intends to apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2023 estimated revenue used to evaluate the Rate Year year-end target. HSCRC staff will adjust the revenue split to accommodate their normal seasonality for hospitals that do not align with the traditional seasonality described above.

Net Impact of Adjustments

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

Table 2

Balanced Update Model for RY 2023			
Components of Revenue Change Link to Hospital Cost Drivers /Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 3.90% for wages and compensation)			3.64%
- Outpatient Oncology Drugs			0.02%
Gross Inflation Allowance	**A**		**3.66%**
Care Coordination/Population Health			
- Reversal of One-Time Grants			-0.22%
- Regional Partnership Grant Funding RY23			0.20%
Total Care Coordination/Population Health	**B**		**-0.03%**
Adjustment for Volume			
-Demographic /Population			-0.12%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**-0.12%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.00%
- Low Efficiency Outliers	E		0.00%
- Capital Funding: GBMC	F		0.01%
- Complexity & Innovation	G		0.14%
-Reversal of one-time adjustments for drugs	H		-0.04%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.11%**
Quality and PAU Savings			
-PAU Savings	J		-0.32%
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	K		-0.11%
-Current Year Quality Incentives	L		0.00%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.43%**
Total Update First Half of Rate Year 23			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**3.19%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1-0.12%)	**3.32%**
Adjustments in Second Half of Rate Year 23			
-Oncology Drug Adjustment	P		0.00%
-Current Year Quality Incentives	Q		TBD
Total Adjustments in Second Half of Rate Year 23	**R =**	P + Q	**0.00%**
Total Update Full Fiscal Year 23			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**3.19%**
Per Capita Fiscal Year	**T =**	(1+S)/(1-0.12%)	**3.32%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		-0.43%
-Deficit Assessment	V		0.00%
Net decreases	**W =**	U + V	**-0.43%**
Total Update First Half of Rate Year 23			
Revenue growth, net of offsets	**X =**	N + W	**2.76%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1-0.12%)	**2.89%**
Total Update Full Rate Year 23			
Revenue growth, net of offsets	**Z =**	S + W	**2.76%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1-0.12%)	**2.89%**

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

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

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 3.66 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's First Quarter 2022 market basket growth of 3.80 percent with 8.80 percent of the capital growth

index change of 2.20 percent. The adjustment for inflation includes 3.90 percent for wage and compensation. A portion of the 3.66 inflation allowance (0.02 percent) will be allocated to hospitals to more accurately provide revenues for increases in outpatient oncology and infusion drugs. This drug cost adjustment is further discussed below.

- **Outpatient Oncology and Infusion Drugs:** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting led to the creation of separate inflation and volume adjustment for these drugs. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drugs.

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

  Starting in Rate Year 2021, staff began using a standard list of drugs based on criteria established with the industry in evaluating high-cost drug utilization and inflation. This list was used to calculate the inflation allowance as well as the drug utilization adjustment component of funding for these high-cost drugs. Rate Year 2023 continues this practice. While volume continues to grow for these drugs, staff analysis shows that the price per drug of the drugs covered has stabilized and the need for a higher inflation rate on this component of spending has been mitigated. This trend was recognized in Rate Year 2021 through a lowering of the drug inflation factor from 10 percent to 6 percent. Staff reviewed trends from 2018 to 2021 and determined that price and mix trends remain well below prior years. Therefore, staff is proposing a 1 percent drug inflation factor for RY 2023, which calculates to 0.02 percent that will be earmarked for outpatient oncology and infusion drugs.

- **Care Coordination / Population Health:** There were several grant programs aimed at Care Coordination and Population Health in RY 2022 hospital revenues. These programs include Regional Partnership Catalyst Programs for Diabetes and Behavioral Health, Maternal and Child Health Improvement Fund Assessment, Population Health Workforce Support for Disadvantaged Areas, and transition funding for Regional Partnership Legacy Grants. These funds were provided to hospitals on a one-time basis. For this reason, you will see a line in Table 2 reversing out grant funding in RY 2022 of -0.22 percent. RY 2023 funding is expected to be approximately 0.20 percent and includes continued funding for Diabetes and Behavioral Health, as well as Maternal and Child Health.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2022 is -0.12 percent. For RY 2023 the staff is proposing to use the value of the Department of Planning CY 2022 growth estimate for the Demographic Adjustment in keeping with the prior year methodologies.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining inefficient hospitals in the TCOC Model. This policy will utilize the Inter-Hospital cost comparisons to compare relative cost-per case efficiency. This policy will also use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals. Due to the confounding impact that the COVID-19 pandemic has had on data, staff will not implement an efficiency policy effective July 1, 2022, but is assessing if a mid-year efficiency policy that addresses COVID concerns could be utilized in January 2023.

- **Set-Aside for Unforeseen Adjustments:** The intention of the set-aside is to use these funds for potential Global Budget Revenue enhancements and other potentially unforeseen requests that may occur at hospitals. Due to Model year test constraints for CY 2022, staff is not recommending a set-aside at this time.

- **Complexity and Innovation (formerly Categorical Cases):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, the HSCRC staff developed an approach to provide a higher variable cost factor (100% for drugs and supplies, 50% for all other charges) to in-state, inpatient cases when a hospital exhibits dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center in RY 2017, 2018, 2019, 2020, and 2021. Based on this analysis, staff concluded that the historical average growth rate was 0.54 percent, which equates to a combined state impact of 0.14 percent for the RY 2023 Update Factor.

- **PAU Savings Reduction:** The statewide RY 2023 PAU savings adjustment, of -0.32 percent, is calculated based on update factor inflation and demographic adjustment applied to CY 2021 PAU performance

- **Quality Scaling Adjustments:** These pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement program (QBR).

  Over the past several months, staff have worked with the Performance Measurement Workgroup to assess potential modifications to the underlying measurements and methodologies for the RY 2023 pay-for-performance programs due to the confounding effects of the COVID public health emergency. While many workgroup members supported staff's guiding principle to adjust or not adjust for COVID in a uniform fashion across the three core quality programs, other workgroup

members remain concerned about the overall deterioration in revenue adjustments relative to RY 2022.

Staff note that the recently released proposed rule for the Hospital Inpatient Prospective Payment System (IPPS) outlines that various components of the federal value-based purchasing programs will not be included in the federal RY 2023 payment program due to data validity concerns. Specifically, the proposed rule may make the Hospital Value-Based Purchasing (HVBP) program and the Hospital Acquired Conditions Reduction Program (HACRP) revenue neutral for federal RY 2023. These programs are analogous to the QBR and MHAC programs, respectively.

Given the uncertainty of the federal programs, which are the basis for the required at-risk in programs in Maryland, staff are recommending that Quality programs in the RY 2023 Update Factor remain to be determined and that any adjustments determined through further engagement of the Performance Measurement Workgroup be implemented in January rate orders. Depending on the final IPPS rule, which will not be promulgated until after the start of the State fiscal year, staff may revise its recommendations to align with federal guidance. Similarly, if the final IPPS rule recommends any changes to the Hospital Readmissions Reduction Program (HRRP), which is the analog for RRIP, staff will potentially modify revenue adjustments for this program as well.

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

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

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2023 will be -0.43 percent. The amount in rates was 4.65 percent in RY 2022, and the proposed amount for RY 2023 is 4.22 percent, a decrease of -0.43 percent.
- **Deficit Assessment:** The legislature did not propose a further reduction to the Deficit Assessment in RY 2023, and as a result, this line item is 0.00 percent.

Additional Revenue Variables

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

PAU Savings Updated Methodology

The PAU Savings Policy prospectively reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY2020, the calculation of the statewide value of the PAU Savings was included in the Update Factor Recommendation; however, a PAU measurement report was presented separately to the Commission in March of 2019.

For RY 2023, the incremental amount of statewide PAU Savings reductions is determined formulaically by using inflation and the demographic adjustment applied to the amount of PAU revenue (see Table 3). This will result in a RY 2023 PAU savings reduction of -0.32 percent statewide, or $60,153,549. Hospital performance on avoidable admissions per capita and 30 day readmissions, the latter of which is attributed to the index hospital, determines each hospital's share of the statewide reduction.

Table 3

Statewide PAU Reduction	Formula	Value
RY 2022 Total Estimated Permanent Revenue*	A	$18,797,984,034
RY 2023 Inflation Factor**	B	3.52%
CY 2019 Total Experienced PAU $	C	$1,719,724,282
RY 2023 Proposed Revenue Adjustment $	D = B*C	-$60,534,295
RY 2023 Proposed Revenue Adjustment %	E = D/A	-0.32203%
RY 2023 Adjusted Proposed Revenue Adjustment %	F = ROUND(E)	**-0.32%**
RY 2023 Adjusted Proposed Revenue Adjustment $	G = F*A	**-$60,153,549**
Total PAU %	H	9.77%
Total PAU $	I = A*H	$1,835,962,632
Required Percent Reduction PAU	J = G/I	-3.28%

*Does not include revenue from McCready, or freestanding EDs.
** Inflation factor is subject to revisions related to updated data and Commission approval

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

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

Medicare Financial Test

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

Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were summed to determine total *hospital* savings. The TCOC Model

requires that the State reach an annual total cost of care savings of $300 million relative to the national growth rate by 2023, relative to a 2013 base year. Thus, there must be sustained improved performance overtime to meet the new TCOC Medicare Savings Requirements. The new TCOC Model contains specific annual Medicare Savings Requirements for each year. Based on the CY 2021 estimated performance, staff calculates that Maryland hospitals have exceeded the TCOC Model's annual savings requirement of $222 million for performance year three (CY 2021). However, while the State has favorable savings for CY 2021, guardrail performance when compared to the nation is expected to be unfavorable, with Maryland growing faster than the nation in 2021. Final CY 2021 data is in the process of being reconciled and approved with CMS and will be released at a later date, but staff anticipate that the State will miss the guardrail target by greater than 0.5 percent. Similar to the All-Payer Model, there are 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.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In past years, staff compared Medicare growth estimates to the all-payer spending limits, to estimate that Model savings and guardrails were being met. Prior to the pandemic staff established an approach whereby prior year national trend was used to estimate national trend. However due to the ongoing COVID-19 pandemic and the related uncertainty and volatility, staff created an alternative approach to measure projected savings and compliance with the Total Cost of Care guardrails in RY 2022. For RY 2023 staff is using a similar approach as the prior year trend is, once again, not likely to be an accurate reflection of future trends.

Actual revenue resulting from RY 2022 updates affect the CY 2022 results. As a result, staff must convert the recommended RY 2022 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2022 to assist in estimating the impact of the recommended update factor together with the projected RY 2023 results. The overall increase from the bottom of this table is used in Tables 5a-5c.

Table 4

Estimated Position on Medicare Test		
Actual Revenue CY 2021		18,951,788,063
Step 1:		
Approved GBR RY 2022		19,638,102,984
Actual Revenue 7/1/21-12/31/21		9,501,433,932
Approved Revenue 1/1/22-6/30/22		10,136,669,052
FY22 Undercharge in First Half of CY22		(178,000,000)
Anticipated Revenue 1/1/22-6/30/22	**A**	**9,958,669,052**
Step 2:		
Approved GBR RY 2022		19,638,102,984
Reverse One Time Extraodinary Adjustments:		(189,274,421)
Adjusted GBR RY 2022		19,448,828,563
Projected Approved GBR RY 2023		19,986,207,313
Permanent Update RY 2023		2.76%
Adjusted Change from GBR RY 2022		1.77%
Step 3:		
Estimated Revenue 7/1/22-12/31/22 (after 49.73% & seasonality)		9,939,140,897
CARES Act $ Payback		-
FY23 Inflation Advance Payback		(98,505,808)
FY21 Undercharge Release in Second Half of CY22		95,754,888
Projected Revenue 7/1/22-12/30/22	**B**	**9,936,389,977**
Step 4:		
Estimated Revenue CY 2022	**A+B**	**19,895,059,029**
Increase over CY 2021 Revenue		4.98%

Steps to explain Table 4 are described as below:

The table begins with actual revenue for CY 2021.

Step 1: The table uses global revenue for RY 2022 and actual revenue for the last six months for CY 2021 to calculate the projected revenue for the first six months of CY 2022 (i.e., the last six months of RY 2022). Hospitals currently project they will not be able to charge all of RY 2022 revenue by the end of the Rate Year, the estimated shortfall is $178 million (the RY 2022 Undercharge). The RY 2022 Undercharge is either (a) forfeited as penalties or (b) deferred and added to revenue as a catch-up in the first half of CY 2023, or some combination of the two, with the actual result varying by hospital. Under either scenario it does not impact CY 2022 revenue and is therefore subtracted in Step 1.

Step 2: This step begins with the approved revenue for RY 2022 and reverses out the extraordinary one-time adjustments from RY 2022 that were a result of the COVID-19 pandemic. These one-times include: RY 2020 GBR settle up, RY 2021 price variance, COVID surge funding, and RY 2023 advanced inflation funding. The result is an adjusted RY 2022 GBR. The proposed update of 2.76 percent, as shown in Table 2, is then applied to the adjusted RY 2022 GBR amount to calculate the projected revenue for RY 2023.

Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2023 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2023. Additionally, staff applied the RY 2023 Advanced Inflation payback and release of the remaining RY 2021 undercharge to determine the projected revenue for the final six months of the calendar year.

Step 4: This step shows the resulting estimated revenue for CY 2022 and then calculates the increase over actual CY 2021 Revenue. The CY 2022 increase based on this year's recommended update is 4.98 percent. The 4.98 percent is used to estimate CY 2022 hospital spending per capita for Maryland in our guardrail calculation, which is explained next in this policy.

Staff modeled three different scenarios to project the CY 2022 guardrail position. Each scenario is described in more detail below. The one data element that is constant in each scenario is Maryland hospital growth. Because global budget revenues are a known data element, staff applied the estimated CY 2022 growth of 4.98 percent, shown in Table 4 to Maryland hospital spending per capita from 2021. The Maryland hospital growth estimate takes into account available hospital specific factors, such as the estimated RY 2022 Undercharge, remaining RY 2021 undercharge release and advanced inflation payback. Tables 5a-5c below show the results of these analyses. These analyses assume that Medicare growth equals All-Payer growth.

Scenario 1, shown in Table 5a, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. This takes the average trend from 2017 to 2019 and trends the data forward using 2021 as the base. This is a similar trend that staff used to predict 2021 growth, with an updated base.

Table 5a

Scenario 1 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,706	$11,974	Predicted Variance
YOY Growth	4.73%	3.88%	0.85%

Scenario 2, shown in Table 5b, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 2 takes the average trend from 2015 - 2019 and trends the data forward using 2021 as the base. This is the most conservative estimate of the three scenarios. Staff added this scenario because the trend used in Scenario 1 proved to be higher than actual trend in CY 2021 and resulted in an overestimate of national growth. Utilizing a longer period

to establish the "typical" trend results in a lower trend estimate, as the more recent 2017 to 2019 period utilized in Scenario 1 was a relatively high trend window.

Table 5b

Scenario 2 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,661	$11,850	Predicted Variance
YOY Growth	4.38%	2.80%	1.57%

Scenario 3, shown in Table 5c, utilizes the 2022 projection as published by the Office of the Actuary which is predicted to be 5.0 percent for 2022. The non-hospital portion of Maryland estimate utilizes the OACT national non-hospital growth prediction of 4.1 percent. Staff has some concerns that this may be too low of a growth to use for Maryland non-hospital because Maryland has historically trended higher than the nation. There is considerable variation among staff's three national trend forecasts - high (5.0 percent) and low (2.8 percent). This illustrates considerable uncertainty about how health care costs will "bounce back" as the healthcare market incorporates the COVID-19 pandemic window into the future patterns of care[1].

Table 5c

Scenario 3 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,705	$12,103	Predicted Variance
YOY Growth	4.72%	5.00%	-0.28%

In addition to modeling the CY 2022 guardrail position, staff also modeled estimated savings under each scenario. The savings target for CY 2022 is $267 million. Achieving an annual run rate of $267 million in CY 2022 is crucial as we move to the next phase of Model negotiations because this year will serve as the

[1] During the workgroup process around this recommendation hospital stakeholders suggested using the US Per Capita Cost trends used to project Medicare Advantage increases. This methodology estimates a much higher 9 percent growth for the nation for CY 2022. Staff have concerns about differing from the national estimate that is provided by OACT, which the HSCRC has used as a reference in past years, given that these are projections and there is considerable uncertainty regarding the likely bounce back. As discussed above the approach used in Scenario 1 proved to be an overestimate in CY 2021.

basis for the federal government's evaluation of the Model. Tables 6a-6c below highlight our annual savings or dissavings and anticipated 2022 run rate under each scenario.

Scenario 1 and Scenario 2 estimate that Maryland would miss the savings target for CY 2022, while under Scenario 3 Maryland would achieve the target. This range of outcomes illustrates the considerable uncertainty in the national projections. Given the significant negative consequences to missing the savings target and the material financial reserves accumulated by most hospitals, staff believes that the risk to underfunding in the short term, while additional information on national growth is accumulated, is far less than the risk of providing funding that turns out to be beyond national growth and in turn results in an existential threat to the Model or sudden draconian revenue cuts. Therefore, this recommendation proposes funding inflation as reported by Global Insights for RY 2023 but not does not provide additional funding based on higher prior inflation or anticipated future inflation, at this time.

Of note, the final line item in Table 6a and Table 6b estimate CY2022 savings if we applied the MPA-SC (Medicare Performance Adjustment - Savings Component) to the Medicare portion of the remaining undercharge that will be released in July rate orders. Staff believe that invoking this option would be a path of last resort. In addition, staff believes that the only revenue that would be appropriate to have this applied to would be one-time revenue adjustments, as application to permanent revenue would undercut the all-payer nature of the Model.

Table 6a

Scenario 1 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$81 M
2022 Savings (Run Rate)	$257 M
2022 Savings with One-Time Revenue Adjustments Removed	$292 M

Table 6b

Scenario 2 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$163 M
2022 Savings (Run Rate)	$175 M
2022 Savings with One-Time Revenue Adjustments Removed	$210 M

Table 6c

Scenario 3 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	$29 M
2022 Savings (Run Rate)	$367 M

Staff also modeled the growth and compared it to economic growth in Maryland as measured by the Gross State Product. 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 GSP numbers available (CY18-CY21). The 3-year CAGR calculation shows a per capita amount of 2.22 percent. Staff then compared that number to the 3-year CAGR for Hospital Acute Charges using (CY18-CY22). Staff was able to estimate CY 2022 charges using the proposed RY 2023 update factor. The CAGR for hospital charge growth equated to 3.59 percent. Staff believes using a 3-year comparison of GSP to hospital charges provides a more accurate assessment of affordability. The chart below shows this comparison. While unfavorable, staff would note that given the volatility in the economy over the past few years and the extraordinary actions the Commission and the Federal government took to provide more funding to hospitals during the COVID public health emergency, this analysis should be considered with caution. Moreover, given the unprecedented increases in inflation over the past year that have yet to prove temporal, staff do not believe it is prudent to use prior affordability assessments as a hard cap on global budget revenue allotments in RY 2023.

Table 7

GSP (2018 - 2021)	Hospital Charges (2019-2022)	Variance
2.22%	3.59%	1.38%

Medicare's Proposed National Rate Update for FFY 2023

CMS released its proposed rule for the change to the Inpatient Prospective Payment System's (IPPS) payment rate on April 18, 2022. In the proposed rule, CMS would increase rates by approximately 3.20 percent which includes a market basket increase of 3.10 percent, a productivity reduction of -0.40 percent, and a legislative increase of 0.50 percent. This proposed increase will not be finalized until August 2022 and will not go into effect until October 1, 2022. This also does not take into account volume changes, nor does it take into account projected reductions in Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments as well as potential reductions for additional payments for inpatient cases involving new medical technologies and Medicare Dependent Hospitals.

Inflation Reconciliation Proposal

The annual update factor relies on an estimate of the inflation for the future period being funded. As a result, the approved Update Factor could over- or under-fund inflation for a given period versus the actual experience for that period.

The Commission has not historically adjusted for this because amounts are often small and adjusting inflation for prior estimation error would add additional complexity to the update factor process, it is likely that under- and over-estimates will cancel out over time, and the Commission's mandate is to provide financial stability and not a margin guarantee and therefore it is not necessary to exactly fund inflation in every period, as hospitals can bear some risk for variations between funding and inflation.

Hospital stakeholders have argued that because the inflation estimate used in the RY 2022 update factor was a significant underestimate of actual inflation the Commission should depart from historic practice and provide additional inflation, a "catch-up", in RY 2023, in order to fund full inflation on a permanent basis.

The Commission and staff have been watching inflation and wage and labor cost pressures carefully. In response to concerns raised by the hospital field around rising labor costs, the Commission advanced a one-time increase of $100 million in January 2022, and accelerated the release of prior year undercharges. Additionally, the Governor also made available $30 million to hospitals to support unusually high workforce costs. Finally, an additional $50 million is anticipated to be awarded from the State to hospitals in RY 2023 to further cover workforce demands that have sustained through the year. While these are one-time adjustments to hospital rates, they do provide financial support to hospitals in the short term until more is understood about the permanency of those labor cost increases.

While staff acknowledge that the shortfall of permanent inflation for RY 2022 was much more significant than the variance in prior years, staff are not recommending the Commission reverse historic practice and adopt a catch-up adjustment as of July 1, 2022, because of the availability of extraordinary one-time funding available to hospitals in RY 2022 as mentioned above, pressure on the Medicare guardrail and savings tests documented above, as well as uncertainty surrounding national growth trends.

Instead, staff recommend that the Commission direct staff to convene a stakeholder workgroup and report back to the Commission in November 2022 on (a) a policy for addressing differences between actual and estimated inflation in future update factors within the parameters outlined below (or that such a policy is not required) and (b) a recommendation to the Commission for a reconciliation inflation adjustment for experience through RY 2022 to be applied to hospital rates on January 1, 2023, consistent with the policy developed under item (a), and with the State's savings position and other factors considered in the typical annual update factor process. Staff's bias is that such an adjustment is appropriate but the feasibility of providing such adjustment and the size of the adjustment will depend on the State's savings position, national growth rates and the policy parameters described for the general policy and that by waiting for January 1, 2023, to apply any adjustment the Commission will have better information on these factors.

The parameters for the general policy described in (a) above are:

1. That any policy is two-sided and would apply to both over and underestimates of inflation
2. That any policy looks at cumulative inflation over or under funding since 2013, including consideration of the impact of the PAU inflation adjustment, the infrastructure funding and other permanent funding adjustments as applicable
3. That any policy would have a materiality provision such that an adjustment would only apply when the cumulative under or overfunding of inflation reached a specified threshold (e.g., 0.75 percent)

Stakeholder Comments

In a series of meetings beginning in early CY 2022, HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2023 update.

MHA submitted a proposal that outlined the requested increase of their members. This is outlined below with staff's response in italics.:

1. Fund IHS Market's RY2023 cost inflation, expected to be at least 3.58%
   Staff agree and have updated our tables and projections to include the release of the First Quarter Book from Global Insights. The inflation amount of 3.66 percent is reflected in this recommendation.
2. Make the $100 million advance funding permanent, requiring no repayment
   Staff does not agree. Model tests do not have room to fund additional inflation beyond standard processes.
3. Modify the savings adjustment for potentially avoidable utilization (PAU): A) Set rewards and penalties around a base of 0 percent, measuring year-over-year change; B) Set a statewide average benchmark as hold harmless floor, and apply adjustments to hospitals that exceed the benchmark; and C) Use a national benchmark to set a PAU savings target
   Staff believe that the proposal has merit since global budgets are already an incentive to reduce PAU and PAU inflation cannot theoretically be defunded in perpetuity without adversely affecting core inflation for non-PAU services. However, this assertion rests on the notion that hospitals, primarily due to the incentives of the global budgets, have successfully eliminated almost all avoidable utilization, even independent of the current definition of PAU (30 day readmissions and acute exacerbations of chronic conditions). To date, no data has been provided to suggest that Maryland has grossly surpassed current national performance on current definitions of PAU or other definitions not yet reflected in payment policy (excess imaging, canonical examples of low value care - knee arthroscopy for individuals with osteoarthritis, etc). Therefore, to discontinue the PAU savings adjustment, especially in a year where TCOC guardrails and savings are a concern, does not seem prudent, but staff defer to the judgment of the Commission.
4. Limit the projected reduction in uncompensated care funding
   Staff do not agree. The uncompensated care policy has historically relied on a retrospective statistic of uncompensated care to determine funding. This approach has provided higher than anticipated levels of uncompensated care as the Affordable Care Act and other factors, e.g. lower unemployment, steadily reduced charity care and bad debts. Thus, staff do not believe it is

appropriate to stray from policy in this year purely based on the assertion that uncompensated care will increase due to sunsetting federal stimulus payments. Furthermore, staff believe that the large decline in UCC levels may be due to changing practice patterns that result in an increased utilization of telemedicine, urgent care centers, and other alternatives to emergency room care. As such, staff do not support this request because UCC levels may not rebound.

5. Monitor inflation and Model performance for six months and adjust rates effective January 1, 2023, if conditions permit.
   Staff are committed to working with a workgroup to determine if any additional funding will be appropriate at January 1. Our proposal is outlined in this recommendation.

In addition to the request outlined above, MHA proposed using a much higher national growth estimate when trending forward 2022. These growth rates of 9 percent were mentioned earlier in this recommendation. *Staff do not believe it is appropriate to stray away from the OACT for the national growth projection and the internal projection approaches based on recent trends used in prior years. Office of Actuary projections are projected for Fee-for-Service. The USPCC projections cited by MHA are used in projection MA (Medicare Advantage) increases.*

HSCRC staff will update this section with additional detail for the Final Recommendation after formal comment letters are submitted.

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 2023 update factors.

For Global Revenues:

(a) Provide an overall increase of 2.76 percent for revenue (including a net change to uncompensated care) and 2.89 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target.

Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

(b) Provide all hospitals a base inflation increase of 3.66 percent and apply 0.02 percent of this total inflation allowance based on each hospital's proportion of drug cost to total cost, thereby adjusting hospitals' budgets more equitably for increases in drug prices and high-cost drugs.

(c) Staff be tasked with developing, by November 2022, in accordance with the parameters outlined in this recommendation, a new recommendation to the Commission containing a general policy for adjusting for variations between the actual inflation and estimated inflation in future

update factors or determining such a policy is not needed. In addition, if applicable, the recommendation will include a specific adjustment for cumulative variances from RY 2014 to RY 2022, based on the newly developed general policy, to be implemented in rates on 1/1/2023.

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

(a) Provide an overall update of 3.66 percent for inflation.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Appendix A: Reconciliation of Set Aside for RY 21 and RY 22

As part of the RY 2022 recommendation, Commissioners requested that staff provide a reconciliation of previous years set aside funding. Below is an overview of this request for RY 21 and RY 22.

Distribution of Set Aside for RY 2021			
RY 2021 GBR Revenue		$19,105,021,605	
Set Aside %		0.25%	
Set Aside $		$47,762,554	
Hospital	**Set Aside $ Value**	**Set Aside %**	**Reason**
Mercy	$15,000,000	0.08%	Integrated Efficiency
Suburban	$11,933,939	0.06%	Integrated Efficiency/Capital
Shock Trauma	$2,564,524	0.01%	Shock Trauma Standby
Anne Arundel	$5,270,679	0.03%	Cardiac Program Funding
Statewide	$13,291,872	0.07%	Statewide Vaccination Adj.
Total	$48,061,024	0.25%	

Distribution of Set Aside for RY 2022			
RY 2022 GBR Revenue		$19,638,102,984	
Set Aside %		0.25%	
Set Aside $		$49,095,257	
Hospital	**Set Aside $ Value**	**Set Aside %**	**Reason**
Fort Washington	$6,253,680	0.03%	Integrated Efficiency

Howard County	$12,500,000	0.06%	Integrated Efficiency
Holy Cross	$8,704,705	0.04%	Integrated Efficiency
Anne Arundel	$1,364,501	0.01%	Cardiac Program Funding
Garrett	$2,072,192	0.01%	New Services: LIT, Pain Mgmt, Pop Heath.
Dorchester	$3,400,000	0.02%	Integrated Efficiency
Sinai	$5,500,000	0.03%	Integrated Efficiency (one-time)
Total Used	$39,795,078	0.20%	
Total Remaining	$9,300,179	0.05%	

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Nurse Support Programs I & II

Draft Recommendations for Permanent Renewal for NSP I and

Final Recommendations for NSP II Competitive Institutional Grants Funding

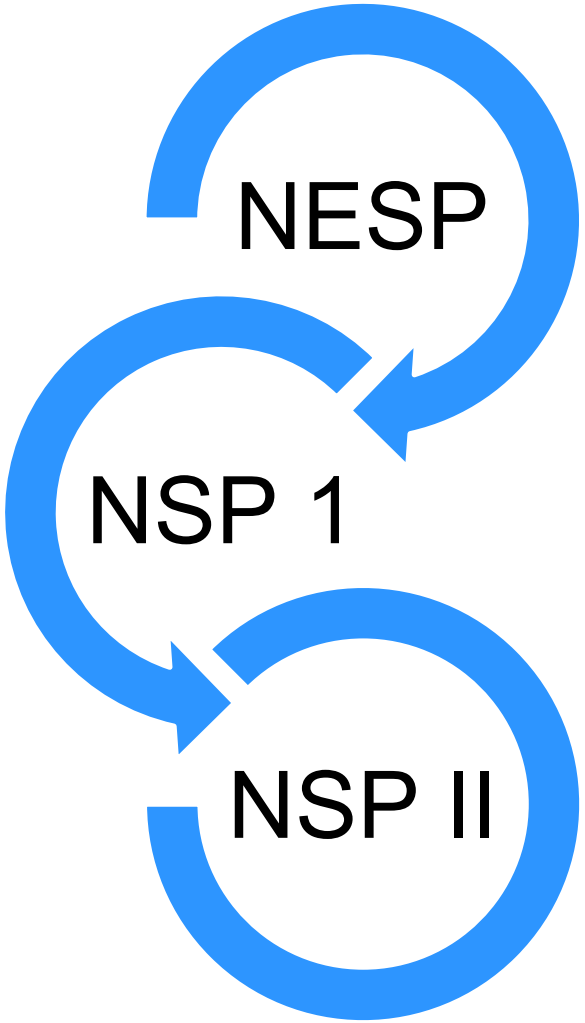
May 11, 2022

Claudine Williams, Deputy Director, MEDA

Ben Quintanilla, NSP I Program Manager, MEDA

Peg E. Daw, NSP II Program Administrator, MHEC

Overview of NSP Programs



Nurse Education Support Program (NESP)

- 1986-1995
- $7 Million in total funding to 37 participating hospitals
- Goal: support college and hospital-based training of Registered Nurses (RNs) and Licensed Practical Nurses (LPNs)

Nurse Support Program (NSP) I

- FY 2001 – Present
- $245.7 M in total funding to 54 participating hospitals
- Administered by HSCRC
- Funded through non-competitive grant equal to 0.1% of hospital total gross patient revenue

Nurse Support Program (NSP) II

- FY 2005 – Present
- $216 M in total funding 27 schools/programs
- Administered by the MD Higher Education Commission (MHEC)
- Funded through pooled assessments totaling up to 0.1 % of hospital regulated gross patient revenue

NSP I and NSP II: Two Sides of the Same Coin

	Nurse Support Program I	Nurse Support Program II

What is the program?	• Non-competitive grant to hospitals to fund projects that address the individual needs of the hospitals as they relate to nurse recruitment and retention.
	• Not intended to fund existing programs
		• Competitive grants comprised of two components:
		  • Competitive institutional grants funds providers of nursing education
		  • Statewide initiatives fund full-time nurse faculty to recruit, retain and develop their long-term career

What are the goals of the program?	• Increase the number of nurses in Maryland through retention and recruitment • Increase the number of nurses with higher levels of education • Improve the clinical competencies of nurses • Elevate the practice of nursing through evidenced-based research	• Increase nursing faculty capacity and diversity • Expand the education pipeline and address barriers to nursing education pathways • Promote innovation in nursing education models

How is the program implemented?	Hospitals are given leeway as to how the programs are implemented, if the programs are aligned with the goals of the NSP I program. Some examples of funded programs/initiatives include:
	  • Nurse Residency Programs
	  • Scholarships for nurses to pursue advanced degrees
	  • Development of nursing leadership and nurse councils
	  • Magnet© Journey or Pathway to Excellence©
	  • Evidenced-based Practice research
		For the Competitive Institutional Grants, Maryland higher education nursing institutions are given leeway as to how the programs are implemented, as long as the programs are aligned with the goals of NSP II. Applicants are encouraged to collaborate, develop partnerships and address current issues in nursing workforce and nursing education. Some examples of funded program/initiatives include:
		  • Creating dual roles for nurse clinicians in teaching and clinical care
		  • Pathways that fast-track qualified students entering nursing education through community colleges to successfully complete their BSN or MSN

State of the Nursing Workforce in Maryland

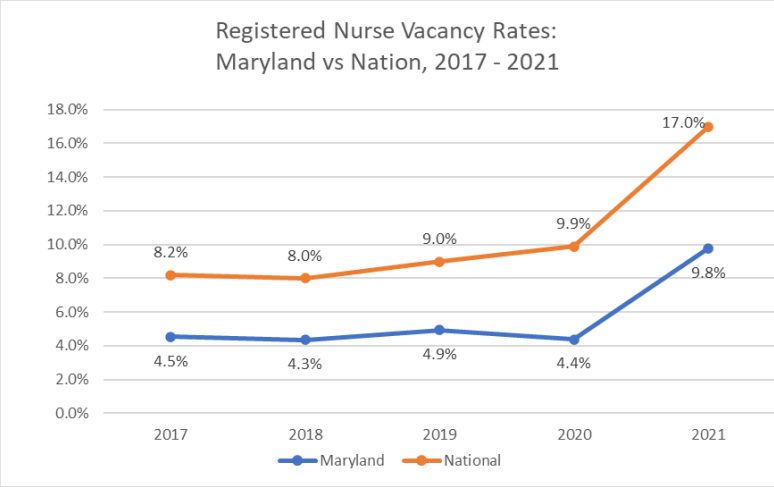
State of the Nursing Workforce in Maryland

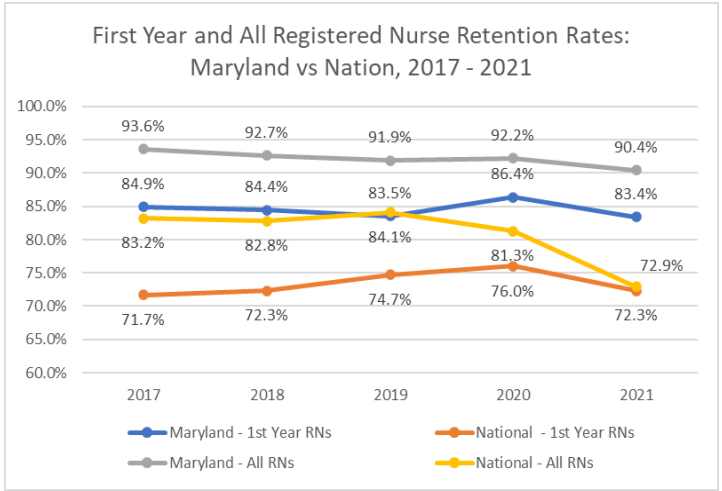
- Maryland has a Location Quotient (LQ) of .94 for nurses, indicating the occupation has a lower share of employment than the national average.
- NSP I Annual report data show agency Nurse usage continues to be high in MD, echoing national trends.
- According to a recent Maryland Nursing Workforce Center survey, nurses are burned out and morale is low.
- Evidenced-based strategies to reduce nurse turnover

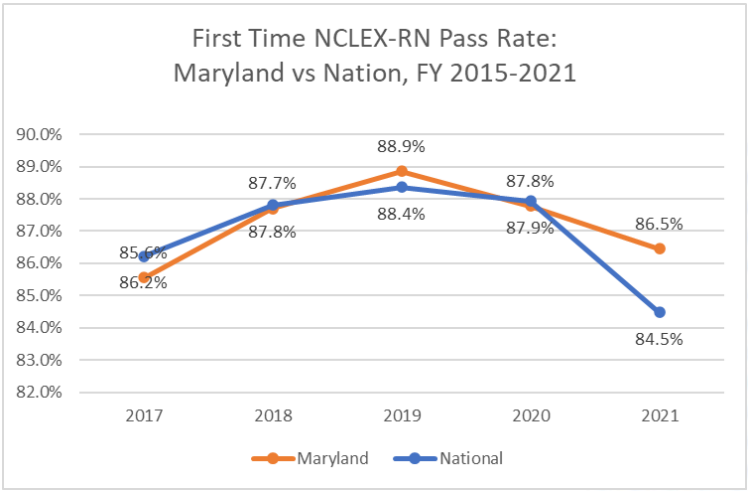
NSP Program Accomplishments

NSP: Major Accomplishments (FY 2017-2022)

- Maintained **lower RN vacancy rates** than the Nation
- Maintained **higher retention rates** than the Nation for RNs, First –Year and Overall
- **Exceeded national average in first-time NCLEX-RN passing rates** since FY 2019







Source: Maryland: NSP I Annual Report Data; National: NSI National Healthcare Retention Report

Source: Maryland Board of Nursing. National Council State Boards of Nursing, and Pearson Vue.

NSP I: Major Accomplishments (FY 2017-2022)

- **Increased** the number of **certified nurses by 10%**
- More than **6,100 newly-licensed and experienced nurses** were funded to participate in **Transition-to-Specialty Care programs**; average completion rate of 89%
- **Over 800** hospital-based **nurses hold BSN and Advanced degrees** with NSP I funding
- **More than half** of MD hospitals have achieved **ANCC Magnet® or Pathway to Excellence®** or currently pursuing these designations
- **Higher percentage of ethnic/racial minority nurses** in Maryland (35%), compared to national average (27%)

Source: Maryland: NSP I Annual Report Data; National: NSI National Healthcare Retention Report

NSP II: Major Accomplishments (FY 2021-2022)

- **Ensured educational capacity for nursing pre-licensure students and graduates** through recruiting additional 97 nurse faculty, and **holding nurse faculty vacancy rates below the national average** (9.2% vs 10.2%, respectively)
- **Advanced academic preparation of entry-level nurses and existing nurses** to meet the needs of hospitals and health systems (80 Percent BSN) by improving time-to-completion of ATB programs and **increasing the proportion of BSN nurses to 67%**
- **Increased the number of nurses and nurse faculty with doctoral degrees by** funding 42 full-time nurse faculty to complete terminal doctoral degrees
- **Promoted academic/practice partnerships and developed statewide resources and models for interprofessional education, alternative clinical practice sites, and clinical faculty preparation** through a variety of initiatives that benefited nurse residents and students, as well as hospitals and nursing programs.

Draft Staff Recommendations for NSP Programs

Staff Recommendation #1: Permanent Continuation of NSP I

- Currently, the Commission votes to continue the NSP I program every 5 years
- This is an HSCRC policy and there is no statute requiring the Commission to reauthorize the program every 5 years
- To streamline the process, staff proposes that the Commission authorize the NSP I program to receive permanent funding, beginning in FY 2023.
- Staff proposes to provide annual reports to the Commission on funded activities and successes.

Staff Recommendation #2: Increase Funding for NSP to .2%

- **Increase funding** in future fiscal years (if unable to increase funding due to current guardrail constraints) for proven initiatives that have shown to increase retention and reduce vacancies.
- **Develop initiatives to address health disparities** by increasing the number of minorities and men in all nursing roles. Specifically, NSP I programs can implement initiatives to:
  - Increase the number of minority and male mentors and preceptors
  - Increase the number of minority and male nurses in leadership positions.
  - Develop recruitment strategies to target racial/ethnic minorities, particularly in areas with high minority populations.
- **Fund programs specifically aimed at Licensed Practical Nurses (LPN)** for internal and external continuing education, leadership/preceptor/mentorship programs, as well as **more funding for advanced nursing degrees and specialty practice programs**.

Staff Recommendation #2: Increase Funding for NSP to .2%

- **Expand *Lead Nursing Forward* website** to market nursing as a positive career choice and share newly created, emotional intelligence self-assessments and core skills modules
- **Enhance clinical simulation** with virtual reality and other updates
- **Expand second-degree programs** and inter-professional education (IPE) opportunities
- **Provide grants to hospital-based educators** unable to complete service agreements in exchange for time in an in-house pool of graduate degree prepared nurse educators, and available to the hospital education departments as preceptor, mentor, or assist with other educational assignments within their current roles

Staff Recommendation #3: Explore Other Sources of Funding

- **Explore additional funding** available through the legislation:
  - **HB 625 / SB 440:** Commission to Study the Health Care Workforce Crisis in Maryland – Establishment
  - **HB 1208:** Health Occupations - Health Care Workforce Expansion
  - **SB 518 / HB 821:** Career Pathways for Health Care Workers Program
  - **SB 696 / HB 975:** Maryland Loan Assistance Repayment for Nurses and Nursing Workers - Program Establishment and Funding
  - Portion of **$50M from Supplemental Budget Amendment No. 13**

Final Staff Recommendations for NSP II

NSP II: Final Staff Recommendations For Funding

Proposal	School	Title	Total Funding Request
NSP II-23-101	Allegany College of Maryland	Evening Cohort Expansion	$749,215
NSP II-23-104	Anne Arundel Community College	Expanding Nursing Capacity	$444,652
NSP II 23-110	Salisbury University	Lead Nursing Forward Cont.	$617,392
NSP II 23-111	Towson University	Entry Level MSN	$1,258,176
NSP II 23-112	University of Maryland Global Campus	Implementing ATB Program	$742,510
NSP II 23-201	Coppin State University	Resource Grant NGN	$25,535
NSP II 23-202	Howard Community College	Resource Grant NGN	$83,575
NSP II 23-203	Johns Hopkins University	Resource Grant NGN	$55,029
NSP II 23-204	Notre Dame of Maryland University	Resource Grant NGN	$10,172
NSP II 23-205	Prince George's Community College	Resource Grant NGN	$46,350
NSP II 23-206	Towson University	Resource Grant NGN	$27,000
NSP II 23-207	Washington Adventist University	Resource Grant NGN	$16,161
NSP II 23-208	Wor-Wic Community College	Resource Grant NGN	$26,080
TOTAL			**$4,101,847**

Appendix: Charts and Graphs

Nursing Shortage: Maryland vs Nation

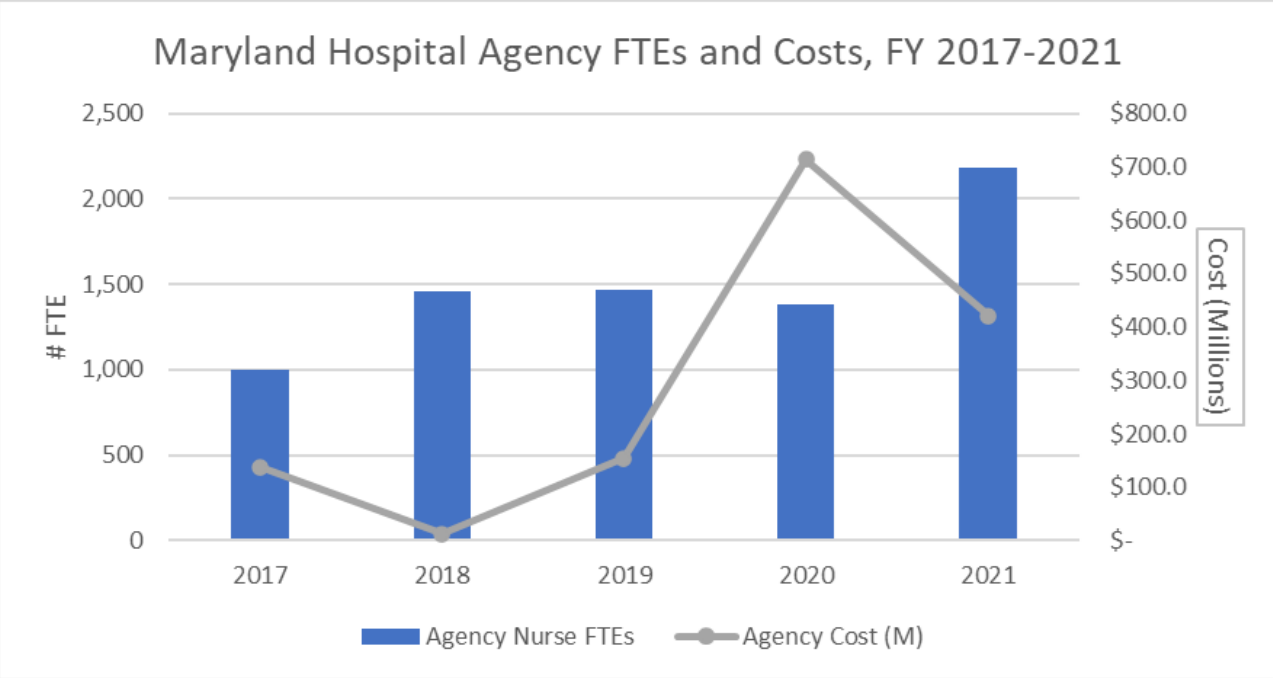
Location Quotient (LQ) quantifies how concentrated the nursing industry is in this region as compared to the nation. A LQ less than one (1) indicates the occupation has a lower share of employment than average.

	Location Quotient (LQ)	RN Employed	Annual Mean Wage	Cost of Living Compared to US
Maryland	**0.94**	**51,550**	**$82,660**	**21.01%**
West Virginia	1.39	19,800	$67,640	0.68%
Delaware	1.25	11,760	$77,760	7.04%
Pennsylvania	1.24	149,270	$76,000	5.73%
New Jersey	0.94	77,980	$89,690	14.03%
Virginia	0.83	66,980	$76,680	4.86%

Source: US Bureau of Labor Statistics, May 2021 and Insure.com

Agency Nurses: Impact of COVID on Nursing Workforce

Agency Nurse usage continues to be high in MD and nationally.



Pre-COVID, average agency nurse cost were $101.4M, compared to post-COVID of $567.4M

Source: NSP I Annual Report Data

Impact of COVID on Maryland's Nurses

According to a recent Maryland Nursing Workforce Center survey, nurses are burned out and morale is low…

- **48%** had experienced **sleep disturbances**,
- **40%** experienced moderate to **severe stress**
- **48%** percent felt **anxious**
- **43%** were unable to control **worrying**, felt **hopeless**, and had **little pleasure** in usual things
- **Almost 50%** had symptoms of **burnout**
- **62%** felt their **physical health and safety were compromised** without their consent
- **More than 60%** indicated an **intent to leave their current nursing job**

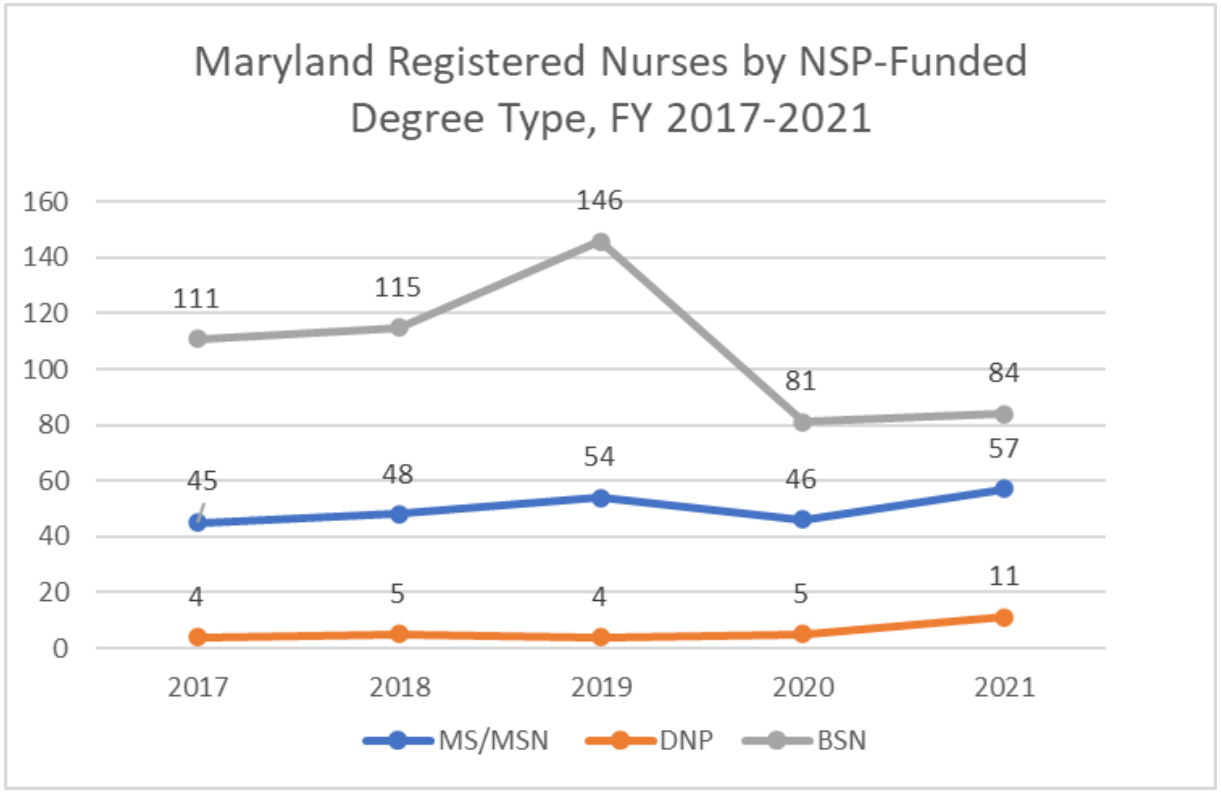
How to Address the Needs of Nurses?

Evidenced-based strategies to reduce nurse turnover

- **Reducing overtime** and eliminating mandatory overtime.
- **Developing shared governance programs** that give nurses a voice in scheduling, workflows, and hospital policies.
- **Ensuring adequate nurse staffing levels** and supporting acuity-based staffing tools.
- **Recognizing nurses' need for work-life balance**.
- **Encouraging and developing a workplace culture** of collaboration between nurses and physicians.

Source: American Sentinel College of Nursing & Health Sciences at Post University ,The Sentinel Watch, 2020

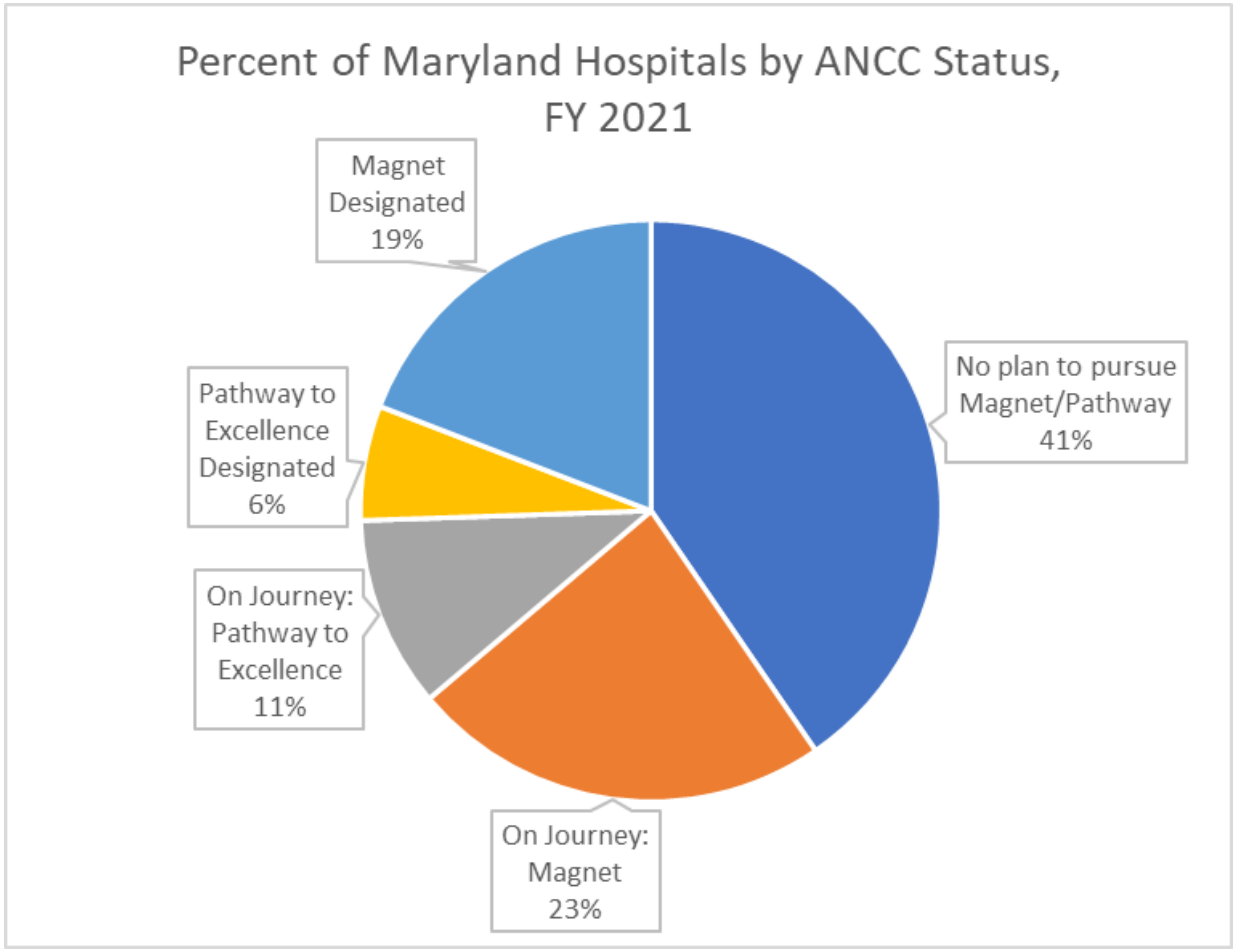
NSP I: Major Accomplishments (FY 2017-2022)



Source: NSP I Annual Report Data

- **Increased** the number of **certified nurses by 10%**
- More than **6,100 newly-licensed and experienced nurses** were funded to participate in **Transition-to-Specialty Care programs**; average completion rate of 89%
- **Over 800** hospital-based **nurses hold BSN and Advanced degrees** with NSP I funding

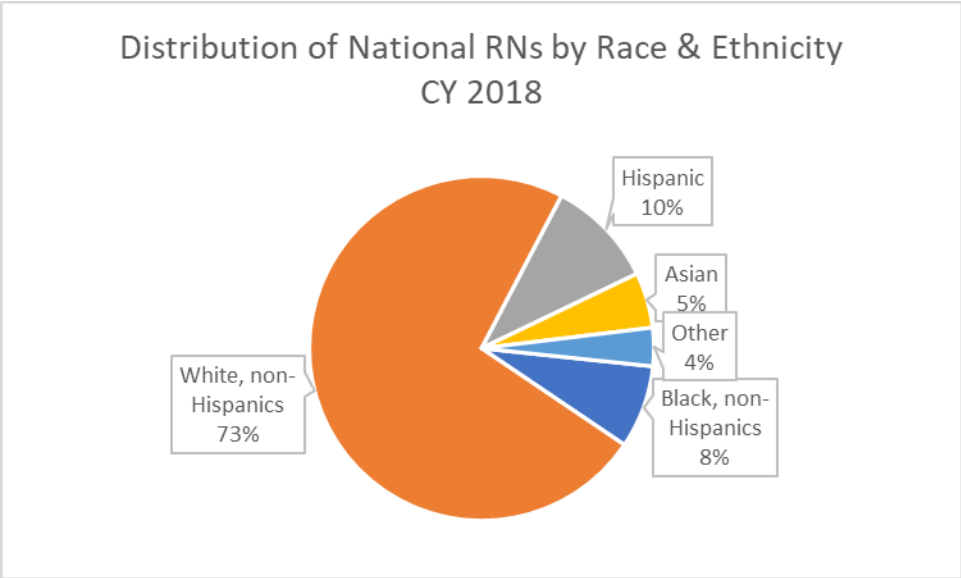
NSP I: Major Accomplishments (FY 2017-2022)



Source: NSP I Annual Report Data

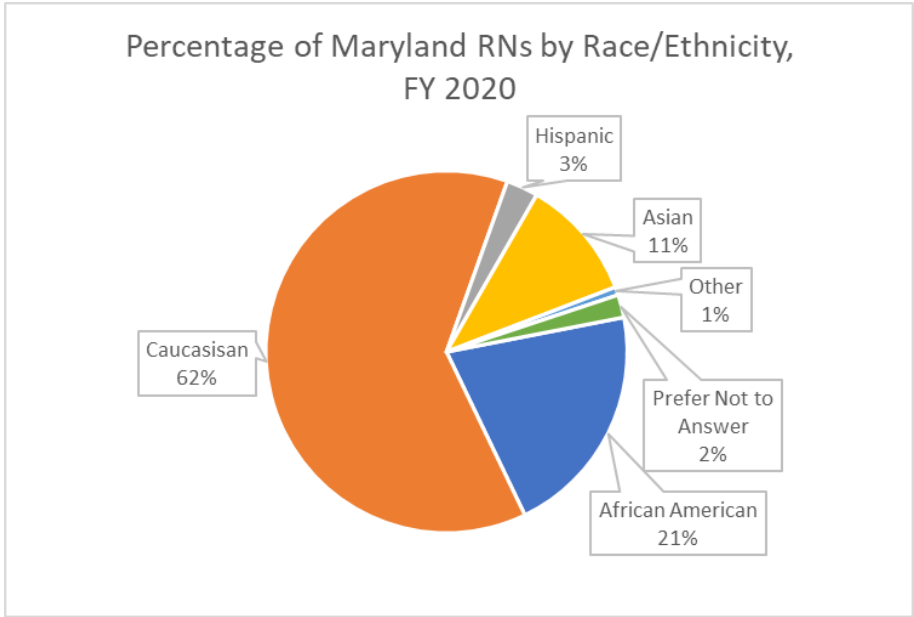
More than half of MD hospitals have achieved **ANCC Magnet® or Pathway to Excellence®** or currently pursuing these designations

NSP I: Major Accomplishments (FY 2017-2022)



Source: 2018 National Sample Survey of RNs (HRSA, 2019)

Higher percentage of ethnic/racial minority nurses in Maryland (35%), compared to national average (27%)



Source: NSP I Annual Reports, FY 2020

NSP II: Major Accomplishments (FY 2021-2022), cont.

Successful Academic/Practice Partnerships

- **Utilized the partnership with the Maryland Nurse Residency Collaborative for Transition to Practice and Universal Onboarding programs** benefiting nurse residents, hospitals, nursing programs and nursing students.
- **Expanded the Renewal, Resilience and Retention (R^3) of Maryland program** as a resource for academia and clinical nurses; 20 shared R-3 modules on the new website.
- **Implemented monthly NSP I and NSP II Advisory Group meetings** to increase synergy, collaboration and engagement in both programs
- Over the past 2 years, **80 new Fellows completed** the intensive year-long **Nurse Leadership Institute (NLI) program** that address a variety of leadership skills including effective communication, team and relationship management, and finance, health policy and economics.

Source: American Sentinel College of Nursing & Health Sciences at Post University ,The Sentinel Watch, 2020

NSP II: Major Accomplishments (FY 2021-2022), cont.

Funded Statewide Resources and Models

- **Developed a series of Next Generation (NGN) NCLEX-RN workshops** to prepare all pre-licensure nursing programs for changes in the licensure examination set for Spring 2023.
- **Provided funding for over 150 educators to participate in the statewide Maryland Clinical Simulation Resource Consortium (MCSRC)**, a program designed to increase the quality and quantity of simulation used in nursing education.
- **Provided 6 NLN Certified Nurse Educator (CNE) Workshops** to prepare faculty for national examination and **increased the number of faculty credentialed as CNE's by 76**. The goal has been reset to double by 2025.

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Nurse Support Program II

Competitive Institutional Grants Program

Review Panel Recommendations for FY 2023

May 11, 2022

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Table of Contents

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Introduction

This report presents recommendations for the Nurse Support Program II (NSP II) Competitive Institutional Grants Review Panel for Fiscal Year (FY) 2023. The staff of the Maryland Higher Education Commission (MHEC) and the Maryland Health Services Cost Review Commission (HSCRC or Commission) jointly submits this final report and recommendations for approval by the HSCRC. The FY 2023 NSP II recommendations align with the NSP I and II overarching goals of excellence in nursing practice and education.

Background

The HSCRC has funded programs to address cyclical nursing workforce shortages since 1986. In July 2001, the HSCRC implemented the hospital-based NSP I to address the nursing shortage impacting Maryland hospitals. Since that time, the NSP I completed three five-year program evaluation cycles, with the next renewal due by June 30, 2022.

The HSCRC established the NSP II on May 4, 2005, to increase Maryland's academic capacity to educate nurses. Provisions included a continuing, non-lapsing fund with a portion of the competitive and statewide grants earmarked for attracting and retaining minorities in nursing and in nurse faculty careers in Maryland. 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 statewide initiatives. MHEC was selected by the HSCRC to administer the NSP II programs as the coordinating board of higher education. After the conclusion of the first ten years of funding, the HSCRC continued to renew the NSP II funding, through June 30, 2025.

Since its inception, the NSP II program has gone through several revisions:

- The *Annotated Code of Maryland, Education Article § 11-405 Nurse Support Program Assistance Fund [2006, chs. 221, 222]* was amended in 2016 to delete

"bedside" to ensure the best nursing skills mix for the workforce was not limited to just bedside nurses.

- In 2012, the NSP II program was modified to include support for development of new and existing nursing faculty through doctoral education grants. Revisions to the Graduate Nurse Faculty Scholarship (GNF) included renaming the nurse educator scholarship in honor of Dr. Hal Cohen and his wife Jo, and sunsetting the living expense grant component.
- In 2012, the NSP I and NSP II initiatives were aligned with the National Academy of Medicine (NAM), formerly the Institute of Medicine, Future of Nursing report recommendations (2010). Recently, the NAM released the Future of Nursing 2020-2030 to chart the path over the next decade. The NSP I and NSP II Advisory Group met to consider how the new recommendations should be incorporated into the NSP programs and agreed that nurse retention should be the critical takeaway item to focus the joint efforts.
- In Spring 2020, the GNF was renamed the Cohen Scholars (CS) program. Additionally, the evaluation responsibility for this program was transitioned from the MHEC Office of Student Financial Assistance to the NSP II staff for future oversight. During the transition, NSP II staff clarified the NSP II eligible service facilities and standardized the teaching obligation for all GNF/Cohen Scholars.

Nursing Workforce Trends: Maryland vs Nation

The registered nurse (RN) workforce is the single largest group of health professionals, with more than four million nationally and 51,550 RNs employed in Maryland (US Bureau of Labor Statistics, 2021). To better understand whether Maryland's nursing shortage is unique, researchers use a Location Quotient (LQ) to quantify how concentrated the nursing industry is in this region as compared to the nation. A LQ greater than one (1) indicates the occupation has a higher share of employment than average. Although Maryland's share of nurses (LQ=.94) is slightly less than the national average, LQs for specific specialties (Nurse Practitioners (0.83), and Nurse Anesthetists (0.61) suggest supply shortages in these areas. The Bureau of Labor Statistics data

indicate the annual mean wage in Maryland is notably higher than five out of six neighboring states, however, the cost of living (COL) comparison reveals that Maryland is also one of the 10 most expensive states to live in and exceeds all neighboring states COL (insure.com) (Table 1).

Table 1. RN Employment and Wages for Maryland and Neighboring States, 2021

	Location Quotient (LQ)	RN Employment	Annual Mean Wage	Cost of Living Compared to US
Maryland	0.94	51,550	$82,660	21.01%
West Virginia	1.39	19,800	$67,640	0.68%
Delaware	1.25	11,760	$77,760	7.04%
Pennsylvania	1.24	149,270	$76,000	5.73%
New Jersey	0.94	77,980	$89,690	14.03%
Virginia	0.83	66,980	$76,680	4.86%

Source: US Bureau of Labor Statistics, May 2021 and Insure.com.

Nursing Workforce Trends: Entry-to-Practice in Maryland

According to researchers, caution should be used when the basis of policy modeling and decision making is employment trends, as nursing shortages are highly sensitive to multiple variables and complex to pinpoint beyond regional trends. A better reflection of the state of Maryland's workforce may be trends related to RN entry-to-practice, as it is the most important factor affecting projections of the nursing workforce supply (Auerbach, et al., 2017, pg. 294). In Maryland, the best indicator of entry-to practice is first-time passing rates for the National Council Licensure Examination – Registered Nurse (NCLEX-RN), available through the Maryland Board of Nursing (MBON).

Maryland continues to exceed the nation in first time NCLEX-RN passing rates (Table 2). The upward trend is expected to continue through FY 2023 due, in part, to funding the expansion of existing programs, Licensed Practical Nurses (LPN) to RNs and second-degree BSN options, a new MS-entry program, and increasing enrollment in new programs with evening cohorts.

Starting in Spring 2023, entry-to-practice nursing graduates will be tested using the Next Generation NCLEX (NGN) for registered nursing licensure. This format focuses on clinical judgment and includes a variety of question types with related case studies that go

beyond the usual multiple-choice options. Maryland Deans and Directors of Nursing Programs requested additional resources to prepare faculty and students for this change, and NSP II funded free workshops utilizing in-state faculty with expertise. Additional workshops are scheduled for June 2022.

Table 2. Maryland's First Time NCLEX-RN Rates, FY 2015 – 2021

Fiscal Year	Maryland BSN Programs		Maryland ADN Programs		Maryland MS Entry Programs		Total For All Maryland Programs		Passing Rates	
	No. Tested	No. Passed	No. Tested	No. Passed	No. Tested	No. Passed	No. Tested	No. Passed	MD	US
2015	1,207	930	1,658	1,355	70	64	2,935	2,349	80.03%	82.53%
2016	1,158	957	1,557	1,291	44	37	2,759	2,285	82.82%	83.94%
2017	961	806	1,457	1,252	163	150	2,581	2,208	85.55%	86.22%
2018	773	676	1,316	1,145	261	240	2,350	2,061	87.70%	87.81%
2019	867	743	1,375	1,245	305	275	2,547	2,263	88.85%	88.36%
2020	775	650	1,467	1,299	304	286	2,546	2,235	87.78%	87.93%
2021	926	755	1,376	1,218	362	330	2,664	2,303	86.45%	84.48%

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 US jurisdiction.*

Nursing Licensure Trends: BLS vs MBON Data

In 2019, the MBON reported 81,238 RNs and 8,903 Advanced Practice Nurses (APRNs) were licensed in the state (MMWC, 2022). This differs significantly from data from the US Bureau of Labor Statistics (BLS), which reported 51,550 RNs and 4,250 APRNs in 2021. There is no obvious explanation for the difference in these figures, Previous evaluations of the NSP programs have acknowledged there were limitations to the data collected by MBON. For instance, only renewals were completed online, and each new entry erased earlier data on the nurse.

Attempts to fund new electronic systems were postponed or derailed by competing budget priorities. In December 2021, the MBON experienced a cyber-attack that continues to impact services despite adding 20 new employees and a dedicated technology team. Ongoing discussions about delays in licensure verification, and renewals, as well as barriers experienced by nursing students trying to secure certificates to work as nursing assistants has solidified the importance of the MBON to be fully

resourced to operate at a high level of responsiveness. These concerns are impacting hospitals, nursing programs, RNs, and ultimately, patients.

Nursing Workforce Trends: Maryland New Graduate Retention

As a nationally recognized leader in nurse residency programs, Maryland became the first state in the US to have all acute care hospitals fund and offer nurse residency programs (NRPs) for new nurse graduates in 2018. The purpose of the residency program is to build upon nursing school's foundational knowledge to smoothly transition new nurses into professionals and retain them in the workforce. Between 2013 and 2016, retention rates for Maryland hospitals offering an NRP ranged between 91 to 93 percent. High retention rates resulted in significant cost savings to participating hospitals; the average cost to replace one RN ranges from $40,038 to upwards of $88,000 (NSI, 2021; Jones, 2008). Prior to the coronavirus pandemic, Maryland hospitals overall retained more than 88 percent of their new to practice nurses annually (Table 3) compared to an average of 76 percent nationally (NSI, 2021). Moreover, hospital leaders and nurse residents report they are more confident and competent after completing their 12-month nurse residency program, resulting in better-prepared nurses and significant hospital cost savings.

Not unexpectedly, the retention rate declined in 2020 due to the coronavirus pandemic. Although the retention rate for 2021 so far appears promising (91 percent), this data is incomplete due to lags in reporting. Additionally, staff shortages and safety requirements forced more than half the hospitals to stop their residency programs in April 2020. The Collaborative hospitals are reinvigorating their programs in 2022. However, persistent staff shortages continue to impact these programs for nurse residents.

Table 3. MNRC Data on Retention of New Nurse Graduates, CY 2017-2021

	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Number of Residents Hired	1,573	1,513	1,846	1,995	2,417
Percent of Residents Terminated	8%	12%	11%	17%	9%
Retention Rate	92%	88%	89%	83%	91%

Source: Vizient/ AACN NRP Data for MONL, Inc. /MNRC, April 20, 2022

Maryland Nursing Workforce Center Registered Nurse Survey Results

Recent surveys have demonstrated, both nationally and in Maryland, that nurse well-being and their intent to remain in the profession were being negatively affected by pandemic-related stress, staffing levels, working conditions, increased violence in the workplace, and day-to-day uncertainties with changing patient acuity. In a three-part longitudinal study, the American Organization for Nursing Leadership (AONL) documented continually worsening job satisfaction, burnout, and intent to leave the profession by nursing leaders. A 2021 Washington Post-Kaiser Family Foundation survey found that 30 percent of healthcare workers are considering leaving their profession altogether. Exacerbating the losses is the imminent retirement of all baby boomers that will reach the traditional retirement age of 65 by 2030, leaving a gap in accumulated skills, knowledge, and experience. Unfortunately, this loss in the RN workforce coincides with the increased healthcare needs of our aging population who have more acute and chronic conditions.

In a recent report entitled *Analysis of COVID-19 Impact on the Maryland Nursing Workforce* Survey, the Maryland Nursing Workforce Center (MNWC) wrote:

> *"As of December 2021, several Maryland hospitals had enacted crisis standards of care, a framework for the gradual degradation of health care services when there are not enough resources available to meet the demand for care. Maryland hospitals have plenty of beds but not enough available nurses to cover them. Nurses have become a scarce resource during the pandemic, putting patients at risk. As the Omicron variant pushes the nation into year three of the pandemic, nurses are physically, mentally, and morally exhausted and are leaving the employment situations in large numbers. Hospitals in Maryland are facing a severe shortage of RNs and many have had to contract with nursing staffing agencies for temporary contractual "travel" nurses"* (Excerpt, MNWC 2021, pg. 9).

For the report, MNWC surveyed nearly 2,000 nursing staff and the results are concerning, many respondents reporting that they were physically exhausted. Additionally:

- 48 percent had experienced sleep disturbances,
- 40 percent experienced moderate to severe stress,

- 48 percent felt anxious,
- 43 percent were unable to control worrying, felt hopeless, and had little pleasure in usual things, and
- 49 percent had symptoms of burnout.

Furthermore, about 62 percent of nurses felt their physical health and safety were compromised without their consent, and more than 60 percent indicated an intent to leave their current nursing job.

When asked what would make them more willing to remain in the Maryland nursing workforce, 83 percent said that financial incentives with salary increases, annual bonuses, hazard pay, and/or increased retirement contributions, while 74 percent indicated improved staffing and nurse to patient ratios, the ability to self-schedule and flexibility in shift work would make a difference. Other motivators were acknowledgements, wellness resources, and personal protection during large-scale emergencies. The NSP I and NSP II Advisory Group have reviewed and will incorporate this information into their efforts. Hospital executives and nursing leaders are encouraged to review and consider its recommendations for staff retention strategies.

NSP II Program and Recommendations

New NSP II Programs

Transition to Nurse Residency Program (TNRP)

Safety concerns and the strain on hospital resources due to the pandemic necessitated halting on-site student clinical experiences in March 2020. In response, a statewide task force of Maryland hospital and academic leaders was formed to develop onboarding strategies for new nurses transitioning into practice (Warren, et al., in press). Members used data from an environmental scan, as well as national and local best practices, to build an innovative curriculum to help hospitals onboard new nurses graduates who had their education disrupted by this unprecedented healthcare crisis.

The goal of the Transition to Nurse Residency Program (TNRP) is to restore the skills and competencies of new-to-practice nurses to pre-pandemic levels. The TNRP does not duplicate nor replace NRP; rather, it is a precursor to the NRP offered at onboarding and before new-to-practice nurses assume patient assignments. Since its creation, more than half of Maryland hospitals have implemented the program, and most are using NSP I funding to support it.

Nurse Resiliency Programs

NSP II partnered with the Maryland Organization of Nurse Leaders, Inc./Maryland Nurse Residency Collaborative (MONL Inc. /MNRC) on the NSP II-funded R^3 – Renewal, Resilience, and Retention of Maryland Nurses Program in FY 2021. The program engaged 50 Faculty Champions in three cohorts from eight Maryland Schools of Nursing to participate in the 2021-2022 R^3 faculty training workshops. The first workshop provided opportunities for nurse faculty to practice a variety of self-stewardship tools and skills, fostering a renewed commitment to the profession and their roles. In early 2022, a second workshop offered the Champions access to 20 modules (developed by the R^3 team and available on their website) to integrate resilience, integrity, and ethical practice content into existing curricula for pre-licensure nursing students.

Through this NSP II-funded program, NRP coordinators participated in immersion workshops and were trained using evidence-based resilience tools, practices, and resources. Ultimately, this program will enhance the residency curriculum and equip residents with successful strategies to strengthen their resiliency and well-being. At this year's annual R^3 Conference in April 2022, participants representing Maryland hospitals, schools of nursing, the Maryland Nurses Association (MNA), MHEC, National League for Nursing (NLN), and the Department of Defense were in attendance.

Universal Onboarding

NSP II also partnered with MONL, Inc. /MNRC and MNWC on a NSP II grant to offer nursing students an online universal onboarding training system. Learning Management System (LMS) platform will enable students from nursing schools

throughout Maryland to access the modules, and administrative and instructional design support. MNWC developed the content through hospital practice and nursing education RN volunteers.

The Maryland Deans and Directors of Nursing Programs requested the platform to streamline the nursing student onboarding process which would address any individual hospital's requirements; saving money and time for hospitals, students, and programs. By July 1, 2022, hospitals will complete their final review of the seven Joint Commission-required modules and will be used by students enrolled in the Fall 2022 semester. The goal is to have all Maryland nursing school students complete this training annually, reducing redundant work and increasing opportunities for clinical experiences.

NSP II Program Updates

Progress on "80 Percent BSN by 2025" Goal

In 2021, the proportion of BSN or higher prepared nurses increased to 67 percent (RWJF, 2021), making steady progress towards achieving the 80 percent goal of nurses holding a BSN by 2025. To reach this goal, NSP II funded Associate to Bachelor's (ATB) programs to streamline entry-level education options for nursing students, combining pre-licensure completion at the community college and dual enrollment and curriculum alignments at the university. This program has significant benefits to students by saving both money and the time to complete the Bachelor of Science in Nursing (BSN) degree. In addition, RN-BSN programs expanded online and hybrid delivery options. Finally, second-degree students who successfully completed a BS degree in a different career path were offered an accelerated individualized program to complete their BSN in 12 to 15 months and enter nursing. Ongoing research findings confirms a hospital's proportion of BSN nurses, regardless of educational pathway, are associated with lower odds of 30-day inpatient surgical mortality (Porat-Dahlerbruch, et al., 2022). Different educational pathways to the BSN are noted to increase accessibility and promote greater RN diversity.

Nurse Faculty Workforce

Overall, the outlook for Maryland faculty is outpacing the nation and has remained stable. According to data collected for the NSP II program, Maryland's nurse faculty vacancy rates increased slightly from an average of 8.1 percent between the 2015-2017 academic years (AY), to an average of 9.2 percent between the AY 2019-2021; still below the average vacancy rate for the US (10.2 percent) for AY 2021-2022 (AACN, 2021). NSP II program data between AY 2017- AY 2021 demonstrated an increase of 111 full-time faculty at both community colleges and universities (for a total of 629), which tracks along with the MBON figures from a decade ago (Table 4).

Table 4. Changes in Maryland Nurse Faculty Vacancy, AY 2015 - 2021

	FT Faculty	FT Faculty Vacancy	% FT Faculty Vacancy
AY 2015-2017 (N=25)	518	42	8.1%
AY 2019- 2021 (N=26)	629	58	9.2%
Difference (increase/(decrease))	111	16	1.1%
AACN US Faculty Vacancy Rate (AY 2020-2021)			10.2%

Source: NSP II Mandatory Data Tables for Nursing Program Comparison April 13, 2022, AACN faculty vacancy information

The number of doctoral-prepared faculty increased by 12.5 percent in 2021. In Maryland nursing programs, the majority (61.5 percent) of faculty were doctoral prepared, compared to the national data where only 13 percent of faculty holds a graduate degree, and fewer than 1 percent hold a terminal doctoral degree.

Aging of the nursing workforce continues to be a state and national concern. The number of FT faculty aged 60+ increased in Maryland nursing programs. The AONL Guiding Principles for the Aging Workforce outlines how employers can invest in the productivity of the older RNs including:

- Adapting work environments: providing environmental modifications for injury prevention; reducing the physical demands with bedside computers, automated beds, and non-professional staff assistance,

- Re-designing jobs: developing new and emerging roles; promoting a culture that supports older nurses and post-retirement options to avoid leaving gaps in advanced skill levels and years of expertise at the bedside.
- Other incentives: generational motivators in health benefits, and flexible schedules

Older RNs are needed to guide new nurses and maintain patient safety and quality of care.

Increased Certification of Nurse Faculty

Maryland has 520 CNE credentialed nurses and ranks eighth nationally and internationally for the total number of CNE credentialed faculty (L. Simmons, NLN, 4/14/22), however, this figure includes part-time and retired nurses, as well as nurses who reside in Maryland but work in a neighboring state. According to the NSP II Data, the percent of faculty holding CNE credentials increased by 9.9 since AY 2015, with an average of 23.6 percent of the 629 full-time faculty at the 26 Maryland nursing programs participating (Table 5), exceeding the goal of doubling the number of faculty by 2025.

Table 5. Changes in Maryland Nurse Faculty CNE Completion, AY 2015 - 2021

	FT Faculty	FT with CNE	% FT with CNE
AY 2015-2017 (N=25)	518	65	12.6%
AY 2019- 2021 (N=26)	629	141	22.4%
Difference (increase/(decrease))	111	76	9.9%
Total # of CNE in MD (NLN, 2022)		520	

Source: NSP II Mandatory Data Tables for Nursing Program Comparison April 13, 2022 & personal communication with NLN, L. Simmons, April 14, 2022

The goal is now reset to target 50 percent of Maryland full-time faculty holding the CNE by 2025. This will include first-time credentialed and existing CNEs completing the required continuing education and advancement as an educator to maintain the credential, renewed every 5 years. There is already a NSP II FY 2022 funded project to promote the CNE-Clinical with professional development. Faculty recruitment efforts should include these previously untapped CNE credentialed nurses, who with their proven expertise, would be an excellent resource to institutions, and encourage early career educators to move into full-time roles.

Staff Recommendations for the Competitive Institutional Grants Program

Competitive Institutional Grants Program

The Competitive Institutional Grants Program builds educational capacity and increases the number of nurse educators to adequately supply hospitals and health systems with well-prepared nurses. The FY 2023 NSP II Review Panel was composed of eight members with backgrounds in healthcare, regulation, nursing education, and hospital administration, and included former NSP II project directors, NSP I and NSP II staff members.

Staff Recommendation: HSCRC and MHEC staff recommend the following thirteen proposals presented in Table 6 for the FY 2023 NSP II Competitive Institutional Grants Program. This final recommendation describes the panel's recommendations for Commission approval.

Table 6: FY 2023 Recommendations for Funded Proposals

Proposal	School	Title	Total Funding Request
NSP II-23-101	Allegany College of Maryland	Evening Cohort Expansion	$749,215
NSP II-23-104	Anne Arundel Community College	Expanding Nursing Capacity	$444,652
NSP II 23-110	Salisbury University	Lead Nursing Forward Cont.	$617,392
NSP II 23-111	Towson University	Entry Level MSN	$1,258,176
NSP II 23-112	University of Maryland Global Campus	Implementing ATB Program	$742,510
NSP II 23-201	Coppin State University	Resource Grant NGN	$25,535
NSP II 23-202	Howard Community College	Resource Grant NGN	$83,575
NSP II 23-203	Johns Hopkins University	Resource Grant NGN	$55,029
NSP II 23-204	Notre Dame of Maryland University	Resource Grant NGN	$10,172
NSP II 23-205	Prince George's Community College	Resource Grant NGN	$46,350
NSP II 23-206	Towson University	Resource Grant NGN	$27,000
NSP II 23-207	Washington Adventist University	Resource Grant NGN	$16,161
NSP II 23-208	Wor-Wic Community College	Resource Grant NGN	$26,080
TOTAL			**$4,101,847**

These highly recommended proposals include:

- Continuation of the successful *Lead Nursing Forward* program to provide a site for the public and nurses to seek more information on a career in nursing, nursing

education, and connect job seekers with employers free of charge to MD hospitals and nursing programs.

- Increasing enrollment in the Anne Arundel Community College nursing program by 114 pre-licensure nursing students.
- Developing a new evening cohort of nursing students at Allegany College of Maryland for 60 additional pre-licensure RNs.
- Implementing the Master of Science (MS) Entry to Practice nursing program at Towson University for an additional 80 second-degree MS-Entry to practice RNs.
- Assisting 8 nursing programs at universities and community colleges with the resources (exam software, testing, and tools) to prepare students for the NGN Licensure Examination starting Spring 2023.
- Implementing an Associate-to-Bachelor's program to the existing RN-BSN program at University of Maryland Global Campus, for 50 additional BSNs.

Future Funding Considerations

Based on the available data presented in this report, there is a demonstrated need to increase funding for the NSP II program. **If the Commission were to approve an additional .1 percent in total patient revenue for the NSP II program**, NSP I and NSP II Advisory group discussed potential opportunities to expand or create new NSP II programs, such as:

- Utilizing the well-established *Lead Nursing Forward* Platform to market nursing as a positive career choice, while portraying realistic visuals to motivate young students entering high school to pursue science backgrounds. An estimated $2 million could be used to develop high-quality, personalized videos and tools. In addition, the Platform could be expanded to share newly created, emotional intelligence self- assessments and core skills. These modules teach empathy and communication skills, improving social skills of users through the innovative use of social media. With an estimated investment of $3 million, incorporating these modules into the Platform will provide various users (nursing students, faculty,

nursing programs, hospital educators, nurse residents and others) with access to valuable resources that highlight nursing as both an art and a science.

- There are very few resources to teach competencies; however, advancing to virtual reality, in addition to clinical simulation, would be forward thinking. While clinical simulation allows for hands-on practice of skills, virtual reality adds the dimension of interactivity with an avatar patient, analysis of presenting patient problems and scenarios for nurses to evaluate and act. The learning occurs in the debriefing and real-time reflection with instant feedback. Another investment option would be to enhance the existing clinical simulation modules and revisit the baseline assessments for all nursing programs after a four-year pause in clinical simulation equipment. The cost will depend on the licensure fee, equipment, number of users, and number of scenarios to be purchased, plus personnel. A realistic estimate for the virtual reality implementation would be about $7 million and another $7 million for clinical simulation upgrades across the 28 nursing programs.
- Nursing programs require additional faculty and clinical educators to increase the number of full-time positions, expand nursing program capacity, and graduate more RNs. One area of potential expansion is second-degree programs at universities. At present five out of eleven (5 of 11) universities have second degree options. These students chose nursing after completing a bachelor's degree in another field and bring more mature and diverse perspectives to the clinical setting. To expand existing programs and add new programs, costs are estimated at $9 million. To double graduates at every nursing program, the cost is estimated at $30 million when considering a 1-to-8 faculty ratio for 2,400 graduates with an average salary of $100K per faculty.
- Another opportunity is to expand interprofessional education (IPE) opportunities for students. IPE provides opportunities for students from various healthcare professions to learn communication and collaboration skills to be effective clinicians. Students would include all members of the new models of care delivery team, including social workers, pharmacists, physicians, PAs, APRNs, and others.

With the top-ranked nursing schools in the country, the faculty expertise exists to develop curriculum and learning modules that can be shared with all 28 programs. A projected estimated cost would be $4 million for these shared resources and be included with the existing repository through the Maryland Clinical Simulation Resource Consortium and available for free to Maryland schools and hospitals.

- The final funding opportunity is focused on an identified pool of nursing educators who have a service commitment to NSP II. These hospital-based educators are critical to the employing hospital to help nurses remain in their roles as bedside nurses or in other key positions. The new grant program would be offered to hospitals who would identify nurse educators to be included in an in-house pool of graduate degree prepared nurse educators, and available to the hospital education departments as preceptor, mentor, or assist with other educational assignments within their current roles. This program could alleviate the burden on hospitals and their long-term nursing staff who demonstrated commitment and worked extra hours to support their organization and would be a win-win for nurses, their employers and hospital educators. The estimated costs may be up to $5 million.

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Nurse Support Program I

Draft Recommendations for Permanent Renewal and Future Funding

May 11, 2022

Please send public comments to oscar.ibarra@maryland.gov through May 18, 2022.

P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

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Table of Contents

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Introduction

Maryland's unique Nurse Support Program I (NSP I) was designed to address the short-and long-term issues of recruiting and retaining nurses in acute care hospitals. Approximately $245 million in NSP I funds have been provided to hospitals in rates to support the NSP I initiatives since it was implemented in June 2001.

In 2010, the Institute of Medicine (IOM) published a groundbreaking report which laid out eight (8) recommendations to address the increasing demand for high quality and effective healthcare services and provided an action-oriented blueprint for the future of nursing. The HSCRC incorporated four of the recommendations into the scope of the NSP I program:

- *IOM Recommendation 3:* Implement nurse residency programs
- *IOM Recommendation 4:* Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020
- *IOM Recommendation 6:* Ensure that nurses engage in lifelong learning
- *IOM Recommendation 7:* Prepare and enable nurses to lead change to advance health

Incorporating the four (4) recommendations from the IOM, the NSP I program focuses on three (3) main areas to provide support and training for Maryland nurses:

1. *Education and Career Advancement*. This area includes initiatives that increase the number of advanced degree nurses, preparing them as future leaders; recruitment and retention of newly licensed nurses through nursing residency programs, and supporting nursing students and experienced RNs who are re-entering the workforce after an extended leave.
2. *Patient Quality and Satisfaction.* This area includes lifelong learning initiatives such as certification and continuing education linked to improved nursing competency and patient outcomes.
3. *Advancing the Practice of Nursing.* These activities in this area advance the nursing practice, for example, nurse-driven evidenced-based research; innovative

organizational structures for clinical nurses to have a voice in determining nursing practice, standards, and quality of care; and American Nurses Credentialing Center's (ANCC) Magnet®, and Pathway to Excellence programs demonstrating nursing excellence.

With input from the NSP I Advisory Committee, staff developed nursing and organizational metrics to assess hospitals' progress in achieving these program aims. This report provides the results of NSP I initiatives since the last report to the Commission in FY 2016, through FY 2021, including program achievements and recommendations for increased funding.

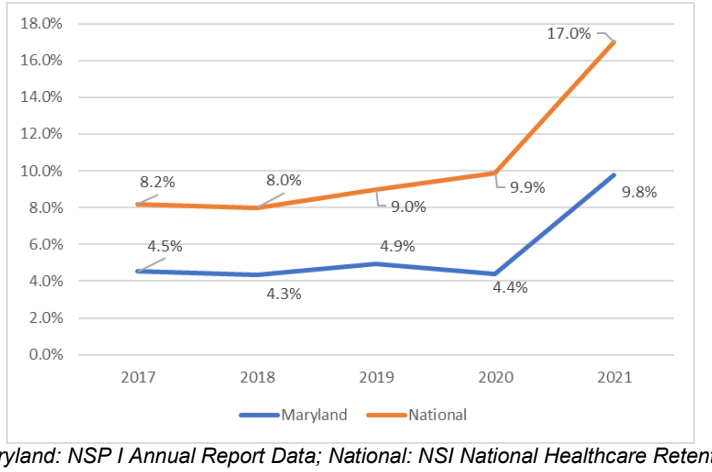
NSP I Accomplishments (FY 2017 – 2021)

Maintained Low Vacancy and Retention Rates Compared to Nation

Prior to the pandemic (between 2017 and 2019), Maryland was experiencing notably lower vacancies rates (4.6 percent) compared to the nationally (8.4 percent) (NSI, 2022). All national statistics cited for vacancies and retention data are derived from the *National Health Care Retention and RN Staffing Report*, an annual survey of approximately 192 facilities from 32 states, and is published by the Nurse Solution, Inc.

Although the success cannot solely be attributed to NSP I, programs that are funded by the NSP (including nurse residency programs (NRP), continuing education, leadership development and shared governance, preceptorship, and mentorship) are known to attract and retain nurses (Lee, 2008; Trofino, 2003). Not unexpectedly, vacancy rates increased sharply during the height of the pandemic in 2021, both in Maryland and nationally. Despite the challenges, Maryland’s average vacancy rates (9.8 percent) remained well below the national average (17 percent) (Graph1).

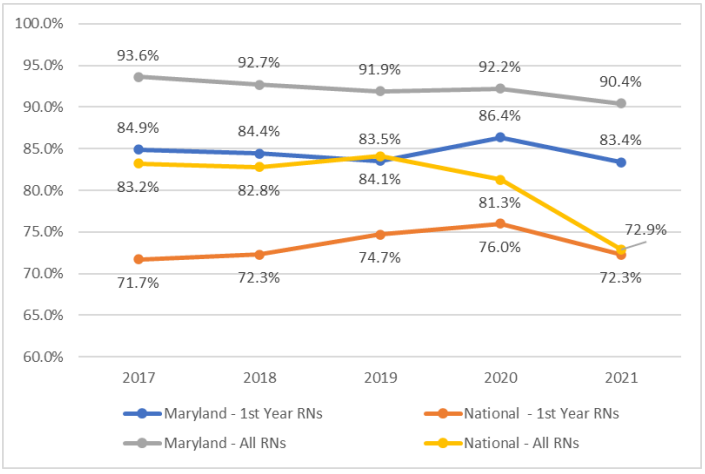
Graph 1. Registered Nurse Vacancy Rates: Maryland vs Nation, 2017 - 2021



Source: Maryland: NSP I Annual Report Data; National: NSI National Healthcare Retention Report

Nursing retention in Maryland has remained above 90 percent since FY 2017, ranging from 94 percent to 90 percent in 2021 (Graph 2). In Maryland, the average post-COVID retention rate was 91 percent, compared to the national average of 77 percent (falling from 83 percent pre-COVID). For first year RNs, the retention rates for Maryland hospitals averaged 85 percent, compared to 73 percent nationally (Graph 2). The retention rates pre versus post-COVID did not change as significantly in Maryland.

Graph 2. First Year and All Registered Nurse Retention Rates: Maryland vs Nation, 2017 - 2021



Source: Maryland: NSP I Annual Report Data; National: NSI National Healthcare Retention Report

Maintained Retention Rates for First Year Nurses with Nurse Residency Programs

Nurse residency programs (NRPs) have been instrumental in retaining first year nurses in Maryland and the success of the program is evidenced by retention rates that are higher than the nation. The purpose of the NRP is to build upon nursing school's foundational knowledge to smoothly transition new nurses into professionals and retain them in the workforce. Nurse residency programs for newly licensed RNs builds confidence and improves their organization, management, communication, and clinical skills (Wagner, 2020). Maryland is the first, and one of three states in the US, to have all acute care hospitals fund and offer nurse residency programs (NRPs) for new nurse graduates.

Additionally, NRPs reduce hospital costs associated with attrition (National Academies of Sciences, Engineering and Medicine, 2015). High retention rates result in significant cost savings to hospitals; the average cost to replace one RN ranges from $40,038 to upwards of $88,000 (NSI, 2021; Jones, 2008). Prior to the coronavirus pandemic, Maryland hospitals overall retained more than 88 percent of their new to practice nurses annually (Graph 2) compared to an average of 76 percent nationally (NSI, 2022). Moreover, hospital leaders and nurse residents report they are more confident and competent after completing their 12-month nurse residency program, resulting in better-prepared nurses and significant hospital cost savings.

Increased the Number of Certified and Specialty Care Nurses

The NSP I program funds initiatives that support courses and the associated costs to obtain and maintain certification. Certification offers patients and families the validation that the nurse caring for them has demonstrated the experience and knowledge in the complex specialty of critical care (American Association of Critical-Care Nurses, 2022). The number of certified nurses increased by 10 percent between FYs 2017 and 2021.

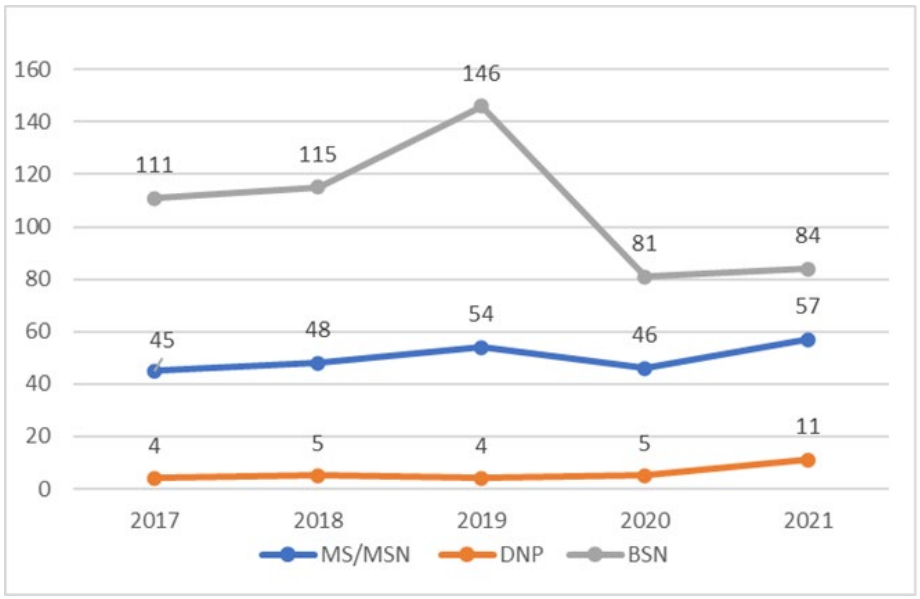
The aim of Transition-to-Specialty Care programs is to address hard-to-fill specialty clinical and critical leadership roles. Specialty care nurses, which include nurses working in hard-to-fill areas such as ICU, Psych and ED, were especially desirable during the

pandemic when these nurses were of critical need. More than 6,100 newly licensed and experienced nurses participated in NSP I funded programs, with average completion rates of 89 percent.

Increased the Number of Nurses with BSN and Advanced Degrees

RNs are in new and expanded roles to provide care across the healthcare continuum with increased focus on health disparities. According to *The Future of Nursing 2020-2030* report, it is imperative for RNs to achieve higher levels of education, as "*nurses play multiple roles in acute care, community, and public health settings, through which they can influence the medical and social factors that drive health outcomes, health equity, and health care equity…Nurses have a critical role to play in achieving the goal of health equity, but they need robust education, supportive work environments, and autonomy*" (National Academy of Sciences, 2021).

Graph 3. Maryland Registered Nurses by NSP I-Funded Degree Type, FY 2017- 2021



Between 2017 and 2021, 27% increase in MS/MSN grads vs 24% decline in BSN grads

Source: NSP I Annual Report Data

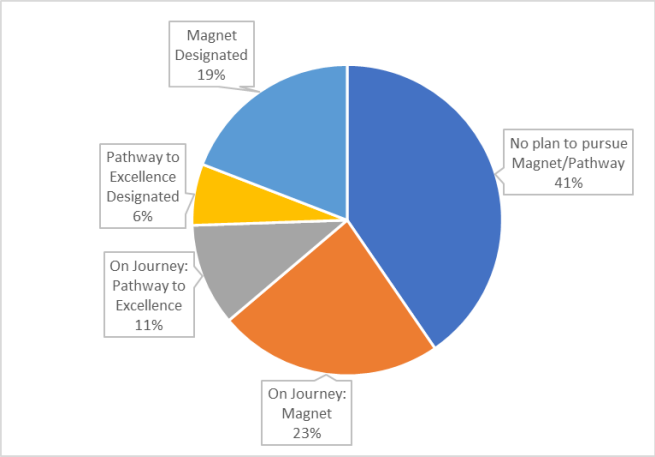
Strong research evidence has linked lower mortality rates, fewer medication errors, and positive outcomes to nurses prepared at the baccalaureate and graduate degree levels (IOM, 2011). Quality patient care hinges on a well-educated, highly functioning, motivated nursing workforce. The IOM Future of Nursing 2010 report called for 80 percent

of RNs to hold a BSN degree by 2020 and a doubling of doctoral-prepared RNs. In 2019, the Commission approved the staff recommendation to amend the goal for Maryland to "80 Percent BSN by 2025", and the Nurse Support Program II (NSP II) has made steady progress toward that goal. In FY 2021, 67 percent of RNs in Maryland hold a BSN or higher (Final NSP II FY 2023 Report, 2022). Through the NSP I funds, there was a 22 percent increase in the number of hospital-based nurses holding BSN and Advanced degrees between 2017-2019 (Graph 3).

Advanced the Practice of Nursing

The American Nurses Credentialing Center (ANCC) Magnet® Recognition Program recognizes healthcare organizations for quality patient care, nursing excellence, and innovation in professional nursing practice. Between FYs 2017 and 2021, nine (9) hospitals in Maryland have successfully achieved Magnet® and three (3) have achieved Pathway to Excellence® designation with funding from the NSP I program (Graph 4). Sixteen (16) hospitals are pursuing either Magnet® or Pathway to Excellence® designation in FY 2021.

Graph 4. Percent of Maryland Hospitals by ANCC Status, FY 2021



Source: NSP I Annual Report Data

Enhanced Diversity in the Nursing Workforce

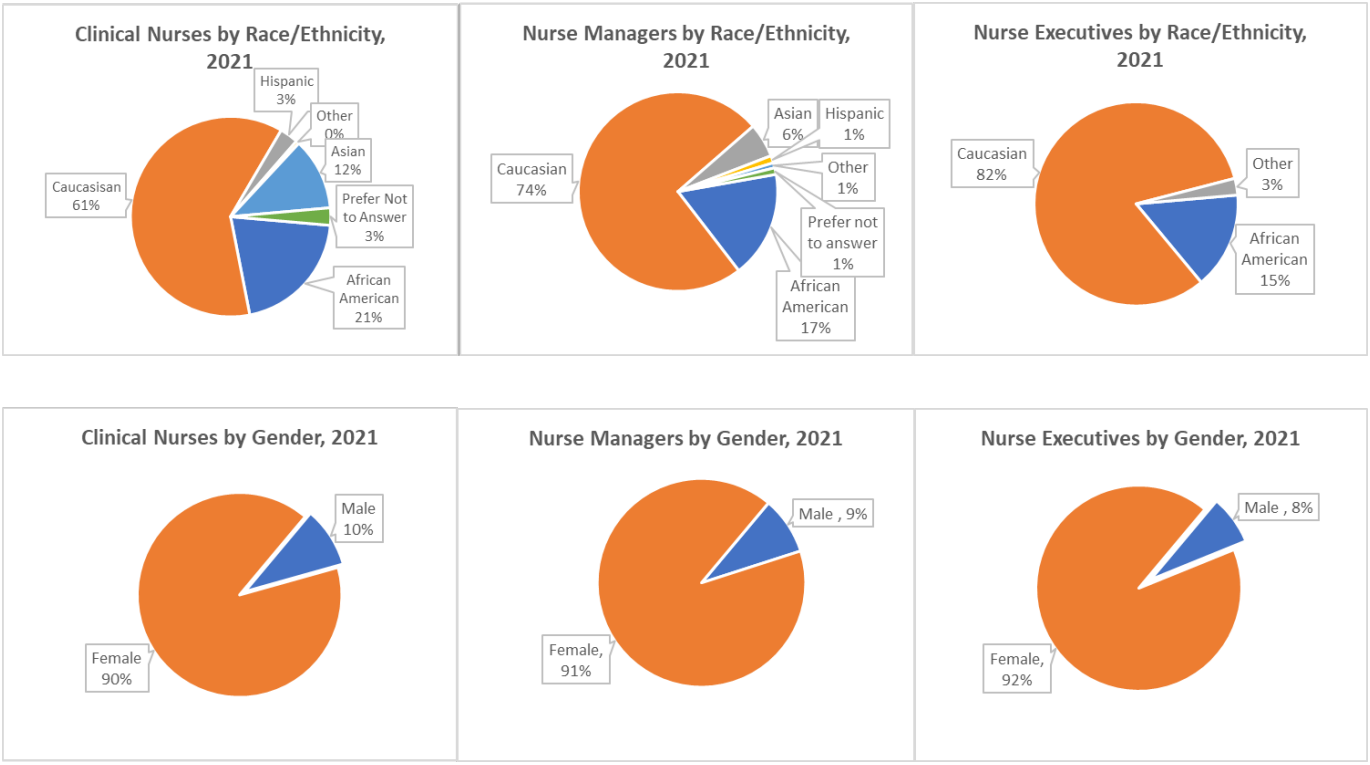
According to the American Association of Colleges of Nursing, "*Though nursing has made great strides in recruiting and graduating nurses that mirror the patient*

population, more must be done before adequate representation becomes a reality. The need to attract students from underrepresented groups in nursing – specifically men and individuals from African American, Hispanic, Asian, American Indian, and Alaskan native backgrounds - is a high priority for the nursing profession" (2019). As the spotlight has grown on health disparities, the need for providers who look like the patients they are serving has become an important mission for nursing schools and should extend to post graduation as well.

Nationally, 27 percent of RNs are from racial and ethnic minority groups (HRSA, 2019). The HSCRC began collecting data for all clinical nurses, nurse managers and nurse executives employed at Maryland hospitals in FY 2020 (Graph 5). Overall, 36 percent of clinical RNs are represented by ethnic and racial minorities in FY 2021. For Nurse Managers and Executives, ethnic and racial minorities account for 25 and 17 percent, respectively. Similar to the nation, where the percentage of male nurses was around 12 percent in 2021, nurses in Maryland are overwhelmingly female, regardless of position (Graph 5) (BLS, 2021).

The inclusion of minority and male nurses in clinical and management roles is crucial to addressing health disparities. Several studies have concluded that minority nurses leaders are in better positions to "influence resource allocation and the recruitment and retention of a diverse workforce…[as well as] shape organizational and national policies aimed at eliminating health disparities" (Philips and Malone, 2014). Increasing the number of minorities in nursing, especially in leadership positions, is an area of opportunity for the NSP I program to address in the coming years.

Graph 5. Demographics for Clinical Nurses, Nurse Managers and Nurse Executives in Maryland, FY 2021



Source: NSP I Annual Report Data

Impact of COVID on the Nursing Workforce

Nursing Burnout

As illustrated in Graphs 1 and 2 above, vacancy rates increased, and retention suffered in the wake of the COVID pandemic. The repeated surges of COVID made the situation dire for healthcare personnel, increasing burnout and moral distress among nurses (Yang and Mason, 2022). In a recent survey of 2,000 nursing staff, the Maryland Nursing Workforce Center (MNWC) found that over 40 percent of respondents experienced moderate to severe stress, were unable to control worrying, felt hopeless, and had little pleasure in usual things. Close to 50 percent of respondents indicated that they had symptoms of burnout, felt anxious, and had experienced sleep disturbances. Furthermore, about 62 percent of nurses felt their physical health and safety were compromised without their consent, and more than 60 percent indicated an intent to leave

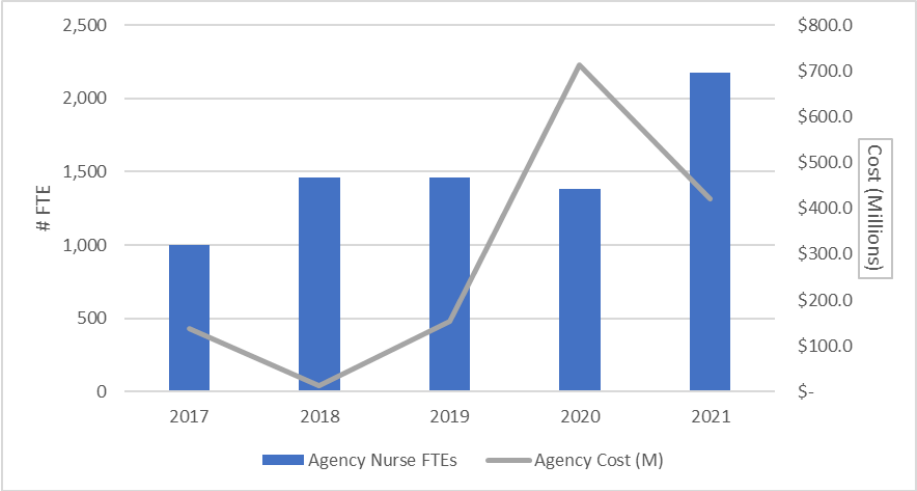
their current nursing job (MNWC, 2021). These findings are echoed in across the nation (Hansen and Tuttas, 2021)

Increased Reliance on Agency Nurses

Anecdotally, nurses were leaving their positions to go to competing hospitals for signing bonuses, or to agencies for better pay, better hours, and less stress (Vesoulis and Abrams, 2022). The increase in agency nurses and the resulting high turnover, creates additional burdens on staff nurses as they must constantly orient the new people. In discussions with nurses from various roles, the main complaint regarding agency nurses is they are paid significantly more than staff nurses but not responsible for regulatory reporting and other burdens that are placed on staff nurses.

As more nurses leave hospitals for agencies, a costly feedback loop is created as hospitals rely more on agencies to backfill the reduction in the workforce. The pandemic exacerbated costs to a high of $713 million (Graph 6) in Maryland, as reported to the HSCRC in the FY 2020 NSP Annual Reports. Nationally, most hospitals are not anticipating reducing their reliance on agency nurses, while costs continue to increase (NSI, 2022). Several organizations, including the American Hospital Association and the American Health Care Association/National Center for Assisted Living (the major nursing home trade group) are requesting Congressional intervention to help prevent the travel agencies “from exploiting our organizations’ desperate need for health care personnel” (Vesoulis and Abrams, 2022).

Graph 6: Maryland Hospital Agency FTEs and Costs, FY 2017-2021



Source: NSP I Annual Report Data

Addressing the root cause of nurse dissatisfaction is complicated. In addition, the nursing profession faces significant shortages due to an aging workforce, increasingly aging population, nurse burnout, violence in the workplace and other region-specific issues (Haddad et al.,2022). However, there are identified strategies that can reduce turnover, according to an article by the American Sentinel College of Nursing & Health Sciences at Post University (The Sentinel Watch, 2020):

- Reducing overtime and eliminating mandatory overtime.
- Developing shared governance programs that give nurses a voice in scheduling, workflows, and hospital policies.
- Ensuring adequate nurse staffing levels and supporting acuity-based staffing tools.
- Recognizing nurses' need for work-life balance.
- Encouraging and developing a workplace culture of collaboration between nurses and physicians.

Historically, the NSP program has funded similar initiatives, but staff analysis has shown hospitals have shifted their funding priorities. The share of spending on programs for entry-level nurses (such as NRP) increased from 30 percent to 55 percent, compared to spending on programs for experienced nurses (such as continuing education and

Advanced Degrees) that declined from 45 percent to 26 percent. Increasing the amount of NSP funding would allow hospitals to continue to sustain the progress that has been made with new nurses, while making an important investment in experienced nurses.

Future Funding Considerations

To address the issues that have come to the forefront during the pandemic, the NSP I and NSP II Advisory Committee suggest that the two programs be expanded to meet the current demands. With an additional 0.1 percent in funding, the Advisory Committee recommends the following:

- Increasing funding for proven initiatives (as described above) that have shown to increase retention and reduce vacancies.
- Develop initiatives to address health disparities by increasing the number of minorities and men in all nursing roles. Specifically, NSP I programs can implement initiatives to:
    - Increase the number of minority and male mentors and preceptors
    - Increase the number of minority and male nurses in leadership positions.
    - Develop recruitment strategies to target racial/ethnic minorities, particularly in areas with high minority populations.
- Carve out funding specifically aimed at Licensed Practical Nurses (LPN) for internal and external continuing education, leadership/preceptor/mentorship programs, as well as funding advanced nursing degrees and specialty practice programs.
- Funding additional NSP II initiatives that were described in the NSP II FY 2023 Staff Recommendation.

This year, the Maryland legislature passed several bills that focus on the ongoing crisis in the healthcare workforce broadly, though there are several bills that specifically address the issues in nursing. Staff recommends tasking the NSP I and II Advisory Committee with exploring how hospitals and nursing schools can access potential funding through the following legislation:

- **HB 625 / SB 440** (*Commission to Study the Health Care Workforce Crisis in Maryland – Establishment*): Establishes a Commission to study the health care workforce crisis.
- **HB 1208** (*Health Occupations - Health Care Workforce Expansion*): Requires the State Board of Nursing to evaluate the workforce based on data from nursing certificate renewals and promulgate regulations related to requirements for CNAs. Also provides tax benefits for certain activities (such as nurses who act as preceptors to train nurses).
- **SB 518 / HB 821** (*Career Pathways for Health Care Workers Program*): Creates a program in the Department of Labor that provides matching grants to employers for training programs attended by healthcare workers and requires the Governor to provide at least $1M for the program in the budget.
- **SB 696 / HB 975** (*Maryland Loan Assistance Repayment for Nurses and Nursing Workers - Program Establishment and Funding*): Establishes a Maryland Loan Assistance Repayment Fund for Nurses and "Nursing Workers". $400K is provided per year for this fund.

Additionally, the Supplemental Budget Amendment No. 13 authorizes "$50,000,000 appropriation made for program M00A01.01 Executive Direction for the purpose of hospital assistance/workforce support shall be allocated to acute and psychiatric care hospitals based on a plan developed by the Health Services Cost Review Commission." While a portion of the funds could be used specifically for NSP I & II initiatives, the remainder could be directed to other support healthcare professionals, such as paramedics, medical assistants, and others who support nurses on the front lines.

Staff Recommendations

The HSCRC staff present the following recommendations for the NSP I program:

1) Continue the Nurse Support Program I (NSP I) as an ongoing program with permanent funding that does not require renewal. The NSP I staff will provide annual reports on the funded activities and accomplishments.

2) Consider increasing funding in future years from 0.1 percent to 0.2 percent of total patient revenue for each NSP program to further address the impact of the pandemic on the nursing workforce. For FY 2023, the staff recommends that the Commission prioritize additional funding to support workforce initiatives such as those included in the NSP I and II initiatives.
3) Charge the NSP I and II Advisory Committee to investigate other potential sources of funding from new legislation that can support nursing initiatives.

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CRISP

FY23 HIE Draft Funding Request

May 11, 2022

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HIE Status

- CRISP is funded by hospital and carrier participation fees, state grants, CMS matching through Medicaid, and competitive federal grants, and those ratios are necessarily changing over time:
  - Federal Medicaid dollars moved from HITECH to Medicaid Enterprise System (MES)
  - The allocation methodology changes as new services are certified
- Many of the services built for Covid, the Insights data lake in particular, are now part of the long-term HIE infrastructure
  - MDH is providing general funds to leverage the HIE for Public Health
  - Recent legislation codified CRISP's role as a Health Data Utility
- CRISP will continue to seek opportunities to reduce burden by reusing data and technology, while surfacing critical health information

HSCRC Staff Funding Recommendation

Direct HIE Operations	$2,500,000
Reporting and Program Administration	$3,800,000
Maryland Total	**$6,300,000**
Reserves	*$1,500,000*
Funding Request	**$4,800,000**

Maryland Revenue	Hospital Rates	Federal Funds	User Fees	MDH	Total
HIE Operations	$2.5M	$9.0M	$5.0M	$0.3M	**$16.8M**
Reporting and Program Admin	$3.8M	$8.0M	----	$2.3M	**$14.1M**
Other Non-HSCRC Programs	----	$1.6M	$0.3M	$0.9M	**$2.7M**
Total Funding	**$6.3M**	**$18.6M**	**$5.3M**	**$3.4M**	**$33.6M**
Percent of Total	*19%*	*55%*	*16%*	*10%*	*100%*

Note: This schedule does not include CRISP projects anticipated to be funded entirely by MDH or federal grants

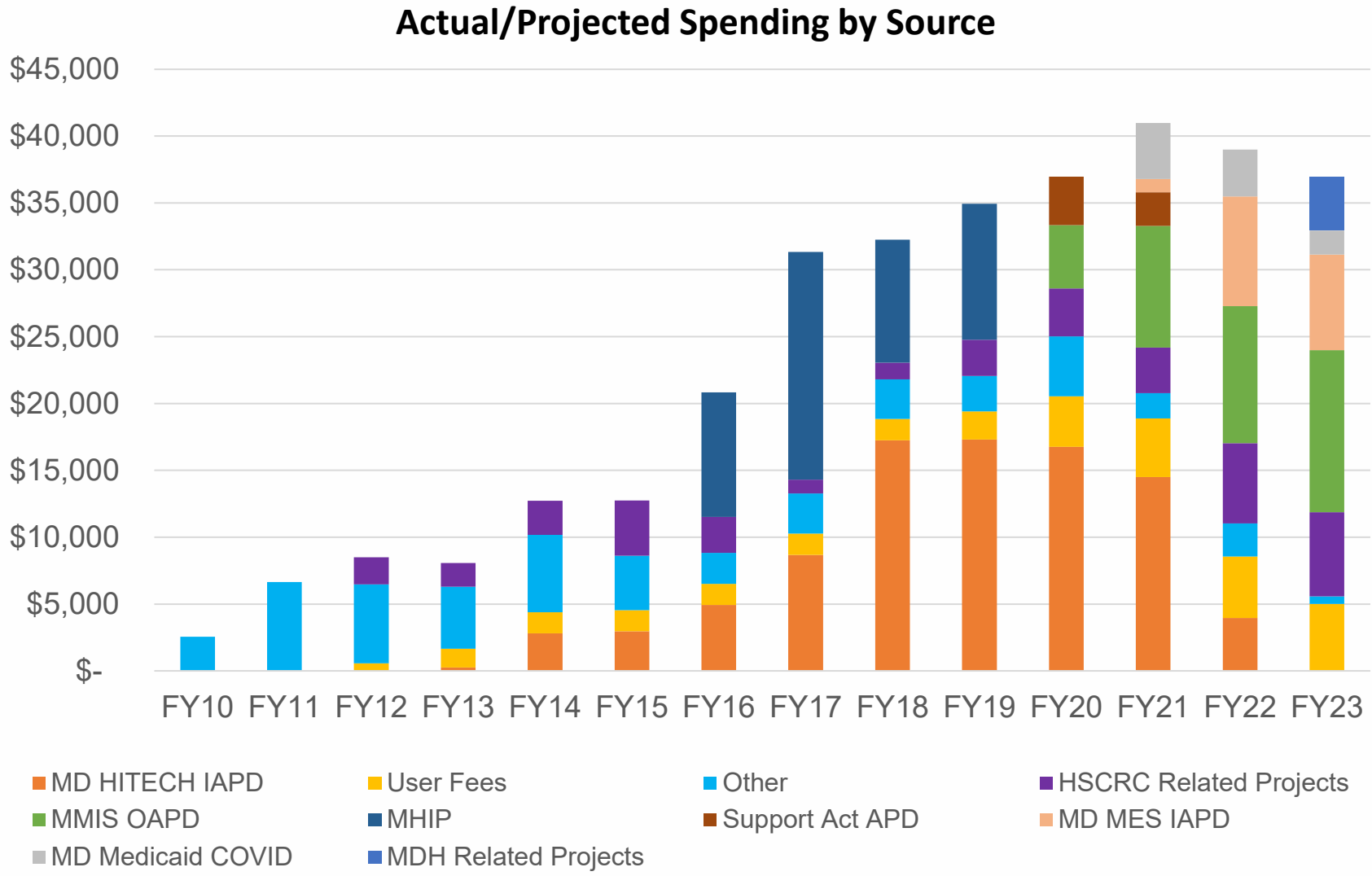
Key Takeaways:

1. Direct HIE Operations funding is consistent with prior years and allows CRISP to continue to build and support infrastructure aligned with the Total Cost of Care Model.
2. Reporting and Program Administration will continue to enable population reports, regulatory programs, and related care interventions.
3. User Fees are growing as a share funds; the CRISP Board recently raised rates on payers for the first time.
4. New reports and services that were brought online for Regional Partnerships, Care Redesign Programs, and CTIs are steady-state operations, meaning that future funding increases will be moderate.

Long-term Funding Trend

HSCRC CRISP Funding	
FY 2013	$1,313,755
FY 2014	$1,166,278
FY 2015	$1,650,000
FY 2016	$3,250,000
FY 2017	$2,360,000
FY 2018	$2,360,000
FY 2019	$2,500,000
FY 2020	$5,390,000
FY 2021	$5,170,000
FY 2022	$9,240,000
FY 2023*	**$6,300,000**

**Requested funding not including $1.5M to be used from reserves*



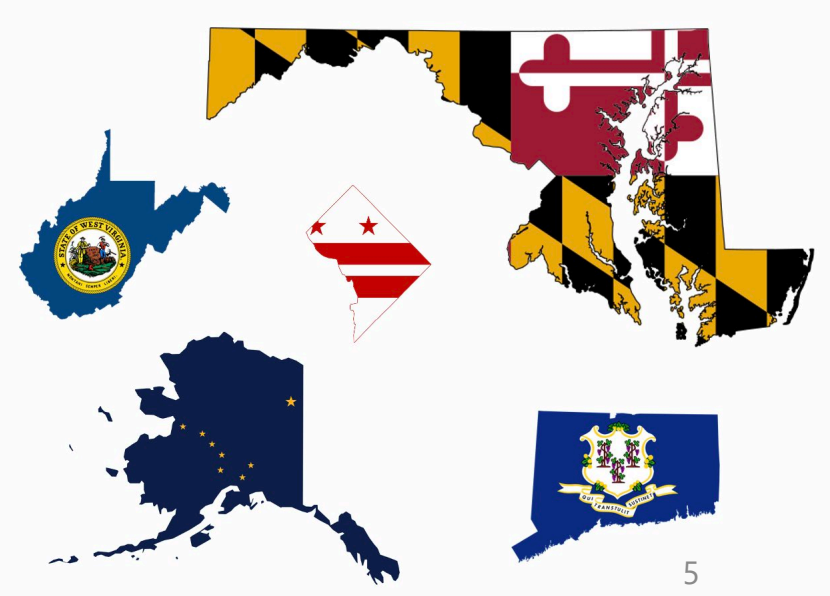
CRISP Beyond Maryland

CRISP affiliates with HIEs through CRISP Shared Services for the purposes of:

1. **Preserving the independence** of the HIEs in each jurisdiction, such that all regions can prioritize and fund their own initiatives, leveraging the shared infrastructure.
2. **Improving HIE technologies** available to serve all patients, providers, public health officials, and other stakeholders.
3. **Reducing costs** by taking advantage of the favorable economics of sharing HIE infrastructure technologies.

Benefits to Maryland stakeholders include:

- Leveraging project funds from other regions to build mutually desired tools
- Deploying full-time staff strategically based on need
- Sharing ideas as a community of practice and then influencing a broader conversation



maryland
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Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2023 Funding to Support HIE Operations and CRISP Reporting Services

Draft Recommendation

May 11, 2022

Please submit all comments to william.henderson@maryland.gov by COB May 18, 2022.

P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

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Table of Contents

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List of Abbreviations

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

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Policy Overview

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

Summary of the Recommendation

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Total Cost of Care Model and the public interest,[1] this recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2023 to the Chesapeake Regional Information System for our Patients (CRISP):

- Direct funding and matching funds under Medicaid Enterprise System (MES) Federal Programs for Health Information Exchange (HIE) operations and infrastructure ($2.5 million)
- Direct funding and Medicaid Enterprise System (MES) matching funds for reporting and program administration related to population health, the Total Cost of Care Model, and hospital regulatory initiatives ($3.8 million). Staff propose using $1.5 million of accumulated reserves to reduce the revenue generated through rates for FY2023 to $2.3 million for this component.

Therefore, Staff recommends that the HSCRC provide funding to CRISP totaling $4.8 million for FY 2023, a decrease of $4.4 million (48 percent) from FY 2022. As a result, the HSCRC will be funding approximately

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

19 percent of CRISP's Maryland funding, compared to budgeted 31 percent in FY 2022 (as federal funding was never lowered, actual FY22 share is closer to the FY23 budgeted of 19 percent). The remainder of CRISP's Maryland funding is derived from user fees, federal matching funds and the Maryland Department of Health (MDH).

The significant decrease in the funding level is driven by 2 factors: (1) the change in federal matching rules anticipated in the prior year's recommendation (that required more State funding) did not occur, resulting in a significant reduction in the required funding for FY 2023, and (2) the use of $1.5 million in reserves related to accumulated CRISP funding from prior years (due to better than expected federal match) to offset the current request. Without the use of these reserves, this year's request would have been $6.3 million, reflecting a moderate increase over the approximately $6 million anticipated in FY 2022 spending.

Staff note the net request of $4.8 million is the lowest amount in CRISP funding since the Maryland Health Insurance Plan (MHIP) funding was terminated in FY 2020.

Background – Past Funding

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

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

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

User fees generated by payers have historically been a small share of total CRISP revenue and remained unchanged since inception. In FY2022, the CRISP Finance Committee approved an increase of $300,000 in payer fees, which now represents 10% of user fee revenue.

Funding Through Hospital Rates

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

Funding Through Federal Matching

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

Medicaid Enterprise System (MES) Matching Funds

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

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

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

Other Funding

CRISP's Maryland activities are also financed through user fees paid by hospitals and payers as well as funding received from MDH (See Table 2). Payer user fees have historically been a small share of total CRISP revenue and remained unchanged since inception. In FY2022, the CRISP Finance Committee approved an increase of $300,000 in payer fees, which now represents 10% of user fee revenue.

Description of Activities Funded

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

Category 1: HIE Operations Funding and Infrastructure

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

The total amount of funding recommended by staff for FY 2022 for the HIE function is $2.5 million.

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

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

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

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

(1) Funding for population health and cost and quality management reporting in support of HSCRC regulations and the TCOC Model

(2) Funding for program administration related to programs under the TCOC Model

(3) Funding for innovative reporting initiatives such as enhanced data on social determinants of health and the integration of electronic health record data into statewide hospital quality measurement

The total amount of funding recommended by staff for FY 2021 for the activities described above is $3.8 million.

Staff Recommendation

Staff is recommending the Commission approve a total of $4.8 million in funding through hospital rates in FY 2023 to support the HIE and continue the investments made in the TCOC Model initiatives through both direct funding and obtaining federal MES matching funds. Staff anticipates actual CRISP spending of $6.3 million but proposes to use $1.5 million of prior reserves, limiting the actual assessment to $4.8 million.

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

Table 2. FY 2023 Recommended Rate Support for CRISP as a share of estimated total Maryland Funding

FY 2023 Project Name	Hospital Rates	Federal Budgeted Funding	User Fees	Maryland Department of Health	Maryland Total
HIE Operations	$2,500,000	$9,016,000	$5,005,000	$297,000	$16,818,000
Reporting and Program Administration	$3,800,000	$8,010,000	$0	$2,264,000	$14,074,000
Other non-HSCRC programs	$0	$1,578,000	$275,000	$857,000	$2,710,000
Total Funding	**$6,300,000***	**$18,604,000**	**$5,280,000**	**$3,418,000**	**$33,602,000**
% Of Total	**19%**	**55%**	**16%**	**10%**	**100%**

*Note: Prior to reduction for use of accumulated reserves to reduce FY2023 assessment.

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Draft Recommendation on Revisions and Updates to Clinic Relative Value Units

5/11/22

Background

On November 16, 2020, the HSCRC staff convened a workgroup to review and initiate changes to the Clinic RVUs and guidelines for the Clinic rate center. The members of this workgroup included Hospitals, Maryland Hospital Association, Insurance Companies, and Hospital Consultants. These changes were initiated for the following reasons:

1. Staff is progressively standardizing RVUs for all ancillary and outpatient rate centers using national CPT code definitions and MPFS cost weights.
2. To assign RVUs for procedures that are currently being reported as “By Report.”
3. Standardization using the Medicare Physician Fee Schedule weights, updating new codes and removing inactive codes from Appendix D of the Accounting and Budget Manual.

Clinic services may include either one of both of the following two components: an evaluation of management visits and/or a non-surgical procedure.

Methodology

Clinic RVUs were developed with the aid of an industry task force under the auspices of and approved by the HSCRC. The descriptions of the new codes in Appendix D, of the Accounting and Budget Manual were obtained from the 2022 edition of the CPT manual and the 2022 edition of the HCPCS. In assigning RVUs, the group used the 2022 MPFS released December 15, 2021.

Draft Recommendation

The HSCRC staff recommends that the Commission approve the revisions to the RVU scale for the Clinic Rate Center effective July 1, 2022.

The conversion of the Clinic RVUs will be revenue neutral to the overall Hospital Global Budget Revenues.

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Changes to Relative Value Units for Clinic Effective July 1, 2022

Draft Recommendation

May 11, 2022

This is a draft recommendation for Commission consideration at the May 11, 2022, Public Commission Meeting. Please submit comments on this draft to the Commission by Wednesday, May 18, 2022, via email to William Hoff at William.Hoff@maryland.gov.

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Table of Contents

maryland
health services
cost review commission

Definitions

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

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

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

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

Background

On November 16, 2020, the HSCRC staff convened a workgroup to review and initiate changes to the Clinic RVUs and guidelines for the Clinic rate center. The members of this workgroup included Hospitals, Maryland Hospital Association, Insurance Companies, and Hospital Consultants. These changes were initiated for the following reasons:

1. Staff is progressively standardizing RVUs for all ancillary and outpatient rate centers using national CPT code definitions and MPFS cost weights, consistent with the strategy that staff is executing over time for all services.
2. RVUs standardization using the Medicare Physician Fee Schedule weights, updating new codes, and removing inactive codes from Appendix D of the Commission's Accounting and Budget Manual.
3. Assignment of RVUs procedures that are being reported as "By Report."
4. The nature of the clinic visits has changed over time. Clinic visits now focus primarily on chronic conditions, specialized services, and behavioral health.
5. The Clinic Rate Center generates the largest number of consumer complaints. This is principally because the price of a clinic visit is generally more expensive than a visit to a doctors' office.

Clinic services include diagnostic, preventive, therapeutic, rehabilitative, and educational services provided to non-emergent outpatients in a regulated setting. On rare occasions, clinic services may be provided to inpatients; for example, if specialized staff from the clinic must provide care to an inpatient at the patient's bedside.

Surgical procedures, diagnostic tests and other services that are better described in a separate cost center, such as Labor and Delivery, Electroencephalography, Echocardiography, Interventional Cardiology, Laboratory, Lithotripsy, Occupational Therapy, Operating Room, Physical Therapy, Radiation Therapy, Radiology, or Speech Therapy, are to be reported in those specific rate centers.

Clinic services may include either one or both of the following two components: an evaluation and management (E/M) visit and/or non-surgical procedure(s).

Methodology

Clinic RVUs were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of the new codes in Appendix D, of the Accounting and Budget Manual were obtained from the 2022 edition of the CPT manual and the 2022 edition of the HCPCS. In assigning RVUs, the group used the 2022 MPFS released December 15, 2021, and then assigned using the following protocol.

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

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

Recommendation

1. The HSCRC staff recommends that the Commission approve the revisions to the RVU scale for the Clinic Rate Center. The revisions are specific to the Chart of Account and Appendix D of the Accounting and Budget Manual (Attachment 1- Chart of Account). These revised RVUs are based on MPFS weights and were reviewed by a workgroup facilitated by the HSCRC staff;

2. The RVU scale was updated to reflect linkages of RVUs to the CPT codes to reflect: the changes in clinical practices, and to link charging guidelines for Clinic services to the national definition, consistent with the HSCRC plan to adopt MPFS RVUs where possible (Attachment 2 – Appendix D); and

3. The new and updated RVUs should be effective July 1, 2022. The conversion of the Clinic RVUs will be revenue neutral to the overall Hospital Global Budget Revenues.

6720 CLINIC SERVICES

Function

Clinics provide organized diagnostic, preventive, curative, rehabilitative, and educational services on a scheduled basis to ambulatory patients. Additional activities include, but are not limited to the following:

Participating in community activities designed to promote health education; assisting in administration of physical examinations and diagnosing and treating ambulatory patients having illnesses which respond quickly to treatment; referring patients who require prolonged or specialized care to appropriate other services; assigning patients to doctors in accordance with clinic rules; assisting and guiding volunteers in their duties; making patients' appointments through required professional service functions.

Description

The cost centers contain the direct expenses incurred in providing clinic services to ambulatory patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical-surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Relative Value Units

Clinic Relative Value Units as developed by the Health Services Cost Review Commission. A count of visits must also be maintained and reported on Schedule V2. Visits made by clinic patients to ancillary cost centers are not included here but are accumulated in the appropriate ancillary cost center.

Data Source

The number of Relative Value Units shall be the actual count maintained by the formally organized clinic within the hospital.

Reporting Schedule

Schedule D - Line D19

7/1/2022APPENDIX D CLINICAL SERVICES#
STANDARD UNIT OF MEASURE REFERENCES

Account Number 6720

Clinic services include diagnostic, preventive, therapeutic, rehabilitative, and educational services provided to non-emergent outpatients in a regulated setting. On rare occasions, clinic services may be provided to inpatients; for example, if specialized staff from the clinic must provide care to an inpatient at the patient's bedside.

Surgical procedures, diagnostic tests and other services that are better described in a separate cost center, such as Labor and Delivery, Electroencephalography, Echocardiography, Interventional Cardiology, Laboratory, Lithotripsy, Occupational Therapy, Operating Room, Physical Therapy, Radiation Therapy, Radiology, or Speech Therapy, are to be reported in those specific rate centers.

Clinic services may include either one or both of the following two components: an evaluation and management (E/M) visit and/or non-surgical procedure(s).

Approach

Clinic Relative Value Units (RVUs) were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of the codes in this section of Appendix D were obtained from the 2022 edition of the Current Procedural Terminology (CPT) manual and the 2022 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2022 Medicare Physician Fee Schedule (MPFS) released December 15, 2021, and then assigned using the following protocol.

RVU Assignment Protocol

RVUs were proposed based on the Medicare Physician Fee Schedule (MPFS) Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there is a Technical Component (TC) modifier line item, that value was used. To maintain whole numbers in Appendix D, RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 were rounded down and all other values were rounded up. For example, the psychotherapy CPT of 90832 shown below has a NON-FAC PE RVU of 0.48. 0.48 * 10 = 4.8. 4.8 rounded = 5. 5 is the proposed RVU.

HCPCS	MOD	DESCRIPTION	NON-FAC PE RVU
90832		Psytx w pt 30 minutes	0.48

Here is another example where there is a TC modifier. In this case, the Corneal Topography CPT of 92025 shown below has a NON-FAC PE RVU for TC modifier of 0.50. 0.50 * 10 = 5.0. 5.0 rounded = 5. 5 is the proposed RVU.

HCPCS	MOD	DESCRIPTION	NON-FAC PE RVU
92025		Corneal topography	0.70
92025	TC	Corneal topography	0.50
92025	26	Corneal topography	0.20

1) For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.
2) For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not properly reflect the facility resources associated with the service), the proposed RVU was modified as noted in the table of RVUs.
3) For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.
4) Unlisted services or services rarely performed have been assigned as By Report (BR). Similar logic should be utilized to assign RVUs to any services that are not found or BR.
    - If there are no MPFS RVUs for a service, mirror an existing code that has similar facility resources or mirror an existing code that has similar facility resources with adjustments if needed (for example, if a BR service is slightly less resource intensive than an existing service, the RVU can be lower). The BR methodology for each code must be documented and readily available in the event of an audit.

PART 1: EVALUATION AND MANAGEMENT (E/M) COMPONENT

CLINICAL CARE TIME

The evaluation and management portion of the clinic visit is based on a 5-point visit level scale. The amount of clinical care time provided to the patient during the E/M portion of the visit determines the visit level. Clinical care time is the combined total amount of time that each non-physician clinician spends treating the patient (such as nurses, medical technicians, residents, and other staff employed by the hospital clinic). The time does not necessarily have to be face-to-face with the patient, but the patient must be present in the department, except during specific times when telehealth (i.e., virtual) services are permitted. The time spent by physicians, and other non-physician providers (NPP), who bill professionally for their services is not included. It

is possible for multiple clinic personnel to be providing CCT to the same patient simultaneously. Therefore, in each time interval, the hospital may record and report CCT greater than the actual clock time that as elapsed.

Both direct and indirect patient care may be included in CCT. Direct patient care will always be included in CCT. Indirect patient care may be included when the skills of a clinician are required to provide the care. Direct patient care includes tasks or procedures that involve face-to-face contact with the patient. These tasks may include specimen retrieval, administration of medications (when not separately charged), family support, patient teaching, and transportation of patients requiring nurse or other clinical personnel whose cost is assigned to the Clinic. Indirect patient care includes tasks or procedures that do not involve face-to-face contact with the patient but are related to their care. These tasks may include arranging for admission, calling for lab results, calling a report to another unit, documentation of patient care, and reviewing prior medical records.

EXAMPLES OF SERVICES INCLUDED IN E/M COMPONENT

The following are examples of services performed by nursing and other clinical staff that may be included in CCT provided during the E/M portion of a clinic visit. The list is not all-inclusive and is only meant as a guide.

- Patient evaluation and assessment
- Patient education and skills assessment
- Patient counseling
- Patient monitoring that does not require equipment or a physician order (different from observation)
- Skin and wound assessment
- Wound cleansing and dressing changes
- Application of topical medications
- Transporting of patient when it requires the skill of a clinician
- Coordination of care and discharge planning that requires the skill of a clinician

EXAMPLES OF SERVICES EXCLUDED FROM E/M COMPONENT

Services that do not require the skills of a clinician should be excluded from CCT. Examples of excluded activities are listed below. The list is not all-inclusive and is only meant as a guide.

- Patient waiting time
- Time spent on the phone with a payer
- Time spent securing payment authorization
- Chart set-up, room preparation
- Appointment setting
- Calling in prescriptions and entering orders and/or charges

7/1/2022APPENDIX D CLINICAL SERVICES#
STANDARD UNIT OF MEASURE REFERENCES

TELEMEDICINE

Per the May 4, 2020, HSCRC memo:
https://hscrc.maryland.gov/Documents/TELEHEATH%20MEMO%20AND%20ADDENDUM.pdf

For services provided real-time in an audio-visual format or for telephonic/audio only services when an audio-visual format is not accessible by the patient: where the service is provided by non-physician providers who cannot bill a professional fee for their services; where the service provided utilizes the same staffing structure as face-to-face; and where the only difference is that the patient is at home vs. at the hospital receiving services; in these instances, hospitals are to use the existing Appendix D to report and charge for the service with the exact same RVUs and pricing as face-to-face visits.

In instances where a patient receives the telehealth services from an outside provider who bills a professional fee for the services rendered, such as a physician, the hospital shall not report nor charge an E/M visit or charge for other services, procedures, or therapies provided to the patient by non-physician clinicians who cannot bill a professional fee. The only instance when a hospital clinic fee or other fee for telehealth services can be charged is when the only telehealth services rendered are those provided solely by providers that cannot bill for their service

Until the end of the federal public health emergency (PHE), the temporary guidance provided related to telemedicine services will remain in effect. At the conclusion of the federal PHE, additional guidance will be provided to hospitals regarding the reporting of these services.

PROFESSIONAL SERVICES ONLY VISIT

In instances where a patient sees only an *outside provider,* the hospital may only report a Level one E/M visit regardless of the amount of time a patient spends with the outside provider. An outside provider is a physician or other provider who bills professionally. A level one E/M visit may also be reported when a patient is seen by clinic personnel and CCT totals 1-10 minutes, as per the E/M visit level guidelines below.

INTERNAL GUIDELINES

The RVUs for each visit level remain the same across every clinic. However, each clinic within a hospital is expected to develop and maintain a set of internal guidelines to standardize the amount of CCT required to perform common E/M services in the clinic. Hospitals are expected to conduct in-service programs to assure that new and existing clinic staff understand the guidelines and apply them fairly and consistently. The over-riding consideration is that there must be a “reasonable” relationship between the intensity of resource use and the assigned visit level.

7/1/2022APPENDIX D CLINICAL SERVICES#
STANDARD UNIT OF MEASURE REFERENCES

The clinic's internal guidelines should include a typical time range for all the commonly performed services in that clinic. The time range allows for the circumstances of the visit and judgment of the clinician, while maintaining a degree of uniformity among clinicians. The guidelines are not expected to dictate a definitive time value for every service that could be performed in a clinic. Instead, their purpose is to provide an average time frame for commonly performed procedures. The format and content are at the facility's discretion. For example, taking vital signs: 5 minutes.

VISIT LEVELS

The minutes and RVUs for each of the five levels of an E/M visit are:

	New/Established	Minutes	RVUs
Level 1	99211	0-10	2
Level 2	99202/99212	11-25	3
Level 3	99203/99213	26-45	4
Level 4	99204/99214	46-90	5
Level 5	99205/99215	>90	6

HCPCS code G0463 can be used for Medicare billing with the above assigned RVUs.

Consultation codes (such as CPT 99242) or prolonged E/M codes (such as CPT 99354) are for professional services and should not be used for facility services. Only E/M codes (99202-99215 and G0463) should be used for facility E/M visits.

If codes for preventive (such as CPT 99387) or other specific services will be used, the RVUs should be based on the minute-to-RVU logic shown above. For example, if CPT 99387 typically takes 45 minutes, then 4 RVUs should be used, etc. Codes are noted as "E/M" on the table of RVUs if they are to be based on the minute-to-RVU logic above.

Code	Description	RVU	Rationale
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	1	Based on prior BR
G0463	Hospital outpatient clinic visit for assessment and management of a patient	E/M	Match RVUs as stated above
Q0091	Screening Papanicolaou smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	0	Included as an E/M component
Q0111	Wet mounts, including preparations of vaginal, cervical, or skin specimens	LAB	Report in Lab rate center

PART II: SERVICES AND NON-SURGICAL PROCEDURES

7/1/2022APPENDIX D CLINICAL SERVICES#
STANDARD UNIT OF MEASURE REFERENCES

Each section includes tables with CPT codes, descriptions, and RVU values. This manual is not meant to give direction or interpretation to Medicare or other payer billing or coding rules. Moreover, it is the goal of every work group that recommends revisions to RVUs that the revised system may be as impervious as possible to future changes in billing rules and correct coding guidelines. Codes below are grouped in subsections and are in CPT code order with numeric and new technology codes listed before alpha-numeric codes. COVID-19 related services are listed at the end.

When a service has By Location (BL) instead of a relative value unit (RVU) assigned to it, this means that the service may be provided in multiple areas of the hospital based on hospital protocols, patient condition, and other factors. The RVU for the service should be assigned based on the respective rules for the location. For example, and the list below is not all-inclusive:

- If the service is provided in an Operating Room (OR), OR minutes should be used.
- If the service is provided in an Imaging Suite, Interventional Radiology Cardiovascular (IRC) minutes should be used.
- If the service is provided in an outpatient clinic or other outpatient area where scheduled services are provided that is not an operating room or imaging suite, Operating Room-Clinic (ORC) minutes should be used. For any services where ORC minutes are indicated, but the hospital does not have an ORC rate, the hospital should report the service under the Clinic (CL) rate center using a BR RVU.

TRANSFUSIONS

RVUs for transfusion of blood or blood components (36430) will be assigned based on the number of hours. Stratifying by the number of units transfused was rejected because the resources consumed in the transfusion of units vary by patient diagnosis and type of product. The timing of the transfusion begins and ends with the start and stop of the transfusion, and/or resolution of any reaction to the blood product. Any fraction of the first hour can be reported as a full hour, subsequent hours are subject to simple rounding rules (i.e., must be 30 minutes or more).

Code	Description	RVU	Rationale
36430	Transfusion, blood, or blood components, first hour (0-90 min)	11	MPFS
36430	Transfusion, blood or blood components, two hours (91-150 min)	16	MPFS base RVU plus add-on of 5 RVUs for each additional hour (11 was slightly less than prior value of 12 and add-on of 5 is slightly less than prior add-on of 6)

Code	Description	RVU	Rationale
36430	Transfusion, blood or blood components, three hours (151-210 min)	21	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, four hours (211-270 min)	26	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, five hours (271-330 min)	31	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, six hours (331-390 min)	36	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, seven hours (391-450 min)	41	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, eight hours (451-510 min)	46	MPFS base plus add-on of 5 RVUs for each additional hour
36455	Exchange transfusion, blood; other than newborn	21	Resources like 180 minutes of blood transfusion

VENOUS PROCEDURES

RVUs for therapeutic apheresis and photopheresis were based on prior established By Report RVUs in use by hospitals and kept consistent with the Outpatient Prospective Payment System (OPPS) relationship weights. Note that these services are NOT the same as pheresis services that appear in the LAB rate center.

Code	Description	RVU	Rationale
36511	Therapeutic apheresis; for white blood cells	50	Prior BR average RVUs
36512	Therapeutic apheresis; for red blood cells	50	Prior BR average RVUs
36513	Therapeutic apheresis; for platelets	50	Prior BR average RVUs
36514	Therapeutic apheresis; for plasma pheresis	50	Prior BR average RVUs
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion	150	Base code for apheresis adjusted based on OPPS relationship (weight of CPT 36516 approximately 3x weight of CPT 36511)
36522	Photopheresis, extracorporeal	150	Consistency with CPT 36516

Code	Description	RVU	Rationale
36591	Collection of blood specimen from a completely implantable venous access device	8	MPFS
36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified	9	MPFS
36593	Declotting by thrombolytic agent of implanted vascular access device or catheter	10	MPFS
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	9	MPFS
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	9	MPFS

IMMUNIZATIONS

Code	Description	RVU	Rationale
90460	Immunization administration through 18 years of age via any route of administration, with counseling by qualified health care professional; first or only component of each vaccine or toxoid administered	3	MPFS
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/ toxoid)	3	MPFS
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/ toxoid)	2	MPFS
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/ toxoid)	3	MPFS
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/ toxoid)	2	MPFS
G0008	Administration of influenza virus vaccine	3	Consistency with CPT 90471
G0009	Administration of pneumococcal vaccine	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
G0010	Administration of hepatitis B vaccine	3	Consistency with CPT 90471

PSYCHIATRY (EXCLUDES PARTIAL HOSPITALIZATION – PHP)

In instances where a patient only sees an outside provider who bills professionally, the hospital may only report two RVUs regardless of the amount of time a patient spends with the outside provider. Two RVUs corresponds to a level one E/M visit that is used to report the facility component of an E/M visit when a clinic patient is seen only by an outside provider. (*See Professional Service Only Visit under Part II: E/M Component.*) The following RVUs are to be assigned only when the service is performed by a non-physician provider who does not bill professionally for the service.

Code	Description	RVU	Rationale
90785	Interactive complexity	1	MPFS
90791	Psychiatric diagnostic evaluation	12	MPFS
90792	Psychiatric diagnostic evaluation with medical services	15	MPFS
90832	Psychotherapy, 30 minutes with patient	5	MPFS
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	5	MPFS
90834	Psychotherapy, 45 minutes with patient	6	MPFS
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service	6	MPFS
90837	Psychotherapy, 60 minutes with patient	9	MPFS
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service	9	Consistency with CPT 90837
90839	Psychotherapy for crisis; first 60 minutes	9	MPFS
90840	Psychotherapy for crisis; each additional 30 minutes	5	MPFS
90845	Psychoanalysis	6	MPFS
90846	Family psychotherapy (without the patient present), 50 minutes	4	MPFS
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	4	MPFS
90849	Multiple-family group psychotherapy	4	MPFS

7/1/2022APPENDIX D CLINICAL SERVICES#
STANDARD UNIT OF MEASURE REFERENCES

Code	Description	RVU	Rationale
90853	Group psychotherapy (other than of multiple-family group)	2	MPFS
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	2	MPFS
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarbital (Amytal) interview)	BR	No volumes
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	5	MPFS
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	10	MPFS
90880	Hypnotherapy	8	MPFS
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	0	Not a hospital service
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	0	Not a hospital service
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	0	Not a hospital service
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	0	Not a hospital service
G0176	Activity therapy, such as music, dance, art, or play therapies, not for recreation, related to the care and treatment of patient's	PDC	Report in PHP rate center

Code	Description	RVU	Rationale
	disabling mental health problems, per session (45 minutes or more)		
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	PDC	Report in PHP rate center
G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	BR	Services may vary by hospital
G2068	Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	BR	Services may vary by hospital
H0001	Alcohol and/or drug assessment	12	Consistency with CPT 90791
H0004	Behavioral health counseling and therapy, per 15 minutes	3	Based on prior BR
H0005	Alcohol and/or drug services; group counseling by a clinician	2	Consistency with CPT 90853
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education	6	Consistency with CPT 90853 x 3hrs
H0016	Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)	9	Based on prior BR
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	9	Based on prior BR
H0032	Mental health service plan development by non-physician	PDC	Report in PHP rate center
H0035	Mental Health Partial Hospitalization, treatment, less than 24 hours	PDC	Report in PHP rate center

Code	Description	RVU	Rationale
H0047	Alcohol and/or other drug abuse services, not otherwise specified	BR	Unlisted service

BIOFEEDBACK TRAINING

No RVUs were assigned to these services (e.g., CPT 90901. 90912, and 90913). These services are reportable via the rehabilitation (Physical and Occupational Therapy) rate centers.

OPHTHALMOLOGY

Ophthalmology is a section where the MPFS RVUs for many services included equipment and overhead and required adjustment.

Code	Description	RVU	Rationale
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	4	Based on E&M value
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits	4	Based on E&M value
92012	Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate, established patient	4	Based on E&M value
92014	Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits	4	Based on E&M value
92015	Determination of refractive state	2	MPFS
92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete	OR	Report in OR rate center

Code	Description	RVU	Rationale
92019	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited	OR	Report in OR rate center
92020	Gonioscopy	4	MPFS
92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report	5	MPFS
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., Restrictive, or paretic muscle with diplopia) with interpretation and report	8	MPFS
92065	Orthoptic training	10	MPFS
92071	Fitting of contact lens for treatment of ocular surface disease	4	MPFS
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., Tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopi 3 or 7 equivalent)	5	MPFS
92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	8	MPFS
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	11	MPFS
92100	Serial tonometry with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (e.g., diurnal curve or	2	Based on hospital BR as MPFS value is equipment intense

Code	Description	RVU	Rationale
	medical treatment of acute elevation of intraocular pressure)		
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	4	MPFS
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	4	MPFS
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	5	MPFS
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation	6	MPFS
92201	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral	3	MPFS
92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula (e.g., for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral	2	MPFS
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral	2	Based on hospital BR as no MPFS value
92230	Fluorescein angioscopy with interpretation and report	0	Not a hospital service
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral	4	Based on hospital BR as MPFS value is equipment intense
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral	2	Based on hospital BR as MPFS value is equipment intense
92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient	6	Based on hospital BR as MPFS value is equipment intense

Code	Description	RVU	Rationale
	encounter with interpretation and report, unilateral or bilateral		
92250	Fundus photography with interpretation and report	5	MPFS
92260	Ophthalmodynamometry	4	MPFS
92265	Needle oculoelectromyography, 1 or more extraocular muscles, 1 or both eyes, with interpretation and report	12	MPFS
92270	Electro-oculography with interpretation and report	20	MPFS
92273	Electroretinography (ERG), with interpretation and report; full field (i.e., ffERG, flash ERG, Ganzfeld ERG)	27	MPFS
92274	Electroretinography (ERG), with interpretation and report; multifocal (mfERG)	16	MPFS
92283	Color vision examination, extended, e.g., anomaloscope or equivalent	13	MPFS
92284	Dark adaptation examination with interpretation and report	13	MPFS
92285	External ocular photography with interpretation and report for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereophotography)	6	MPFS
92286	Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis	5	MPFS
92287	Anterior segment imaging with interpretation and report; with fluorescein angiography	14	Based on hospital BR as MPFS value is equipment intense
92499	Unlisted ophthalmological service or procedure	BR	Unlisted service
95930	Visual evoked potential (VEP) checkerboard or flash testing central nervous system except glaucoma, with interpretation and report	EEG	Report in EEG rate center

OTORHINOLARYNGOLOGIC SERVICES

Code	Description	RVU	Rationale
92504	Binocular microscopy	7	MPFS
92511	Nasopharyngoscopy with endoscope	SLP	Report in Speech Language Pathology rate center

REHABILITATION SESSIONS AND OTHER SERVICES

Code	Description	RVU	Rationale
93668	Peripheral arterial disease (PAD) rehabilitation, per session	4	MPFS
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	PT/OT	Report in PT/ OT rate center
93750	Interrogation of ventricular assist device (VAD), in person, with qualified health care professional analysis of device parameters (e.g., drivelines, alarms, power surges), review of device function (e.g., flow and volume status, septum status, recovery), with programming, if performed, and report	EKG	Report in EKG rate center
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ration (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed	E/M	Align with E&M RVUs
93797	Qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	3	MPFS
93798	Qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	5	MPFS
94625	Qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)	15	MPFS
94626	Qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)	16	MPFS

Code	Description	RVU	Rationale
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	1	Based on hospital BR as no MPFS value
G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)	3	MPFS
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)	3	MPFS
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)	4	MPFS
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session	3	Consistency with CPT 93797
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session	5	Consistency with CPT 93798

ALLERGY TESTING/IMMUNOTHERAPY

Code	Description	RVU	Rationale
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	1	MPFS
95017	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests	2	MPFS
95018	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests	5	MPFS

7/1/2022APPENDIX D CLINICAL SERVICES#
STANDARD UNIT OF MEASURE REFERENCES

Code	Description	RVU	Rationale
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	2	MPFS
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests	1	MPFS
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests	4	MPFS
95044	Patch or application test(s) (specify number of tests)	1	MPFS
95052	Photo patch test(s) (specify number of tests)	2	MPFS
95056	Photo tests	BR	No volumes
95060	Ophthalmic mucous membrane tests	BR	No volumes
95065	Direct nasal mucous membrane test	8	MPFS
95076	Ingestion challenge tests (sequential and incremental ingestion of test items, e.g., food, drug, or other substance); initial 120 minutes of testing	19	MPFS
95079	Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug, or other substance); each additional 60 minutes of testing	10	MPFS
95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection	0	Not a hospital service
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections	0	Not a hospital service
95180	Rapid desensitization procedure, each hour (e.g., insulin, penicillin, equine serum)	19	MPFS
95199	Unlisted allergy/clinical immunologic service or procedure	BR	Unlisted service

7/1/2022APPENDIX D CLINICAL SERVICES#
STANDARD UNIT OF MEASURE REFERENCES

ENDOCRINOLOGY

Code	Description	RVU	Rationale
95249	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording	**7**	Equipment intense; OPPS APC weight more appropriate
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; qualified health care professions (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording	**7**	Consistency with CPT 95249, patient vs provider equipment not a factor
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report	0	Not a hospital service

ELECTROMYOGRAPHY

No RVUs were as assigned to these services (e.g., CPT 95874). These services are reportable via the Electroencephalography (EEG) rate center.

GENETIC COUNSELING

Code	Description	RVU	Rationale
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family	2	Service equivalent to E/M charges, various increments determined value

PSYCHOLOGICAL ASSESSMENTS, TESTING, AND INTERVENTIONS

Code	Description	RVU	Rationale
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgement, [e.g., acquired knowledge, attention, language, memory, planning, and problem solving, and visual spatial	8	MPFS

Code	Description	RVU	Rationale
	abilities]), by qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour		
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgement, [e.g., acquired knowledge, attention, language, memory, planning, and problem solving, and visual spatial abilities]), by qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour	5	MPFS
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	SLP or PT/OT	Report in SLP or PT/OT rate center
96130	Psychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	8	MPFS
96131	Psychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour	6	MPFS
96132	Neuropsychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the	12	MPFS

Code	Description	RVU	Rationale
	patient, family member(s) or caregiver(s), when performed; first hour		
96133	Neuropsychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour	9	MPFS
96136	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method; first 30 minutes	7	MPFS
96137	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method; each additional 30 minutes	7	MPFS
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	10	MPFS
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes	10	MPFS
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	1	MPFS
96156	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)	6	MPFS
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	4	MPFS
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	1	MPFS
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	1	MPFS

Code	Description	RVU	Rationale
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	1	MPFS
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	4	MPFS
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	2	MPFS
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	7	MPFS
96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes	3	MPFS

DRUG ADMINISTRATION AND DELIVERY

Code	Description	RVU	Rationale
95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed	6	Equipment intense; RVU is in line with prior By Report values
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	8	MPFS
96361	Intravenous infusion, hydration; each additional hour	3	MPFS
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis; initial, up to 1 hour	18	MPFS
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis; each additional hour	4	MPFS
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis; additional sequential infusion of a new drug/substance, up to 1 hour	7	MPFS
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion	4	MPFS

Code	Description	RVU	Rationale
96369	Subcutaneous infusion for therapy or prophylaxis; initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)	18	Consistency with CPT 96365
96370	Subcutaneous infusion for therapy or prophylaxis; each additional hour	4	Consistency with CPT 96366
96371	Subcutaneous infusion for therapy or prophylaxis; additional pump set-up with establishment of new subcutaneous infusion site(s)	6	Consistency with CPT 95990
96372	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular	2	MPFS
96373	Therapeutic, prophylactic, or diagnostic injection; intra-arterial	4	MPFS
96374	Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug	10	MPFS
96375	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of a new substance/drug	4	MPFS
96376	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of the same substance/drug provided in a facility	1	MPFS
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection	4	MPFS
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	7	Drug intense; OPPS APC weight more appropriate
96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic	7	Drug intense; OPPS APC weight more appropriate
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	7	Drug intense; OPPS APC weight more appropriate
96406	Chemotherapy administration; intralesional, more than 7 lesions	7	Consistency with CPT 96405
96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug	10	Consistency with CPT 96374
96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug	4	Consistency with CPT 96375

Code	Description	RVU	Rationale
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	18	Consistency with CPT 96365
96415	Chemotherapy administration, intravenous infusion technique; each additional hour	4	Consistency with CPT 96366
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	18	Consistency with CPT 96413
96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour	1	Consistency with CPT 96376
96420	Chemotherapy administration, intra-arterial; push technique	BL	Invasive service
96422	Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour	BL	Invasive service
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour	BL	Invasive service
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	BL	Invasive service
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	BL	Invasive service
96446	Chemotherapy administration into peritoneal cavity via indwelling port or catheter	BL	Invasive service
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	BL	Invasive service
96521	Refilling and maintenance of portable pump	6	Consistency with CPT 95990
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	6	Consistency with CPT 95990
96523	Irrigation of implanted venous access device for drug delivery systems	3	Based on hospital BR as MPFS value is equipment intense

Code	Description	RVU	Rationale
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	6	Based on hospital BR as MPFS value is too high
96549	Unlisted chemotherapy procedure	BR	Unlisted service
C8957	Intravenous infusion for therapy/ diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable of implantable pump	18	Consistency with CPT 96413
G0498	Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/other outpatient setting, includes follow up office/other outpatient visit at the conclusion of the infusion	18	Consistency with CPT 96416
0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day	0	Bundled service with the biologic
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	18	Consistency with CPT 96413
0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	9	Based on hospital BR as no MPFS value
0663T	Scalp cooling, mechanical; placement of device, monitoring, and removal of device	12	Based on hospital BR as no MPFS value

PHOTODYNAMIC THERAPY/DERMATOLOGY

Code	Description	RVU	Rationale
96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day	BR	No volumes

Code	Description	RVU	Rationale
96570	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes	3	MPFS
96571	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes	2	MPFS
96900	Actinotherapy (ultraviolet light)	7	MPFS
96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality	2	MPFS
96904	Whole body integumentary photography, for monitoring of high-risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	6	Based on hospital BR as MPFS value is equipment intense
96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B	2	Based on hospital BR as MPFS value is equipment intense
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	2	Based on hospital BR as MPFS value is equipment intense
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)	BR	No volumes
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm	BR	No volumes
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm	BR	No volumes
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm	BR	No volumes
96999	Unlisted special dermatological service or procedure	BR	Unlisted service

7/1/2022APPENDIX D CLINICAL SERVICES#
STANDARD UNIT OF MEASURE REFERENCES

ACTIVE WOUND CARE MANAGEMENT

No RVUs were as assigned to these services (e.g., CPT 97597). These services are reportable via the rehabilitation (Physical and Occupational Therapy) rate centers. Clinic staff costs should be reallocated to the therapy rate centers for appropriate matching of revenue and expense.

MEDICAL NUTRITION THERAPY AND DIABETES MANAGEMENT

Code	Description	RVU	Rationale
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	5	MPFS
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	5	MPFS
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes	2	MPFS
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	7	MPFS
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes	2	MPFS
G0270	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen, (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	5	MPFS
G0271	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen, (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes	2	MPFS
0403T	Preventative behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day	4	Consistency with CPT G0109 x2

ACCUPUNCTURE AND CHIROPRACTIC

Code	Description	RVU	Rationale
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	5	MPFS
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	3	MPFS
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	7	MPFS
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	5	MPFS
98925	Osteopathic manipulative treatment (OMT); 1-2 body regions involved	4	MPFS
98926	Osteopathic manipulative treatment (OMT); 3-4 body regions involved	6	MPFS
98927	Osteopathic manipulative treatment (OMT); 5-6 body regions involved	7	MPFS
98928	Osteopathic manipulative treatment (OMT); 7-8 body regions involved	8	MPFS
98929	Osteopathic manipulative treatment (OMT); 9-10 body regions involved	9	MPFS
98940	Chiropractic manipulation treatment (CMT); spinal, 1-2 regions	3	MPFS
98941	Chiropractic manipulation treatment (CMT); spinal, 3-4 regions	4	MPFS
98942	Chiropractic manipulation treatment (CMT); spinal, 5 regions	5	MPFS
98943	Chiropractic manipulation treatment (CMT); extraspinal, 1 or more regions	3	MPFS

7/1/2022APPENDIX D CLINICAL SERVICES#
STANDARD UNIT OF MEASURE REFERENCES

EDUCATION AND TRAINING

Code	Description	RVU	Rationale
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	7	Consistency with CPT G0108
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	2	Consistency with CPT G0109
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	2	Consistency with CPT G0109

NON-FACE-TO-FACE AND NON-MEDICAL SERVICES

Code	Description	RVU	Rationale
98966	Telephone assessment and management service provided by a qualified nonphysician heath care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion	0	Professional service
98967	Telephone assessment and management service provided by a qualified nonphysician heath care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or	0	Professional service

Code	Description	RVU	Rationale
	procedure within the next 24 hours or soonest available appointment: 11-20 minutes of medical discussion		
98968	Telephone assessment and management service provided by a qualified nonphysician heath care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion	0	Professional service
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	0	Professional service
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	0	Professional service
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	0	Professional service
98975	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	5	MPFS
98976	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	0	Not a regulated service
98977	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy	0	Not a regulated service

Code	Description	RVU	Rationale
	response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days		
98980	Remote therapeutic monitoring treatment management services, qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes	0	Not a regulated service
98981	Remote therapeutic monitoring treatment management services, qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes	0	Not a regulated service
99078	Qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)	0	Not a regulated service
99441	Telephone evaluation and management service by a qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion	0	Professional service
99442	Telephone evaluation and management service by a qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest	0	Professional service

Code	Description	RVU	Rationale
	available appointment: 11-20 minutes of medical discussion		
99443	Telephone evaluation and management service by a qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion	0	Professional service
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	0	Not a regulated service
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to a E/M service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion	0	Not a regulated service

SUBSTANCE ABUSE SERVICES

Code	Description	RVU	Rationale
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	2	MPFS

Code	Description	RVU	Rationale
99407	Smoking and tobacco use cessation counseling; intensive, greater than10 minutes	3	MPFS
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	0	Not a regulated service
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	0	Not a regulated service

COVID-19-RELATED CODES

Codes will continue to be added as COVID-19 treatments are identified.

Code	Description	RVU	Rationale
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose	3	Consistency with CPT 90471
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose	3	Consistency with CPT 90471
0003A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; third dose	3	Consistency with CPT 90471
0004A	Immunization administration by intramuscular injection of severe acute	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
	respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; booster dose		
0011A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose	3	Consistency with CPT 90471
0012A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose	3	Consistency with CPT 90471
0013A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; third dose	3	Consistency with CPT 90471
0021A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose	3	Consistency with CPT 90471
0022A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free,	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
	5x1010 viral particles/0.5mL dosage; second dose		
0031A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage; single dose	3	Consistency with CPT 90471
0034A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage; booster dose	3	Consistency with CPT 90471
0041A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage; first dose	3	Consistency with CPT 90471
0042A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage; second dose	3	Consistency with CPT 90471
0051A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; first dose	3	Consistency with CPT 90471
0052A	Immunization administration by intramuscular injection of severe acute	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
	respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; second dose		
0053A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; third dose	3	Consistency with CPT 90471
0054A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; booster dose	3	Consistency with CPT 90471
0064A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25mL dosage; booster dose	3	Consistency with CPT 90471
0071A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2mL dosage, diluent reconstituted, tris-sucrose formulation; first dose	3	Consistency with CPT 90471
0072A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
	mcg/0.2mL dosage, diluent reconstituted, tris-sucrose formulation; second dose		
0073A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation: third dose	3	Consistency with CPT 90471
0081A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation: first dose	3	Consistency with CPT 90460
0082A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation: second dose	3	Consistency with CPT 90460
0094A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, booster dose	3	Consistency with CPT 90471
M0220	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for who vaccination	4	Consistency with CPT 96372 X 2

Code	Description	RVU	Rationale
	with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 component(s), includes injection and post administration monitoring		
M0222	Intravenous injection, bebtelovimab, includes injection and post administration monitoring	18	Consistency with CPT 96365
M0240	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses	22	Consistency with CPT 96365 plus CPT 96368
M0243	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring	22	Consistency with CPT 96365 plus CPT 96368
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring	22	Consistency with CPT 96365 plus CPT 96368
M0247	Intravenous infusion, sotrovimab, includes infusion and post administration monitoring	18	Consistency with CPT 96365
M0249	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, first dose	0	Inpatient procedure
M0250	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, second dose	0	Inpatient procedure

GASTROENTEROLOGY

All GI services (codes 91000-91299) will be reported through the operating room center. (See the Surgical Procedure section for more information.)

PART III: SURGICAL PROCEDURES

Any surgical procedures performed in a clinic should be reported via the Operating Room-Clinic (ORC) cost center, and associated surgical costs allocated to the ORC rate center (excluding the exceptions listed in more detail below.) Surgical procedures are defined as all procedures corresponding to CPT codes from 10000 to 69999 (surgery), 91000 to 91299 (gastroenterology), and 93000 to 93050 (cardiography).

A few rate centers include a limited number of surgical procedures with CPT codes between 10000 and 69999 that have already been assigned RVUs relative to other procedures in that cost center. For the most part, the RVU values and reporting of these procedures will remain unchanged. The procedures and how they should be reported are:

- *Clinic*-Specimen Collection via VAD (CPT 36591), Declotting (CPT 36593), and Blood Transfusions (CPT 36430) have been assigned Clinic RVUs and should be reported as clinic revenue.

- *Delivery*-Non-Stress Tests, amniocentesis, external versions, cervical cerclages, dilation and curettage/evacuation and curettage, hysterectomies, deliveries, etc. Continue to report via DEL by assigned RVUs.

- *Interventional Cardiology*-certain IRC procedures have surgical CPT codes are defined in the IRC rate center with RVUs. Hospitals should continue to report using those IRC RVUs until instructed otherwise.

- *Laboratory*-Venipuncture/Capillary punctures. These procedures are part of the E/M component of a clinic visit. If a hospital chooses to code and report them separately in the clinic, the RVU is zero. If a phlebotomist comes to the clinic to do the procedure, the revenue and expenses are allocated to LAB.

- *Lithotripsy* -Procedures will continue to be reported in the LIT cost center as the number of procedures.

- *Occupational and Physical Therapy*-Splinting, Strapping and Unna Boot application (CPT codes 29105-29590) continue to report with assigned PT/OT RVUs.

- *Radiation Therapy*-Stereotactic Radiosurgery (61793). Continue to report with assigned RAT RVUs.

- *Speech Therapy*-Laryngoscopy (31579). Continue to report via STH by assigned RVUs.

CAPTURING MINUTES FOR SURGICAL PROCEDURES PERFORMED IN CLINIC

The counting of minutes for surgical procedures performed in clinics is different than the rules in the operating room Chart of Accounts [See Operating Room Chart of Accounts.]

Clinicians need to document procedure stop and start times in the medical record unless the hospital is using average times. It is not necessary to keep a log like the one kept in the Operating Room (OR) to document the minutes of each procedure. Unlike in the OR, clinic staff may enter and leave the room during a procedure. Please reference additional information in this section regarding reporting of actual minutes (included vs. excluded minutes).

As an alternative to reporting actual minutes, hospitals may report procedures using average times that are "hard coded". To report average procedure times, hospitals should conduct time studies to find the average time it takes to perform common procedures and periodically verify these average times. Please reference additional information in this section regarding reporting of average minutes (included vs. excluded minutes).

ACTIVITIES INCLUDED IN PROCEDURE TIME

For surgical procedures performed in the clinic, some activities that are integral to the procedure may not be typically thought of as included in the time of the procedure. The following lists of included and excluded activities are examples to guide the decision of which activities to include and exclude from the timing of surgical procedures performed in clinics. These lists are not all-inclusive but should be used as a guide when reporting minutes for these services.

INCLUDED ACTIVITIES

When the following activities are integral to a procedure, the time it takes to perform the activity should be included in the procedure time. These services are all above and beyond the actual performance of the surgical service, i.e., "cut to close". Many of these examples apply directly

to wound care but should also be applied to all surgical procedures performed in the clinic. The overriding consideration is that the minutes associated with the procedure along with the minutes associated with clinical care time spent preparing the recovering the patient are reportable surgical minutes.

- Positioning of the patient in preparation for the procedure
- Removal of dressing/casting/Unna boot (i.e., whatever covers the wound)
- Cleansing of wound
- Wound measurement and assessment
- Applications of topical/local anesthetic
- Application of topical pharmaceuticals and dressing post procedure
- Monitored time when waiting for anesthetic to become effective
- Taking vital signs
- Monitored time when waiting for cast to dry

Monitored time post procedure when waiting for recovery from anesthetic

EXCLUDED ACTIVITIES

The time it takes to perform the following activities should not be included in the procedure time.

- Waiting time in general
- Teaching
- Non-monitored time when waiting for topical and/or local anesthetic to become effective
- Non-monitored time when waiting for cast to dry
- Non-monitored time post procedure when waiting for recovery from anesthetic

7/1/2022APPENDIX D CLINICAL SERVICES#

STANDARD UNIT OF MEASURE REFERENCES

maryland
health services
cost review commission

Update on Medicare FFS Data & Analysis

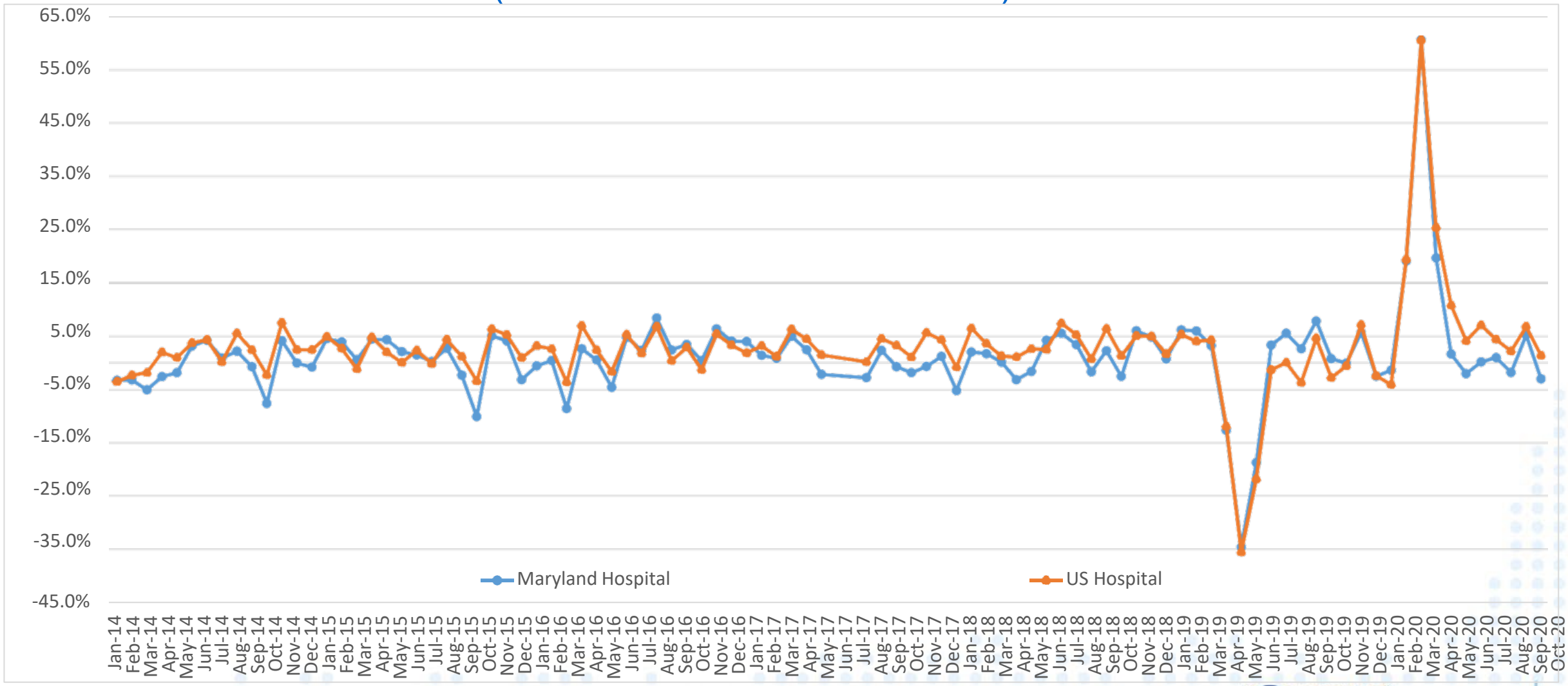
March 2022 Update – FINAL DATA

Data through December 2021, Claims paid through March 22

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

Medicare Hospital Spending per Capita

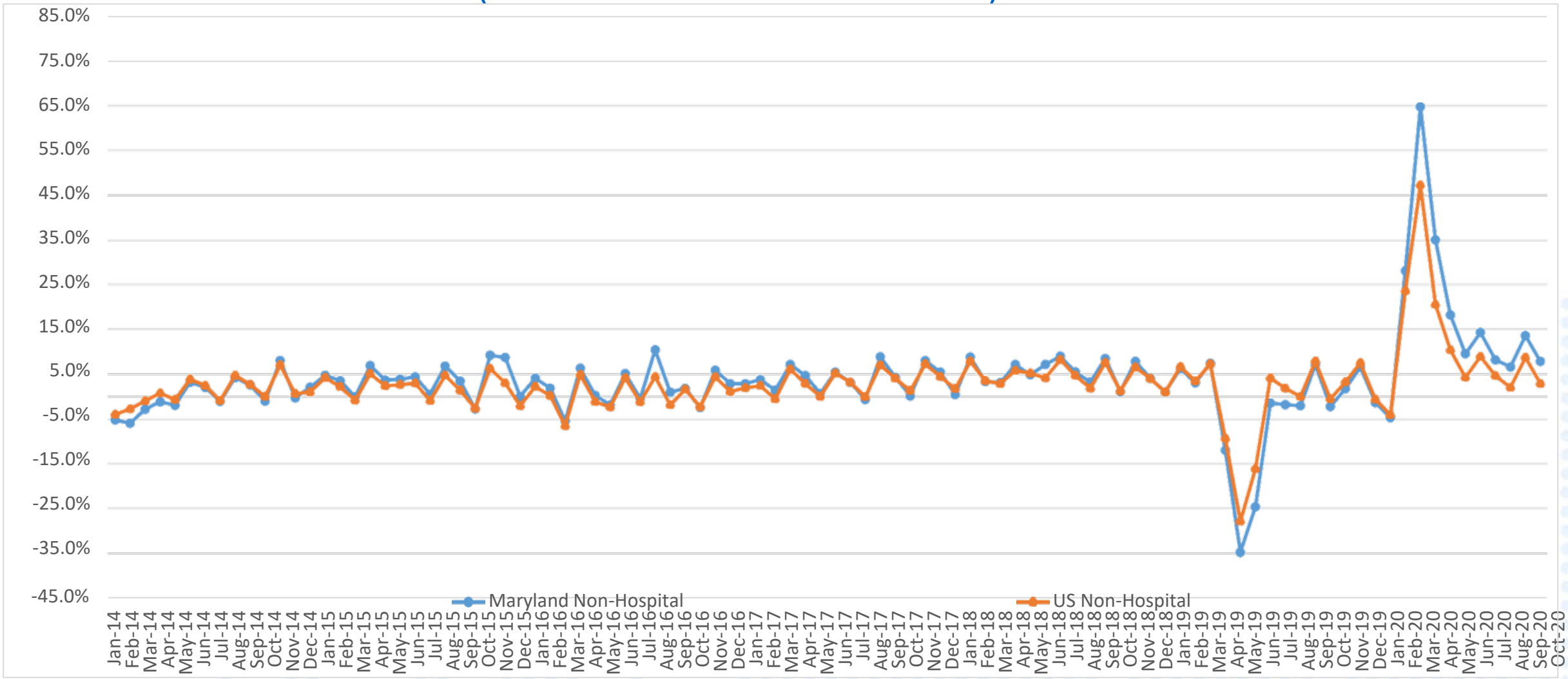
Actual Growth Trend (CY month vs. Prior CY month)



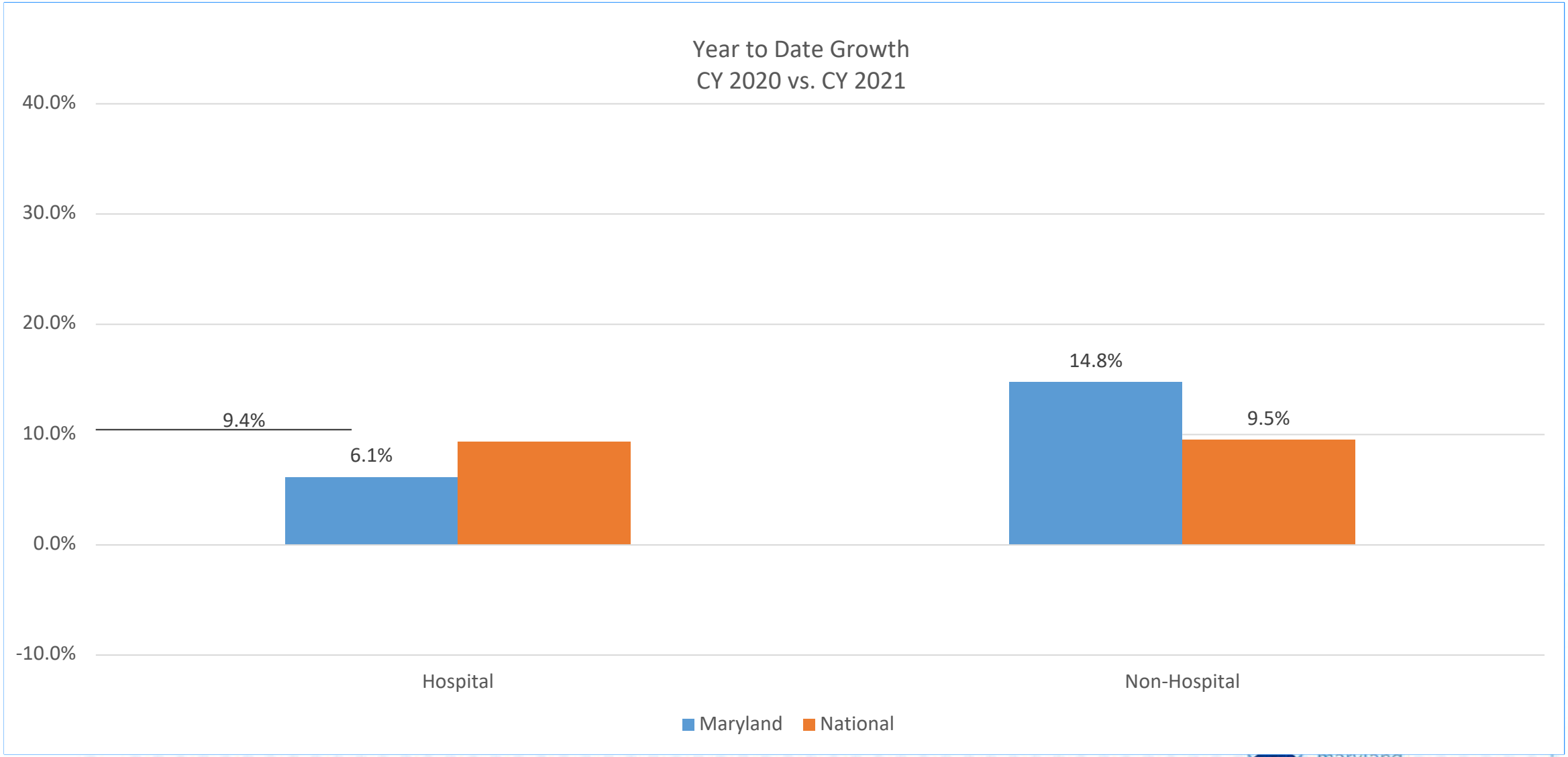
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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

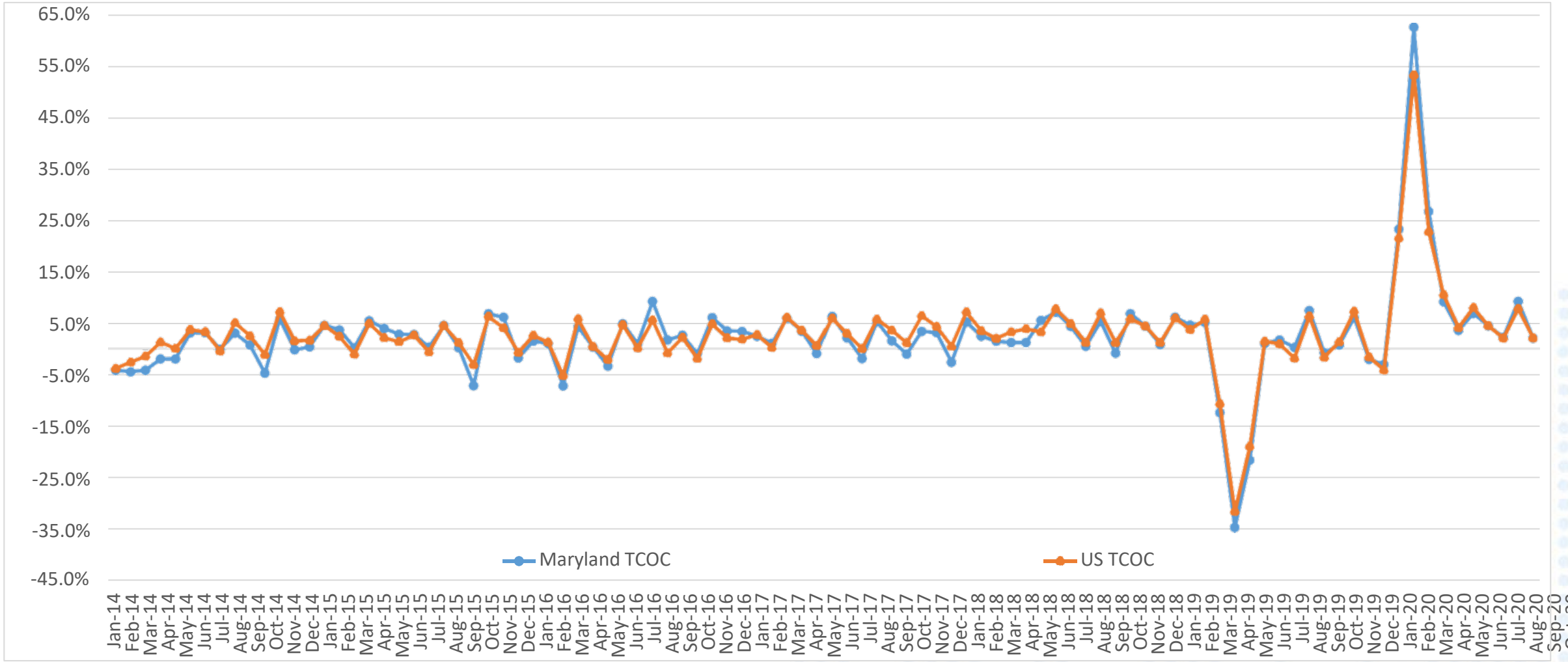


Medicare Hospital & Non-Hospital Payments per Capita



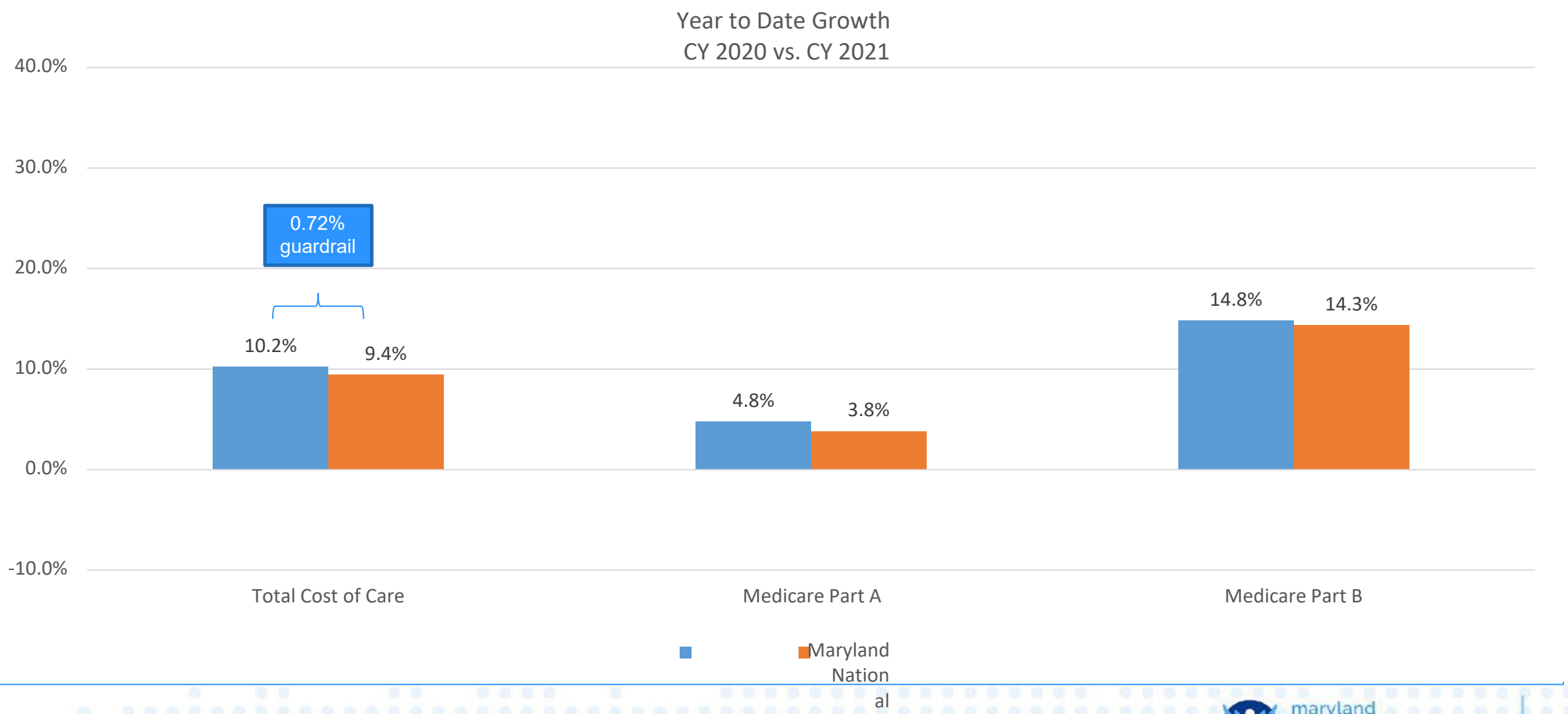
Medicare Total Cost of Care Spending per Capita

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



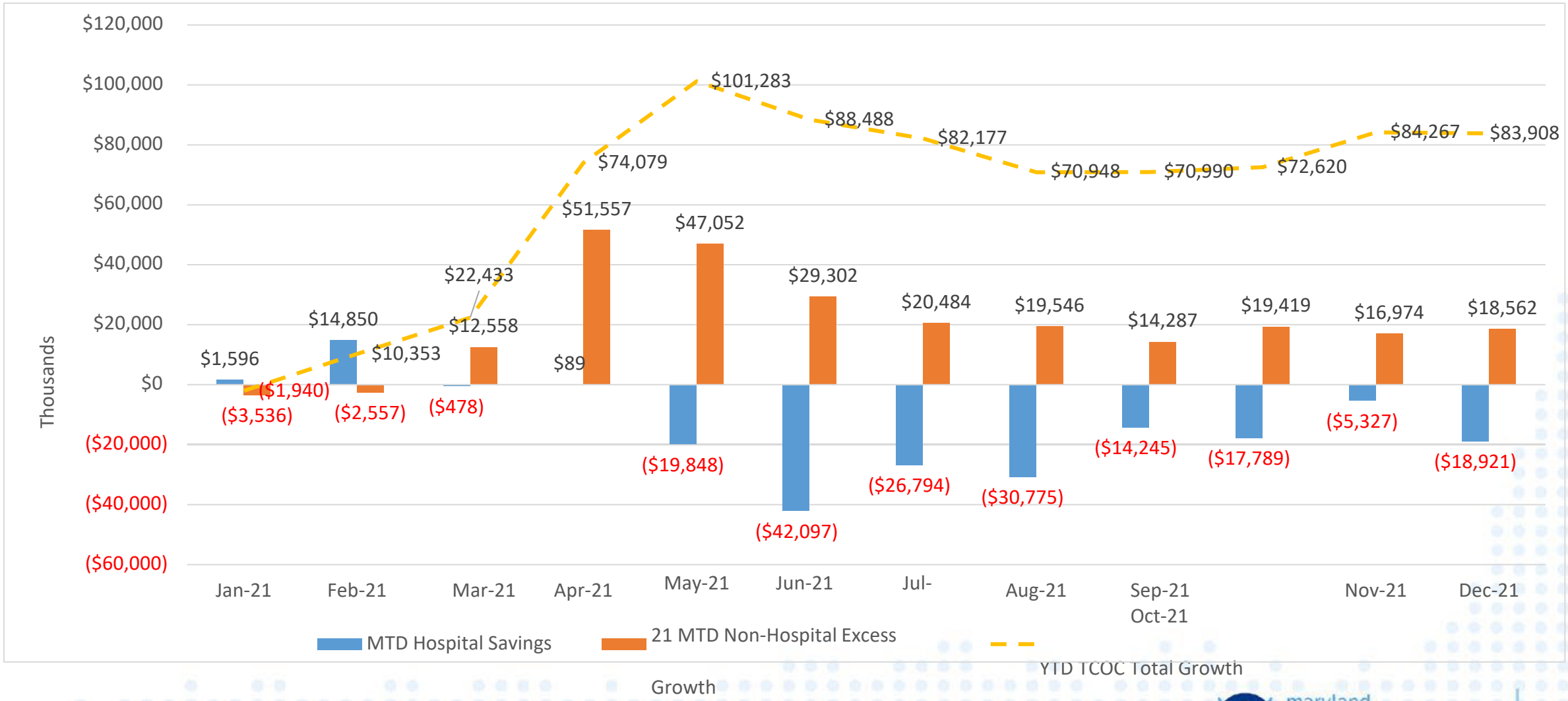
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through December 2021



maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: May 11, 2022

RE: Hearing and Meeting Schedule

June 8, 2022 To be determined - GoTo Webinar

July 13, 2022 To be determined - GoTo Webinar

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

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