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566th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
November 13, 2019

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

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

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

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public and Closed Meetings held on October 16, 2019**

2. **Docket Status – Cases Closed**
   2500A-University of Maryland Medical Center

3. **Docket Status – Cases Open**
   2490R-Suburban Hospital
   2492A-MedStar Health
   2493A-Johns Hopkins Health System
   2497N-UM Shore Emergency Center Queenstown
   2498A- University of Maryland Medical Center
   2499A-Maryland Physicians Care
   2501A-University of Maryland Medical Center
   2502A-University of Maryland Medical Center
   2503R-Johns Hopkins Bayview Medical Center
   2504A-Johns Hopkins Health System
   2505A-Johns Hopkins Health System
   2506A-University of Maryland Medical System
   2507A- University of Maryland Medical System
   2508A – Johns Hopkins Health System

4. **Recommendation on Suburban Full Rate Review**

5. **Final Recommendation on Regional Partnership Grant Program**

6. **Final Recommendation on Medicare Performance Adjustment for RY 2022**

7. **Draft Recommendation on Maximum Quality Guardrail**

8. **Draft Recommendation on Quality-Based Reimbursement (QBR) Policy for RY 2022**

9. **Draft Recommendation on the Nurse Support Program (NSP) II Renewal**

10. **Final Recommendations on Requests for HSCRC Confidential Data:**

    a. **Emory University, Rollins School of Public Health**
    b. **UM School of Medicine, Baltimore's Shock Trauma and Anesthesiology Research Center (STAR), National Study Center for Trauma and EMS (NSC)**

11. **Policy Update and Discussion**

    a. **Model Monitoring Update**
    b. **Laurel Regional Volume Dissipation**

12. **Hearing and Meeting Schedule**

Closed Session Minutes
Of the
Health Services Cost Review Commission

October 16, 2019

Upon motion made in public session, Chairman Sabatini 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

The Closed Session was called to order at 11:33 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance in addition to Chairman Sabatini were Commissioners Antos, Bayless, Cohen, Colmers, Elliott, and Kane.

In attendance representing Staff were Katie Wunderlich, Allan Pack, Chris Peterson, William Henderson, Will Daniel, Tequila Terry, Alyson Schuster, Joe Delenick, Claudine Williams, Amanda Vaughn, Bob Gallion, and Dennis Phelps.

Also attending were Eric Lindemann, Commission Consultant, and Stan Lustman and Tom Werthman, Commission Counsel.

Item One

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

Item Two

The Commissioners and the staff discussed the status and oversight of the Maryland Primary Care program.

Item Three

Joe Delenick, Associate Director-Revenue & Rate Regulation, updated the Commission on the status of the issuance of rate orders and the shift of revenue from regulated to unregulated.

Item Four

Staff updated the Commission on the status of full rate applications filed with the Commission.

Item Five

Chris Peterson, Director-Payment Reform and Provider Alignment, updated the Commission and the Commission discussed the draft Memorandum of Understanding between the Centers for Medicare and Medicaid Services and the State of Maryland on population health improvement strategy.

Item Six

Staff updated the Commission and the Commission discussed Emergency Department performance.

Item Seven

The Commission was updated on possible legislation concerning the value of the tax exempt status of hospitals and possible revisions of the HSCRC's Community Benefit Report.

Item Eight

Katie Wunderlich, Executive Director, updated the Commission on the status of the Federal No Surprise billing legislation and Maryland's efforts to protect the All-Payer System.

The Closed Session was adjourned at 1:00 p.m.

MINUTES OF THE
565th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
October 16, 2019

Chairman Nelson Sabatini called the public meeting to order at 11:33 a.m. Commissioners Joseph Antos, Victoria Bayless, Stacia Cohen, John Colmers, James Elliott, M.D., and Adam Kane were also in attendance. Upon motion made by Commissioner Antos and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Sabatini reconvened the public meeting at 1:13 p.m.

REPORT OF OCTOBER 16, 2019 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the October 16, 2019 Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM SEPTEMBER 11, 2019 CLOSED SESSION AND PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the September 11, 2019 Public Meeting and the minutes of the Closed Session.

ITEM II
DOCKET STATUS CLOSED CASES

2485A - Johns Hopkins Health System
2486A - Johns Hopkins Health System
2487A - Johns Hopkins Health System
2488A - Johns Hopkins Health System
2489A - MedStar Health
2491A - MedStar Health
2494A - Johns Hopkins Health System
2495A - Johns Hopkins Health System
2496A - Johns Hopkins Health System

ITEM III
OPEN CASES
2500A UNIVERSITY OF MARYLAND

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on September 27, 2019 requesting approval to continue its participation in a global rate arrangement with BlueCross and BlueShield Association Blue Distinction Centers for solid organ and blood and bone marrow transplant services for a period of one year beginning November 1, 2019.

The staff recommends that the Commission approve the Hospital's application for an alternative

method of rate determination for blood and bone marrow transplant services, for a one year period commencing November 1, 2019. The Hospital 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 Hospital for the approved contract

Commissioners voted unanimously to approve Staff's recommendation.

ITEM IV
NEW MODEL MODELING

Ms. Caitlyn Cooksey, Assistant Chief, Hospital Rate Regulation presented CY2019 Medicare Fee-For-Service (FFS) data through June 2019 (with claims paid through August 2019). During this period, Maryland Medicare per capita Total Cost of Care (TCOC) spending has been mixed with the last three months being favorable when compared to the nation. More specifically, Maryland Medicare per capita hospital spending has been mixed with the month of June being favorable when compared to the nation; however, per capita non-hospital spending has been mostly unfavorable. This results in Medicare Hospital and Non-Hospital savings of $24,974,000 over the same period last year.

Ms. Amanda Vaughan, Associate Director Financial Data Administration, reported that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of August 2019 focuses on the fiscal year (July 1 through June 30) as well as calendar year results.

Ms. Vaughan reported that for the two months of the fiscal year ending August 31, 2019, All-Payer total gross hospital revenue increased by 2.26% over the same period in FY 2019. All-Payer total gross hospital revenue for Maryland residents increased by 2.10%. All-Payer gross hospital revenue for non-Maryland residents increased by 3.96%.

Ms. Vaughan reported that for the eight months of the calendar year ending August 31, 2019, All-Payer total gross hospital revenue increased by 1.62% over the same period in CY 2018. All-Payer total gross hospital revenue for Maryland residents increased by 1.53%. All-Payer gross hospital revenue for non-Maryland residents increased by 2.68%.

Ms. Vaughan reported that for the two months of fiscal year ending August 31, 2019, Medicare FFS gross hospital revenue increased by 0.42% over the same period in FY 2018. Medicare FFS gross hospital revenue for Maryland residents increased by 0.28%. Maryland FFS gross hospital revenue for non-residents increased by 1.99%.

Ms. Vaughan reported that for the eight months of the calendar year ending August 31, 2019, Medicare FFS gross hospital revenue increased by .18% over the same period in CY 2018.

Medicare FFS gross hospital revenue for Maryland residents increased by .22%. Maryland FFS gross hospital revenue for non-residents declined by 0.32%.

Ms. Vaughan reported that for the two months of the fiscal year ending August 31, 2019, over the same period in FY 2018, All Payer in State per capita hospital revenue growth was 1.80%. Ms. Vaughan noted that the Medicare Fee-For-Service in State per capita hospital revenue for the same period declined by 2.03%.

Ms. Vaughan reported that for the eight months of the calendar year ending August 31, 2019, over the same period in CY 2018, the All Payer in State per capita hospital revenue growth was 1.22%. The Medicare Fee for Service per capita hospital revenue growth declined by 2.09% over the same period in CY 2018.

ITEM V
FINAL RECOMMENDATION ON MPA FRAMEWORK POLICY

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, presented Staff's draft recommendation on the Medicare Performance Adjustment Framework policy (see, "Final Recommendation for the Medicare Performance Adjustment Framework" on the HSCRC website).

The Medicare Performance Adjustment (MPA) Framework policy is designed to incentivize hospitals to engage with partners in Care Transformation Initiatives (CTIs) with a goal to reduce the Medicare Total Cost of Care (TCOC) across all care settings, while ensuring that the State meets its Medicare savings targets in the TCOC Model Agreement.

This recommendation for the MPA Framework replaces the prior draft recommendation which referred to the MPA Efficiency adjustment. For clarity, Staff is no longer using the term MPA Efficiency or MPA Efficiency Component. Instead, this policy will be referred to as the MPA Framework, and within this framework there will be two components that will allow adjustments to Medicare rates:

- The MPA Reconciliation Component (MPA-RC): to be used to encourage Care Transformation Initiatives
- The MPA Savings Component (MPA-SC): to be used to help the State achieve its savings benchmarks by reducing hospital Medicare payments

The original Medicare Performance Adjustment policy will be referred to as the Traditional MPA. The Traditional MPA is not governed by this policy.

Maryland's initial All-Payer Model agreement ended on December 31, 2018, after the State successfully met or exceeded its obligations to the federal government. To meet its financial savings obligation, the State targeted an annual growth rate for hospitals' Global Budget

Revenue (GBR) to $330 M of cumulative savings to Medicare. By limiting the growth of hospital GBRs, this savings approach created benefits to all payers. By allowing hospitals to keep savings associated with hospital utilization reductions, hospitals were encouraged to engage in care transformation activities and reduce unnecessary utilization. Combined, the All-Payer Model generated savings for all payers, improved quality of care, and incentivized the creation and expansion of successful care transformation programs.

The Maryland TCOC Model replaced the All-Payer Model in January 2019. Under the TCOC Model, the State committed to reach an annual Medicare total cost of care savings rate of $300 million by 2023, inclusive of non-hospital costs. The new model provides a flexible Medicare payment adjustment mechanism. The MPA Framework policy articulates an approach to using this new tool, which incentivizes hospitals to develop CTIs and reduce costs, as well as achieve the Medicare TCOC Savings. The CTI program, which started in 2019, rewards quantifiable care innovation that hospitals have invested in under the Model.

In short, the MPA Framework will allow hospitals to keep savings they produce from non-hospital costs through reconciliation payments (the MPA-RC). This is similar to the way that the GBR allows hospitals to keep hospital utilization savings. In addition, the MPA Framework can prospectively reduce hospital Medicare payments in order to meet the TCOC Medicare savings requirements, if required (the MPA-SC). Combined, the components of this policy will create savings to Medicare and incentivize the creation of successful CTIs that reduce the total cost of care in an intelligent fashion.

The TCOC Model Agreement allows the State to apply an adjustment to hospital payments in order to reward or penalize hospitals based on their success at controlling Medicare total cost of care. The adjustment is effectuated through a change to the amount paid by the Centers for Medicare & Medicaid Services (CMS) to hospitals after a claim has been received by the Medicare Administrative Contractor (MAC). The State calculates the amount and passes that amount to CMS, which then reduces all claims paid to the hospital by the indicated percentage. This adjustment is additive with other adjustments, like the sequestration adjustment, and is applied by CMS prior to paying a claim. The change does not go into hospital HSCRC rates, does not affect hospitals' GBR calculations, and is not reflected in rate orders.

Stakeholders expressed support for the use of the MPA-SC to meet the Medicare savings targets. They agreed that the MPA-SC would not be necessary to meet the savings target in the first half of 2020. Some stakeholders emphasize that the MPA-SC should be paired with an emphasis on efficiency which would mitigate the impact on hospitals with high Medicare share.

Stakeholders expressed support for the general principles of the MPA-RC, which include

- Incentives to hospitals to develop care transformation initiatives and reduce Medicare TCOC.
- Understanding individual hospital effort and success at reducing TCOC.

- Identify and penalize free-riders

Some stakeholders expressed concern about the effect of the MPA-RC offset.

Stakeholders expressed their concerns about limitation in the scope of the current CTI policy including:

- Limiting triggers to claim-related events
- Needing to include public health investments
- Lacking inclusion of other payers
- Using an earlier baseline than 2016

Staff recognizes there are limitations with the current data availability. Staff will work to expand the scope of the CTI policy by:

- Inviting interested hospitals to give Staff access to their Electronic Health Records
- Inviting other payers to share their claims data in order to develop a similar approach
- Working with stakeholders on modifications to the cost report to identify both CTI related costs and large public health investments

Some stakeholders expressed concern about the timing and approach for finalizing the CTI process and requested the HSCRC staff:

- Allow for more discussion of methodology, thematic groupings, triggering events, and episode duration before finalizing the policy
- Monitor performance rather than adding payments
- Discuss the overlap with other policies in more detail
- Formalize CTI calculation methodology in a Commission recommendation

Staff agreed that it will continue to discuss the methodology, CTI proposals, and discussion of the overlap with other policies through July 1st, 2020. However, staff does not consider it feasible to delay an assessment of care transformation activities given that the timeline currently extends to July 2022, which is already towards the end of the five year TCOC Model period. Staff also has added detail on the CTI methodology in the appendix of the final recommendation and will release a stand-alone, comprehensive user guide.

Staff final recommendation is as follows:

1. MPA-RC will be used to reward hospitals for Care Transformation savings (at up to 100% of savings) with reward payments offset across all hospitals.

2. Commission staff will continue to work with hospitals, providers, and other partners to develop CTIs. Qualifying CTIs will be made available to all hospitals to accelerate delivery system reform and encourage the sharing of best practices.

3. The Update Factor will be set to ensure that hospitals' Medicare payments do not exceed the Medicare total cost of care (TCOC) Guardrail, thereby constraining the growth of hospital costs for all payers in the system. No savings "cushion" will be provided to achieve Medicare savings; instead, the MPA-SC will be set to prospectively attain additional incremental savings necessary to achieve the $300 million Medicare savings target by CY 2023, if needed.

4. There will be no MPA-SC adjustment to hospital rates effective January 1, 2020 due to the total cost of care savings achieved through CY 2018.

Mr. Robert Murray, CareFirst Consultant, stated that CareFirst supports the Staff Recommendation. In regards to the MPA-SC (savings component), Mr. Murray noted that CareFirst had reservations regarding decoupling savings and allowing Medicare a direct payment offset. However, Staff has addressed these concerns during this year's update factor process by incorporating conservative update target limits. As a result, CareFirst supports using the MPA-SC as a mechanism to achieve TCOC model savings.

In regard to the MPA-RC (reconciliation component), Mr. Murray believes that it is a reasonable revenue-neutral approach to encourage hospitals to participate in CTIs since it allows hospitals to retain up to 100% of their Medicare TCOC savings originating from their sponsored CTIs. Under the TCOC model, it is critical for all hospitals to participate in programs designed to improve population health, and CareFirst supports the Staff's efforts to develop a policy to both encourage and reward hospitals for their participation.

Mr. Brett McCone, Maryland Hospital Association, Senior Vice President, Health Care Payment, stated that Maryland hospitals support the establishment of the MPA-SC. Mr. McCone noted that the MPA-SC will decouple the Medicare savings required under the Maryland's TCOC contract from the annual update factor. Mr. McCone asserted that the Update Factor should contribute to sustainable growth and should not be used to achieve Medicare only savings. Mr. McCone agreed with Staff's conclusion that the MPA-SC is not needed in 2020 because Maryland's performance under the Medicare total cost of care guardrail.

Mr. McCone also noted that Maryland hospitals support the ideal of recognizing savings from CTI, but it was premature to finalize a mechanism to adjust Medicare payments. The MPA-RC would establish a methodology to reward hospitals for demonstrated Medicare savings from CTI. As proposed, the policy would increase Medicare payments for hospital-specific CTI savings and offset the total amount of savings proportionately across all Medicare hospital payments. Hospitals appreciate the importance of showing that hospitals are improving care to produce per

capita savings under the TCOC. Hospitals agree we need to measure program savings, including CTIs beyond the formal care redesign programs. Because the proposed MPA-RC affects hospital payments, hospitals urge the Staff to be deliberate in measuring CTI savings. Staff's recommendation should include details on measuring CTI, accounting for costs associated with CTI, and providing the rationale for how the staff will prioritize the policy.

Commissioner Colmers stated that he was not fully clear on how all the components in Staff's recommendation fit together. For example, how does a CTI relate to a regional partnership and other activities. Commissioner Colmers expressed his strong support of the recommendation; however, would like to see how it all fits together, particularly how calculations are done. Commissioner Colmers directed Staff come back to the Commission prior to the implementation of the MPA Framework to address his concerns.

Commissioner Colmers offered an amendment to the Staff recommendation to require progress reports, which was agreed to by the Commission

Commissioners voted unanimously to approve Staff's amended recommendation.

ITEM VI
DRAFT RECOMMENDATION ON INTEGRATED EFFICIENCY POLICY

Mr. Allan Pack, Principal Deputy Director, Population-Based Methodologies, presented an update on Staff's draft Integrated Efficiency Policy (see "Final Recommendation on Integrated Efficiency Policy" on the HSCRC Website).

Since December of 2017, staff has been working with Commissioners and stakeholders to develop a formulaic and transparent methodology that identifies and addresses relative efficiency outliers in order to bring those outlier hospitals closer to peer average standards over time by measuring both cost per case and a per capita Medicare total cost of care growth performance. The purpose of this exercise is to update the HSCRC's efficiency measures to be in line with the per capita goals of Maryland's Total Cost of Care Model. Subsequently, in July 2019, a staff draft recommendation was brought before the Commission and for public comment that recommended the following policy components:

- Formally adopt policies to:
    a. Determine relative efficiency outliers;
    b. Evaluate Global Budget Revenue enhancement requests;
- Use the Inter-Hospital Cost Comparison, including its supporting methodologies, to compare relative cost per case for the above evaluations;

- Use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance for the above evaluations;
- Withhold the Medicare portion of the Annual Update Factor for efficiency outlier hospitals based on criteria described herein, effective January 1, 2020; and
- Use set aside outlined in the Annual Update Factor (.1% in RY 2020) and funding secured from withhold from outlier hospitals to fund potential Global Budget Enhancement Requests.

However, during the course of review following the publication of the July draft recommendation, a number of outstanding concerns were identified by staff, Commissioners, and stakeholders regarding the case mix adjustment for rehabilitation cases, use of a growth calculation in lieu of a benchmark attainment analysis for total cost of care performance, and concern that the policy should identify larger amounts of retained revenue. In light of these concerns, staff is recommending delaying the implementation of this policy until RY 2021. Instead, staff will bring a revised final recommendation in Spring 2020 that would affect the Annual Update Factor for RY 2021, the revised policy will incorporate a new cost per case analysis based on updated data using the Inter-Hospital Cost Comparison tool and total cost of care benchmarks for both commercial and Medicare costs for a more comprehensive efficiency analysis.

Commissioner Colmers agreed that the recommendation be delayed to RY 2021. However, he requested that Staff provide a draft recommendation at the February Commission meeting.

Mr. Pack stated that it should not be a problem.

Mr. Murray expressed CareFirst's appreciation for the Staff's work on the recommendation and their support of the ICC Efficiency Policy.

Mr. McCone stated that Maryland hospitals supported both the Staff's recommendation and delaying the Efficiency Policy until RY 2021.

As this is a draft recommendation, no Commission action is required.

ITEM VII
DRAFT RECOMMENDATION ON CAPITAL POLICY

Mr. Pack presented Staff's draft recommendations for the Capital Financing Policy (see "Draft Recommendations for a Capital Financing Policy" on the HSCRC website).

Since 2014, the State has operated under a per capita constraint imposed by the Centers for

Medicare and Medicaid (CMS) as a condition of the All-Payer Model and the TCOC Model. The Commission has set the Global Budget Revenue (GBR) for hospitals and the annual update factor to manage the per capita growth rate. The GBR limits a hospital's incentive to grow volume unnecessarily. However, volume growth combined with HSCRC rate support were historically used to finance new capital projects, creating an inherent tension between the incentives of the TCOC Model and the ability to generate sufficient revenue to replace aging facilities.

Stakeholders have expressed concern that there is no defined or predictable route for hospitals to receive additional money for new capital projects under the GBR methodology. This recommendation establishes a policy to provide predictable rate updates for new capital projects, while also taking into account increased excess capacity produced by volume declines over the past 5 years and the inefficient use of fixed costs. Therefore, Staff recommends that the rate updates for capital financing be scaled by the hospital's efficiency and excess capacity.

Predictability in capital funding is important not just for hospitals but also for the Commission to manage the various total revenue constraints incorporated in the Total Cost of Care Model, as capital projects could increase costs suddenly when they come online. If a very large project or several simultaneous projects come online, the increase in costs could endanger the State's annual total cost of care guardrail test as well as its annual total cost of care savings rate test. Staff, therefore, considered limiting the amount of capital funding that could be distributed in any given year, which would require hospitals to potentially wait until the system could afford capital funding.

In order to avoid potentially large growth in capital costs and to ensure that hospitals utilize retained revenues related to avoided utilization to finance smaller projects, staff recommends that a rate update be limited to projects whose value exceeds 35 percent of the hospital's annual GBR or $50 million, whichever is greater. Staff believe this will limit applications for capital funding to large projects that could not be financed without rate support. Smaller projects should be financed out of existing revenues as hospitals currently receive funding for capital projects in the annual update factor, and hospitals retain the interest and depreciation costs on all their previous capital projects, even after those projects have completed their useful life.

Additionally, staff recommends establishing a policy for when partial rate applications for capital projects can be filed. When applying for a Certificate of Need for a capital project, a hospital must indicate whether it is seeking a rate update to cover a portion of the costs. A hospital is not required to seek a rate update and may delay doing so until a later date. However, Staff is recommending that a financing formula based on the ICC and Medicare TCOC growth be established. In the event that a hospital delays applying for a rate increase to cover capital costs, staff recommends that the amount of capital funding that can be approved be equal to the lesser of the financing formula result when the hospital Certificate of Need was approved and the financing formula results when the hospital actually applies for the capital funding.

Staff recommends a three-step algorithm to calculate the rate increase that a hospital can receive in order to finance a capital project. The three steps are:

1. First, determine the amount of a capital project that will be supported through rates.
2. Second, scale the amount of funding that a particular hospital will receive for its capital project by determining its relative capital efficiency as well as that hospital's ICC and TCOC efficiency.
3. Third, credit/penalize hospitals based on their potentially avoidable utilization (PAU) and excess capacity in order to ensure that efficient hospitals are funded while inefficient hospitals finance new capital through other cost reductions.

Staff will calculate the depreciation costs of the hospital's project using the straight line method with the hospital's estimate of the project's useful lifetime. Staff will also calculate cumulative interest on 70 percent of the project's value. Staff expects that at least 30 percent of the project be paid by the hospital either through cash, philanthropy, or other sources of funding that are not direct rate support. Staff will calculate the hospital's estimated annual interest payments at the effective annual rate at which the project is expected to be financed.

Staff will determine the amount of capital funding that the hospital could receive on a project; however, staff recommends that a hospital be eligible to receive only portion of that amount, depending on its relative efficiency. Staff recommends using two measures of efficiency: the hospital's capital efficiency, and the hospital's integrated cost per case and total cost of care efficiency.

To measure integrated cost per case and total cost of care efficiency, staff will employ the ICC and a Medicare total cost of care growth calculation. The ICC measures the efficiency of the hospital's cost per case relative to its peer group and in the case of capital evaluations does not include productivity adjustments, per historical practice. The ICC's productivity adjustment was intended to eliminate costs related to excess capacity.

Staff recommend modifying the amount of capital funding the hospital can receive for potentially avoidable utilization and excess capacity. The dollar value of these two credits will be added or subtracted from the amount of capital spending in determining the final amount that a hospital is eligible to receive.

The PAU adjustment reflects the hospitals' "opportunity" to reduce unnecessary utilization. Historically, hospitals financed a portion of their capital project through volume growth. That strategy is not viable under the GBR. Instead, hospitals are expected to reduce unnecessary utilization (e.g., PAU) and reinvest the savings into capital and population health activities. However, hospitals that do not have as much PAU do not have as much opportunity to save money by reducing PAU. Therefore, staff recommend providing them with a credit for their capital projects.

Staff's draft recommendation is as follows:

Staff recommends that rate support be limited to capital projects that exceed 35 percent of the hospital annual GBR or $50 million, whichever is greater, and that the amount of funding that a hospital's capital project could receive be determined through the three-step algorithm:

- Determine the Hospital's eligible funding based on the proposed project
- Apply a scaling factor based on efficiency
- Adjust for PAU and excess capacity

Staff further recommends that the amount determined by the algorithm be added to the hospitals permanent revenue beginning in the year in which a capital project comes online. In that year, staff will recommend that the amount of the capital project be subtracted from the inflation portion of the update factor regardless of guardrail constraints.

Finally, if a hospital applies for a rate increase for a project that has already come online, staff recommends that the amount of funding it receives should be equal to the lesser of the algorithm when the hospital submits a rate request and the year that the project was approved through the Certificate of Need process.

Commissioner Colmers expressed his appreciation for the Staff's efforts on this recommendation.

Draft comments are due by November 6th.

Mr. Pack noted that the final recommendation will be presented at the December Commission Meeting.

ITEM VIII
DRAFT RECOMMENDATION ON REGIONAL PARTNERSHIP GRANT PROGRAM

Ms. Tequila Terry, Deputy Director Payment Reform and Provider Alignment, presented Staff's draft recommendation for Regional Partnership Grants (see " Draft Recommendation for Competitive Regional Partnership Catalyst Grants" on the HSCRC website).

Staff has prepared the following draft recommendation to reauthorize the funding and to establish an updated approach for the Regional Partnership Transformation Grant Program. Funding for the current program is set to expire on June 30, 2020. Therefore, Staff has outlined a new design for the grant program to support the goals of the Total Cost of Care Model. Under the proposed new grant program, hospitals and their partners would collaborate on interventions and infrastructure investments to support statewide population health priorities. If approved, the new grant program referred to herein as the Regional Partnership Catalyst Grant Program would become effective July 1, 2020.

The Commission authorized the Regional Partnership Transformation Grant program in June 2015. This four-year competitive grant-based program was designed to create and fund hospital-led multidisciplinary teams that work across statewide geographic regions to develop interventions for high-risk and high-utilizing Medicare beneficiaries, who often present at hospitals with multiple complex and chronic conditions. As part of the program, hospitals partnered with neighboring hospitals and/or diverse community organizations including local health departments, provider organizations, community health workers, and behavioral health resources, to develop interventions that were intended to result in more efficient care delivery under the metrics of the All-Payer Model.

There are 14 hospital-led partnerships created and funded through the grant program which include 41 of Maryland's acute care hospitals and serve both rural and urban areas across the State. The most common interventions performed by Regional Partnerships include behavioral health integration, care transitions, home-based care, mobile health, and patient engagement/education strategies and have focused primarily on reducing potentially avoidable utilization for high-need and high-risk Medicare patients.

The funding model for the Regional Partnership Transformation Grant program was approved by the Commission in June 2015 and authorized up to 0.25 percent of FY 2016 total statewide all-payer hospital revenue to be distributed to grant applicants under a competitive bidding process. Based on this, the HSCRC released a "Request for Proposals" (RFP) and subsequently awarded hospitals $37 million in FY 2017 to implement the regional programs. Awards were reduced annually in an effort to prepare hospitals to develop financial alternatives for sustaining programs. An annual ten percent hospital cost sharing requirement was established each year through the final year of funding (FY2020).

Given the scheduled expiration of the Regional Partnership Transformation Grant program, Staff recommends a new competitive grant program be established effective July 1, 2020. The new Regional Partnership Catalyst Grant Program will build upon the original vision of this grant program and enable hospitals to continue working with community resources to build infrastructure needed to sustainably support the population health goals of the Total Cost of Care Model.

The new Regional Partnership Catalyst Grant Program will be based on the HSCRC grant philosophy that the funding is designed to foster collaboration between hospitals and community partners. It is also designed to enable the creation of infrastructure to disseminate evidence-based interventions.

The following core principles will apply to the new Regional Partnership Catalyst Grant Program:

- **Eliminate duplication** – Given Maryland's shift from the All-Payer Model to the Total Cost of Care Model, care must be taken to ensure both interventions and grant funds are not duplicative with other new elements of the Model.
- **Ensure alignment with State priorities** – Funded interventions must support the goals of the Total Cost of Care Model and priority conditions identified under the Statewide Integrated Health Improvement Strategy.

- **Ensure broad collaboration** – There must be widespread engagement of local resources with a common agenda and mutually reinforcing activities to more effectively implement interventions.
- **Leverage evidence-based practices** – Funded interventions should be based on evidence that a model being proposed will achieve success.
- **Identify impact** – As a condition of funding, impact will be measured through the achievement of scale targets and progress goals, health improvement, and/or return on investment (ROI).
- **Ensure sustainability** – Funded interventions must have a plan for sustainability that includes both a plan to integrate successful interventions into hospital operations and a financial plan to ensure there is a permanent source of funding to continue the intervention after the grant expires.
- **Revamp grant oversight** – The HSCRC will leverage grant-making best practices and will provide additional oversight resources to ensure there is visibility, shared learning opportunities, and compliance with the intended purpose of the grant program.
- **Communicate & collaborate with stakeholders** – The HSCRC will continue the culture of collaboration with grantees to ensure information is clear, sensitive to concerns, and timely

The new Regional Partnership Catalyst Grant program will require hospitals to competitively bid for funding that would begin July 1, 2020. The HSCRC staff proposes that funding be narrowly focused to support interventions that align with goals of the Total Cost of Care Model and support the Memorandum of Understanding that Maryland is establishing with the Centers for Medicare & Medicaid Services (CMS) for a Statewide Integrated Health Improvement Strategy (SIHIS). The Regional Partnership Catalyst Grant Program will include allocations of funds called "funding streams" that are designed to encourage focus on the key state priorities. The three recommended funding streams are as follows:

- **Funding Stream I: "Diabetes Prevention & Management Programs"** – This funding stream would award grants to Regional Partnerships to support the implementation of the Centers for Disease Control (CDC) approved diabetes prevention and American Diabetes Association (ADA) recommended diabetes management programs.

- **Funding Stream II: "Behavioral Health Crisis Programs"** – This funding stream would award grants to Regional Partnerships to support the implementation and expansion of behavioral health crisis management models that improve access to crisis intervention, stabilization, and treatment referral programs.

- **Funding Stream III: "Population Health Priority Area #3"** – This funding stream would award grants to Regional Partnerships to support the third population health priority area that will be defined for Maryland by December 31, 2020.

The HSCRC staff recommendation includes the following components:

- Establish a competitive bidding process for the Regional Partnership Catalyst Grant Program that would require the submission of new applications to be eligible for funding effective for July 1, 2020. Staff will form an evaluation committee to review the grant applications and make recommendations on scoring. Additionally, the HSCRC will engage key subject matter

experts with diabetes prevention/management and behavioral health crisis management expertise to assist in the review and evaluation of grant applications.

- Allocate 0.25 percent of annual statewide all-payer hospital revenue for the following five year period:

    1. Year 1: FY2021 (July 1, 2020 – June 30, 2021)
    2. Year 2: FY2022 (July 1, 2021 – June 30, 2022)
    3. Year 3: FY2023 (July 1, 2022 – June 30, 2023)
    4. Year 4: FY2024 (July 1, 2023 – June 30, 2024)
    5. Year 5: FY2025 (July 1, 2024 – June 30, 2025)
    6. Grants will expire on June 30, 2025;

- Create three grant funding streams that align with statewide population health priorities as identified under the MOU with CMS;

- Require hospitals to collaborate with community partners;

- Use the HSCRC impact measurement approach that establishes scale targets and/or ROI methodology;

- Issue an RFP to competitively bid grant funds;

- Require each participating hospital CEO & CFO to agree to sustain successful interventions through other funding sources at the end of the grant period;

- Establish accountability and oversight as described in this document; and

- Design a transition approach in order to support qualifying existing Regional Partnerships for a limited time.

Commissioner Colmers expressed concern with the January timeline to complete the Regional Partnership Grant applications and to create new partnerships. He noted that he would have less concern if the application process was pushed back and the grant rewards were pushed back from July to September.

As this is a draft recommendation, no Commission action is required.

ITEM IX
DRAFT RECOMMENDATION ON MEDICARE PERFORMANCE ADJUSTMENT FOR RY 2022

Mr. Henderson presented Staff's draft recommendation for the Medicare Performance Adjustment Policy for Rate Year 2022 (see "Draft Recommendation for the Medicare Performance Adjustment Policy for Rate Year 2022" on the HSCRC website).

The State implemented a value-based payment adjustment, referred to as the Medicare Performance Adjustment (MPA), with performance beginning in Calendar Year (CY) 2018. The MPA brings direct financial accountability to individual hospitals based on the total cost of care (TCOC) of Medicare fee-for-service (FFS) beneficiaries attributed to them. Staff is proposing limited changes in this policy because of many other areas of change at the HSCRC (e.g., Efficiency Policy, Capital Policy, MPA Framework, etc.) and a desire to allow a longer term view of performance by minimizing attribution changes.

Since 2014, the State and CMS have operated Maryland's unique all-payer rate-setting system for hospital services to adopt new and innovative policies aimed at reducing per capita hospital expenditures and TCOC spending, while improving health care quality, patient outcomes, and population health. Under this initiative, hospital-level global budgets are established, so that each hospital's total annual revenue is known at the beginning of each fiscal year. Annual revenue is determined from a historical base period that is adjusted to account for inflation updates, infrastructure requirements, population-driven volume increases, and performance in quality-based or efficiency-based programs, changes in payer mix, and changes in levels of uncompensated care. Annual revenue may also be modified for changes in services levels, market share shifts, or shifts of services to unregulated settings.

The MPA provides a mechanism to further support aligned efforts of hospitals with other providers. This includes the opportunity for physicians who partner with hospitals under Maryland's Care Redesign Programs (e.g., Hospital Care Improvement Program (HCIP), Complex and Chronic Care Improvement Program (CCIP), and Episode Care Improvement Program (ECIP)) to be eligible for bonuses and increased payment rates under the federal MACRA law.

Although outside the scope of the MPA attribution algorithm and other aspects described in this document, the State also has the flexibility to apply an MPA Framework to adjust hospitals' Medicare payments for other purposes. There are two primary use cases for the MPA Framework. First, the MPA Framework can permit the flow of Medicare funds to hospitals based on their performance in other programs (the MPA Reconciliation Component (MPA-RC). For example, Medicare payments to qualifying hospitals under ECIP will occur through an MPA-RC separate from the MPA's adjustment based on the hospital's performance on its attributed population. In addition, the MPA Framework may also be used to reduce hospital payments if

necessary to meet Medicare financial targets that are not approved on an all-payer basis (the MPA Savings Component (MPA-SC).

For each hospital, its TCOC Performance compared to the TCOC Benchmark, as well as an adjustment for quality, will be used to determine the MPA's scaled rewards and penalties. For RY 2022, the agreement with CMS requires the maximum penalty be set at 1.0% and the maximum reward at 1.0% of hospital federal Medicare revenue. However, the HSCRC will be reviewing the reward/penalty maximum in the MPA next year, as CMS has indicated interest in increasing the amount at risk.

The agreement with CMS also requires that the Maximum Performance Threshold (that is, the percentage above or below the TCOC Benchmark at which the Maximum Revenue at Risk is attained) be set at 3% for RY 2022. Before reaching RY 2022 Maximum Revenue at Risk of ±1.0%, the Maximum Performance Threshold results in a scaled result — a reward or penalty equal to one-third of the percentage by which the hospital's TCOC differs from its TCOC target.

In addition, the agreement with CMS requires that a quality adjustment be applied that includes the measures in the HSCRC's Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Conditions (MHAC). For RY 2022, staff proposes to continue to use the existing RRIP and MHAC all-payer revenue adjustments to determine these quality adjustments; however, staff recognizes that the Commission may choose to add to the programs used for the quality adjustments over time, in order to increase the alignment between hospitals and other providers to improve coordination, transitions, and the provision of effective and efficient care. Both MHAC and RRIP quality programs have maximum penalties of 2% and maximum rewards of 1%. The sum of the hospital's quality adjustments will be multiplied by the scaled adjustment. Regardless of the quality adjustment, the maximum reward and penalty of ±1.0% will not be exceeded. The MPA reward or penalty will be incorporated in the following year through adjusted Medicare hospital payments on Maryland Medicare FFS beneficiaries.

With the maximum ±1.0% Medicare FFS hospital adjustment, staff continues to recommend that the MPA be included in the HSCRC's portfolio of value-based programs and be counted as part of the aggregate revenue at risk for HSCRC quality programs.

This policy for RY 2022 represents a continuation of an improvement-only methodology. HSCRC staff is not recommending adopting an attainment policy at this time. An attainment policy for the MPA requires consideration of a number of complex issues, such as an appropriate attainment benchmark, intrinsic differences between hospital payment rates (such as labor market differences, Graduate Medical Education payments, etc.), and an appropriate risk adjustment methodology. The Total Cost of Care Work Group will continue to discuss attainment as part of its work plan.

Based on the assessment above, staff recommends the following for RY 2022 (with details as described above):

- Continue measuring Medicare Total Cost of Care (TCOC) by attributing Medicare fee-for-service beneficiaries to non-hospital providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships. Implement only minor changes from the RY 2021 approach.

- Maintain the maximum penalty at 1.0% and the maximum reward at 1.0% of federal Medicare revenue with maximum performance threshold of ±3%.

- Set the TCOC benchmark as each hospital's risk-adjusted (demographics only) TCOC from 2019, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2020. Consistent with the road map laid out in last year's policy, exclude MDPCP Performance-based Incentive Payments, but include Care Management Fees and Comprehensive Primary Care Payments for Track 2 practices in both the base and performance period.

- Continue to assess performance on each hospital's own improvement in its attributed population's per capita TCOC.

    a) Adjust for year-over-year changes in the demographic characteristics of the hospital's attributed population.

    b) For future years, continue to explore incorporating attainment and further risk adjustment into the MPA's performance assessment.

- Include the MPA as part of the aggregate revenue at risk under HSCRC quality programs.

- Focus TCOC Work Group on more comprehensive review of the MPA policy for Rate Year 2023 (Performance in CY 2021), including but not limited to revisiting the fundamental attribution method, coordinating with the CTI process, adding attainment with benchmarking, and considering changes to amount at risk.

- Provide national Medicare growth rate estimates relative to Maryland throughout the year to help hospitals monitor their progress.

- Continue to work with CMS and CRISP to provide information to hospitals so they can more effectively engage in care coordination and quality improvement activities, assess their performance, and better manage the TCOC by working in alignment with both independent and affiliated providers whose beneficiaries they serve.

As this is a draft recommendation, no Commission action is required.

ITEM X
POLICY UPDATE AND DISCUSSION

Ms. Katie Wunderlich, Executive Director, introduced two new Staff members, Mr. Thomas Werthman and Mr. Wayne Nelms. Mr. Werthman's is the new Assistant Attorney General. Mr. Nelms is the new Assistant Chief Audit & Compliance.

Medicare Advantage Environment Scan

Mr. Willem Daniel, Deputy Director, Payment Reform and Provider Alignment, presented an update of the Maryland Medicare Advantage market (see, "Landscape of the Maryland Medicare Advantage Market" on the HSCRC website).

Overhead and Management Costs

Mr. Henderson presented an analysis of hospital administration cost (see "Analysis of Hospital Administration Costs" on the HSCRC website).

Staff presentation focuses on Management costs. Highlights from the presentation are as follows:

- Since FY 2010, Net Operating Revenue has grown at a rate of 3.2%. Management costs have grown at an annual rate of 5.8% over the same period an increase of over 81% over net operating revenue.
- Management Costs are reported on the Schedule TRE (Transactions with Rate Entity Schedule) on the HSCRC Annual Filing report.
- Medicare home office management costs are reported on the Medicare home office cost report.
- Staff was not able to establish a relationship between the HSCRC Schedule TRE and the Medicare Home Office cost report.
- Potential Cost Report Enhancements

    1. Increase required reporting on related entity allocation

        a) More Structure
        b) Better alignment with regulated cost enters
        c) Reconciliation with the Medicare Home Office cost report

- Additional cost centers to capture broad population health expenditures
- Additional cost centers to capture specific costs under Care Transformation Initiatives and allow credit through the ICC methodology.

ITEM XI
LEGAL UPDATE

Regulations

Proposed Action

Update to Accounting and Budget Manual – COMAR 10.37.01.02

The purpose of this action is to update the Commission's Accounting and Budget Manual which has been incorporated by reference.

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register.

ITEM XII
HEARING AND MEETING SCHEDULE

November 13, 2019	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
December 11, 2019	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:59 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 NOVEMBER 3, 2019

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2490R	Suburban Hospital	8/13/2019	1/10/2020	1/10/2020	FULL RATE	GS	OPEN
2492A	MedStar Health	8/22/2019	N/A	N/A	ARM	DNP	OPEN
2493A	Johns Hopkins Health System	8/26/2019	N/A	N/A	ARM	DNP	OPEN
2497N	UM Shore Emergency Center Queenstown	9/11/2019	11/15/2019	2/10/2020	OBSERVATION	WH	OPEN
2498A	University of Maryland Medical Center	9/17/2019	N/A	N/A	ARM	DNP	OPEN
2499A	Maryland Physicians Care	9/17/2019	N/A	N/A	ARM	DNP	OPEN
2501A	University of Maryland Medical Center	10/16/2019	N/A	N/A	ARM	DNP	OPEN
2502A	University of Maryland Medical Center	10/16/2019	N/A	N/A	ARM	DNP	OPEN
2503R	Johns Hopkins Bayview Medical Center	10/15/2019	3/13/2020	3/13/2020	FULL RATE	GS	OPEN
2504A	Johns Hopkins Health System	10/31/2019	N/A	N/A	ARM	DNP	OPEN
2505A	Johns Hopkins Health System	10/31/2019	N/A	N/A	ARM	DNP	OPEN
2506A	University of Maryland Medical System	11/3/2019	N/A	N/A	ARM	DNP	OPEN
2507A	University of Maryland Medical System	11/3/2019	N/A	N/A	ARM	DNP	OPEN
2508A	Johns Hopkins Health System	11/8/2019	N/A	N/A	ARM	DNP	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**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2019**
MEDICAL CENTER	*****	**FOLIO:**	**2308**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2498A**

Staff Recommendation

November 13, 2019

I. INTRODUCTION

The University of Maryland Medical Center (the "Hospital") filed a renewal application with the HSCRC on September 17, 2019 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. for a one-year period, effective November 1, 2019.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital component of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff found that the actual experience under this arrangement for the prior year (FY

2019) has been unfavorable. The unfavorable performance was the result of four extreme outlier cases. Prior to last year the experience under this arrangement has been favorable every quarter since January 2015. Staff believes that the Hospital can still achieve favorable experience under this arrangement. If the experience continues to be unfavorable in FY 2010, the Hospital will be informed that the arrangement must be modified in order to for staff to recommend that the approval be continued.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning November 1, 2019.

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 Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2019**
MEDICAL CENTER	*****	**FOLIO:**	**2311**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2501A**

Staff Recommendation

November 13, 2019

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed a renewal application with the HSCRC on October 16, 2019 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a new global rate arrangement for solid organ and blood and bone marrow transplant services with Humana for a one-year period, effective December 1, 2019.

II. OVERVIEW OF APPLICATION

The contract will continue be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital component of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff reviewed the experience under this arrangement for the last year and found that

it was favorable. The staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning December 1, 2019.

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 Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2019**
MEDICAL CENTER	*	**FOLIO:**	**2312**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2502A**

Staff Recommendation

November 13, 2019

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on October 16, 2019 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with INTERLINK for a period of one year, effective December 1, 2019.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI). UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital component of the global rates was developed by calculating mean historical charges for patients receiving like procedures. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Although there has been no activity under this arrangement in the last year, staff believes that the Hospital can achieve a favorable experience under this arrangement.

V I. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services with INTERLINK for a one year period commencing December 1, 2019. 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 Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2019**
SYSTEM	*****	**FOLIO:**	**2314**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2504A**

Staff Recommendation

November 13, 2019

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on October 31, 2019 on behalf of its member Hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for joint replacement and joint replacement consult services with Carrum Health, Inc. The System also seeks approval to add Bariatric, Cardiovascular, and Spine surgery to the arrangement. The System requests that the approval be for a period of one year beginning January 1, 2020.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar joint replacement services at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will 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 the risk of potential losses.

V. STAFF EVALUATION

Staff found that the little activity under this arrangement has been positive and believes that the modified arrangement is similar to several other successful arrangements approved by the Commission.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement, joint replacement consult services, bariatric, cardiovascular and spine surgery services for a one year period commencing January 1, 2020. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2019**
SYSTEM	*	**FOLIO:**	**2315**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2505A**

Staff Recommendation

November 13, 2019

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on October 31, 2019 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center ("the Hospitals") for renewal of a renegotiated alternative method of rate determination arrangement, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in the revised global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers for Transplants for a period of one year beginning December 1, 2019.

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II. OVERVIEW OF APPLICATION

The contract will be 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 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 utilizing historical charges for patients receiving solid organ and bone marrow transplants at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the experience under this arrangement was favorable for the last year. Staff believes that the Hospitals can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period commencing December 1, 2019. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
JOHNS HOPKINS HEALTH	*****	**COMMISSION**	
SYSTEM	*****	**DOCKET:**	**2019**
	*****	**FOLIO:**	**2318**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2508A**

Staff Recommendation

November 13, 2019

I. Introduction

On November 7, 2019, the Johns Hopkins Health System (JHHS) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of its constituent hospitals (the "Hospitals"). JHHS seeks approval for Hopkins Health Advantage. Inc. ("HHA") to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. HHA is the JHHS entity that assumes the risk under this contract. JHHS is requesting approval for one year beginning January 1, 2020.

II. Background

On September 1, 2015, CMS granted HHA approval to operate a Medicare Advantage Plan to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Calvert, Carroll, Howard, Montgomery, Somerset, Washington, Wicomico, Worcester counties and Baltimore City. HHA is jointly controlled by Johns Hopkins HealthCare, LLC, Advanced Health Collaborative II, LLC (consisting of Adventist Healthcare, Inc., Frederick Regional Health System, Inc., Lifebridge Health, Inc., and Peninsula Regional Health System, Inc.) and Anne Arundel Medical Center, and Mercy Health Services, Inc. The application requests approval for HHA to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. HHA will pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees. HHA has supplied the HSCRC staff with a copy of its contract with CMS.

III. Staff Review

Staff reviewed the reviewed the financial projections for CY 2020, as well as HHA's

experience and projections for CY 2019. The information reflected the anticipated negative financial results associated with the start-up of a Medicare Advantage Plan.

IV. Recommendation

Based on the financial projections, staff believes that the proposed arrangement for HHA is acceptable under Commission policy.Therefore, staff recommends that the Commission approve the Hospitals' request to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2020. The Hospitals must file a renewal application annually for continued participation. In addition, HHA must meet with HSCRC staff prior to August 31, 2020 to review its financial projections for CY 2021. In addition, HHA must submit a copy of its quarterly and annual National Association of Insurance Commissioner's (NAIC's) reports within 30 days of submission to the NAIC.

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

IN RE: THE FULL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
SUBURBAN HOSPITAL	*	DOCKET: 2019
BETHESDA, MARYLAND	*	FOLIO: 2300
	*	PROCEEDING: 2490R

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STAFF RECOMMENDATION

November 13, 2019

List of Abbreviations

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

Key Methodology Concepts and Definitions

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

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

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

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

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

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

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

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

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

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

Potentially preventable complications (PPCs): 3M originally developed 65 PPC measures, which are defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. PPCs, like national claims-based hospital-acquired condition measures, rely on present-on-admission codes to identify these post-admission complications.

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

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

Overview

Suburban Hospital ("Suburban," or "the Hospital") submitted a full rate application on May 6, 2019, requesting an increase to its permanent Global Budget Revenue (GBR) of $24,728,649 effective July 1, 2019 with an additional increase of $5,866,044 effective July 1, 2020. In total, the requested revenue increase of $30.6 million, or 9.1 percent of Suburban's approved 2019 revenues, is comprised of a capital adjustment of $11.7 million (3.5 percent) and a general revenue increase of $18.9 million (5.6 percent) to address the appropriateness of Suburban's current rates. The revenue increases that Suburban is requesting are exclusive of HSCRC approved adjustments for the update factor, volume adjustments, demographic adjustments, or population health infrastructure.

Following the submission of additional required information not included with its original submission, the HSCRC staff accepted Suburban's full rate application and considered it filed on August 13, 2019.

Suburban's request for a capital adjustment of $11.7 million is for the new depreciation and interest costs related to the Hospital's renovation and expansion project that is projected to be completed by January 1, 2020. The Hospital is requesting that half of the revenue increase, related to the capital costs, be provided in the approved revenue for Fiscal Year 2020 with the remaining half added to rates on July 1, 2020.

Suburban justifies its request for $18.9 million in additional operating revenue, to address the appropriateness of the Hospital's current rate structure, by comparing its cost structure to hospitals with cardiac surgery programs, rather than to the peer group of hospitals which are used for the HSCRC's Interhospital Cost Comparison (ICC) methodology. Suburban claims if it were allowed the cost structure of the cardiac hospitals, this would justify a revenue increase of $11,102,638 or 3.3 percent. Suburban also claims that the excess capacity productivity adjustment made to the costs of the cardiac surgery group of hospitals by HSCRC staff is excessive. Suburban calculates that if this adjustment were modified, Suburban would be justified to receive an additional $7,759,966 increase in revenues, or 2.3 percent.

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Background

Full Rate Applications

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

Similar to the evaluation of Garrett Regional Medical Center in 2018, the first full rate review conducted under the new regulations, the HSCRC staff has evaluated the performance of Suburban by reviewing the total cost of care performance for Medicare, measures of avoidable utilization and quality using the latest data available, and evaluating cost per case under the HSCRC's ICC methodology.

Background on Suburban

Suburban is a 233 licensed bed hospital located in Bethesda, Maryland. Its total approved revenue cap for Fiscal Year 2019 was $335,595,510. The Hospital is a Level II trauma center and is one of two hospitals in Montgomery County that provide open heart surgery services.

Suburban, a member of Johns Hopkins Medicine since 2009, is located across the street from the National Institutes of Health and within a block of the Walter Reed National Military Medical Center. The community hospital nearest to Suburban is Sibley Memorial Hospital, also part of Johns Hopkins Medicine. Sibley is located approximately 6 miles from Suburban in the District of Columbia and shares many of the same medical staff, particularly in the surgery areas.

Suburban received approval in 2015 for a Certificate of Need (CON) totaling $200 million to replace and renovate the Hospital facility. The Hospital is projecting that the new facility will open on January 1, 2020. When Suburban obtained approval for the CON, the Hospital projected that it would not need an approved rate increase from the HSCRC for the additional depreciation and interest costs associated with the project, but did reserve the right to request additional revenue from the HSCRC to fund the project if circumstances changed in the future.

Suburban has operated successfully under a global revenue cap for the last five years. From Fiscal Year 2014 through Fiscal Year 2018, Suburban has averaged an operating profit margin of 9.4 percent on regulated services and a total profit margin, including investment income, of 6.6 percent on all services. Suburban and HSCRC staff have worked together over the last few years to accommodate changes in utilization by out-of-state patients and for an increased concentration of Kaiser Permanente's patients at Suburban. For Calendar Year 2014 through Calendar Year 2018, HSCRC calculates that it has provided $27.0 million for volume changes at Suburban of which $9.0 million was for out-of-state, Kaiser Permanente, and other growth. For Fiscal Year

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2019, the percentage of Suburban's revenue derived from out-of-state patients totaled 11.5 percent of total revenue, a decline from the 12.2 percent reported for Fiscal Year 2018. Suburban has indicated that volume declines experienced in Fiscal Year 2019 are expected to be temporary in nature.

As part of the CON, Suburban provided projected financial statements for Fiscal Year 2015 through Fiscal Year 2022. For Fiscal Year 2015 through Fiscal Year 2018, Suburban projected that it would generate an average operating profit margin of 4.4 percent on all services (both regulated and unregulated). HSCRC obtained audited financial statements for Suburban for the year ended June 30, 2019 that show a total profit margin, including investment income, of 6.7 percent and a total operating margin on all services (both regulated and unregulated) of 3.7 percent. The Fiscal Year 2019 operating profit level is below the CON projections. It is on the basis of lower operating profit margins and future projections of operating results that Suburban now seeks a capital cost adjustment.

The profit projected in the CON projections and the full rate application did not include non-operating revenue generated from the Hospital's investments. Suburban reported $20,828,000 in non-operating revenue in its Fiscal Year 2018 Statement of Revenue and Expenses (RE schedule) and $9,365,000 in its audited financial statements for Fiscal Year 2019. Because Suburban reported having approximately $275 million of cash and investments as of June 30, 2019, the Hospital will continue to generate investment income that will improve the Hospital's total profit level above the levels projected in the full rate application and CON application.

Staff Analyses

The HSCRC staff reviewed costs, financial trends, system financial statements, unregulated losses, volume trends, quality performance, and Medicare per capita trends in the primary service area, among others. The HSCRC staff also reviewed the results of the Rate Year 2019 ICC (the most recent version). Summaries of several of these analyses follow.

Price Per Case Efficiency

Suburban is a relatively efficient hospital when compared to other Maryland hospitals in its price per case. During the past year of discussions and evaluations, staff compared Suburban's charge per equivalent case mix adjusted discharge (ECMAD) to the State average and peer hospitals. These comparisons showed that Suburban's charge levels were well below the State average, as expected, and also well below its peer group average.

As discussed below, staff has completed an Interhospital Cost Comparison and Suburban appears relatively efficient in these cost-per-case comparisons, but the efficiency level is not high enough to justify a revenue increase, particularly in light of higher than average growth in Medicare total cost of care in Suburban's primary service area.

Interhospital Cost Comparison (ICC)

The HSCRC staff recently updated the ICC tool, which is used to evaluate cost-per-case efficiency in a full rate review. In the ICC, each hospital's costs per case are compared to a peer group adjusted cost per case. Based on the most recent (Rate Year 2019) ICC calculations, the HSCRC staff estimates that 98.9 percent of Suburban's revenue ($319.4 million) would receive a revenue decrease from a full rate review if cost per case were the only criterion for review, and that the rate decrease could reach up to 1.93 percent ($6.2 million)[1]. For revenue included in the ICC tool, Suburban shows relative efficiency compared to the peer group, performing more favorably than other hospitals in the group; however, Suburban is not efficient enough to meet the historical ICC standard, whereby a hospital receives additional revenue through a full rate review application.

[1] The ICC does not, at this time, assess the efficiency of all hospital revenue. Revenue is excluded from the ICC for the following reasons: outpatient drugs are not reliably case mix adjusted using the ECMAD methodology; charges associated with chronic care beds are unique to four hospitals and, therefore, are not susceptible to statewide analyses of efficiency using standard APR-DRG weights, and charges associated with "categorical exclusions," e.g., organ transplants, research cases at academic medical centers, are not susceptible to statewide analyses of efficiency. HSCRC staff has a method for analyzing outpatient drug costs, and work to obtain national benchmarks for other excluded hospital charges is ongoing.

The table below describes the results of the current ICC methodology. These results do not account for hospital quality performance, total cost of care, or the minor adjustment that would be needed to add back drugs that were not deregulated.

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

ICC Methodology	Revenue Assessed	Rate Change	ICC Recommend Revenue
	$319,383,849	-$6,156,939	$313,226,910

Utilization Efficiency

Staff evaluated how the volume increases at Suburban affected the per capita goals of the All-Payer Model. At present, staff has developed data on total cost of care per capita for Medicare. If volumes move from higher cost hospitals to lower cost hospitals, per capita costs could decrease. However, to the extent that volumes simply increase, this could result in unfavorable performance under the Model. As discussed below, staff has determined that the volume increases at Suburban did not produce net cost savings in Medicare total cost of care in Suburban's primary service area through Calendar Year 2018.

Staff also evaluated the levels of potentially avoidable utilization (PAU) at Suburban compared to levels of PAU at all other Maryland hospitals, and Suburban's experience in reducing these volumes. As discussed below, Suburban has relatively low rates of PAU. Suburban has seen a small decrease in PAU as a percentage of eligible revenue from Calendar Year 2013 to 2018, but has not significantly decreased the percentage of potentially avoidable revenue. Similarly, Suburban has low rates of admissions for ambulatory-care sensitive conditions (PQIs) for its geographic service area, which have not significantly decreased over time.

As part of its full rate application, Suburban submitted a three-page Care Redesign document summarizing Suburban's previous initiatives to reduce avoidable utilization and planned efforts to reduce avoidable utilization in the future. Suburban's Care Redesign included working with Nexus Montgomery to improve the continuum of care in Montgomery County. Suburban is also active in the Johns Hopkins Medicine Skilled Nursing Facility (SNF) Collaborative to improve quality of care and communications between hospitals and SNFs.

Total Cost of Care Growth

HSCRC staff has made progress in evaluating the Total Cost of Care (TCOC) data for Medicare beneficiaries at a geographical level and for attributed beneficiaries. For this analysis, staff focused on the relative growth in Medicare's TCOC per beneficiary in Suburban's primary service area relative to the Medicare TCOC growth per beneficiary statewide. The HSCRC staff believes that it is important to evaluate how the volume growth at Suburban, which makes it appear more efficient on a cost per case basis, is affecting the growth in total cost of care per capita. On the one hand, if Suburban's charge per case levels are lower than competitor average

charge levels and Suburban is growing market share, this may improve the efficiency of the services provided. On the other hand, if the volume growth is not due to shifts in market share but simply growth in the volume of services provided, there may be a lower cost per case, but the volume growth could contribute to a higher growth in cost per capita, undermining the Total Cost of Care Model.

In evaluating Medicare TCOC growth, Suburban ranked 41st out of the 46 hospitals, performing in the most unfavorable quintile of the State on growth in Medicare expenditures per capita in its primary service area from Calendar Year 2013 through Calendar Year 2018.

The HSCRC staff has not yet obtained TCOC data and benchmarks for commercial and Medicaid patients at a granular level, and staff cannot yet offer information on per capita efficiency or per capita cost growth for these payer categories at this time. However, given that Medicare represents approximately 52 percent of revenue at Suburban, Medicare performance is a good proxy for reviewing Suburban's impact on TCOC growth.

Overall, HSCRC is concerned about the growth in total cost of care in Suburban's service area.

Potentially Avoidable Utilization

While recognizing that there is extensive unnecessary and avoidable utilization in the system, and that HSCRC, providers, and the State have more work to do to quantify those opportunities for reduction, the staff analyzed the utilization efficiency of Suburban with the most current tools available. This included an analysis of Potentially Avoidable Utilization (PAU), which currently incorporates all-cause unplanned 30-day readmissions and the Agency for Healthcare Research and Quality's Prevention Quality Indicators.

Overall, Suburban has relatively low PAU revenue as a percent of eligible revenue;[2] however, Suburban has not significantly decreased this percent between Calendar Year 2013 and Calendar Year 2018. In Calendar Year 2018, the Suburban percent of eligible all-payer revenue associated with PAU was14.98 percent, putting it within the top performing quintile in the State (i.e., the percent revenue associated with PAU is lower than at least 80 percent of hospitals). In comparison, the statewide average hospital PAU percent of eligible total revenue was 18.44 percent for Calendar Year 2018.

When the analysis was performed on PQIs per capita using geographic service area, Suburban was in the top quintile of attainment, with about 7 PQIs per 1,000 adults, compared to the statewide average of 16 PQIs per 1,000 adults. However, these figures do not include out-of-state, which would increase the PAUs in Suburban's service area relative to the rest of the State. Suburban's PQI per capita has not decreased as quickly as other parts of the state, with a PQI per

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

capita reduction from Calendar Year 2013 to Calendar Year 2018 of -4.2 percent compared to a statewide average of –7.7 percent.

While there is still work to do to quantify additional categories of PAU, and the PAU results are not risk-adjusted or adjusted for out-of-state, Suburban has shown low rates of PAU revenue and PQI per capita, but limited results in reducing PAU, as it is currently defined. Therefore, significant additional improvements will be required for Suburban to maintain its financial performance and to improve care as called for under the TCOC Model.

Quality Performance

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

Under the HSCRC's Readmissions Reduction Improvement Program, Suburban reduced its risk adjusted readmissions by 7.84 percent between Calendar Year 2016 and Calendar Year 2018, which places Suburban in the second best quintile of statewide improvement. Relative to case-mix adjusted readmissions levels, Suburban's readmission rate is 10.34 percent; however, this does not account for readmissions to hospitals in the District of Columbia or other surrounding states. When adjusted for out-of-state readmissions, the readmission rate increases to 11.38 percent, which is worse than the attainment target of 10.70 percent and is in the third quintile of State performance. Overall, Suburban received a Readmissions Reduction Improvement Program penalty of approximately $0.92 million for Fiscal Year 2020, because it did not meet the reduction target set by HSCRC.

Under the Maryland Hospital Acquired Conditions program, Suburban had a 45 percent improvement in its case mix-adjusted Potentially Preventable Complications rate for Fiscal Year 2020, putting it in the top quintile of State performance. In addition, Suburban's case-mix adjusted Potentially Preventable Complications rate for Calendar Year 2018 of 0.73 per one thousand discharges was in the second best quintile of statewide performance.

Under the HSCRC's Quality Based Reimbursement program, Suburban had a preliminary Fiscal Year 2020 total QBR score of 18.17 percent in Fiscal Year 2020, which is in the worst quintile of statewide performance. Specifically, for patient experience, Suburban scored 13.33 percent, which makes up half of the total QBR score. The most recently available data through June 2018, shows that for the eight Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures, Suburban performed worse than the national average on all measures and declined on 6 measures and stayed the same on two measures compared to the base period (Calendar Year 2016). On the Mortality measure, Suburban scored 30 percent, which places them in the third quintile of statewide performance. For the safety measures, Suburban scored 20 percent, placing them in the lowest quintile of statewide performance.

Volume Changes

The HSCRC uses ECMADs to calculate volume changes, when possible, because ECMADs include volumes of both inpatient and outpatient services with recognition of expected relative costliness of services on a consistent scale. From Calendar Year 2013 through Calendar Year 2018, Suburban has experienced volume increases from its in-state primary service area and from out-of-state. The volume growth calculation was made more difficult by the move to ICD-10 which is used for coding diagnoses on hospital bills. This move to ICD-10 made the use of consistent inpatient DRG groupers and weights, for all years, unavailable. Lacking consistently grouped inpatient data, HSCRC staff adjusted the 2014 ECMADs for estimated changes in DRG weights between Calendar Years 2013 and 2018. Using this method, after including outpatient ECMAD changes, this represents a growth of $34.2 to $36.4 million (in current dollars) before applying any variable cost adjustment.

Suburban has been generously funded for this volume change. Suburban has received one of the highest demographic adjustments in the state for this period, totaling $12.6 million, in current rate dollars. Combined with the out-of-state growth, Kaiser growth, and other adjustments of $9.7 million, a market shift adjustment of $4.0 million and a Medicaid expansion adjustment of $0.7 million, Suburban has received permanent volume funding of $27.0 million. This volume funding provided for a variable cost factor on volume growth of approximately 74 to 79 percent, well above the 50 percent policy level used by the Commission.

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

Market Shift	$ 4.0
Demographic	12.6
Out-of-state, Kaiser, Other	9.7
Medicaid Expansion	0.7
Total	$27.0

Another indicator of volume changes is the change in admissions and emergency room visits. Unlike ECMADs, which require adjustments due to ICD-10 implementation, these statistics can be viewed for each year. Suburban has experienced growth in admissions and emergency room visits over a five year period, although there was a sizeable reduction in admissions for Fiscal Year 2019 over Fiscal Year 2018, which Suburban indicates is a temporary reduction.

Table 3. Suburban Growth in Admissions and Outpatient Emergency Room Visits-For Fiscal Years 2014 - 2019

Year Ended June 30,	Admissions	Outpatient Emergency Room Visits
2014	13,183	34,754
2015	13,621	34,765
2016	13,245	35,331
2017	13,792	37,551
2018	14,136	36,264
2019	13,481	36,761
Percent Change 2014-2019	2.3%	5.8%

Source: HSCRC Monthly Experience Reports.

The HSCRC staff supports competition based on cost and quality, and Suburban is a relatively efficient hospital. However, HSCRC staff is concerned that the per capita model could be undermined if hospitals can come back to capture a revenue adjustment for volume growth, particularly when that growth has been well-funded as it has been at Suburban. As stated in the Total Cost of Care Growth section of this report above, HSCRC staff is concerned about the impact of volume growth on total cost of care. While Suburban may show lower cost per case than some peers that have experienced volume declines, Suburban's growth has been well funded with revenue increases and Suburban has unfavorable Medicare Total Cost of Care growth performance in its primary service area.

Financial Background and Performance

Hospital Charge Per Case History

The table below compares the average charge per ECMAD by year for the Calendar Years ending December 31, 2014 and December 31, 2018 for Suburban:

Table 4. Suburban ECMADs and Charges for CY2014 and CY2018 (in 000s)

ECMADs CY14	ECMADs CY18	Total Charges CY14	Total Charges CY18	Charge Per ECMAD CY14	Charge Per ECMAD CY18	Charge Per ECMAD Change 14-18
25.2	26.5	$ 290,051.7	$ 334,001.1	$ 11.5	$ 12.6	9.40%

In contrast to Suburban whose ECMADs grew by 5.2 percent during this period, statewide ECMADs declined by 3 percent, as hospitals reduced avoidable utilization. As expected, due to the global budget system, statewide charge per ECMAD grew by 13 percent compared to Suburban's 9.4 percent.

Hospital Rate History

Suburban entered into a Global Budgeted Revenue (GBR) agreement effective July 1, 2013. Under the GBR agreement, Suburban reported that it received the following adjustments over the last five years:

Table 5. Suburban's GBR Adjustments, July 1, 2014-2018

	Year Beginning July 1,				
Component:	2014	2015	2016	2017	2018
Update Factor	2.1%	2.1%	1.9%	2.2%	2.1%
Mark Up Change	(.8)	(1.0)	(.4)	(.2)	(.4)
Quality Adjustments	(.2)		.2	.2	(.8)
Infrastructure	.3	.4			
MHIP Adjustment	(.8)	(.6)			
All Other (primarily volume related)**	1.5	2.5	1.6	3.9	.9
Total	2.1%	3.0%	3.3%	6.1%	1.8%

Source: Rate review work papers, provided by Suburban as part of full rate application, and HSCRC work papers.
**Summarized from Suburban work papers. Includes market shift, demographic adjustment, out-of-state volume adjustments, TAVR, oncology market shift, and other miscellaneous adjustments.

Both Table 4 above, which includes four Calendar Years of volume funding, and Table 5 above, which includes five fiscal years of rate adjustments, show that Suburban was provided substantial funding for volume growth. As previously indicated, the HSCRC staff has worked

with Suburban to provide additional revenues as Kaiser has shifted volumes from in and out-of-state locations to Suburban, and as volumes for non-Maryland residents have grown.

Revenue Growth

Suburban's HSCRC approved regulated revenues have increased by $49.9 million or 17.5 percent since Fiscal Year 2014.

Table 6. Change in Suburban Approved GBR Patient Revenue-For Fiscal Years 2014 - 2019

Year Ended June 30	Approved GBR (in 000's)	Percent Change from Prior Year
2014	$285,712	
2015	$291,827	2.1%
2016	$300,676	3.0%
2017	$310,468	3.3%
2018	$329,540	6.1%
2019	$335,595	1.8%
Change 2013 to 2019	$49,883	17.5%

Source: Rate Application Exhibit 9

Table 7 below shows Suburban's regulated and unregulated operating margins it reported to HSCRC.

Table 7. Suburban Regulated and Unregulated Annual Operating Margins-For Fiscal Years 2014-2018

	Year Ended June 30, ($ in 000's)				
	2014	2015	2016	2017	2018
Regulated Operating Margin $	$17,165	$36,471	$26,701	$23,004	$20,601
Regulated Operating Margin %	7.1%	13.9%	10.1%	8.4%	7.3%
Unregulated Operating Margin $	($14,539)	($24,246)	($9,772)	($11,391)	($12,199)
Unregulated Operating Margin %	(65.3%)	(197.8%)	(40.7%)	(52.4%)	(57.8%)
Total Operating Margin $	$2,626	$12,225	$16,929	$11,613	$8,402
Total Operating Margin %	1.0%	4.4%	5.9%	3.9%	2.8%
Total Net Profit Margin $	$16,402	$9,814	$10,232	$35,570	$29,230
Total Net Profit Margin %	5.9%	3.6%	3.6%	11.2%	9.0%

Source: Suburban HSCRC Annual Reports – Schedule RE.

Suburban has averaged a profit margin of 9.4 percent on regulated services over the last five years. For all sources including investment income, Suburban has averaged a profit margin of 6.6 percent over the last five years.

Fiscal Year 2019 is not included in Table 7 because, at the time of this recommendation, the Hospital had not yet submitted the HSCRC annual report for Fiscal Year 2019 and it is difficult to break out the regulated and unregulated operating income on a consistent basis. Additionally, the CON application reported total operating income; however, for audited year-end financial

statements submitted for the period ended June 30, 2019, Suburban reported an operating profit for both regulated and unregulated services of $11,448,000 or 3.7 percent and a total profit margin (including investment income) of $20,813,000 or 6.7 percent.

In its Fiscal Year 2020 full rate application, Suburban projected an increase in operating losses on unregulated services to $19,115,900 from the reported loss of $12,199,200 shown above for Fiscal Year 2018. The HSCRC has previously stated that it does not intend to directly or indirectly fund physician losses aimed at capturing market share, and it will not take this increased loss into account in evaluating Suburban's request.

Staff Review of Specific Components of Requested Revenue Increases

Capital Request

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

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

The Hospital's rate application requests that the HSCRC grant a revenue increase equal to 95.8 percent of the projected incremental capital costs associated with the project. The CON includes projected first year interest cost of $3,489,000 and first year depreciation cost of $7,751,000 for a total of $11,230,000 in incremental capital cost which when multiplied by 95.8 percent results in the $10,754,218 requested new capital costs. After adding mark-up for uncompensated care and payer differential, the requested revenue increase for these costs is approximately $11.7 million.

The Hospital is requesting that 50 percent of the additional capital costs be added to rates on July 1, 2019 and the remaining 50 percent be added to rates on July 1, 2020. The new facility is projected to open by January 1, 2020 which is the reason why Suburban has requested that 50 percent of the requested capital costs be added to approved revenue on July 1, 2019 with the remaining 50 percent added on July 1, 2020.

The Hospital has assumed an interest rate of approximately 5.0 percent for the project. The Hospital is proposing to finance the project under the Johns Hopkins Health System (JHHS). According to the audited financial statements for JHHS for the year ended June 30, 2018, JHHS issued $500 million of bonds in Fiscal Year 2016 at an interest rate of 3.84 percent and $165 million of bonds in Fiscal Year 2017 at an interest rate of 3.19 percent. Staff believes that the actual interest rate on the debt associated with this project is less than the 5 percent assumed in the CON. Staff believes that an interest rate of 3.84 percent should be assumed for the calculation of approved debt related to the requested rate increase instead of the 5.0 percent assumed in the CON.

Suburban's current capital costs as derived from the Fiscal Year 2018 Annual Cost Survey (ACS schedule) of the Annual Report of Revenue and Expenses includes $3,556,700 in HSCRC

regulated interest expense, and $14,925,900 in regulated depreciation and amortization expense, for a total of $18,482,600 in total capital expense. Suburban reported total costs of $261,990,900 in the Fiscal Year 2018 ACS schedule. The Hospital's percentage of capital costs ($18,482,600) to total costs ($261,990,900) for Fiscal Year 2018 was 7.05 percent.

As stated earlier, the Hospital is requesting new adjusted capital costs of $10,754,218 in line with the first year estimate of 95.8 percent of depreciation and interest on a $200,550,831 capital project that will be amortized over 30 years at an interest rate of 3.84 percent. Under HSCRC's historical capital methodology, the Suburban request would be capped at the 50/50 blend of a hospital's capital cost share (inclusive of the new request's first year estimated depreciation and interest costs) and the peer group average capital cost share, and that value would be scaled for cost per case efficiency. Using the new proposed HSCRC capital methodology, the capital request from Suburban will continue to be capped at the 50/50 blend of the hospital's capital cost share (inclusive of the new request's annualized estimate for depreciation and interest) and the peer group average, and that value will be scaled for cost per case efficiency, total cost of care efficiency, current levels of potentially avoidable utilization and excess capacity.

Specifically, Suburban's capital project of $200,550,831 has an annualized depreciation figure for a 25 year useful facility of $8,022,033 and an annualized interest figure of $4,652,403 on a 30 year loan with a 3.84 percent interest rate. Combined, the depreciation and interest brings Suburban's current capital cost share of 7.05 percent to 11.34 percent, an increase of 4.29 percent (or $18,482,600 to $31,157,036). Averaging the requested capital share of 11.34 percent to the peer group average of 8.68 percent yields an allowed capital cost share of 10.01 percent, which equates to a 2.96 percent increase in capital costs or $7,751,537.

After this figure is derived, the new capital methodology then scales the result by the integrated efficiency of hospital cost per case and total cost of care, which is a relative ranking of hospitals that provides approximately 2 percent for each additional increase in ranking. In the case of Suburban, which is the best hospital in the third quintile of performance, the hospital is entitled to 60 percent of the allowed capital cost share, or $4,650,922 (60 percent of $7,751,537).

Staff has also provided a credit to hospitals that do not have high levels of PAU, as defined by 30 day readmissions and avoidable admissions for PQIs. Suburban has relatively low PAU (15 percent compared to the statewide average of 18.44 percent), thus it earns a credit of $2,342,323. Combined with the allowable cost share that was scaled for integrated efficiency, this brings Suburban's capital allotment to $6,993,245.

The final two steps of the methodology are to remove costs associated with excess capacity, as defined by reductions in bed days from 2010 to 2018, and to markup these cost based figures for uncompensated care and the governmental payer differential. Because Suburban has not experienced any reduction in beds since 2010, there is no adjustment for excess capacity. The hospital's markup in Fiscal Year 2019 was 1.0909; therefore, the final capital allotment Suburban will receive is $7,701,273.

General Revenue Increase

As described in the ICC analysis above, Suburban does not qualify for a revenue increase based on the HSCRC's productivity standard. Also, Suburban's financial performance under the GBR has been positive. Suburban justified the request for a rate increase by comparing itself to hospitals that are not part of the peer group used in the ICC, and making other adjustments to the ICC.

Suburban has requested that staff modify the ICC methodology to develop a new peer group for cost comparison that includes only hospitals that perform specialized cardiac surgery and evaluate Suburban's costs based on the new cardiac surgery peer group. Suburban argues that the Hospital should not be compared to hospitals with obstetric services because those hospitals with obstetric services have a lower case mix index than Suburban. Staff disagrees with Suburban that there should be a separate peer group for hospitals with cardiac surgery for the following reasons:

1. Only a small portion of Suburban's costs (less than 10 percent of total costs) relate to specialized cardiac surgery services.
2. There are many factors that impact hospital comparisons including location, payer mix, the presence of a residency program, etc.
3. HSCRC does not account for severity and intensity through peer grouping, since it already has a well-recognized method to adjust for severity. All hospitals have different case mix.
    a. HSCRC applies the All Patient Refined-Diagnosis Related Groups (APR-DRG) methodology to account for differences in severity levels and resource use (i.e. a case-mix adjustment) among hospitals. This gives a relatively high weight to cardiac surgery and a relatively low weight to obstetric services, based on the actual estimated resource used to provide the service. All ICC comparisons are case-mix adjusted, taking these resource differences into account. DRGs are the industry standard adjustment for case-mix and severity differences. Outside of Maryland, Medicare uses DRGs for the payment of inpatient hospital services, while making separate adjustments to payment for factors such as wage levels and residency programs.
    b. In addition to inpatient services, the HSCRC takes into account differences in severity and relatively costliness of services among hospitals combined inpatient and outpatient services through the use of ECMAD's, which are a combined measure of inpatient and outpatient severity and resource use. This analysis uses APR-DRGs to account for inpatient severity and relative costliness while EAPGs are used to measure difference in outpatient service levels.

Suburban has also requested that the staff modify the ICC methodology to reduce the excess capacity adjustment so that the reduction is applied to indirect costs in the room and board centers only. Suburban's proposed reduction in the excess capacity adjustment to adjust for only

indirect costs would reduce the excess capacity adjustment from the Hospital's estimated 4.13 percent to 2.00 percent for its proposed cardiac surgery peer group.

Staff does not believe that the Hospital has provided any empirical evidence to support the adjustments to the ICC methodology. Suburban's adjustment to fixed costs assumes that room and board costs are the only affected costs when volumes fall. However, room and board costs account for only 39 percent of inpatient charges (Fiscal Year 2018). When admissions are reduced, 61 percent of the charges and related costs, associated with that reduction, are for ancillary and other services. Furthermore, some portion of direct costs will be fixed, unless a service is entirely discontinued. The productivity adjustment in the Rate Year 2019 ICC, which uses all room and board costs as a proxy for fixed costs, i.e. 39 percent fixed cost, removes $902 per day on a statewide level ($760 for Suburban's ICC peer group). This value is significantly less than the fixed cost per diem staff has calculated at the statewide level when excluding the Academic Medical Centers ($1,201). Thus, staff's room and board proxy for fixed costs that should be removed in an efficiency methodology is not excessive and is more likely understating the opportunity for further efficiencies in the system. Additionally, this is irrelevant in Suburban's correct ICC peer group as that ICC standard is subject to a 2 percent minimum productivity adjustment and not a capacity adjustment.

Summary of Findings

The HSCRC staff has reviewed the financial performance and efficiency of Suburban over the last several years. The Hospital's overall profit margin (including investment income) for Fiscal Year 2017 and Fiscal Year 2018 combined exceeded 10 percent and its Fiscal Year 2019 profit margin was 6.7 percent. Suburban is relatively efficient in charge per case performance and in its per case efficiency under the preliminary ICC tool, but it does not qualify for a rate increase under a revenue adjustment under the ICC productivity standard.

Staff does not agree that Suburban's argument to revise the ICC for the Hospital to a group that only includes Cardiac Surgery hospitals is appropriate. There are numerous variables that should be considered when evaluating comparison groups for hospitals including: patient demographics, location, payer mix, the presence of a residency program, etc. Suburban's proposal to change the Hospital's peer group because of one factor related to Cardiac Surgery is not supported by any empirical data and is not reasonable.

As part of the rationale for the requested rate increase, Suburban stated that the Hospital has not received funding for the growth in volumes that Suburban has incurred since the beginning of the GBR program. Staff calculated that volume growth has been well-funded, above the 50 percent standard level.

Suburban has lower levels of potentially avoidable utilization than other Maryland hospitals, although these results may be significantly impacted by out-of-state utilization. Suburban also has performed well on complication measures compared to the rest of the State, but lags behind on patient experience.

Suburban's operating profit margin on all services (both regulated and unregulated) has declined in Fiscal Year 2019 compared to the previous two years and the Hospital has projected continuing lower profits than it projected in its CON application. In light of this financial change, HSCRC staff reviewed Suburban's capital rate request under the proposed capital policy, which would provide for a revenue increase of $7,701,273.

Recommendations

The staff recommends that the Commission deny the $18.9 million of general rate relief requested. While the hospital is relatively efficient compared to other hospitals in its peer group, the Hospital does not qualify for a revenue increase under the cost-per-case productivity standards in the ICC and its Medicare Total Cost of Care growth is in the bottom quintile of performance in the State. The Hospital has been well funded for its volume changes and it has experienced good financial results under the GBR, with most recent Fiscal Year 2019 operating income of 3.7 percent and total profit of 6.7 percent.

Staff recommends a revenue increase of $7,701,273 for capital costs associated with the major renovation project. While Suburban did not expect to need rate relief for this project, the Hospital has experienced a decline in its operating income relative to the projections that were included in its CON application. For this reason, the staff is recommending a revenue increase for capital, consistent with its proposed capital policy.

Staff recommends that half of the capital relief be included in the Fiscal Year 2020 GBR revenue cap with the remainder included in the Fiscal Year 2021 revenue cap, consistent with expectation of project completion in early 2020.

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

November 8, 2019

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

Re: Suburban Hospital rate request

Dear Ms. Wunderlich,

The purpose of this letter is to provide MedChi's comments on Suburban Hospital's full rate request for a $30.6 million permanent rate adjustment. The Maryland Medical Society, at the request of its members, reviewed the rate application, including justification for the rate request as well as supplemental materials and accompanying completeness detail. The request included components related to capital funding for an MHCC-approved Con for replacement of its inpatient facility and additional rate relief to address operating margin erosion related to underfunding of volume growth, clinical salary pressures, and other operating costs.

First and foremost, we are supportive of Suburban's request for incremental depreciation and interest funding for its MHCC-approved CON project. Suburban's current inpatient facilities are outdated and insufficient for modern standards of care. MedChi's members stand in support of the new facility, which will enhance care delivery, reduce operational inefficiencies, increase quality of care, and allow Suburban to invest in innovative population health activities.

Further, we are sympathetic to Suburban's operating pressures. As a high quality, cost-efficient hospital provider with a service mix that is more heavily comprised of complex surgical volumes than any other community hospital besides MedStar Union Memorial Hospital, Suburban has struggled with underfunding on volumes that are more variable by nature of their clinical complexity and associated costs (e.g. TAVRs, open heart surgery, trauma, etc.)

Beyond volume funding, Suburban has experienced operating pressures related to brining clinical salaries in line with the market, a manifestation of the dichotomy between hospitals that have significant retained revenue on volume decline, and hospitals like Suburban that are experiencing pressure related to underfunding of growth. We support a rate adjustment for Suburban that will stabilize the hospital's operating margin at a level commensurate with the state.

MedChi believes that Suburban's full rate request is reasonable and justified given the hospital's current financial circumstances and track record providing care that is high-quality and cost-efficient.

Sincerely,

Gene M. Ransom III
Chief Executive Officer
MedChi, The Maryland State Medical Society

November 13, 2019

Regional Partnership Catalyst Grant Program
Final Recommendation

Tequila Terry, Deputy Director
Health Services Cost Review Commission (HSCRC):
Center for Payment Reform and Provider Alignment

HSCRC
Health Services Cost Review Commission

“Catalyst Grant Program” – 3 Funding Streams

The Regional Partnership Catalyst Grant Program is a reset of the HSCRC grant program in order to:

- Align with the goals of the Total Cost of Care model
- Support the CMMI MOU for a Statewide Integrated Health Improvement Strategy
- Meet Commission requirements to demonstrate a measurable impact of funded activities

Funding Stream I: Diabetes Prevention & Management Programs	Funding Stream II: Behavioral Health Crisis Services	Funding Stream III: Population Health Priority Area #3
• Support implementation of CDC approved diabetes prevention programs • Support diabetes management programs	• Support implementation or expansion of behavioral health models that improve access to crisis services	• To be defined

Regional Partnership Catalyst Grants - Public Comments Summary

- A public comments period was open from October 9, 2019 – October 23, 2019
- HSCRC staff received 18 comment letters
- There was widespread support for the continuance of Regional Partnership grants and the two identified funding priority areas
- The overarching themes for suggested changes were in the below 5 areas:

All-Payer Focus	Flexibility	Collaborator Funding	Timeline	Legacy Transition Funding

HSCRC Response to Public Comments

Theme	Feedback	HSCRC Staff Response

All-Payer Focus	Ensure the measurement focus demonstrates all-payer impact	<u>Impact Measurement</u>
		• Regional Partnerships will be directed to focus investments on the full population in their catchment area regardless of payer source.
		• HSCRC staff recommends a modified impact measurement approach to include Medicaid.
		  • Staff is working with the Medicaid team to obtain baseline and claims data needed to measure Medicaid impact. As data is received, we will incorporate it into the measurement process.
		  • The Scale Targets will be modified to have Year 1 – 5 targets based on Medicare and Medicaid metrics.

HSCRC Response to Public Comments

Theme	Feedback	HSCRC Staff Response

Flexibility	Allow more evidence-based programs to be funded	<u>Diabetes</u>
		• Staff recommends keeping the grant activities specifically focused on the Diabetes Prevention Program (DPP), the Diabetes Self-Management Training (DSMT), and Medical Nutrition Therapy (MNT).
		
		<u>Behavior Health</u>
		• Staff recommends keeping the grant activities specifically focused on the *Crisis Now* framework
		  • Crisis Call Center & "Air Traffic Control" Services
		  • Community-Based Mobile Crisis Teams
		  • Short-term, "sub-acute" residential crisis stabilization programs

Collaborator Funding	Allow non-hospital stakeholders to apply for grants and/or establish a requirement to share grant funds with community collaborators	• Funding will be issued only to hospitals under the rate-setting authority of the HSCRC however meaningful community partnerships (funding, resource sharing, and/or in-kind support) will be required as a condition of grant eligibility. • HSCRC will not establish a pre-determined level of funding, in-kind support, or resource sharing with collaborating organizations however the level of community collaboration will be heavily weighted during the proposal evaluation process and the on-going monitoring process.

HSCRC Response to Public Comments

Theme	Feedback	HSCRC Staff Response

Timeline	Allow additional planning time and/or multiple timeframes for applications	• Staff recommends delaying the grant application process to allow additional Regional Partnership Planning time
		  • RFP Release – January 2020
		  • Proposals Due – June 2020
		  • Rate Orders Issued – January 2021
		• Staff also recommends modifying the year 1 scale targets to reflect a planning period.

Legacy Transition Funding	Provide financial support to legacy Regional Partnerships	• Existing Regional Partnerships can request "temporary transition funding" that would be <u>required to be repaid</u>

Legacy Transition Funding

- **Temporary Transition Funding: "Borrow from Future GBR"**
  - Step 1: Add temporary transition funding in the form of a GBR increase in FY2021 and FY2022
    - Funding is for specific interventions that have potential of TCOC savings
    - Funding will be provided for a maximum of two years (FY2021 and FY2022) and would be required to be repaid
    - The maximum transition amount allowed would be a hospital's FY20 grant amount
    - Each hospital in the Regional Partnership that accepts the funding would be required to sign a Memorandum of Understanding agreeing to repay the funds
  - Step 2: Subtract the temporary transition funding from the hospital GBR beginning in FY2023
    - HSCRC would eliminate the GBR increase for each hospital in the Regional Partnership
    - The hospital would be required to repay the amount of the GBR increase as reductions in GBR for FY2023 and FY2024

Temporary Transition Funding Example

- Example:
  - Hospital A is participating in a Regional Partnership and wants to receive Temporary Transition Funding by borrowing from future GBR
  - Hospital A has a $100 Million Global Budget Revenue (GBR)
  - Hospital A receives approval from their CEO/CFO to apply for transition funding and signs the MOU
  - HSCRC receives the MOU and approves the transition funding request
  - HSCRC issues the temporary funding as an increase GBR in FY2021 and FY2022
  - Hospital repays the temporary funding through a decrease in GBR in FY2023 and FY2024

Time Period	Funding Amount	Effect on GBR
FY2021 (July 2020 – June 2021)	$100 Mil GBR +$2 Mil in Transition Funding	$102 Mil
FY2022 (July 2021 – June 2022)	$100 Mil GBR +$2 Mil in Transition Funding	$102 Mil
FY2023 (July 2022 – June 2023)	$100 Mil GBR -$2 Mil in Transition Funding	$98 Mil
FY2024 (July 2023 – June 2024)	$100 Mil GBR -$2 Mil in Transition Funding	$98 Mil

- Regional Partnerships can also opt to submit interventions to the Care Transformation Initiative (CTI) program to determine eligibility for reconciliation payment(s) if total cost of care savings are generated by the intervention.

Final Recommendation Summary

- Establish a new Regional Partnership Catalyst Grant Program effective January 1, 2021;
- Allocate 0.25 percent of annual statewide all-payer hospital revenue for a five year period (January 2021 – December 2025). Grants will expire on December 31, 2025;
- Create three grant funding streams that align with statewide population health priorities as identified under the MOU with CMS;
- Require hospitals to collaborate with community partners and collect data on fund sharing arrangements;
- Use the HSCRC impact measurement approach that establishes scale targets and/or ROI methodology for Medicare, Medicaid, and other payers as data become available;
- Issue an RFP to competitively bid grant funds;
- Require each participating hospital CEO & CFO to agree to sustain successful interventions through other funding sources at the end of the grant period;
- Establish accountability and oversight as described in the recommendation document; and
- Implement the HSCRC methodology for temporary transition funding that would be required to be repaid by Regional Partnerships.

Final Recommendations for Competitive Regional Partnership Catalyst Grants

November 13, 2019

Health Services Cost Review Commission
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Baltimore, Maryland 21215
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OVERVIEW

The Maryland Health Services Cost Review Commission ("HSCRC," or "Commission") staff have prepared the following final recommendation to reauthorize the funding and to establish an updated approach for the Regional Partnership Transformation Grant Program. Funding for the current program is set to expire on June 30, 2020. Given this, the HSCRC staff have outlined a new design for the grant program to support the goals of the Total Cost of Care Model. Under the proposed new grant program, hospitals and their partners would collaborate on interventions to support statewide population health priorities. The following includes the HSCRC staff final recommendation that incorporates stakeholder feedback received during the public comments period. If approved, the new grant program referred to herein as the *Regional Partnership Catalyst Grant Program*, would become effective **January 1, 2021**.

FINAL STAFF RECOMMENDATION

The final HSCRC staff recommendation for the Regional Partnership Catalyst Grant Program includes the following components:

- Establish the new Regional Partnership Catalyst Grant Program effective January 1, 2021;
- Allocate 0.25 percent of annual statewide all-payer hospital revenue for a five year period (January 2021 – December 2025). Grant funding will end on December 31, 2025;
    - Year 1: CY2021 (January 1, 2021 – December 31, 2021)
    - Year 2: CY2022 (January 1, 2022 – December 31, 2022)
    - Year 3: CY2023 (January 1, 2023 – December 31, 2023)
    - Year 4: CY2024 (January 1, 2024 – December 31, 2024)
    - Year 5: CY2025 (January 1, 2025 – December 31, 2025)
    - Grant funding will end on December 31, 2025;
- Create three grant funding streams that align with statewide population health priorities as identified under the MOU with CMS;
- Require hospitals to collaborate with community partners and collect data on fund sharing arrangements;
- Use the HSCRC impact measurement approach that establishes scale targets and/or ROI methodology for Medicare, Medicaid, and other payers as data become available;
- Issue an RFP to competitively bid grant funds;
- Require each participating hospital CEO & CFO to agree to sustain successful interventions through other funding sources at the end of the grant period;
- Establish accountability and oversight as described in the recommendation document; and

- Implement the HSCRC methodology for temporary transition funding that would be required to be repaid by Regional Partnerships.

STAKEHOLDER FEEDBACK SUMMARY

To ensure stakeholder feedback was considered in the design of the Regional Partnership Catalyst Grant Program, HSCRC staff accepted public comments on the draft recommendation. Staff received eighteen comment letters from stakeholders in response to the draft recommendation. The respondents were:

1. Senator Brian Feldman
2. Behavioral Health System of Baltimore
3. Montgomery County Department of Health and Human Services
4. LifeSpan Network
5. Jewish Social Services Agency
6. Totally Linking Care
7. Delegate Joseline Pe.a -Melnyk
8. Anne Arundel Medical Center & Doctors Community Health System
9. Montgomery County Hospitals (Adventist Healthcare, Suburban Hospital, MedStar Montgomery Medical Center, Holy Cross Health)
10. Nexus Montgomery
11. Maryland Hospital Association
12. University of Maryland Medical System
13. Trivergent Health Alliance
14. MedStar Health
15. CareFirst
16. Maryland Department of Health
17. MedChi
18. Johns Hopkins Health System & Johns Hopkins Medicine

All comment letters expressed support for the continuance of Regional Partnership grants. Additionally, there was widespread support for the two identified funding priority areas – diabetes services and behavioral health crisis services. Staff reviewed all the letters and identified five overarching themes related to suggested changes. Each of these five themes is addressed below.

1. **Stakeholder Comment: The program should have an all-payer focus and impact measurement. The program currently appears too directed towards the Medicare population.**

   Staff Response: The HSCRC intends for the Regional Partnership Catalyst Grant Program to support activities that would positively impact all Marylanders regardless of payer source. Regional Partnerships must focus their investments on the full population in their catchment area, regardless of payer source. HSCRC staff recommends a modified impact

measurement approach that includes Medicare, Medicaid, and other payers' data if it becomes available. Staff is working with the Medicaid team to obtain baseline and claims data. The scale targets for all funding streams will be modified to have year 1 – 5 targets based on all-payer metrics.

2. **Stakeholder Comment: The program should have more flexibility and allow more evidence-based programs to be funded.**

Staff Response: HSCRC staff acknowledge that the current funding streams are more prescriptive than the past grants. Staff also understand that these programs cannot solely address all the population health challenges facing our State. A focus on developing infrastructure in key areas for diabetes and behavioral health will, however, ultimately provide for a long-term and wide-scale population health impact. The more narrow scope of funding is not intended to imply that these areas of focus are the sole factors in improving diabetes and behavioral health services in the State. Rather, HSCRC staff identified programs and infrastructure needs to accelerate these population health goals and recognize that Regional Partnerships may offer complimentary programs that can optimize the impact of these new resources.

Diabetes Funding Stream: Staff has been directive in order to make a substantial impact on expanding the Diabetes Prevention Program (DPP), Diabetes Self-Management Training (DSMT), and Medical Nutrition Therapy (MNT). Regional Partnership grants alone will not decrease the burden of diabetes in Maryland, but can have a marked effect on creating focus on diabetes across the regions and expanding DPP supplier levels. Additionally, DPP has proven long-term ROI in preventing the onset of Type II Diabetes. DPP and DSMT also offer sustainability through billable claims once initial start-up costs are covered by the grants. Staff recommends keeping the grant activities specifically focused on the Diabetes Prevention Program (DPP)), the Diabetes Self-Management Training (DSMT), and Medical Nutrition Therapy (MNT) as identified in the draft recommendation.

Behavioral Health Funding Stream: Staff selected the Crisis Now model for this funding stream as it outlines an evidence-based framework for improving crisis services in the State. The State of Arizona has successfully operated this model for 20 years with proven results for its entire population. There is some flexibility inherently in this funding stream as Regional Partnerships can design implementation strategies related to one or more of the three core components of the model – call centers, mobile crisis teams, and residential stabilization centers. These are foundational elements of sound behavioral health acute support models and therefore must be the initial investments. This core of services provides Maryland an opportunity to organize its acute behavioral health needs and connect regional systems to other programs for optimal behavioral health support. The Regional Partnership grants alone will not solve all of the behavioral health challenges within the State. HSCRC staff carefully selected an area of impact where hospitals and community partners could work collectively under a common agenda, with mutually reinforcing activities that within their scope of influence. Directed funding towards crisis services can substantially expand the availability of an underdeveloped healthcare service, greatly improve patient care and achieve cost savings for the system.

Finally, when initially discussing continuing Regional Partnership supports, the Commission set clear guidelines to focus efforts for a measurable impact on the system. Given this, staff have

prioritized impact measurement in the new Catalyst iteration of the HSCRC grant program. Allowing additional flexibility in program funding would create operational difficulty in measuring impact and likely would lead to inconsistent impact measurement. Furthermore, diffuse activities could weaken the Regional Partnership impact in these key population health areas and lead to unclear return on investment putting future iterations of the program at risk.

3. **Stakeholder Comment: The HSCRC should require Regional Partnerships to share grant funds with community collaborators and/or let non-hospital stakeholders apply directly for funds.**

   Staff Response: Funding will be issued only to hospitals under the rate-setting authority of the HSCRC however community partner support will be required as a condition of grant eligibility. The level of collaboration with other community stakeholders will be an important component in proposal evaluation for the Regional Partnership Catalyst Grants. While staff will not set a pre-determined level of funding, in-kind support, or partnership with collaborating organizations, whether or not the Regional Partnership includes meaningful partnership will be weighted heavily during the proposal evaluation process. Regional Partnerships will be required to provide details on financial and in-kind collaboration agreements as part of the RFP process. Additionally, HSCRC will collect the details about collaboration arrangements as part of the on-going monitoring process

4. **Stakeholder Comment: The current timeline is too accelerated. Regional Partnerships need more time to develop relationships and write their proposals.**

   Staff Response: Staff acknowledges that the originally proposed timeline was accelerated. The intention was to begin the Catalyst Grant Program on July 1, 2020, immediately after the current Transformation Grant Program funding expires. Given that staff also supports providing some transition funding to legacy Transformation Regional Partnerships, the initial urgency to begin the program on July 1, 2020 is less pressing.

   To ensure the Regional Partnerships have ample planning time, staff propose moving the Request for Proposal (RFP) deadline from January 2020 to June 2020. Under this schedule, rate orders would be issued for Catalyst Grant Program awardees in January 2021. The modified Catalyst grant application process would include the following key dates:

   - RFP Release – January 2020
   - Proposals Due – June 2020
   - Rate Orders Issued – January 2021

   The five year grant period would start January 2021 and end December 2025. The HSCRC will fund the grants according to the following schedule:

   - Year 1: CY2021 (January 1, 2021 – December 31, 2021)
   - Year 2: CY2022 (January 1, 2022 – December 31, 2022)
   - Year 3: CY2023 (January 1, 2023 – December 31, 2023)
   - Year 4: CY2024 (January 1, 2024 – December 31, 2024)
   - Year 5: CY2025 (January 1, 2025 – December 31, 2025)
   - Grant funding will end on December 31, 2025.

Additionally, staff also recommends modifying the year 1 scale targets to include a planning period for the Regional Partnerships. The staff will develop year 1 scale targets for each funding stream to reflect expectations associated with building relationships with community partners and other key planning milestones.

5. **Stakeholder Comment: The HSCRC should provide financial support to legacy Regional Partnerships to assist with sustainability of legacy programs.**

   Staff Response: Staff proposes a new methodology designed to provide "temporary transition funding" for existing Regional Partnerships. Under this approach, existing Regional Partnerships can obtain temporary transition funding in the form of "borrowed" funds from future participating hospital global budget revenue (GBR). The HSCRC staff will work with Regional Partnerships to add the temporary transition funding to participating hospital rates as an increase in FY2021 and FY2022. These funds would then have to be repaid in full through a reduction of participating hospital rates in FY2023 and FY2024.

   The temporary transition funding will provide interested Regional Partnerships with funding for a maximum of two years after June 30, 2020. Each hospital currently participating in a Regional Partnership would be eligible for a maximum amount equivalent to their FY2020 Regional Partnership Transformation grant amount. To qualify for the temporary funding, a Memorandum of Understanding (MOU) agreeing to repay the funds would be required from each hospital making the request. Appendix B provides an example of how the temporary transition funding would be issued and repaid.

   While the temporary transition funding will provide extended financial support to enable additional testing time for interventions, Regional Partnerships must still identify a plan for long-term sustainability through alternative funding for these interventions. In addition to the option to request temporary transition funding, legacy Regional Partnership interventions may also qualify for reconciliation payments through the Care Transformation Initiative (CTI) program if the intervention successfully reduces total cost of care using the HSCRC ROI methodology. To determine whether or not a reconciliation payment is possible, Regional Partnerships are encouraged to apply for CTI funding in addition to making a request for temporary transition funding. Finally, hospitals participating in Regional Partnerships should also consider leveraging existing community benefit funding as another option to financially sustain legacy interventions.

REGIONAL PARTNERSHIP CATALYST GRANTS

The HSCRC staff recommends a new competitive grant program be established effective January 1, 2021. The new *Regional Partnership Catalyst Grant Program* will build upon the legacy Regional Partnership Transformation grant program and enable hospitals to continue working with community resources to build infrastructure needed to sustainably support the population health goals of the Total Cost of Care Model.

The HSCRC Grant Philosophy

The new Regional Partnership Catalyst Grant Program will be based on the HSCRC grant philosophy that the funding is designed to a) foster collaboration between hospitals and community partners and b) to enable the creation of infrastructure to disseminate evidence-based interventions. The following core principles will apply to the new Regional Partnership Catalyst Grant Program:

- *Eliminate duplication* – Given Maryland's shift from the All-Payer Model to the Total Cost of Care Model, care must be taken to ensure both interventions and grant funds are not duplicative with other new elements of the Model.
- *Ensure alignment with State priorities* – Funded interventions must support the goals of the Total Cost of Care Model and priority conditions identified under the Statewide Integrated Health Improvement Strategy.
- *Ensure broad collaboration* – There must be widespread engagement of local resources with a common agenda and mutually reinforcing activities to more effectively implement interventions.
- *Leverage evidence-based practices* – Funded interventions should be based on evidence that a model being proposed will achieve success.
- *Identify impact* – As a condition of funding, impact will be measured through the achievement of scale targets and progress goals, health improvement, and/or return on investment (ROI).
- *Ensure sustainability* – Funded interventions must have a plan for sustainability that includes both a plan to integrate successful interventions into hospital operations and a financial plan to ensure there is a permanent source of funding to continue the intervention after the grant expires.
- *Revamp grant oversight* – The HSCRC will leverage grant-making best practices and will provide additional oversight resources to ensure there is visibility, shared learning opportunities, and compliance with the intended purpose of the grant program.
- *Communicate & collaborate with stakeholders* – The HSCRC will continue the culture of collaboration with grantees to ensure information is clear, sensitive to concerns, and timely.

Structure of the New Recommended Grant Program

The new Regional Partnership Catalyst Grant program would require hospitals to competitively bid for funding that would begin January 1, 2021. The HSCRC staff proposes that funding be narrowly focused to support interventions that align with goals of the Total Cost of Care Model and support the Memorandum of Understanding that Maryland is establishing with the Centers for Medicare & Medicaid Services (CMS) for a Statewide Integrated Health Improvement Strategy (SIHIS). The Regional Partnership Catalyst Grant Program will include allocations of funds called "funding streams" that are designed to encourage focus on the key state priorities. The three recommended funding streams are as follows:

- **Funding Stream I: "Diabetes Prevention & Management Programs"** – This funding stream would award grants to Regional Partnerships to support the implementation of the Centers for Disease Control (CDC) approved diabetes prevention and American Diabetes Association (ADA) recommended diabetes management programs.

- **Funding Stream II: "Behavioral Health Crisis Programs"** – This funding stream would award grants to Regional Partnerships to support the implementation and expansion of behavioral health crisis management models that improve access to crisis intervention, stabilization, and treatment referral programs.

- **Funding Stream III: "Population Health Priority Area #3"** – This funding stream would award grants to Regional Partnerships to support the third population health priority area that is yet to be defined for Maryland.

The approach to the Regional Partnership Catalyst Grants would be a departure from the legacy program format, which allowed more flexibility for regional partnerships to develop their own models and interventions. The HSCRC staff believes a more structured approach around key population health priority areas will ensure Regional Partnership efforts align and contribute to State efforts to maximize impact under the Total Cost of Care Model goals, while still allowing for regional customization. While the grant program will be designed to focus on infrastructure in these areas, the HSCRC will encourage Regional Partnerships to also work with communities to develop additional interventions that address upstream factors related to diabetes and behavioral health prevention and supplement the HSCRC grant funded programs.

Funding Stream I: Diabetes Prevention & Management Programs

Under the Total Cost of Care Model, Maryland has identified diabetes as one of two population health priority areas to be included in its Statewide Integrated Health Improvement Strategy. Diabetes is a highly prevalent and devastating chronic condition that is impacting Marylanders. The costs of treating diabetes and ensuring good health outcomes for patients living with diabetes can be addressed by focusing on the prevention of new diabetic cases and more effective management of current populations with diabetes.

The diabetes funding stream will award grants to Regional Partnerships that choose to support and implement the Centers for Disease Prevention & Control (CDC) recommended National Diabetes Prevention Program (DPP). Across the country, diabetes education and self-management programs have a robust evidence base. National DPP is designed to prevent or delay the onset of Type II diabetes, and has shown long-term success in helping to prevent the onset of diabetes and promote weight-loss for those with pre-diabetes. Implementing more education and lifestyle change support has been shown to improve outcomes and spending for those living with diabetes. As a component of this funding stream, the HSCRC will promote and specifically track the development of the Medicare Diabetes Prevention Program (MDPP), a CMMI Model demonstration which enables Medicare reimbursement for National DPP provision to Medicare beneficiaries. HSCRC staff will set scale targets and measure progress of this funding through measuring MDPP claims in Medicare data.

As an additional component of the diabetes funding stream, the HSCRC will also promote and track development of Medicare Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT). These services provide training, lifestyle change help and diabetes management curriculum to Medicare beneficiaries to help better control their Type II diabetes. Organizations must receive American Diabetes Association (ADA) accreditation for their DSMT programs. The goals of DSMT are to increase knowledge and skills of persons with diabetes to manage the disease. MNT is provided by registered dietitians as an intensive, focused and comprehensive nutrition

therapy service. Through MNT dietitians work with diabetic patients to establish goals, a care plan, and interventions based on in-depth individual nutrition assessments. If delivered concurrently, DSMT and MNT have been shown more effective in helping patients manage diabetes. Medicare reimburses for both of these services and therefore scale and progress of this funding will be measured from Medicare claims.

Maryland needs significantly more diabetes prevention and management resources in order to provide the service to all Marylanders in need. Based on modeling performed by HSCRC staff, Maryland would need 227 National DPP suppliers to manage the estimated pre-diabetic population aged 55 and up in Maryland. There are currently 49 in the State and only three participating in the Medicare DPP Model demonstration. Given this shortage, the goals of this funding stream are to build a more adequate National DPP supplier capacity within Maryland that becomes available for the entire health system to utilize and encourage MDPP participation specifically to support the Medicare population. By choosing to support this approach, the HSCRC believes that Regional Partnerships can help to disseminate an evidence-based intervention that will not only aid in more effective prevention and management of diabetes among Marylanders, but also contribute to existing statewide efforts for maximal impact.

In addition to the robust evidence base for these prevention and management programs, the HSCRC also selected these approaches because they provide Regional Partnerships with a pathway to sustainable reimbursement through Medicare and Medicaid after the expiration of grant funding. Medicare billing for these services is available for certified suppliers. However, to be eligible for Medicare diabetes related billing, potential MDPP, DSMT and MNT suppliers must make substantial investments in certification, training, and administration before reimbursement is possible. The HSCRC anticipates that through the Regional Partnership Catalyst Grant funding, Regional Partnerships can help build the infrastructure and address any startup costs – recruitment, training, and certification of diabetes prevention and management support services – and be fully self-sustaining after four years.

Funding Stream II: Behavioral Health Crisis Services

Under the Total Cost of Care Model, Maryland has also identified opioid use disorder as the second population health priority area to be included in its Statewide Integrated Health Improvement Strategy. Across the State, hospitals cite both opioid use disorder and acute mental health treatment access issues as factors that contribute significantly to emergency department (ED) overcrowding. Under the TCOC Model, Maryland has clear incentives to reduce unnecessary ED and hospital utilization. Currently though, Maryland lacks adequate behavioral health infrastructure and services to divert the volume of crisis needs from EDs and inpatient services to more appropriate care settings in the community.

Improving crisis resources necessitates system-wide investment and collaboration. However, economies of scale often make it financially infeasible for a single hospital to invest resources. Further exacerbating this situation, community-based organizations that currently provide many of these services for the State do not receive reimbursement for all of their crisis management services and often struggle to provide the volume of support needed.

Access to crisis services is a key component to developing sustainable health spending and ensuring appropriate utilization of the health system. The Regional Partnership Catalyst Grant Program will include a funding stream for behavioral health crisis services. Specifically, grants will be awarded to focus on developing and expanding infrastructure for comprehensive crisis management services that enable Marylanders to receive care in settings other than traditional hospital EDs. Similar to the diabetes funding stream, this funding will be tied to specific scale targets set to measure progress. Regional Partnerships will also be expected to form a financial sustainability plan, which HSCRC staff will review and vet prior to awarding funds. The HSCRC will consider proposals that include interventions and programs supported in the "Crisis now: Transforming Services is Within Our Reach" action plan developed by the National Action Alliance for Suicide Prevention. These may include one or more of the following:

- Crisis Call Center & "Air Traffic Control" Services
- Community-Based Mobile Crisis Teams
- Short-term, "sub-acute" residential crisis stabilization programs

Funding Stream III: Reserve Fund

Under the SIHIS Memorandum of Understanding with CMS, Maryland has the ability to identify a third population health priority area. The HSCRC is working with State agency partners to make decisions on this. In preparation for this potential additional focus area, the HSCRC staff proposes reserving twenty percent of the Regional Partnership Catalyst Grant funding to support the third priority area when it is defined. If approved by the Commission, this funding would become available for grant applications. By creating a third funding stream, the HSCRC will be able to help Regional Partnerships engage in activities to support State effort.

Collaboration Requirements

Regional Partnership Catalyst Grant applicants will need to demonstrate that widespread collaboration will be part of their proposed model. Partnerships must include a variety of resources that have the ability to influence population health including but not limited to Local Health Improvement Coalitions, Local Health Departments, community-based organizations, local behavioral health authorities, social service organizations, provider organizations, etc. Where needed, the HSCRC staff will collaborate with the Maryland Community Health Resources Commission (CHRC), the Maryland Department of Health (MDH), and other subject matter expert organizations and individuals as necessary to assist hospitals with identifying interested community-based organizations and other healthcare resources that can increase effectiveness of Regional Partnerships.

It is important to note that funding will be issued only to hospitals under the rate-setting authority of the HSCRC however community partner support will be required as a condition of grant eligibility.

While staff will not set a pre-determined level of funding, in-kind support, or partnership with collaborating organizations, whether or not the Regional Partnership includes meaningful partnership will be weighted heavily during the proposal evaluation process. Regional Partnerships will be required to provide details on financial and in-kind collaboration agreements as part of the RFP

process. Additionally, HSCRC will collect the details about collaboration arrangements as part of the on-going monitoring process.

Impact Measurement

Under the Total Cost of Care Model, the State must systematically work to reduce the cost of care for Medicare beneficiaries while also improving statewide population health for all Marylanders. Regional Partnership Catalyst Grants will be designed to help the system develop infrastructure for long term achievement of these goals. The Regional Partnership funds remain important mechanisms to foster partnerships across the State and to mobilize diverse community resources under a unified agenda with mutually reinforcing activities. This collaboration should contribute to the State's progress toward Total Cost of Care Model long-term population health goals. The HSCRC staff proposes two approaches to measuring the impact and effectiveness of interventions performed by Regional Partnerships.

Scale Targets

Quantifying and explaining the impact that Regional Partnership activities have is important to justify continued funding in Maryland's health system. The HSCRC understands that improving infrastructure and resources for diabetes prevention and management and behavioral health crisis services will produce long-term positive impact for the health system. Even so, ROI will only be measureable after the appropriate infrastructure is developed to support interventions. In the interim, the HSCRC has developed *scale targets* to ensure progress is made toward the infrastructure needed to support long-term ROI. Scale targets are pre-determined targets that Regional Partnerships will need to achieve during the grant period in order to receive continued funding. The targets will be set from data, such as claims, so that progress can be independently verifiable and objectively measured between Regional Partnerships. Regional Partnerships will *not* be accountable for a specific total cost of care savings goal during the grant period, but will be held accountable to achieve scale targets instead.

ROI Methodology

The HSCRC will develop a defined methodology for measuring ROI that uses Medicare, Medicaid, and commercial claims (as these data become available) to identify total cost of care savings. This methodology will be used to determine post-grant financing eligibility (through Care Transformation Initiative reconciliation payments or other mechanisms) for funding streams that do not include a claims reimbursement mechanism to achieve long-term sustainability.

The funding streams will incorporate scale targets and components of ROI on an all-payer basis as follows:

Diabetes Prevention Impact Measurement	Diabetes Management Impact Measurement

• Awardees must be able to demonstrate successful completion of Scale Targets for Diabetes Prevention Program for Medicare and Medicaid. These Scale Targets will be designed to measure the growth of DPP in the State, the effectiveness of engaging beneficiaries, and the outcomes of those who receive services. Year 1 in particular will include key planning milestones. • The HSCRC staff will include final impact measurement requirements in the RFP.	• Awardees must be able to demonstrate successful completion of Scale Targets for billing Diabetes Self-Management Training (DSMT) and Medical Nutritional Therapy (MNT) for beneficiaries with diabetes. • The HSCRC staff will include final impact measurement requirements in the RFP.

Behavioral Health Crisis Program Impact Measurement
• Awardees must be able to demonstrate successful completion of Scale Targets for implementation or expansion of the three components in the Crisis Now Model for Medicare and Medicaid. • The HSCRC ROI policy will apply for post-grant funding (e.g., CTI or other mechanisms) • The HSCRC staff will include final impact measurement requirements in the RFP.

Financial Budget

The HSCRC recommends that the new Regional Partnership Catalyst Grant Program have an annual investment of 0.25 percent of statewide all-payer hospital revenue, consistent with prior investments. Given the time needed to sufficiently build partnerships and infrastructure, including workforce and implementation of interventions, the staff recommends the grant period run for five years (CY 2021 through the end of CY 2025). Upon approval by the Commission, the HSCRC staff will launch a competitive bidding process for grants that would be effective January 1, 2021. The grant amounts would be added to hospital annual rates as temporary adjustments for the following five year period:

- Year 1: CY2021 (January 1, 2021 – December 31, 2021)
- Year 2: CY2022 (January 1, 2022 – December 31, 2022)
- Year 3: CY2023 (January 1, 2023 – December 31, 2023)
- Year 4: CY2024 (January 1, 2024 – December 31, 2024)
- Year 5: CY2025 (January 1, 2025 – December 31, 2025)
- Grant funding will end on December 31, 2025.

Competitive Bid Process

The HSCRC recommends establishing a competitive bidding process for the Regional Partnership Catalyst Grant Program that would require the submission of new proposals to be eligible for funding effective for January 1, 2021. Proposed evaluation criteria would include consideration of the following elements:

- Alignment with Total Cost of Care Model Goals
- Infrastructure/ROI Plan
- Widespread Engagement & Collaboration
- Evidence-Based Approach
- Efficacy of Previous Funding
- Governance & Operational Planning
- Innovation
- Sustainability Plan

The HSCRC will form an unbiased evaluation committee to review the grant applications and make recommendations on scoring. Additionally, the HSCRC will engage key subject matter experts with diabetes prevention/management and behavioral health crisis management expertise to assist in the review and evaluation of grant applications.

Oversight & Auditing

The HSCRC staff will establish new requirements to ensure conditions of the Regional Partnership Catalyst Grants are clearly defined and agreed to before acceptance of the award. Each hospital CEO/CFO will be required to sign the award acceptance to ensure mutual understanding of the timeframe of the grant and to ensure there is planning for long-term sustainability. HSCRC grant oversight procedures will include:

- *Biannual Progress/Performance Reports* – Regional Partnerships will provide program performance reporting as defined by HSCRC. Reporting will include information on activities performed to achieve scale targets, collaboration levels, and funding sharing.
- *CRISP Monitoring Reports* – The HSCRC will work with CRISP to design new reporting tools to measure the achievement of scale targets and total cost of care savings. These reports will be readily available and accessible to both the State and Regional Partnership teams.
- *Financial Auditing* – The HSCRC will continue to perform at least annual audits for every Regional Partnership that is funded. The audit procedures will ensure grant funding is used in compliance with awarded proposals.
- *Site Visits* – The HSCRC will conduct site visits regularly with all grantees to understand more about the activities being performed, progress to date, and the levels of success that Regional Partnerships are achieving toward the goals of the program.
- *Additional Oversight & Program Administration* – The HSCRC intends to allocate additional staff resources to the oversight of the Regional Partnership Catalyst Grant program. Additionally, upon approval from the Commission, HSCRC staff intends to procure a grants management consultant to assist with post-award program administration.

Regional Partnership grantees will also be required to increase visibility of programmatic activities through update presentations to Commissioners, information sharing within communities, and participation in a State-supported learning collaborative.

LEGACY GRANTS SUNSET PROCESS

The existing Regional Partnership Transformation Grant funding is scheduled to end on June 30, 2020. The HSCRC recognizes that some Regional Partnerships have promising interventions that have not had time to fully mature and consequently no sustainability plan has been identified. For these Regional Partnerships, additional time may be needed to transition to an alternative source of funding. The HSCRC proposes a "temporary transition funding" approach in order to support existing Regional Partnerships that need the additional financial support for a limited period of time.

Under the temporary transition funding approach, existing Regional Partnerships can obtain funding in the form of "borrowed" funds from future participating hospital global budget revenue (GBR). The HSCRC staff will work with Regional Partnerships to add the temporary transition funding to the participating hospital rates as an increase in FY2021 and FY2022. These funds would then have to be repaid in full through a reduction of participating hospital rates in FY2023 and FY2024.

The temporary transition funding will provide interested Regional Partnerships with funding for a maximum of two years after June 30, 2020. Each hospital currently participating in a Regional Partnership would be eligible for a maximum amount equivalent to their FY2020 Regional Partnership Transformation grant amount. To qualify for the temporary funding, a Memorandum of Understanding (MOU) agreeing to repay the funds would be required from each hospital making the request. Appendix B provides an example of how the temporary transition funding would be issued and repaid.

While the temporary transition funding will provide extended financial support to enable additional testing time for interventions, Regional Partnerships must still identify a plan for long-term sustainability through alternative funding for these interventions. In addition to the option to request temporary transition funding, legacy Regional Partnership interventions may also qualify for reconciliation payments through the Care Transformation Initiative (CTI) program if the intervention successfully reduces total cost of care using the HSCRC ROI methodology. To determine whether or not a reconciliation payment is possible, Regional Partnerships are encouraged to apply for CTI funding in addition to making a request for temporary transition funding. Finally, hospitals participating in Regional Partnerships should also consider leveraging existing community benefit funding as another option to financially sustain legacy interventions.

CONCLUSION

The HSCRC staff believes a newly designed Regional Partnership Catalyst Grant program can make a positive contribution to the State under the Total Cost of Care Model. While the new program will include an overhaul of requirements and administration procedures, the recommendation is to maintain the same historical 0.25 percent of statewide all-payer hospital revenue for budgeting purposes. The staff recommendation includes a number of fundamental changes to ensure the funding impact and effectiveness of the interventions are maximized. To start, grants will be

competitively rebid to ensure all activities comply with the new grant model. Grants would be used to fund initiatives directly linked to Maryland's population health priority areas. This will ensure hospital efforts align with other statewide activities to maximize impact. Additionally, the recommendation includes an emphasis on widespread collaboration with community health resources. Another element of the recommendation is to establish a pre-defined approach for measuring the impact of investment dollars through HSCRC created scale targets and ROI methodology. Finally, the HSCRC will improve its oversight functions to ensure that there is regular reporting, auditing, and best practice sharing about Regional Partnership activities. By incorporating all of the new elements articulated in this draft recommendation, the HSCRC staff believes the grant program can be a highly successful component of the Total Cost of Care Model.

FINAL STAFF RECOMMENDATION

The final HSCRC staff recommendation for the Regional Partnership Catalyst Grant Program includes the following components:

- Establish the new Regional Partnership Catalyst Grant Program effective January 1, 2021;
- Allocate 0.25 percent of annual statewide all-payer hospital revenue for a five year period (January 2021 – December 2025). Grant funding will end on December 31, 2025;
    - Year 1: CY2021 (January 1, 2021 – December 31, 2021)
    - Year 2: CY2022 (January 1, 2022 – December 31, 2022)
    - Year 3: CY2023 (January 1, 2023 – December 31, 2023)
    - Year 4: CY2024 (January 1, 2024 – December 31, 2024)
    - Year 5: CY2025 (January 1, 2025 – December 31, 2025)
    - Grant funding will end on December 31, 2025;
- Create three grant funding streams that align with statewide population health priorities as identified under the MOU with CMS;
- Require hospitals to collaborate with community partners and collect data on fund sharing arrangements;
- Use the HSCRC impact measurement approach that establishes scale targets and/or ROI methodology for Medicare, Medicaid, and other payers as data become available;
- Issue an RFP to competitively bid grant funds;
- Require each participating hospital CEO & CFO to agree to sustain successful interventions through other funding sources at the end of the grant period;
- Establish accountability and oversight as described in the recommendation document; and

- Implement the HSCRC methodology for temporary transition funding that would be required to be repaid by Regional Partnerships.

APPENDIX A: BACKGROUND ON EXISTING REGIONAL PARTNERSHIPS

The Commission authorized the Regional Partnership Transformation Grant program in June 2015. This four-year competitive grant-based program was designed to create and fund hospital-led multidisciplinary teams that work across statewide geographic regions to develop interventions for high-risk and high-utilizing Medicare beneficiaries, who often present at hospitals with multiple complex and chronic conditions. As part of the program, hospitals partnered with neighboring hospitals and/or diverse community organizations including local health departments, provider organizations, community health workers, and behavioral health resources to develop interventions that were intended to result in more efficient care delivery under the metrics of the All-Payer Model.

There are 14 hospital-led partnerships created and funded through the grant program that include 41 of Maryland's acute care hospitals (Appendix A) and serve both rural and urban areas across the State. The most common interventions performed by Regional Partnerships include behavioral health integration, care transitions, home-based care, mobile health, and patient engagement/education strategies and have focused primarily on reducing potentially avoidable utilization for high-need and high-risk Medicare patients.

The funding model for the Regional Partnership Transformation Grant program was approved by the Commission in June 2015 and authorized up to 0.25 percent of FY 2016 total statewide all-payer hospital revenue to be distributed to grant applicants under a competitive bidding process. Based on this, the HSCRC released a "Request for Proposals" (RFP) and subsequently awarded hospitals $37 million in FY 2017 to implement the regional programs. Awards were reduced annually in an effort to prepare hospitals to develop financial alternatives for sustaining programs. An annual ten percent hospital cost sharing requirement was established each year through the final year of funding (FY2020).

- FY 2017 = $37.0M
- FY 2018 = $33.3M (10% Cost Share)
- FY 2019 = $29.6M (20% Cost Share)
- FY 2020 = $25.9M (30% Cost Share)

The grants limited the maximum award to 0.50 percent of a hospital's FY 2016 global budget for each approved application. Funding was issued via HSCRC-approved rate increases for hospitals who participated in Regional Partnerships. The grants are scheduled to expire on June 30, 2020.

Regional Partnership	**Member Hospital(s)**
Bay Area Transformation Partnership	1. Anne Arundel Medical Center 2. UM-Baltimore Washington Medical Center
Calvert Memorial - It Takes a Village	1. Calvert Memorial Hospital
Community Health Partnership of Baltimore	1. Johns Hopkins Hospital 2. Johns Hopkins - Bayview Medical Center 3. MedStar - Franklin Square 4. MedStar - Harbor Hospital 5. Mercy Medical Center 6. Sinai Hospital
GBMC	1. GBMC
Howard Health Partnership	1. Howard County Regional Hospital
LifeBridge	1. Carroll Hospital Center 2. Northwest Hospital 3. Sinai Hospital
MedStar House Call Program	1. MedStar - Good Samaritan 2. MedStar - Union Memorial
Nexus Montgomery	1. Holy Cross Hospital 2. Holy Cross - Germantown 3. MedStar - Montgomery General 4. Shady Grove Adventist Hospital 5. Suburban Hospital 6. Washington Adventist Hospital
Peninsula Regional	1. Atlantic General Hospital 2. McCready Hospital 3. Peninsula Regional Medical Center

Totally Linking Care - Southern MD	1. Calvert Memorial Hospital 2. Doctor's Community Hospital 3. Fort Washington Medical Center 4. UM - Laurel Regional Medical Center 5. MedStar - Southern MD 6. MedStar - St. Mary's Hospital 7. UM - Prince George's Hospital
Trivergent Health Alliance	1. Frederick Memorial Hospital 2. Meritus Medical Center 3. Western Maryland Medical Center
UM-St Joseph	1. UM - St. Joseph
UMUCH-UHCC	1. UM - Harford Memorial Hospital 2. Union Hospital of Cecil County 3. UM - Upper Chesapeake Hospital
West Baltimore Collaborative	1. Bon Secours Hospital 2. St. Agnes Hospital 3. University of Maryland Medical Center 4. UM-Midtown

Additional information about the programs of these grantees may be found on the HSCRC website at: https://hscrc.maryland.gov/Pages/regional-partnerships.aspx

APPENDIX B: TEMPORARY TRANSITION FUNDING EXAMPLE

The following is intended to be an example of the HSCRC proposed temporary transition funding process. Regional Partnership participating hospitals would receive and repay funding through adjustments to participating hospitals' Global Budget Revenue (GBR).

Scenario: Hospital A is currently participating in a Regional Partnership and wants to receive temporary transition funding to support the continuation of an intervention started under the Regional Partnership Transformation Grant Program. Hospital A is willing to "borrow" from future GBR to fund the intervention. Before the temporary transition funding is provided, Hospital A has a $100 Million GBR.

- Step 1: Hospital A receives approval from their CEO/CFO to apply for transition funding and signs the MOU
- Step 2: HSCRC receives the MOU and approves the transition funding request for $2 Million for two years
- Step 3: HSCRC issues the temporary funding as an increase to Hospital A's GBR in FY2021 and FY2022
- Step 4: Hospital A repays the temporary funding through a decrease in GBR in FY2023 and FY2024

Time Period	Funding Amount	Effect on GBR
FY2021 (July 2020 – June 2021)	$100 Mil GBR +$2 Mil in Temporary Transition Funding	$102 Mil
FY2022 (July 2021 – June 2022)	$100 Mil GBR +$2 Mil in Temporary Transition Funding	$102 Mil
FY2023 (July 2022 – June 2023)	$100 Mil GBR -$2 Mil in Temporary Transition Funding	$98 Mil
FY2024 (July 2023 – June 2024)	$100 Mil GBR -$2 Mil in Temporary Transition Funding	$98 Mil

Maria Harris Tildon
Executive Vice President
Marketing, Communications & External Affairs

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October 23, 2019

Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini:

I write to provide CareFirst's comments on the HSCRC Staff's "Draft Recommendation for Competitive Regional Partnership Catalyst Grants."

CareFirst supports the Staff's draft recommendation which appears to bring a more structured approach around key population health priority areas, namely Diabetes Management and Behavioral Health. As a payer, we recognize the impact these conditions have on our members' total cost of care and support any program focused on early detection and treatment that will ultimately provide greater member satisfaction, quality of care, and ultimately control costs.

CareFirst also supports Staff's dual measurement approach that uses both a pre-determined scaled target and a ROI methodology. It is important for program participants to understand the performance measures upfront which these approaches provide, but it is also important that the system ultimately realizes a true return on investment for regional participation continuation. While the proposed policy calls for participating hospital CEOs and CFOs to agree to sustain successful interventions using other funding sources at the end of the grant period, unlike the original Regional Grant Program, the Catalyst Grants do not impose any "cost-sharing" requirements. This requirement should once again be imposed in order to prepare hospitals to develop financial alternatives for sustaining successful programs beyond FY 2025, the final year of the program.

To our knowledge, the HSCRC has not performed an evaluation of the success of the 14 "legacy" regional partnerships in meeting program goals. Such an evaluation could help identify the most effective strategies employed during the first round of Partnership Grants and would also provide needed assurance to the payer community that the programs, in fact, work. Accordingly, we would suggest that a portion of the 0.25% funding for the Competitive Regional Catalyst Grant programs be set aside to fund an independent evaluation to determine the extent to which the Catalyst Grants have met ROI targets and other population health objectives established by staff.

Given the emphasis on diabetes programs identified by hospitals filing Care Transformation Initiatives (CTIs), we would suggest some oversight by the HSCRC to make sure these CTIs are coordinated with the efforts of the Regional Partnerships and there is not a duplication of funding across both sets of programs.

Finally, we think it is imperative that funding for the partnerships should result in meaningful partnerships between hospitals and community partners. To that end, we strongly recommend that any successful applicants must demonstrate engagement with and meaningful support of the Local Health Improvement Coalitions ("Coalitions") in their catchment areas. These Coalitions are multi-stakeholder opportunities to identify cross-sector strategies to address population health goals. We believe that the Coalitions are necessary to support progress on the State's population health goals, and that regional

grant partnership dollars will not result in meaningful returns on investment without partnerships with these Coalitions.

Thank you for this opportunity to comment on the Regional Partnership Policy. We support the goals of this program and hope the HSCRC can structure the Catalyst Grant to make sure they ultimately add true value to our waiver model by addressing key population health factors and ultimately provide a true return to those funding these activities.

Sincerely,

Maria Harris Tildon

Cc: Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
Stacia Cohen
John Colmers
James N. Elliott, M.D.
Adam Kane
Katie Wunderlich, Executive Director

Maryland
Hospital Association

October 23, 2019

Tequila Terry
Deputy Director, Center for Payment Reform
and Provider Alignment
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Tequila:

On behalf of the Maryland Hospital Association's 61 member hospitals and health systems, we support the Health Services Cost Review Commission's plan to make grant funding available to support partnerships that address diabetes and behavioral health. We recognize the significant impact of diabetes and unmet behavioral health needs across the state and see the value in hospitals, doctors, payers, public health and other health care providers and community organizations coordinating to address the multiple contributing factors. We offer the following recommendations to enhance the plan and increase the value of the investments for all communities.

Flexibility within Funding Streams
The commission should consider interventions in addition to the Diabetes Prevention Program (DPP), Diabetes Self-Management Program and Medical Nutrition Therapy. These programs are not widely available because there are significant operational barriers to establish the service, and the cost to provide the service exceeds reimbursement by $661 per beneficiary.[1] Even for payers other than Medicare that offer DPP as a covered benefit, patients may not be able to access the benefit due to insufficient providers of DPP. The American Diabetes Association recognizes several similar—but less onerous—lifestyle and medication-based interventions that are more feasible to adopt and have been shown to be effective in large-scale implementation.[2]

Crisis services are needed, but so is access to behavioral health services when there is not a crisis. Expanding access to can help to alleviate the need for crisis services. An MHA survey of behavioral health patients found that 42% experienced a discharge delay of four hours or more, after a disposition decision is made, from the Emergency Department. Of those patients experiencing a delay, 45% were due to lack of availability in an appropriate setting. This indicates that inadequate access to all types of behavioral health services is contributing to the need for crisis services.

[1] Medical Care: November 2018 - Volume 56 - Issue 11 - p 908–911
[2] Diabetes Care 2016 Jul; 39(7): 1186-1201 https://doi.org/10.2337/dc16-0873

Measurement of Progress
We support the recommendation to increase oversight and more systematically measure the impact of partnerships' activities. However, the focus on Medicare claims to measure diabetes-related interventions is too narrow and may not reflect the impact on the most important target populations, who are more likely to be uninsured or covered by Medicaid and commercial insurers. Focusing on diabetes services for the Medicare population misses the peak opportunity. People 45-64 years old account for more than half of those newly diagnosed with diabetes.[3] Among vulnerable populations, where the interventions can have the biggest impact, the age of onset is often younger. While the recommendation encourages the interventions to be all-payer, measuring only the Medicare population will dampen the measured impact and misalign the incentive with important target populations.

Timing
The commission should consider a rolling submission and start date. Forming and vetting new relationships and creating formal agreements to work together takes time. Partnerships that build on existing programs may be ready to submit applications and begin operations within the timeline specified, but others need additional time.

Legacy Partnerships
We appreciate the commission recognizing the importance of additional time to transition current partnerships to sustainable funding sources. To discontinue funding at the end of the current fiscal year risks the loss of programs that are working or showing early progress. Partnerships and programs take at least a year to ramp up, and it may take another year or two to demonstrate definitive results.

We encourage HSCRC staff to thoughtfully evaluate partnerships' outcomes and be open to suggestions to extend funding beyond fiscal year 2020. In the spring, HSCRC staff began clearly communicating the intent to discontinue funding at the end of fiscal 2020; We encourage HSCRC staff to thoughtfully evaluate partnerships' outcomes and be open to suggestions to extend funding beyond fiscal year 2020. In the spring, HSCRC staff began clearly communicating the intent to discontinue funding at the end of fiscal 2020. Prior communication made clear that the funding would be permanent unless there was material lack of performance or for not meeting the letter or intent of an application. Below are the examples of where the Commission said the funding would be permanent.

Final Recommendations on Update Factors for FY 2016
May 13, 2015
Page 8: *The amount of the **grant awards** would be a **permanent 0.25% adjustment** to hospital rates.*

HSCRC Transformation Program Extension memo
November 13, 2015
Page 8: *Scalability and Sustainability*

[3] CDC National Diabetes Statistics Report, 2017

*This section should detail how the intervention/program is sustainable without additional rate increases in future years (**beyond the ongoing amount associated with this competitive award**.) Plans for funding an expansion of the program/intervention if it proves successful should also be described.*
Page 24: *…The implementation **grants will not be removed** (barring any adjustments made by Commission staff if expectations are not met) and **will be in hospitals' rate bases and global budgets permanently.***
Page 25: *How do you advise we predict ROI for years beyond 2017 when implementation will not start until 2016?*
A: *The Commission expects a continued ROI into the future, **especially since the dollars are permanently in rates….***

Email correspondence
May 2016
Page 1 *The best way to describe [the ROI to payers…in FY 18 each hospitals global budget will be reduced by 10% of the grant amount…In FY 19, the global budget would be reduced…and the same in FY 20. There would be **no further reductions after that**…*
Page 2 In response to request for clarification: *Confirm that "Permanent rate adjustment" means the award is expected to continue after FY20. Yes*

Final Recommendations for Competitive Transformation Implementation Awards
June 8, 2016
Page 7 The Commission reserves the right to terminate or rescind an award at any time for material lack of performance or for not meeting the letter or intent of an application…

We appreciate the opportunity to comment on this draft recommendation. Please feel free to contact me to discuss this further.

Sincerely,

Traci La Valle

Traci La Valle

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James N. Elliott, M.D.
Adam Kane
Katie Wunderlich, Executive Director

Enclosure

Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

October 23, 2019

Nelson Sabatini
Chair
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Sabatini,

The Maryland Department of Health (the Department) appreciates the opportunity to provide comments on the *Draft Recommendations for Competitive Regional Partnership Catalyst Grants*. The Department is eager to continue its partnership with the Health Services Cost Review Commission (HSCRC) to further strengthen these key collaborative efforts to transform care and improve population health in Maryland, with an emphasis on feasibility, sustainability and all-payer participation.

Feasibility

The goals embedded in the Regional Partnership structure should be broad-enough to support population health improvement and set realistic targets.

Broad Scope

The identified interventions for Regional Partnerships under the diabetes funding stream—the Medicare Diabetes Prevention Program (MDPP), Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)—are too narrow to impact the burden of diabetes in Maryland. The proposed additional in-person National Diabetes Prevention Program (National DPP) providers could support increases in uptake. However, overall participation—and subsequent population health-level impact—will be limited due to the estimated 1.5 million Marylanders with prediabetes.

The draft recommendation should build in more flexibility in terms of considering other diabetes prevention and management interventions. For example, Regional Partnerships could design and implement innovative upstream approaches with tightly-designed and -monitored evidence-based approaches focused on nutrition, weight loss and physical activity, to address risk factors not just for diabetes but also for cardiovascular disease, stroke, hypertension and other chronic diseases.

Additionally, the Department appreciates the alignment of the draft recommendations with ongoing efforts in crisis stabilization; at the same time, the scope of allowable Regional Partnership activities should be broadened across the continuum of care, including prevention.

Realistic Targets

The stated target of establishing over 200 additional National DPP suppliers stands out as overly-ambitious, taking into consideration the 49 suppliers (only three of which can currently bill Medicare) that have resulted after several years of federal and State investment and technical assistance. Virtual DPP programs offer an important alternative to individuals who need more flexibility to participate in the program. If the goal through the Regional Partnerships is to build a more adequate National DPP supplier capacity in Maryland, the HSCRC should include virtual National DPP providers in the scale targets and continue efforts for a federal waiver to allow virtual providers to bill Medicare. In addition, because start-up costs for new in-person National DPP suppliers are significant, in addition to establishing new suppliers, HSCRC scale targets should also allow for and specifically invite proposals to expand existing National DPP suppliers.

Additionally, the scale targets for this funding stream should include the ability to bill other payers, *e.g.,* Medicaid. Establishing new DPP suppliers and achieving the full recognition status necessary for MDPP reimbursement requires significant time to accomplish. DPP suppliers may participate with Maryland Medicaid's HealthChoice DPP while they are gathering the year of necessary data and experience to obtain the preliminary recognition status required to become an MDPP supplier. HealthChoice DPP provider enrollment, therefore, could be an effective process measure for the Regional Partnerships, as it acts as a stepping stone to becoming a Medicare DPP supplier.

Medicaid and Public Health are available to leverage their significant experience with National DPP implementation to date and provide technical assistance on the development of scale targets. In addition to target development, the final recommendation and subsequent grant process should offer pre-application technical assistance opportunities around the National DPP, in an effort to optimize and align efforts where applicable and provide information on best practices and other programmatic solutions.

Sustainability

The Regional Partnership structure affords hospitals the ability to go outside their walls and invest in communities, surpassing traditional investments in hospital services. The HSCRC should convene a process to discuss transitioning the Regional Partnership structure beyond the current rate-based, 'grant' approach to create a stable funding source and expectation for the hospitals to make critical investments into the community that align with the Statewide Integrated Health Improvement Strategy. As written, the draft recommendation limits interventions to those presently- or potentially-reimbursable by Medicare, Medicaid and commercial payers. A key feature of the Total Cost of Care Model is that the HSCRC can sustain programs proven to be successful in lowering total cost of care through programs such as the Care Transformation Initiatives or through global budget revenue (GBR)

modifications, both of which are described in the draft recommendation as options to sustain successful current Regional Partnership activities.

Many interventions that support the goals of the Total Cost of Care Model contain components that do not fit within a payer model. For example, should behavioral health crisis stabilization services become payer-reimbursable, elements such as crisis hotlines and room and board (*i.e.,* for stays beyond 23 hours in non-hospital settings) will still need to be covered. Diabetes prevention and self-management instruction could be coupled with investments in the community to provide and sustain safe spaces for physical activity and exercise. Regional Partnerships could support such key interventions through a braided funding approach and partnership with Local Health Improvement Coalitions, in addition to leveraging existing resources, community partners and previous State investments for behavioral health crisis interventions. The Crisis Now model could serve as a framework against which to compare current programs, identify gaps and prioritize areas for intervention. This approach has the potential for a secondary outcome of increasing access to and utilization of existing services, such as medication-assisted treatment.

There is value in maintaining the collaborative, community-facing infrastructure that has been developed by the Regional Partnerships, with great potential for serving as local hubs for investment and integration of health service provision with population health activities. These types of interventions are not one-time investments; rather, they require a sustainable funding source.

All-Payer Participation

The draft recommendation asserts that Regional Partnership-led interventions should positively affect all Marylanders, regardless of payer source. However, the approach to both program design and measurement continually references Medicare beneficiaries. The Department feels this stands in contrast to the collaborative principle of the Statewide Integrated Health Improvement Strategy, steering hospital activities further from interventions that include the majority of individuals with rising risk, including addressing health disparities, as well as the Maryland population at large.

The document states that Regional Partnership activities will be assessed on scale targets but pivots to say that the HSCRC 'may' measure Medicare return-on-investment, citing the readily-available Medicare claims data. This approach will inherently drive applicants toward Medicare-only interventions, as hospitals will 'teach to the test.' The Maryland Medicaid program has frequently expressed its interest in expansion of HSCRC programs to additional payers and its willingness to conduct the requisite analysis in support of Medicaid participation in such programs. This is not reflected in the draft recommendation.

Additionally, within the proposed measurement scheme for Medicare, the reliance on measuring outcomes improvement of referred Medicare beneficiaries excludes individuals who may be at risk of diabetes, who are diabetic but not seen regularly by referring or who are not referred to MDPP. Defining the baseline population is critical to moving the needle on the population health goal of diabetes prevention. Regional Partnership grant proposals should be evaluated on their capacity to assure uptake of funded interventions by a cross-section of the Regional Partnership's total catchment area's

population, with representative samples of the area's underlying socioeconomic and racial-ethnic groups.

Thank you for the opportunity to review the draft recommendation. The Competitive Regional Partnership Catalyst Grant Program has the opportunity to improve access to critical services across for all Marylanders. We are hopeful that our comments will serve to further this aim.

Sincerely,

Robert R. Neall
Secretary

JOSELINE A. PEÑA-MELNYK
Legislative District 21
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Vice Chair
Health and Government
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October 23, 2019

Mr. Nelson Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Sabatini,

I write to you today having had the opportunity to review the October 16 *Draft Recommendations for Competitive Regional Partnership Catalyst Grants*. This is the proposed successor to the existing Regional Partnership Program launched in 2015 to help Maryland achieve the goals of the then *New All Payer Model* for hospital payments.

The Health Services Cost Review Commission (Commission) staff designed and negotiated two significant and transformative programs that have changed the way health care is delivered in Maryland: the *New All Payer Model* and the *Total Cost of Care Model*. I commend the Commission for recognizing that such dramatic transformation is difficult to achieve and required forethought to provide additional support to hospitals and community based organizations as they faced new operational models and partnerships. These joint efforts facilitated the creation and deployment of community based programs that are beginning to show promise in improving patient care while also containing hospital spending. I encourage the Commission to continue supporting these developing efforts. Having seen the success of your initial grant program, I am encouraged that the successor program will also result in significant contributions to the health of our citizens and communities.

The regional partnerships created and funded by the grant program serve rural and urban areas across Maryland. Their interventions - behavioral health, care transitions, home-based care, patient engagement and education strategies, among others - are vital services which must continue even as the Commission expands its duties to achieve the *Regional Partnership Catalyst Grant Program* goals. The new focus on key state priorities (Diabetes Prevention and Management Programs; Behavioral Health Crisis Programs and a third, yet to be designated goal) will deliver tremendous relief to patients, their families and the health care system in general. Please let me know how I may support your efforts. I look forward to working with you in the 2020 session and speaking with you about the as yet undetermined third program goal.

Sincerely,

Joseline Peña-Melnyk

Totally Linking Care in Maryland
TLC-MD

October 22, 2019

Nelson Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini:

Thank you for the opportunity to provide comments on the HSCRC Staff's "Draft Recommendation for Competitive Regional Partnership Catalyst Grants." The purpose of this letter is to provide Totally Linking Care's (TLC-MD) comments in support of the proposed methodology to continue this program.

TLC-MD was created from "ground 0" in 2015 and represented, for the first time ever, the opportunity for hospitals in Southern Maryland to work together to solve shared problems across a vast geographical area; serving some of the state's most underserved patient population. TLC-MD invested HSCRC funds not only to develop patient interventions, but also created a population health software platform and cultivated community partnerships to be prepared to implement new interventions deemed to meet the goals of the HSCRC (TCOC reduction), our hospitals (reducing cost and improving patient outcomes) and most importantly, our patient population.

Thus, the draft recommendations presented would leverage the existing investments made by the HSCRC over the past 4 years. The proposed funding streams would amplify and complement the work TLC-MD is currently doing, and in fact would build on the new TLC-MD/CDC cooperative agreement (in partnership with the Prince George's County Department of Health) to support diabetes and pre-diabetes education and evidence-based programs. In order to effectively serve the entire region, additional support is needed as the cooperative agreement funds pilot programs in 8 specific strategies to test enhancements and innovations around DPP and DSMES programs. This is just one example of the benefit of multiple hospitals working together in a specific geographical region to address population health and to reduce TCOC. As the data indicates, "population health" cannot be achieved in a "silo" of one or two hospitals' catchment areas, but in fact must address a broad geographical area, as patients tend to move from one hospital to another, often presenting for the same condition multiple times.

In the Behavioral Health tract, TLC-MD is suggesting that the commission consider funding not only much needed crisis interventions but ongoing care coordination for citizens struggling with behavioral health diagnoses. Last year TLC-MD began a pilot with 2 member hospitals (using a company called Mindoula Health) to study the impact of disease specific care coordination. Several of our member have implemented or are implementing the SBIRT program, via SAMSHA funding, in Emergency Departments and adding Peer Counselors to better support those struggling with SUD in our communities. We would welcome the opportunity to explore how we might sustain, grow and expand those programs across the region as well.

The HSCRC's creation of the Regional Partnership program and tremendous investment made supporting our partnerships align perfectly with the goals of the new "Maryland Model" to support population health. To discontinue support for these programs will in fact force each hospital to address "population health" individually and would burden already challenged hospital fiscal budgets. The draft recommendations are a perfect solution to address Maryland's new goals for reduction in the TCOC while maintaining the infrastructure already in place created by the HSCRC's investment of approximately $126M in the Regional Partnership program.

Thank you in advance for consideration of the draft recommendations, completely supported by TLC-MD's collaboration of hospitals in Southern Maryland.

Kindest regards,

Christine R. Wray
Board Chair, TLC-MD
President, MedStar Southern Maryland Hospital Center
President, MedStar St. Mary's Hospital
Senior Vice President, MedStar Health

David Chernov

David Chernov
Executive Director, TLC-MD

jssa

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Partner Agency of The Jewish Federation OF GREATER WASHINGTON

CHAP

CHARITY NAVIGATOR four Star Charity

ועידת התביעות Claims Conference
The Conference on Jewish Material Claims Against Germany
www.claimscon.org

October 18, 2019

Nelson Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore. Maryland 21215

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

Dear Mr. Sabatini and Ms. Wunderlich:

Jewish Social Services Agency (JSSA) is a nonsectarian, nonprofit, client-focused health, and social service agency that has been helping individuals and families across the Greater Washington metropolitan area meet emotional, social, and physical challenges for more than 125 years. In FY19, JSSA was selected as the lead implementation agency for *Voice Your Choice*, a program of the Nexus Montgomery Regional Partnership, which seeks to motivate people to express and document their health care wishes in the event they cannot speak for themselves.

By creating the framework of the *Voice Your Choice* model, the Nexus Montgomery hospitals not only recognized the importance of advance care planning on the quality and cost of care at the end of life, but also the central role of community partners in promoting the message and providing education around advance care planning. A four-year, community-driven plan was developed that includes engagement with dozens of community organizations including faith communities, senior service providers, groups in Prince George's County, and physician groups. In the past six months, we have developed an evidence-informed community curriculum, created a shared online platform for advance care planning, developed training and program metrics, engaged a highly diverse Steering Committee, contracted with a third party vendor that will allow for direct access of ACPs in CRISP, and have begun engaging with community partners to begin facilitator training. While this grassroots approach will take several years to mature, evidence from similar efforts in the State and nationally suggest this approach is most likely to have an impact on a large and diverse community such as the Nexus Montgomery target area.

Uninterrupted funding for the Voice Your Choice program is essential to maintaining the momentum and trust that has been developed over the past several months. We encourage the HSCRC to provide ongoing support for promising Regional Partnership programs such as *Voice Your Choice* that are best pursued at the community-level rather than by any individual hospital.

Sincerely,

Todd Schenk, M.Ed., MBA
Chief Executive Officer
Jewish Social Services Agency

October 23, 2019

hscrc.rfp-implement@maryland.gov
Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Comments to the Regional Partnership Catalyst Grant Program

Dear Executive Director Wunderlich:

Thank you for the opportunity to provide comments on the HSCRC's Draft Recommendations for Competitive Regional Partnership Catalyst Grants. LifeSpan is the largest senior care provider association in the Mid-Atlantic, representing more than 350 providers across the continuum of senior care in Maryland and the District of Columbia. We believe post-acute providers have an important role to play in meeting the State's Total Cost of Care goals.

LifeSpan supports the continuation of Regional Partnership grants as a strategy for supporting innovation, fostering collaboration, and effectively aligning community partners with hospital efforts. These grants are particularly important to providing resources to community partners as these partners do not fall under the GBR model. We applaud the inclusion of "widespread engagement and collaboration" as an evaluation criterion. This is an improvement to the existing Regional Partnership Program, which did not specifically require funding of community partners. However, we believe it is essential that the evaluation criteria include specific consideration of the level of funding that the Regional Partnership allocates to community-based partners (for example, total dollars allocated, or percent of grant funds allocated to non-hospital owned partners). The level of funding shared with community partners is the most basic accountability measure for these grants.

LifeSpan adopted a set of policy principles to support Maryland's health payment and delivery system reforms. A key part of these principles was the need for shared savings between hospitals and other providers in the continuum of care. Regardless of whether it is through a grant program, such as the Regional Partnerships Catalyst Grants, or other care redesign efforts, it is essential to align the financial incentives of hospitals and their care partners. LifeSpan believes that this lack of shared savings or financing of community providers has been a disincentive to the active engagement of providers across the continuum of care.

In addition, as identified by the Post-Acute Care Workgroup, the availability of behavioral health services is critical in this State, especially in the rural areas. While we strongly support the inclusion of this subject as a funding stream, we do believe that the proposal should be broadened beyond crisis services. In order to stem the tide of individuals needing repeated high-cost crisis services, there must be a component to ensure that after a crisis an individual has access to community supports. Likewise, as the State continues to search for options to assist in relocating "hard to place" patients from hospitals, this funding stream should be expanded to provide greater assistance.

Lastly, as the State works to identify a third population health priority by December 31, 2020 LifeSpan believes that this funding stream should have a strong focus on models that specifically seek to improve care for post acute services. We believe this is a policy area that the State should support with clear direction and funding as the State has already committed to developing a plan for Post-Acute Care and Long-Term Support Services by 2021.

We look forward to seeing these same concepts of innovation and collaboration available in other models that support post-acute providers.

Sincerely,

Kevin Heffner
President

cc: Danna Kauffman, Consultant, Schwartz, Metz and Wise, PA

Attachment

August 2019

LIFESPAN NETWORK

Maryland Health Payment and Delivery Reforms
Policy Principles

Maryland's post-acute provider community is facing a number of potential changes to the way services are financed and provided. Maryland's Total Cost of Care Model, the State's agreement with the federal Center for Medicare and Medicaid Services (CMS), encourages new care reforms that intend to achieve post-acute savings and engage post-acute providers in care redesign programs.

These reform discussions present an opportunity for post-acute providers to engage in care redesign and support Maryland's Total Cost of Care goals. LifeSpan developed the following policy principles to contribute to the success of Maryland's model by fully engaging Post-Acute Care (PAC) providers in Maryland's payment and delivery system reforms.

Policy Principles

1. **Shared Savings**: Care redesigns intended to affect post-acute care delivery to improve care and achieve savings must create incentives for post-acute providers to be a part of care transformations. PAC providers will take on risks and implementation costs to engage in these reforms, which are not clearly funded by current policies. PAC providers need to have clear and understandable mechanisms to share in savings associated with these models and payment for new costs incurred if they are expected to engage in strategies.

   Currently, the Total Cost of Care Model generally and Episode Care Improvement Program (ECIP) specifically expect savings from the PAC setting. ECIP provides an opportunity for hospitals to share savings with their care partners; however, hospitals are not required to do so. This lack of a guaranteed path to sharing savings makes it challenging for PAC providers to fully engage in care redesigns. A sustainable and effective health care system will need the full continuum of providers engaged in collaborative efforts.

2. **Dedicated Resources for Policy Development and Provider Transformation**: The State has committed to CMS that it will develop a plan for Post-Acute Care and Long-Term Support Services by 2021. Additionally, the General Assembly required MDH to submit a report with a detailed plan to begin implementation of a Duals Accountable Care Organization by July 1, 2020. These are both complicated areas of policy development and require dedicated resources to design reforms. This process must engage the provider community in both the development of strategies as well as preparing them to engage in care transformation.

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The State has invested significantly in developing its policy direction and programs for the initial phases of the All Payer Model as well as supporting care transformation for many providers. Investments in transformation support have included engaging contractors to collaborate with to design strategies, funding provider infrastructure, offering consulting support, and making targeted grant funding available. Providing clear policy direction and tools will create a path to transformation for post-acute providers that will help the State meet its Model goals.

3. **Monitoring and Measurement:** The monitoring of the TCOC Model and care redesign programs should broadly consider the impact on providers across the continuum of care.

   Care redesign and payment reform is already underway in Maryland. These reforms are complex and have potential impacts to providers across the continuum of care. HSCRC provided an inventory of hospitals engaged in ECIP listing each hospital's care partners. This type of transparency supports PAC providers' understanding of the care redesign landscape and encourages their engagement. This inventory should be expanded to include all care reform programs, information such as program costs, infrastructure investments made by the State through transformation grants and rate adjustments, resources shared with care partners, program savings, and the extent to which savings are shared with care partners. It is also important to understand how care redesign programs are impacting the larger financing and delivery systems, including how the payer mix for PAC providers is changing and the implications for Medicare and Medicaid (e.g., payer shifts by facility).

4. **Policy Development to Address Barriers**: Maryland should test policy approaches, which remove regulatory barriers and drive efficiencies in how PAC providers support the care continuum.

   State policy makers have encouraged PAC providers to come forward with care reform concepts. This openness to gaining input is a strong foundation for engaging the full continuum of providers in care redesign. As the first five years of care redesign efforts have shown, health reform policy development is resource intensive and takes collaboration between federal and State policy makers and providers. State policy makers need dedicated resources to continue to work with PAC providers to support the development and refinement of concepts into fully developed care redesigns that Maryland can support and implement.

5. **Access to Data:** The State should continue to make data available to PAC providers to support their engagement in care transformation.

   PAC providers recently gained access to aggregate Medicare data. This is an important step to support their efforts to partner with hospitals under ECIP. PAC providers will need continued access to data and refined analytic reports based on evolving care redesign program concepts. Providing transformation support tools to PAC providers is also critical for their ability to use data and to build capacity to engage in care transformation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Marc Elrich
County Executive

Raymond L. Crowel, Psy.D.
Director

October 23, 2019

Mr. Nelson Sabatini
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

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

Dear Mr. Sabatini and Ms. Wunderlich:

The Montgomery County Department of Health and Human Services (DHHS) appreciates the opportunity to provide public comment on the draft recommendation for the Regional Partnership Catalyst Grant Program. We have met with Nexus Montgomery, our Regional Partnership of the six local hospitals to understand the proposed redesign of the Regional Partnership program. The DHHS and the six hospitals are also partnering in Healthy Montgomery, Montgomery County's community health improvement process which have Diabetes and Behavioral Health as two of the top priorities for our county. We have significant interest ensuring the funding streams being proposed will support alignment of all efforts within our county with County and State goals.

Our specific comments on the draft Partnership Catalyst Grant Program are below:

- Diabetes Funding Stream: The Montgomery County Executive has set an ambitious outcomes-based agenda to create a more equitable and inclusive Montgomery County. This includes diabetes metrics, specifically to reduce hospital emergency department use by those with Type II Diabetes. The State has also released its Diabetes Action Plan, for which DHHS is taking action. We fully support a funding stream to increase Diabetes Prevention Program (DPP) and Diabetes Self-management Training (DSMT) program availability, and participant enrollment and completion. Please consider the following when finalizing the design of the Diabetes funding stream:

  - Allow flexibility for other programs. Both DPP and DSMT are gold standards, however in our highly linguistically and ethnically diverse county, flexibility to offer other programs may provide a greater penetration into the population.

  - Allow funding use to cover medical management and coordination of care. Examples include linkage to primary care, wrap-around services to address social determinants such as food and transportation, and nontraditional services such as fitness programs.

  - Allow funding use for provision of diabetes programs across the full spectrum of insurance status and income levels. Though often viewed as a wealthy county, our epidemiological data show significant health disparities - geographic and by race/ethnicity. In addition, the Nexus Montgomery service region has nearly half the uninsured in the State.

- Behavioral Health: We support a focus on behavioral health and crisis services. We ask that the funds be flexible for substance use treatment and suicide prevention. For the senior population, we recommend adding a focus on activities that reduce social isolation, depression and substance use. This will serve to avert crises.

The DHHS has an interest in the continuance of existing Nexus Montgomery Regional Partnership activities and offers the following comments about the legacy grant sunset process.

- Specialty care for the uninsured: Nexus Montgomery Regional Partnership currently provides financial support for about 1,000 specialty care encounters each year, through a DHHS program called Montgomery Cares Project Access. The patients are all uninsured and have been hospitalized or are at risk of hospitalization without specialty care. Approximately half these patients are Montgomery County residents and half Prince George's County residents. We request that the Health Services Cost Review Commission (HSCRC) allow continuation of this funding through Global Budget Revenue modification.

- Programs such a Wellness and Independence for Seniors at Home: We support the HSCRC's inclusion of a transition process to allow impactful programs such as the *Wellness and Independence for Seniors at Home* to continue uninterrupted with service to our residents while other sustainable funding sources are obtained.

We appreciate the opportunity to comment on the Regional Partnership program.

Sincerely,

Travis A. Gayles, M.D., Ph.D.
Health Officer and Chief

TG:ss

Behavioral Health System Baltimore

October 22, 2019

Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Subject: Draft Recommendation on Regional Partnership Transformation Grant Program

Dear Chair Sabatini and Members of the Commission:

As you consider updating the approach to the Health Services Cost Review Commission (HSCRC) Regional Partnership Transformation Grant Program, Behavioral Health System Baltimore (BHSB) is pleased to see that the draft recommendation include behavioral health crisis programs as a key funding priority.

BHSB a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. BHSB oversees a full range of quality behavioral health (mental health and substance use) services and advocates for innovative approaches to prevention, early intervention, treatment and recovery for individuals, families, and communities. Baltimore City represents nearly 35 percent of the public behavioral health system in Maryland, serving nearly 75,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.

In Baltimore City, the demand for behavioral health crisis services continues to increase, however, because we do not have 24/7 "on demand" access to behavioral health crisis services, individuals turn to hospitals and other emergency services.

- In FY 2017, Emergency Medical Services responded to 154,000 behavioral health crisis calls, which is a 20 percent increase over the past two years.
- During the same time 26,025 Baltimore City residents presented in hospital EDs for both mental health and substance use disorders.

Behavioral health crisis response services help countless individuals overcome life-threatening crises, reduce unnecessary ED visits and hospitalizations, and serve as a key access point into the broader system of care. The Regional Partnership Transformation Grant Program provides an important opportunity for BHSB to build on our partnership with hospitals to strengthen and expand these critical services.

BHSB applauds the HSCRC for identifying "Crisis Now" in the draft recommendations as a model for considering Regional Partnership proposals. The Crisis Now Model is a nationally recognized approach for establishing comprehensive, integrated behavioral health crisis response system.

Baltimore City is fortunate to have some key interventions of this model in our system, including:

- A crisis hotline that operates 24/7. Trained counselors respond to over 46,000 calls annually to help people find treatment or other resources they need for themselves or someone else experiencing a crisis.
- Mobile crisis response teams provide services in the community for people in crisis. The teams respond to over 2,500 calls with more than half of those being to emergency departments. Unfortunately, this service is not available 24/7.
- A Crisis Stabilization Center, which provides 24/7 sobering services to individuals who are under the influence of drugs or alcohol. Individuals sober under medical supervision and then are linked to ongoing treatment and provided 30 days of case management to support their treatment goals.
- One 21-bed community-based residential crisis unit that provides an alternative to or step-down from hospital-based mental health crisis services for adults.

BHSB has long supported efforts to strengthen and expand behavioral health crisis services beyond the above-referenced interventions. In June of 2019, BHSB released our Behavioral Health Crisis Response System Plan, which was developed to identify the gaps in our system and guide BHSB's work to strengthen the behavioral health crisis response system in Baltimore City.[1] BHSB also has been working closely with the Baltimore Police Department and other Baltimore City representatives regarding the consent decree with the US Department of Justice, which has important implications for behavioral health crisis response in Baltimore City. As required by the consent decree, the city completed a gaps analysis of the public behavioral health system, Baltimore Public Behavioral Health System Gap Analysis.[2] This report identifies that expanding behavioral health crisis response services is needed to reduce the interaction between police and people in the midst of behavioral health crises.

Although, Baltimore City has these interventions, they are not resourced at a level to meet the growing need for crisis services in our community. Another gap within Baltimore City's behavioral health crisis response system is the infrastructure to support the timely response and coordination of care across the system in real-time. Without this, our system is neither maximizing efficiencies nor being fully accountable to the individuals we are serving. The draft recommendation focus on developing and expanding infrastructure for crisis services provides an opportunity for Baltimore City to invest in the technology and resources needed to address this gap, and we hope that the HSCRC looks favorable on funding these initiatives. In addition, BHSB would recommend that funding initiatives go beyond crisis services but ensure that

[1] *Baltimore City's Behavioral Health Crisis Response System: Plan to Strengthen and Expand the System*, Behavioral Health System Baltimore, June 2019, https://www.bhsbaltimore.org/wp-content/uploads/2019/06/BHSB-Behavioral-Health-Crisis-System-Plan-Final.pdf

[2] *Baltimore Public Behavioral Health System Gap Analysis*, HSRI, October 2019, https://www.powerdms.com/public/BALTIMOREMD/documents/623350

individuals continue to be monitored and have access to services with the community. Without this aspect, individuals will continue to spiral in and out of crisis services.

BHSB thanks the HSCRC for including behavioral health crisis programs as a key funding priority in the draft recommendation on the Regional Partnership Grant Program and urges that the Commission approve this recommendation at the November 2019 meeting.

Sincerely,

Adrienne Breidenstine
Vice President, Policy and Communications
Behavioral Health System Baltimore

Brian J. Feldman
Legislative District 15
Montgomery County

Vice Chair
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The Senate of Maryland
ANNAPOLIS, MARYLAND 21401

October 21, 2019

Mr. Nelson Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Sabatini,

The Health Services Cost Review Commission (HSCRC) has built a successful regional partnership structure in the form of the Regional Partnership Program and I am pleased to have Nexus Montgomery, the regional partnership for Montgomery County, serving my District.

Since the Program's inception, Nexus Montgomery has both introduced important programs to improve the health of my constituents and generated significant annual healthcare savings. These programs range from stabilizing older adults at risk for adverse health events ($4.5M saved) to improving outcomes for people transitioning from hospitals to nursing homes ($3.3 M saved) and adding capacity to support people experiencing a mental health crisis ($2.2 M saved).

In order for the Regional Partnership Program to continue to excel, it is important that they have the required financial support and flexibility to meet the unique needs of Montgomery County. With over one million residents, Montgomery County is the most populous and diverse County in Maryland. And, like the rest of the State, the County is challenged by critical public health concerns such as diabetes and behavioral health. I support the HSCRC's decision to emphasize interventions in these critical areas and encourage the HSCRC to allow flexibility for the Program to be effective and culturally appropriate for residents with various economic, linguistic, cultural, ethnic and religious backgrounds.

Thank you for your attention to this issue and I look forward to the future success of the Regional Partnership Program in improving the health of Montgomery County residents.

Sincerely,

Brian J. Feldman

NEXUS MONTGOMERY

October 23, 2019

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

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

Dear Mr. Sabatini and Ms. Wunderlich:

Nexus Montgomery appreciates the opportunity to provide feedback on the draft recommendations for the *Regional Partnership Catalyst Grants* program.

The current Regional Partnership program has provided an important proving ground for collaborative programming to improve population health. In our recently filed FY19 report, Nexus Montgomery documents more than $11 million in annual gross savings[1], far exceeding the $6.1 million awarded in FY19 GBR rates, and identifies reduced hospital utilization and/or total cost of care for all program target populations. Our partnership creates value beyond shared programming, providing a regular forum for senior hospital leaders across the six hospitals located in Montgomery County to collaborate. Nexus Montgomery has developed a strong and adaptable infrastructure, with rigorous governance, management and evaluation to ensure accountability for the Regional Partnership funds, all of which were spent in FY19.

Structure of the New Recommended Grant Program

Nexus Montgomery supports the HSCRCs efforts to increase accountability and rigorous evaluation. We agree with the focus on implementing at scale and measuring at the target population level. Below are our recommendations to strengthen the structure of the proposed Catalyst Grant Program.

- **Modify Diabetes Impact Measures:** Few accredited DPP or DSMT programs exist in our region. Therefore, much of the effort in the Catalyst Grant first year will be development of community partner programs, Medicare billing capability and other infrastructure as well as the participant identification, referral and enrollment processes. We request HSCRC address this by focusing Year 1 scale targets on numbers and geographic location of programs and progress toward accreditation, rather than beneficiary referrals. Additionally, we recommend that HSCRC considers the impact of cultural, ethnic and socio-economic factors in partnership target populations when setting scale targets. Evidence suggests that non-Hispanic white individuals have higher retention rates and weight loss than other groups[2], an important factor for a region as highly diverse as the Nexus Montgomery service area. We encourage the HSCRC to

[1] WISH program ($4.5M), Hospital Care Transition programs ($3.4M) and SNF Alliance ($3.3M)
[2] Ely EK, Gruss SM, Luman ET, et al. A national effort to prevent type 2 diabetes: participant-level evaluation of CDC's National Diabetes Prevention Program. Diabetes Care 2017;40:1331–1341 https://care.diabetesjournals.org/content/40/10/1331

incorporate impact measures for other payers and those who are uninsured when reliable data are available.

- **Broaden Diabetes Program Scope:** We support a focus on evidence-based diabetes prevention and management, including the goals of increasing the number/location of accredited Diabetes Prevention Programs (DPP), Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) providers as well as increasing participation in and completion of these programs, but funding should not be limited to only these programs. To meet these goals, we recommend HSCRC:
    - **Allow grant funds to be used for a wide range of initiatives that support diabetes prevention and management goals.** This could include wrap around support such as food, transportation, diabetes supplies, and insulin; and care coordination for attachment to primary care and social services**.** This added support is essential to achieve diabetes prevention and management goals for insured and uninsured patients as they move through these programs and learn self-management. Wrap around support is also critical to ensure that programs can be successfully expanded to vulnerable populations and benefits of this funding stream do not accrue disproportionately to populations with resources.
    - **Permit use of funds for community implementation and adaptation activities.** In Montgomery County - the most populated county in the state and where a third of residents are foreign born - creation of culturally adapted curriculum may be necessary. Culturally and linguistically appropriate community partners will need technical assistance with program infrastructure, marketing and promotion.
    - **Include other evidence-based programs such as the Diabetes Self-Management Program (DSMP), Chronic Disease Self-Management Program, Inpatient Diabetes Management Service[3] and evidence-informed prevention and management programs.** In the experience of the Nexus hospitals, a wider range of programs will increase engagement and success in the region's diverse population and will allow hospitals to build upon existing successful programs and partnerships.

- **Require Sustainability Planning:** There is insufficient evidence that billing revenue will be adequate to support the expected program expansion. We agree hospitals should commit to planning for long-term sustainability (as described on page 8). However, we ask HSCRC to recognize that the long-term viability of the programs and the source for long-term funding will not be known when the Catalyst grants are awarded. We request hospitals not be required to commit five years in advance to sustaining any program (as described on p. 10).

[3] Mandel SR, Langan S, et al. Retrospective study of inpatient diabetes management service, length of stay and 30-day readmission rate of patients with diabetes at a community hospital. J Community Hosp Intern Med Perspect. 2019 Apr; 9(2): 64–73. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6484466/

- **Broaden Behavioral Health Focus Beyond Crisis Services:** There is clearly a need for crisis services, inclusive of coordinated activities such as those described in the Crisis Now action plan. Nexus Montgomery has developed considerable community crisis capacity. We have found that, in addition to these activities, an effective and robust program should not only divert those in crisis to more appropriate settings, but also seek to avert crises. For the senior population in particular, interventions that address social isolation, depression and substance use would be beneficial. We recommend HSCRC allow for proposal of expansive community-based services that also avert crises by addressing prevention, treatment, and recovery, including:
    - Same day access to Outpatient Mental Health Services
    - ED Bridge to Medication Assisted Treatment[4]
    - An adaption of the CMS Behavioral Health Integration model to support and connect unengaged patients to community-based behavioral and primary care where they can receive ongoing support from MDPCP programming.

Legacy Grant Sunset Process

Nexus Montgomery is extremely proud of its results and strongly supports HSCRC establishing a mechanism to continue successful programs. Our understanding from 2015/2016 written communication from HSCRC staff was that this was permanent funding. With strong program results and no negative performance feedback from HSCRC, announcement of the end of the program was unexpected. We appreciate the proposal to create a legacy grant sunset process and request that in designing it, the HSCRC address the following recommendations.

- **Provide a Multi-Year Year Legacy Grant Transition Program.** We strongly support a legacy program transition process providing multi-year funding. This will allow current programs that are already demonstrating results to build additional evidence of savings in order to secure alternative funding and achieve long-term sustainability.

- **Accelerate the Legacy Grant Funding Decision.** To preserve program services and trust with community partners and participants, we request the HSCRC create an accelerated process to determine legacy grant sunset funding by early 2020. This will allow smooth continuance of programs that will receive ongoing funding and provide time for orderly closure of any not funded. We look forward to an opportunity to discuss the design of this process with HSCRC staff.

[4] https://ed-bridge.org/

NEXUS MONTGOMERY

We thank the HSCRC for its interest in the regional partnership program. For the Nexus Montgomery hospitals and service region, the HSCRC's creation of the regional partnership program in 2015 was the catalyst for our strong governance structure that promotes health and manages total cost of care for our shared community in ways no single hospital or community organization would achieve on its own.

We look forward to partnering with you in the next phase of the Regional Partnership Program.

Sincerely,

Annice Cody
Chair, Nexus Montgomery Regional Partnership

MedStar Montgomery Medical Center

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

Adventist HealthCare

HOLY CROSS HEALTH

October 23, 2019

Nelson Sabatini, Chairman
Katie Wunderlich, Executive Director

Dear Mr. Sabatini and Ms. Wunderlich:

Over the past three years, the Regional Partnership program has been the impetus for unprecedented collaboration among the six hospitals located in Montgomery County.

Nexus Montgomery Regional Partnership brings together hospitals and community partners to promote population health, reduce hospital utilization and manage total cost of care for our shared community in ways that no single hospital could achieve on its own. As reported in the FY19 Report to HSCRC, three Nexus programs have a positive Return on Investment based on gross savings, and there has been reduced hospital utilization and/or total cost of care for all program target populations. Though preliminary, these early indicators are positive. Other programs such as Community Advance Directives and Specialty Care for the Uninsured deliver value to the community, although it is difficult to measure impact over the short term. Overall, because Nexus Montgomery programs are designed to create an impact at the community level, it is challenging to connect results to the bottom line of an individual hospital for making hospital investment decisions.

We are supportive of the Regional Partnership Catalyst Grant Program emphasis on diabetes prevention and management and behavioral health. To preserve the gains made thus far, we support HSCRC's inclusion of a legacy grant sunset process. This will enable promising programs to continue as additional data is gathered and sustainable funding achieved.

Nexus Montgomery Regional Partnership has created value beyond shared programming, providing a regular forum and platform for senior leaders across the six hospitals to exchange information, share learnings, and collectively consider opportunities. This governance infrastructure is a powerful platform from which the state can launch new initiatives.

We look forward to continued success under the newly designed Regional Partnership program and thank you for considering this feedback on program design to ensure that success.

Sincerely,

Terry Forde
President & CEO
Adventist Healthcare

Jacky Schultz
President
Suburban Hospital

Thomas J. Senker, FACHE
President
MedStar Montgomery Medical Center

Norvell V. Coots, MD
President & CEO
Holy Cross Health

Anne Arundel Medical Center | DOCTORS COMMUNITY HEALTH SYSTEM

October 23, 2019

Chris Peterson
Principle Deputy Director, Payment Reform and Provider Alignment
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Peterson:

On behalf of Anne Arundel Medical Center (AAMC) and Doctors Community Health System (DCHS), thank you for the opportunity to comment on the Competitive Regional Partnership Catalyst Grants draft recommendation. As recipients of the original Regional Partnership grants, we know firsthand the importance of this seed funding to invest in population health activities. Over the last four years, our Regional Partnerships have made significant improvements in our communities and seen positive results in reducing utilization, improving transitions of care, managing social determinants of health, and addressing behavioral health issues.

We support the Staff's focus on two of the most pressing health needs of Maryland's communities- diabetes care and behavioral health. We also support the renewed focus on creating community partnerships to manage these initiatives. Hospitals cannot control the total cost of care and health outcomes alone, and engaging community partners is critical to the success of population health efforts.

As the funding transitions to new population health opportunities, we respectfully ask the Commission to:

(1) Allow hospitals to provide additional comments once the Staff confirms Regional Partnership grant metrics. Our clinical teams should have the opportunity to provide meaningful input into the metric definitions and targets to ensure they align with best practices. Additionally, diabetes and behavioral health initiatives will take many years to see substantial results, and it is important that the metrics are realistic and impactful.

(2) Use "Funding Stream III: Population Health Priority Area #3" in FY2021 to continue funding existing Regional Partnership work that has seen promising results. Funds should not be withheld from hospitals during the time that CMS and HSCRC Staff are developing the third priority area. Instead, they should be used for population health activities, as

intended. Care Transformation Initiative (CTI) reconciliation payments, although recommended by Staff as a potential funding source for existing Regional Partnership programs, are not a viable solution for hospitals. The CTI's 2-year payment lag time and unpredictable payment amounts make it an inappropriate option for hospitals making investments in infrastructure and employees to administer the Regional Partnership programs. Using "Funding Stream III" to fund existing Regional Partnerships in FY2021 allows hospitals to maintain impactful programs as they seek new funding sources to sustain their investments.

Thank you again for the opportunity to provide comments. Please let us know if we can be of assistance.

Sincerely,

Paul Grenaldo
President, DCHS

Bob Reilly
Chief Financial Officer, AAMC

Cc: Victoria Bayless, Chief Executive Officer, Luminis Health
Nelson J. Sabatini, Chairman, HSCRC
Katie Wunderlich, Executive Director, HSCRC

UNIVERSITY of MARYLAND MEDICAL SYSTEM

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Finance Shared Services

October 23, 2019

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

Dear Katie:

The University of Maryland Medical System (UMMS) appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendations for Regional Partnership Catalyst Grant funding beginning in Fiscal Year (FY) 2021. We acknowledge HSCRC's ongoing commitment to help develop and support care transformation delivery that will promote sustainability of the Maryland Model.

We encourage the HSCRC to consider the following points before finalizing its recommendations:

1. The proposal to only provide grant funding for specific diabetes management/prevention and behavioral health crisis models is too narrow a focus and does not promote population health management based on unique population needs.

2. The funding stream for behavioral health should support other models and does not support long-term sustainability.

3. The accelerated timeline makes model development and implementation challenging.

4. The HSCRC should continue to fund existing regional partnerships if they can demonstrate impact based on a reasonable return on investment (ROI) methodology.

5. The proposed ROI methodology is insufficient to demonstrate the "true" impact of the partnerships.

The proposed areas of focus are too narrow

UMMS supports the premise that HSCRC should prioritize funding for evidence-based models that can be scaled appropriately. We are concerned, however, with the limited scope of the current proposal. Hospital systems may already be working toward or have received accreditation for this model, but require resources to expand to other sites. HSCRC should evaluate these various implementation stages as it relates to the funding hospitals are appropriated and consider whether the scale targets are appropriate.

In addition, HSCRC should consider other nationally recognized models that would be eligible for reimbursement and produce similar outcomes (e.g. the American Diabetes Association (ADA) recognized diabetes education program). Implementation of DPP statewide could prove challenging as a result of the resource intensive nature of the program. For example, reimbursement for services requires lifestyle coaches to obtain certification and national provider identification (NPI) registration. Patient engagement is also concerning, as it requires a twelve month participation commitment.

Another limitation of the proposed funding streams is the inability to address the needs of unique populations. The proposed tracks will prevent hospitals and their community partners from serving patients who present with comorbidities and complex social needs. Effective management of these populations cannot be addressed by disease-specific interventions alone and requires more innovative approaches.

In its draft recommendations, the HSCRC outlines a third funding stream that will become available in FY2022. UMMS is supportive of the addition of a third funding stream that allows for broader focus areas that support unique population needs.

HSCRC should consider that approved interventions cannot be implemented unless the appropriate infrastructure is in place and re-evaluate funding capital costs. Funding is also required during the start-up period to support operational cost that are incurred. UMMS recommends allocating a portion of the funding streams to support such costs.

The behavioral health funding stream does not support long-term sustainability

UMMS is supportive of the components of the Crisis Now model, as components are already in place and funding available through the Regional Partnership Catalyst Grant program would enable the development of partnerships to create an integrated network of mental health crisis services for those in need.

Although we recognize behavioral health crisis response is an appropriate and important need, building behavioral health capacity within the State and preventing patients from reaching a crisis state will require additional consideration of preventative models and those focused on special populations, such as patients who experience substance use disorders (SUD). UMMS recommends that the HSCRC consider other behavioral health models that are evidence-based and address additional interventions and investments necessary to provide our patients with the

appropriate level of care, including reversed integration of SUD, tele-psychiatry, supportive housing with mental health services, residential crisis beds and interventions focused on high utilizer populations who present with mental health needs.

HSCRC should also ensure that the behavioral health funding stream also promotes long-term sustainability. The proposed diabetes funding streams provide an appropriate path because billable codes exist for these programs. The behavioral health funding stream, however, does not address the lack of adequate reimbursement for these services on a fee for service (FFS) basis. Hospitals and their community partners will struggle with long-term sustainability without a sustainable reimbursement mechanism.

It should also be noted that the proposed funding stream is limited to Medicare FFS beneficiaries. Building sustainable behavioral health capacity and crisis response capabilities within the state will require support from Medicaid and commercial payers. The HSCRC should engage with these payers to determine the plausibility of billable services that can be piloted through this funding stream.

The accelerated timeline makes development and implementation challenging

The condensed timeframe to develop and implement these regional partnerships will be challenging. Hospitals will have a limited amount of time between receiving the request for proposals (RFPs) and the deadline for submission, in addition to the two month "ramp up" period between the final award recommendations to Commissioners and expected "go-live" date. This does not provide the appropriate lead time to effectively identify, outreach, and build coalitions with community partners, as well as develop implementation plans. This is especially true for the behavioral health funding stream, which will require coordination between a multitude of community partners inclusive of regional hospitals, their local health departments, social service agencies, first responders, and the criminal justice system, among others.

UMMS recommends that the HSCRC build a planning phase into its grant cycle period. In the first iteration of the regional partnerships, hospitals were awarded one year planning grants. This helped ensure that hospitals and their partners had the necessary agreements, protocols and staffing structures in place to meet the expectations of their shared objectives. Similar to the planning grants, HSCRC could outline criteria for continuation of funding at the end of the planning phase.

HSCRC should continue to fund existing regional partnerships

The HSCRC should continue to fund existing regional partnerships for several reasons. When the original RFP was released, funding was communicated to hospitals as permanent rate increases. The HSCRC stated in a November 2015 FAQ, "The implementation grants will not be removed (barring any adjustments made by Commission staff if expectations are not met) and will be in hospitals' rate bases and global budget permanently" (Attachment 1). Applicants were required to include measurement and outcomes goals in addition to how they would generate total cost of

care savings in their grant proposals. These conditions were accepted by the HSCRC and were monitored through an annual reporting process. UMMS hospitals and their regional partners have shown favorable outcomes to date.

Successful regional partnerships are in jeopardy of discontinuing as a result of the quick and unexpected removal of permanent funding. Hospitals were given short notice that all funding would be removed at the end of FY2020 and would not have the necessary lead time to explore options for sustained funding.

UMMS is supportive of the HSCRC's proposed option to continue regional partnership funding via global budget revenue modification given that they can demonstrate a successful impact based on a reasonable ROI methodology. Conditions of modification requests and the basis of approval should be outlined by the HSCRC in advance of the FY2020 end date.

The ROI methodology is insufficient to demonstrate the "true" impact of the partnerships.

UMMS remains concerned with HSCRC's methodology to measure ROI in its evaluation of partnership success. The proposed methodology solely relies on triggering events identifiable via claims data. The existing partnerships may use clinical decision points or social determinants of health to enroll patients, which cannot be linked to claims data.

The HSCRC should also consider that successful programs will require community partnerships outside of traditional care settings, such as the justice system and first responders. The HSCRC should identify additional evaluation criteria that can be used to evaluate the "true" impact, which may include 911 calls, interaction with the criminal justice system, etc.

Additionally, the proposed methodology and HSCRC's scale targets are too prescriptive. For example, achieving ROI depends on achieving patient compliance and other factors that hospitals cannot influence in totality. The HSCRC should provide for flexibility where needed, and re-evaluate the reasonableness of the methodology.

Finally, it is important to note that public health initiatives historically require a long lead time before ROI can be measured. HSCRC should consider the feasibility of grantees achieving outcome targets in early years as opposed to process metrics that can be captured to ensure progress is achieved.

Conclusion

UMMS encourages the HSCRC to consider our recommendations to foster the likelihood of success of the Maryland Model, which will require increased alignment from nontraditional care partners and all payers. We believe that revising the recommendations to address our concerns will help hospitals better engage with these partners and promote statewide accountability.

Thank you for your continued collaboration with UMMS and consideration of our feedback on the proposed Regional Partnership Catalyst Grants. We would welcome the opportunity to participate in additional conversations as HSCRC finalizes its recommendations.

Sincerely,

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

cc: Nelson J. Sabatini, Chairman
HSCRC Commissioners
John Ashworth, UMMS CEO
Micelle Lee, UMMS CFO

JOHNS HOPKINS
MEDICINE

Kevin W. Sowers, MSN, RN, FAAN

President
Johns Hopkins Health System

Executive Vice President
Johns Hopkins Medicine

October 23, 2019

Tequila Terry
Deputy Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Terry,

On behalf of the Johns Hopkins Health System (JHHS) and the four Maryland hospitals represented by JHHS, Johns Hopkins Bayview Medical Center, Howard County General Hospital, Suburban and The Johns Hopkins Hospital, thank you for the opportunity to provide comments on the draft recommendation for the Regional Partnership Catalyst Grants. JHHS applauds the HSCRC on this revised approach to the Regional Partnerships and strongly believes that this approach, with a defined focus on diabetes and behavioral health, creates greater opportunity to demonstrate measurable health care transformation.

JHHS supports HSCRC staff's assessment in the draft recommendation that "a more structured approach around key population health priority areas will ensure Regional Partnership efforts align and contribute to State efforts to maximize impact under Total Cost of Care Model goals, while still allowing for regional customization."

The Regional Partnership Transformation Grant program authorized in 2015 provided important lessons learned, most notably the value of partnership in addressing unmet health care needs of the community. Despite the numerous successes achieved under the original Regional Partnerships, the overall impact of the partnerships is harder to quantify due to the variability of interventions and programs pursued by each individual partnership. The revised Regional Partnership approach expands on the necessity of partnership while also appropriately targeting specific population health priorities.

While JHHS clearly supports this revised approach, we offer some recommendations that are consistent with the defined core principles that will apply to the new Regional Partnership

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Catalyst Grant Program that may improve the overall impact of the Program on the health of Marylanders.

Recommendations

As noted above, JHHS strongly favors the framework set forth in the HSCRC staff's draft recommendation for the Regional Partnership Catalyst Grants, and believe this framework could be improved with modest changes in the areas of Diabetes Prevention & Management Programs, Behavioral Health Crisis Services, Impact Measurement, Financial Budget, and Sustainability.

Diabetes Prevention & Management Programs

The current recommendation is for diabetes self-management training (DSMT) and medical nutrition therapy (MNT) to be delivered by American Diabetes Association (ADA)-recognized programs; however, this will result in inequitable treatment of diabetes, particularly for minority and underserved populations. The ADA recognition program standard was designed for diabetes specialty care settings (e.g. endocrinology practices and comprehensive diabetes centers) and it limits the personnel to certified diabetes educators (CDE). Most patients with type 2 diabetes, and particularly those most in need of education and support, are treated in primary care. Data show that high-risk, minority, low socioeconomic status, and rural patients are much less likely to access or complete these services. Often, these services focus solely on medical education, and recommendations are not appropriate for or able to be implemented by populations of health inequity (e.g. CDE or registered dietician recommended food lists, exercise recommendations).

We recommend the following modification to the diabetes treatment approach to be consistent with a population health strategy that will also address health inequities in Marylanders with diabetes:

- Include the addition of diabetes educators to primary care settings, which can be accomplished by not requiring the DSMT be in an ADA-recognition program.
- Include use of evidence-based diabetes self-management support (DSMS) interventions as a requirement as these were specifically designed to address health equity needs. They utilize a range of personnel and provider extenders (including health educators, care managers, community health workers [CHWS]), who receive program-specific training, and deliver services in communities where high-risk, minority, and lower SES patients can access them. A list of "gold standard" programs is available through the American Diabetes Association.
- Include use of the Medicare-reimbursed Collaborative Care Model (CoCM) as a requirement. This allows behavioral health integration both in primary care and in specialty care (e.g. endocrinology, cardiology) to address diabetes and co-morbid behavioral health issues. Such a collaborative care model integrating specialty care into primary has been successfully demonstrated for patients with poorly controlled type 2

diabetes and/or coronary heart disease and depression (Katon, New England Journal of Medicine, 2010). In this study, 14 primary care clinics in an integrated health care system in Washington State involving 214 patients with poorly controlled diabetes, coronary heart disease, or both and coexisting depression were randomized to an intervention or usual-care group (Katon, 2010). Components of the intervention clinics included incorporation of CDEs and nurse case managers into primary care practices; algorithms to guide pharmacotherapy to control depression; hyperglycemia, hypertension, and hyperlipidemia; motivational coaching for problem-solving and adherence to self-care; and weekly care meetings with the nurse supervisor, psychiatrist, primary care physician, and psychologist. After 12 months, patients in the intervention group had greater reduction in HbA1c, LDL-cholesterol, systolic blood pressure (5.1 mmHg), and depression scores, compared to usual care. Patients in the intervention group were also more likely to have insulin, anti-hypertensive medications, and anti-depressant medications adjusted. The Medicare-reimbursed CoCM is described in the Medicare Learning Network. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf. The CoCM workforce/team member trainings, the procedures for scaling up in clinical practice, and the body of research and ROI analyses are available on the AIMS Center website: https://aims.uw.edu/collaborative-care.

Behavioral Health Crisis Services

The staff recommendation appropriately highlights the statewide lack of adequate behavioral health infrastructure and services and the negative impact this has on hospital emergency departments. The recommendation focuses on the need for improving crisis services, however it is important to note that behavioral health crisis interventions will only be successful if they are part of a broader continuum of behavioral health care. The Crisis Now Model, highlighted in the staff recommendation, does in fact include elements that must be "baked in" to a successful crisis system and these element span across the continuum of care; however considering the critical nature of access to appropriate behavioral care at every level, JHHS felt compelled to highlight that the Regional Partnerships should not focus on crisis services alone.

Impact Measurement

The Total Cost of Care Model measures reductions in health care costs for Medicare beneficiaries, however, the Model maintains an all-payer approach. Under this all-payer approach, it is critical that every health care transformation effort focus on all patients regardless of insurance status and that all stakeholders, including Medicaid and commercial payers fully participate as well. While the staff recommendation appropriately notes that "interventions should be designed to positively impact all Marylanders regardless of payer source," the current plan measures the return on investment (ROI) impact using only Medicare claims. This approach will undoubtedly under-estimate the impact of the Regional Partnerships. While there is an appreciation that currently the HSCRC has access only to

Medicare claims data, there must be a commitment from Medicaid and commercial payers to share claims data with the HSCRC. Failure to do so will hinder the success of the Regional Partnership and all other care transformation programs under the HSCRC.

The recommendation notes that Regional Partnerships will be evaluated on both scale targets and return on investment requirements. Some of the transformation efforts will require a longitudinal approach in determining success. For example, the establishment of Crisis Stabilization facilities, which are a core component of the Crisis Now Model, could take several years to even launch, making an ROI well beyond the five year grant period. JHHS hopes that the HSCRC will give considerable flexibility, based on the proposed interventions, in evaluating success of Regional Partnerships.

Financial Budget

Staff recommend maintaining the annual investment in the new Regional Partnerships at 0.25 percent of statewide all-payer revenue. This amount may be adequate to support all the qualifying Regional Partnership applications, however considering the significant infrastructure investments that must be made in order to truly "move the needle" on population health targets, the HSCRC should consider a methodology that fund all worthy proposals rather than a hard cap. Additionally the HSCRC should consider a process to extend the grant beyond the 5 year period so long as the Partnership is demonstrating meaningful progress. As noted above, some infrastructure investments, such as Crisis Stabilization facilities, will require a longer planning and implementation period.

Additionally, JHHS supports the creation of a third funding stream to support other population health initiatives. However, given the substantial investments that will be needed to launch diabetes and behavioral health partnerships, we hope that the third, yet to be defined funding stream, will not divert funding from the diabetes and behavioral health partnerships.

Sustainability

The draft recommendation appropriately highlights the need for Regional Partnerships to demonstrate a sustainability plan beyond the grant period. JHHS supports this recommendation, but also hopes that the HSCRC takes action to ensure that Medicaid and commercial payers participate in ensuring sustainability. The successful long term funding of behavioral health crisis services will likely require Medicaid state plan amendments or waivers as well as transitioning Medicaid behavioral health services towards risk based models. Because the revised Regional Partnership design encourages a payer agnostic approach, if interventions are successful, all payers must also commit to participate in sustainability, either through on-going rate support, or direct support. Changes to state law may also be required to support the delivery of crisis services or diabetes services in the most appropriate settings. The HSCRC should advocate for legal and regulatory changes that are necessary for optimal success.

While not directly mentioned in the draft recommendation, JHHS hopes that the HSCRC will once again establish a planning period that is sufficient to promote the launch of robust Regional Partnerships. As experienced in the first round of Regional Partnerships the start-up phase is detail orientated and labor intensive. The new Regional Partnerships will likely require an equivalent planning phase especially considering the HSCRC's desire to ensure broad collaboration; establishing a framework to support partnership across multiple hospitals, community organizations and providers, and state and local government will require thoughtful planning. Additionally, considering these efforts, JHHS would also support a longer timeframe between the issuance of the RFP and the due date for proposals.

JHHS believes that the new approach outlined under the Regional Partnership Catalyst Grants will make significant strides in not only health improvement, but also in reducing total cost of care for all Marylanders. HSCRC staff have developed a focused and thoughtful proposal aimed at addressing two key state priorities, diabetes and behavioral health. JHHS welcomes the opportunity to collaborate with the state and other stakeholders in addressing these priorities. JHHS hopes and expects that hospital efforts to support these state priorities will complement and not supplant the state's historical commitment to meet the health care needs of Maryland's most vulnerable populations. Successful investments in addressing diabetes and behavioral health programs will have a positive impact on all stakeholders; JHHS looks forward to participating in this meaningful transformation.

Sincerely,

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

Peter Hill, M.D., M.S., F.A.C.E.P.
Senior Vice President, Medical Affairs, Johns Hopkins Health System
Associate Professor of Emergency Medicine

cc: Nelson Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James Elliott, MD
Adam Kane
Katie Wunderlich, Executive Director

MedChi The Maryland State Medical Society

October 25, 2019

hscrc.rfp-implement@maryland.gov
Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Regional Partnership Catalyst Grant Program

Dear Ms. Wunderlich:

On behalf of the Maryland State Medical Society, please accept our comments related to the HSCRC's Draft Recommendations for Competitive Regional Partnership Catalyst Grants.

MedChi supports the "reboot" of the Regional Partnership Program and is especially supportive of the need to engage in "widespread collaboration." However, while the document specifies that collaboration will be a requirement for funding, there is no criteria or measurement for determining the adequacy of the collaboration. As I stated during the Stakeholders Innovation Group this past Tuesday, evaluation criteria must include specific consideration of both the level of funding that the Regional Partnership Catalyst Grants allocate to community-based partners as well as the type of community-based partners, meaning that hospitals must be required or incentivized to collaborate with those that are not hospital owned. Equally important is the need to require shared savings among partners. Until this point, hospitals have had sole discretion as to whether to share savings, which has not been embraced. Going forward, this should also be part of the Catalyst Grants criteria.

We look forward to continuing to work with the HSCRC in further implementing Maryland's Total Cost of Care Contract. Thank you.

Sincerely,

Gene M Ransom III

Gene Ransom, Chief Executive Officer
MedChi, The Maryland State Medical Society

cc: Tequila Terry, HSCRC

MedStar Health

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October 23, 2019

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

Dear Katie:

MedStar Health System, Inc. appreciates the opportunity to provide feedback on the draft recommendations for the *Regional Partnership Catalyst Grants* Program.

We support Maryland Hospital Association's comment letter. Attached is a letter sent to HSCRC staff at their request to provide recommendations on Behavioral Health programs for the HSCRC to consider funding in the next iteration of grant funding. Just as MHA discussed flexibility needed with funding streams, we believe that is important to ensure maximal impact on the health of Marylanders. Thus, in our letter attached, we also included suggestions on important diabetes interventions to consider for funding.

We also additionally believe if the system is continuing to fund grants, a pooling mechanism should be put in place so that all hospitals are impacted equally, and hospitals that are awarded grant funding are not disadvantaged by increases to their rates.

Finally, to further the goal of improvements in population health, we urge the HSCRC staff to seek evaluation methods beyond the claims-based population analyses being utilized by the care transformation initiatives, as these will not capture many population health interventions and impacts.

We appreciate the opportunity to comment. Please reach out to me if you have any questions.

Sincerely,

Meena Seshamani, MD, PhD
Vice President
Clinical Care Transformation
MedStar Health

cc: Nelson Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Adam Kane
Victoria W. Bayless
James Elliott, M.D.
Stacia Cohen, RN
John M. Colmers

MedStar Health

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October 17, 2019

Ms. Tequila Terry
Deputy Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Tequila,

MedStar Health appreciates the opportunity to provide the Commission feedback on the Competitive Regional Partnership Catalyst Grant. While we know that the Commission is specifically seeking comments around the behavioral health funding stream, we would like to take this opportunity to also provide feedback on the diabetes funding stream.

Behavioral Health

We recognize and support the need to implement and expand behavioral health crisis management models that improve access to crisis intervention, stabilization, and treatment referral programs. Another significant challenge to health care systems from a quality and utilization perspective is the older adult with cognitive impairment or dementia – an issue which, if addressed, could prevent the behavioral health crisis in the first place. Dementia is prevalent – approximately 11% of Medicare beneficiaries have received treatment for Alzheimer's disease or dementia.[i] This population is at high risk of potentially preventable hospitalization[ii] and total health care spending for patients with dementia in their last 5 years of life is approximately 57% greater than costs associated with other types of mortalities.[1] This equates to an estimated spending of $287,000 for dementia patients as compared to $183,000 for other Medicare beneficiaries.[2]

This growing population may experience behavioral changes that can include psychosis, depression, and anxiety that are difficult to manage by their caregivers. As a result, older adults are brought to hospital emergency departments in crisis as a last resource.[iii] Indeed, between 20-40% of older adults who present at the emergency department are cognitively impaired with symptoms of dementia, delirium or other cognitive impairments[iv]. Emergency departments are often not equipped to manage such complex behavioral issues, resulting in emergency department overcrowding, prolonged hospitalization and suboptimal care leading to worsening behavior and complications such as delirium, infections, falls, fractures and death.[v] Hospitals are further challenged with discharging older adults with dementia due to lack of safe or experienced discharge locations, limited resources and denials from post-acute facilities due to the complexity of needs, inability to manage on site, lack of expertise and scarce staffing support.

The proposed HSCRC Regional Partnership Behavioral Health Funding Stream is focused on comprehensive crisis management services, but there are significant opportunities to address behavioral health crises through better management of the most prevalent issues facing our populations. We

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[1, iii] Kelley, A. S., McGarry, K., Gorges, R., & Skinner, J. S. (2015). The burden of health care costs for patients with dementia in the last 5 years of life. *Annals of internal medicine*, *163*(10), 729-736

encourage the HSCRC to consider expanding this funding stream to include evidence-based interventions that address care and coordination for older adults with dementia including, but not limited to, caregiver education interventions, appropriate post-acute care transition and treatment, and long-term community-based solutions to reduce utilization of emergency departments by older adults.

We also recommend the inclusion of other psychiatric conditions common in the Medicare population such as depression (18% of Medicare beneficiaries[vi]) and delirium (20% of hospitalized older adults), as beneficiaries with these conditions face similar issues with coordination of care, placement in post-acute care, and bounce backs to the hospital. The inclusion of these additional populations would allow for new and expanded partnerships between hospitals and community partners to create safe procedural protocols, promote post-acute care transitions and service expansion, and safe transitions to home. The opportunity to devote intensive work by applying evidenced-based practices to these deserving and highly complex populations will reduce hospital utilization, complications and expand care management capability.

Diabetes

The recommended grant looks to increase the number of educators providing Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT). MedStar has a robust program for uncontrolled diabetics (HbA1c>9), which is a 12-week Diabetes "Boot Camp." The technology-enabled intervention offers learner-centered survival skills, self-management education (SSE) and algorithm-driven diabetes (DM) medications titration by Endocrinologist-supervised Certified Diabetes Educators (CDE), in collaboration with MedStar Medical Group.

DSMT and MNT are important components, but there are other patient care models that hold promise for managing this very high cost population. Virtual care tools such as remote monitoring, interactive patient messaging, and video visits can be used to overcome social determinants of health and other access barriers for this uncontrolled population. Therefore, we would recommend that HSCRC consider a concerted focus on these technology-enabled care tools for diabetes management to better address these issues for this population.

Thank you for your support and the opportunity to provide feedback on the Competitive Regional Partnership Catalyst Grant. Questions should be directed to Dr. Meena Seshamani, Vice President, MedStar Health Meena.X.Seshamani@medstar.net.

We look forward to working with you.

Meena X. Seshamani, MD, PhD
Vice President

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[i] https://www2.ccwdata.org/web/guest/medicare-charts/medicare-chronic-condition-charts/#p_56_INSTANCE_0cpBYgJ4Nos1

[ii] Maust, D. T., Kim, H. M., Chiang, C., Langa, K. M., & Kales, H. C. (2019). Predicting Risk of Potentially Preventable Hospitalization in Older Adults with Dementia. *Journal of the American Geriatrics Society*.

[iii] LaMantia, M. A., Stump, T. E., Messina, F. C., Miller, D. K., & Callahan, C. M. (2016). Emergency department use among older adults with dementia. *Alzheimer disease and associated disorders*, *30*(1), 35.

[iv] Gerson, L. W., Counsell, S. R., Fontanarosa, P. B., & Smucker, W. D. (1994). Case finding for cognitive impairment in elderly emergency department patients. *Annals of emergency medicine*, *23*(4), 813-817.

[v] Handley, M., Bunn, F., & Goodman, C. (2017). Dementia-friendly interventions to improve the care of people living with dementia admitted to hospitals: a realist review. *BMJ open*, *7*(7), e015257.

[vi] https://www2.ccwdata.org/web/guest/medicare-charts/medicare-chronic-condition-charts/#p_56_INSTANCE_0cpBYgJ4Nos1

Trivergent Health Alliance
Management Services Organization

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October 23, 2019

Tequila Terry
Deputy Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Terry:

On behalf of Trivergent Regional Partnership, (comprised of the three community based health systems spanning the western portion of Maryland: Meritus Medical Center, Frederick Health, and Western Maryland Health System); the Partnership appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) proposed "Draft Recommendations for Competitive Regional Partnership Catalyst Grants".

The Partnership supports the three funding stream options detailed within the program proposal, and offers the following comments for consideration regarding how to further improve upon the proposed Regional Partnership Catalyst Grant Program. The comments provided are based on lesson learned through: the existing grant program, assessment of current programmatic barriers specific to diabetes prevention and management, and current needs in the area of behavioral health and substance abuse disorders.

1. **DM Program Enrollment/Referral Barrier- Policy:** Nurse practitioners are currently empowered to order DSME, yet it requires a physician order to refer a patient to DM MNT program. **It would be most efficient and prevent delay in care if Nurse Practitioners were given the authority to order DM MNT for patients that meet criteria for appropriateness and need.**

2. **Program participation barrier and sustainability: Endorse alternative diabetes program sustainability plans that work to balance TCOC benefit with methods to improve programmatic participation rates.** Diabetic prevention and management programs require a high level of patient engagement to foster and yield the behavioral changes necessary to change the diabetes disease progression curve. Many patients currently express that they are unable to pay the out of pocket co-pays associated with this high touch program offering, thus are unable to participate. **With respect to managing TCOC, our Regional Partnership has recognized it is most beneficial to offer diabetes prevention and management programs at no cost; as the benefit to the patient and savings generated from avoided disease progression related complications is greater than the fee collected for the program.** Program participation interrupts the incidence of diabetes, diabetic disease progression, and subsequent utilization costs associated with caring for patients affected by multi-system dysfunction or failure resulting from uncontrolled diabetes.

3. **Scope of BH Funding Stream II: The Behavioral Health funding stream scope should be expanded to include interventions aimed at prevention, detection, and management of behavioral health and substance abuse conditions that are driving utilization of crisis services.** This approach would then be in alignment with the proposed diabetes funding stream scope. Such interventions are able to decrease avoidable inpatient and emergency department utilization as they serve as a mechanism to promote early detection and intervention in a community based setting, thus equipping the patient with tools and resources to mitigate escalation to crisis, and subsequently reduce the demand for crisis services.

4. **Interventions targeting prevention and detection among the youth, adolescence, and teen populations in the areas of behavioral health and substance use disorders will be critical for managing TCOC in the years to come.** Each of the health systems are currently seeing a notable increase in adolescence requiring crisis care. Opportunities are present to partner with the school systems and local law enforcement.

5. **Importance of leveraging existing infrastructure and successful interventions deployed through first RP grant program:** Given the reduction of readmission and ED revisit rates achieved through implementation of the existing Behavioral Health grant funded interventions, it is of critical importance to sustain those interventions, and leverage the infrastructure now present which integrated BH services in primary care, and provides community based BH case management. The Trivergent Regional Partnership recognizes the need to stay the course, build upon existing resources, and expand success programs to reach deeper into the communities served. There is great benefit to be gained from enhancing crisis services to meet demand, and leveraging existing infrastructure to reduce the need for crisis intervention through early detection and preventative measures.

6. **Advocacy for measurement of programmatic effectiveness beyond Medicare Claims data:** The majority of the population driving utilization of Behavioral Health Services are covered by Maryland Medical Assistance. While impacting this population will not highlight immediate savings to Medicare, if this population remains without interventions aimed at prevention, early detection, and crisis intervention- this same population will drive greater demand on the Medicare system in the years to come. To help manage future Medicare associated utilization, it is important to focus on all payor strategies.

On behalf of the Regional Care Transformation (RCT) Executive Committee Members for the Trivergent Regional Partnership:

Jo Wilson

Jo Wilson, Trivergent Regional Partnership Executive Committee Chair
Vice President, Population Health
Western Maryland Health System

Trivergent Health Alliance
Management Services Organization

Dr. Manny Casiano
Senior VP Population Health and Ambulatory Services, and CMO
Frederick Health

Jennifer Teeter, Vice President Clinical Integration & Contracting;
Executive Director, Frederick Integrated Healthcare Network ACO A2492, CTO 0089
Frederick Health

Heather Kirby
VP of Integrated Care Delivery
Frederick Health

Josh Repac
Executive Director of Revenue Cycle and Reimbursement
Meritus Medical Center

Dr. Douglas Spotts
VP/Chief Population Health Officer
Meritus Health

Cc: Katie Wunderlich

MPA Year 3:
Final Recommendation

November 13, 2019

HSCRC
Health Services Cost Review Commission

MPA Y3 Changes

- MPA Year 3 final recommendation reflects only:
  - **Attribution**: Minor technical changes
  - **MPA quality adjustment**: No changes to the measures or small weight
  - **Revenue at risk**: No plans to change the amount at risk from Y2
  - **Performance measurement**: Maintain improvement-only methodology for Y3 and defer attainment and further review of benchmarking to Y4
  - **Other Adjustments**: Consistent with the approach approved in the Y2 policy-
    - Comprehensive Primary Care Payments for Track 2 practices will be added to both the base and performance periods. MDPCP Care Management Fees will be included in MPA Y4.
    - Hospitals will not be credited with the differential change (applicable to the first 6 months only)

Comments on the Purpose of the MPA

- Six stakeholders commented on the MPA Y3 policy.
- Stakeholders were generally supportive of the policy recommendation:

Commenter	Feedback
AAMC & DCHS	• Helps meet TCOC Model goals • Creates TCOC accountability
CareFirst	• Holds hospitals at risk for Medicare performance • Allows hospitals to meet their Medicare at-risk levels (required for quality program exemptions) • Encourages hospitals to become more efficient and reduce potentially avoidable utilization and TCOC
MHA	• Allows Maryland's TCOC Model to qualify as an Advanced Alternative Payment Model – providing eligibility for MACRA payments
MedStar	• Supports MHA's letter
UMMS	• Demonstrates progress in developing policies that have a positive impact on Maryland TCOC

Comments on Moving from Improvement to Attainment

- All but one stakeholder offered feedback on moving the MPA from improvement-only to attainment.
- The feedback was not consistent across stakeholders:

Comment	AAMC	CareFirst	JHHS	MHA	MedStar
Urge move to attainment	✓	✓			
Discussed but did not endorse moving to attainment			✓	✓	✓
Include socio-economic risk factors adjustments in attainment approach			✓	✓	✓

- The HSCRC is currently working with a contractor on benchmarking and will discuss a move to attainment in MPA Y4.

Comments on Adjustments to Revenue-at-Risk

- Four stakeholders expressed support for holding revenue-at-risk at 1% and one stakeholder encouraged an increase.
- CMS has expressed their support for increasing revenue-at-risk to HSCRC staff.

Commenter	Feedback
AAMC & DCHS	• Do not increase the amount of revenue at-risk above 1% of Medicare revenue until attainment is added in
CareFirst	• Encourage increasing maximum reward and penalty under the MPA to levels that are higher than the current +/- 1.0%
JHHS	• Appreciate holding revenue at risk to 1% to maintain stability until comprehensive MPA review
MHA	• Revenue at risk should remain unchanged
MedStar	• Supports MHA's letter

- The HSCRC will consider an increase to the revenue-at-risk for MPA Y4.

Comments on the MPA Attribution Methodology

- Stakeholders expressed a variety of concerns with the MPA attribution methodology:

Commenter	Feedback
JHHS	• Attribution methodology needs to be refined to align with the principles outlined in the development of the MPA • Appreciate TCOC WG doing a comprehensive review
MedStar	• Need to align attribution methodology with revenue-at-risk (current incentives are misaligned)
MHA (and MedStar)	• Use attributed spend per beneficiary analysis to inform most appropriate attribution method • Attribution should allow hospitals to affect total beneficiary spending
UMMS	• Evaluate stability of the attribution methodology and its plausibility in future years – suggesting potential new focus on quantifiable CTI populations

- HSCRC plans to conduct a comprehensive review of the MPA policy in Y4.

Comments on MPA Overlap with Other HSCRC Policies

- Stakeholders expressed general concern with the MPA overlapping with other HSCRC policies:

Comment	AAMC	MedStar	UMMS
Monitor interaction between MPA, CTIs, and other HSCRC policies	✓		✓
Address issues of payment overlap (e.g. double rewards/double penalties)	✓		✓
Align incentives to prioritize competing programs	✓	✓	

- At the request of the Commission the HSCRC staff will be producing a report on the overlap of the CTIs with other HSCRC policies. This overlap will also be considered in the Y4 MPA policy review.

Comments Requesting Further Analyses

- All but one stakeholder requested further analysis on one of the following areas:

Comment	AAMC	JHHS	MedStar	MHA	UMMS
Analysis and clarification on impact of MDPCP funding for hospitals	✓	✓			
Analysis on the attributed spending per beneficiary by hospital		✓	✓	✓	
Analysis on what is driving changes in TCOC			✓		✓

- HSCRC staff recommend removing Track 1 MDPCP payments from hospital's MPA in both the performance and base period, but do not plan to delay this change beyond MPA Y4
- Hospitals are accountable for understanding their population health experience, the HSCRC staff support the creation of a data workgroup for hospitals to understand what is driving their Medicare TCOC and will discuss reporting enhancements with the RAC
- HSCRC staff plan to present an update on Maryland cost drivers at the November TCOC WG

Final Recommendations
MPA Y3:

1. Continue measuring Medicare Total Cost of Care (TCOC) by attributing Medicare fee-for-service beneficiaries to non-hospital providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships. Implement only minor changes from the RY 2021 approach.
2. Maintain the maximum penalty at 1.0% and the maximum reward at 1.0% of federal Medicare revenue with maximum performance threshold of ±3%.
3. Set the TCOC benchmark as each hospital's risk-adjusted (demographics only) TCOC from CY 2019, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2020. Exclude MDPCP Performance-based Incentive Payments and Care Management Fees, but include Comprehensive Primary Care Payments for Track 2 practices in both the base and performance period.
4. Continue to assess performance on each hospital's own improvement in its attributed population's per capita TCOC.
    a) Adjust for year-over-year changes in the demographic characteristics of the hospital's attributed population.
    b) For future years, continue to explore incorporating attainment and further risk adjustment into the MPA's performance assessment.

Final Recommendations, cont.
MPA Y3:

5. Include the MPA as part of the aggregate revenue at risk under HSCRC quality programs.
6. Focus TCOC Work Group on more comprehensive review of the MPA policy for Rate Year 2023 (Performance in calendar year 2021), including but not limited to revisiting the fundamental attribution method, coordinating with the CTI process, adding attainment with benchmarking, and considering changes to amount at risk.
7. Provide national Medicare growth rate estimates relative to Maryland throughout the year to help hospitals monitor their progress.
8. Continue to work with CMS and CRISP to provide information to hospitals so they can more effectively engage in care coordination and quality improvement activities, assess their performance, and better manage the TCOC by working in alignment with both independent and affiliated providers whose beneficiaries they serve.

Final Recommendation for the Medicare Performance Adjustment (MPA) Policy for Rate Year 2022

November 13, 2019

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This document contains the final staff recommendation for changes to the MPA Policy for Rate Year 2022, ready for Commission discussion and vote.

Table of Contents

LIST OF ABBREVIATIONS

AAPM	Advanced Alternative Payment Model
ACO	Accountable Care Organization
CMF	Care Management Fees
CMS	Centers for Medicare & Medicaid Services
CPCP	Comprehensive Primary Care Payments
CTO	Care Transformation Organization
CY	Calendar Year
E&M	Evaluation and Management Codes
ECMAD	Equivalent case-mix adjusted discharge
FFS	Medicare Fee-For-Service
FFY	Federal Fiscal Year
FY	Fiscal Year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MHAC	Maryland Hospital-Acquired Conditions Program
MPA	Medicare Performance Adjustment
MDPCP	Maryland Primary Care Program
NPI	National Provider Identification
PBIP	Performance-based Incentive Payments
PCP	Primary Care Provider
PSA	Primary Service Area
RRIP	Readmission Reduction Incentive Program
RY	Rate Year
TCOC	Medicare Total Cost of Care
TIN	Tax Identification Number

FINAL RECOMMENDATIONS FOR RY 2022 MPA POLICY

1) Continue measuring Medicare Total Cost of Care (TCOC) by attributing Medicare fee-for-service beneficiaries to non-hospital providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships. Implement only minor changes from the RY 2021 approach.
2) Maintain the maximum penalty at 1.0% and the maximum reward at 1.0% of federal Medicare revenue with maximum performance threshold of ±3%.
3) Set the TCOC benchmark as each hospital's risk-adjusted (demographics only) TCOC from CY 2019, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2020. Exclude MDPCP Performance-based Incentive Payments and Care Management Fees, but include Comprehensive Primary Care Payments for Track 2 practices in both the base and performance period.
4) Continue to assess performance on each hospital's own improvement in its attributed population's per capita TCOC.
    a) Adjust for year-over-year changes in the demographic characteristics of the hospital's attributed population.
    b) For future years, continue to explore incorporating attainment and further risk adjustment into the MPA's performance assessment.
5) Include the MPA as part of the aggregate revenue at risk under HSCRC quality programs.
6) Focus TCOC Work Group on more comprehensive review of the MPA policy for Rate Year 2023 (Performance in calendar year 2021), including but not limited to revisiting the fundamental attribution method, coordinating with the CTI process, adding attainment with benchmarking, and considering changes to amount at risk.
7) Provide national Medicare growth rate estimates relative to Maryland throughout the year to help hospitals monitor their progress.
8) Continue to work with CMS and CRISP to provide information to hospitals so they can more effectively engage in care coordination and quality improvement activities, assess their performance, and better manage the TCOC by working in alignment with both independent and affiliated providers whose beneficiaries they serve.

Changes from MPA RY 2022 Draft Recommendation:

The incorporation of MDPCP expenditures in the MPA has been amended in the recommendations and section, "Accounting for Maryland Primary Care Program (MDPCP) Expenditures", to continue excluding Care Management Fees from both the base and performance period in MPA RY 2022, rather than including these fees as stated in the Draft Recommendation.

INTRODUCTION

The State implemented a value-based payment adjustment, referred to as the Medicare Performance Adjustment (MPA), with performance beginning in Calendar Year (CY) 2018. The MPA brings direct financial accountability to individual hospitals based on the total cost of care (TCOC) of Medicare fee-for-service (FFS) beneficiaries attributed to them. This policy addresses updates for Rate Year 2022. Staff are proposing limited changes in this policy because of many other areas of change at the HSCRC (Efficiency Policy, Capital Policy, MPA Framework, etc.) and a desire to allow a longer term view of performance by minimizing attribution changes.

Throughout this policy, the periods involved will be referred to as follows:

- Year 1: Rate Year 2020, Performance Year 2018, Base Year 2017
- Year 2: Rate Year 2021, Performance Year 2019, Base Year 2018
- Year 3: Rate Year 2022, Performance Year 2020, Base Year 2019

MEDICARE PERFORMANCE ADJUSTMENT MECHANICS

To calculate the MPA percentage adjustment to each hospital's federal Medicare payments (limited beginning in Year Two to a positive or negative adjustment of no more than 1.0%), the policy must determine the following: an algorithm for attributing Maryland Medicare beneficiaries and their TCOC to one or more hospitals without double-counting; a methodology for assessing hospitals' TCOC performance based on the beneficiaries and TCOC attributed to them; and a methodology for determining a hospital's MPA based on its TCOC performance.

The HSCRC explored potential changes to the MPA based on feedback from the industry and other stakeholders via its Total Cost of Care Workgroup and other meetings. This recommendation reflects valuable insights provided by the work group—which has held regular public meetings over the past three years—as well as analyses by HSCRC contractors LD Consulting and Mathematica Policy Research (MPR), and other communications and meetings with stakeholders.

Total Cost of Care Attribution Algorithm

For Year 1 of the MPA, a multi-step prospective attribution method assigned beneficiaries and their costs to Maryland hospitals based primarily on beneficiaries' treatment relationship with a primary care provider (PCP) and that PCP's relationship to a hospital. Based on the Total Cost of Care Work Group's input and discussion, as well as Year 1 and 2 experience, HSCRC staff recommends keeping the main elements of the existing algorithm for Year 3, with some minor adjustments. A separate technical guide will be released by HSCRC staff describing the attribution algorithm for Year 3 and updates from the Year 2 Policy. The proposed updates make small changes to the way low volume physicians are handled and implement the treatment of all

employed providers of a hospital as a single group within the attribution (as opposed to individuals).

Review period

Staff will continue to implement an official algorithm review period, as in Year 2. As the initial running of the attribution algorithm for Year 3 is completed, hospitals will have the opportunity to raise concerns about the attribution algorithm output. This period is intended to ensure the attribution algorithm is performing as expected, not as an opportunity to revisit the core elements of the algorithm.

The review period is intended to serve two purposes: (1) identify and correct mechanical errors (e.g., incorrect data submissions); and (2) address specific cases of unintended and misaligned linkages that do not reflect the intent of the MPA policy. For example, in some scenarios, a provider may have significant relationships with more than one hospital. In this case, the hospitals involved may propose to have joint accountability for the total cost of care. In practice, this could result in a portion of the total cost of care attributed to one hospital and the other portion to another hospital. In evaluating any such proposals, HSCRC staff will consider whether the request is reasonable based on the situation and can be implemented into MPA monitoring reports without significant burden. HSCRC staff will work with the TCOC Work Group to determine guidelines associated with review period proposals.

Performance Assessment

For Year 3, hospital performance on Medicare TCOC per capita in the performance year (CY 2020) will be compared against the TCOC Benchmark. The TCOC Benchmark will be the hospital's prior (CY 2019) TCOC per capita, updated by (1) a TCOC Trend Factor determined by the Commission, as described in greater detail below and (2) adjusted for changes in the hospital's risk score over time. This approach is a year-over-year comparison, based on each hospital's own improvement. In the case that external events impact hospitals' Medicare TCOC (e.g., changes to the differential or reductions to hospital rates), the HSCRC reserves the right to adjust base year performance to capture those changes and better reflect a hospital's improvement.

The attribution of Medicare beneficiaries to hospitals will continue to be performed prospectively. Specifically, beneficiaries' connection to hospitals is determined based on the two federal fiscal years preceding the performance year, so that hospitals can know in advance the providers for whom they will be assuming responsibility in the coming performance year. For attribution for Performance Year 2020, data for the two years ending September 30, 2019 will be

used. For attribution for Base Year 2019, data for the two years ending September 30, 2018 will be used.[1]

The risk adjustment methodology based on Medicare New Enrollee Demographics Risk Score adopted in the Year 2 policy will continue to be used in Year 3.

This policy for RY 2022 represents a continuation of an improvement-only methodology. HSCRC staff is not recommending adopting an attainment policy at this time. An attainment policy for the MPA requires consideration of a number of complex issues, such as an appropriate attainment benchmark, intrinsic differences between hospital payment rates (such as labor market differences, Graduate Medical Education payments, etc.), and an appropriate risk adjustment methodology. The Total Cost of Care Work Group will continue to discuss attainment as part of its work plan to assess future policy changes.

TCOC Trend Factor

The MPA for Year 3, which begins July 2021, will be based on hospital performance on Medicare TCOC per capita in the performance year (CY 2020) compared to its TCOC Benchmark. The TCOC Benchmark will be the hospital's prior (CY 2019) TCOC per capita, updated by the TCOC Trend Factor. Final Medicare TCOC data for the State and the nation for calculating the MPA will be available in May 2021.

Consistent with the RY 2020 and 2021 policy, HSCRC staff proposes that the TCOC Trend Factor for RY 2022 remains set at 0.33% below the national Medicare FFS growth rate. Even after being approved by the Commission and CMS, however, the TCOC Trend Factor may be adjusted by the Commission and CMS if necessary to meet Medicare financial tests.

Accounting for Maryland Primary Care Program (MDPCP) Expenditures

The Maryland Primary Care Program is designed to provide additional funding, flexibility, and tools to primary care practices to invest in care management, population health, and other high value services. In the Year 2 recommendation the Commission approved gradually incorporating MDPCP expenditures into the MPA performance assessment. Under this approach, MDPCP Care Management Fees were to be added to both the base and performance period in Year 3. However, the Commission is now expecting a much larger change in these fees between 2019 and 2020 and does not wish this change to impact measured hospital performance. Therefore, staff propose the following for Year 3:

- Include Comprehensive Primary Care Payments (CPCP) paid quarterly to Track 2 MDPCP practices, along with the sum of their reduced fee-for-service revenue

[1] For Base Year 2019 and Performance Year 2020, the algorithm will rely on 2020 ACO lists, MDPCP lists, and employment lists. As a result, each hospital's TCOC performance as assessed for 2019 as the base year will differ from that calculated for 2019 as the performance year, which is based on 2019 ACO lists.

- Exclude Care Management Fees (CMF)
- Exclude Performance-based Incentive Payments (PBIP)

Beginning with the Year 4 (RY 2023) policy, staff intend to include both CMF and PBIP in both the base year and the performance year.

Special Approaches to Increasing Hospital Accountability

The University of Maryland Rehabilitation and Orthopedic Institute (UMROI) provides specialized stroke rehabilitation services along with other rehabilitation services to patients from across Maryland. Recognizing UMROI as a unique State resource and the challenges with operationalizing the MPA for UMROI, the HSCRC piloted an episode-based approach to increase the financial and quality accountability for Medicare beneficiaries receiving services at UMROI in CY 2019. This pilot will continue in CY 2020 with any changes implemented during next year's policy review.

Once again, hospitals also have the opportunity to collectively address TCOC by opting to have multiple hospitals treated as a single hospital for MPA purposes. Such a combination of hospitals must be agreed to by all the hospitals, must include a regional component, and serve a purpose that is enhanced by the combination. Hospitals should submit their request before the Performance Year and cannot be changed once the current Performance Year has begun, except as agreed to by HSCRC.

Medicare Performance Adjustment Methodology

For each hospital, its TCOC Performance compared to the TCOC Benchmark, as well as an adjustment for quality, will be used to determine the MPA's scaled rewards and penalties. For Year 3, the agreement with CMS requires the maximum penalty be set at 1.0% and the maximum reward at 1.0% of hospital federal Medicare revenue. However, the HSCRC will be reviewing the reward/penalty maximum in the MPA next year, as CMS has indicated interest in increasing the amount at risk.

The agreement with CMS also requires that the Maximum Performance Threshold (that is, the percentage above or below the TCOC Benchmark at which the Maximum Revenue at Risk is attained) be set at 3% for Year 3. Before reaching the Year 3 Maximum Revenue at Risk of ±1.0%, the Maximum Performance Threshold results in a scaled result — a reward or penalty equal to one-third of the percentage by which the hospital's TCOC differs from its TCOC target.

In addition, the agreement with CMS requires that a quality adjustment be applied that includes the measures in the HSCRC's Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Conditions (MHAC). For Year 3, staff proposes to continue to use the existing RRIP and MHAC all-payer revenue adjustments to determine these quality adjustments; however, staff recognizes that the Commission may choose to add to the programs used for the quality adjustments over time, to increase the alignment between hospitals and other providers to

improve coordination, transitions, and effective and efficient care. Both MHAC and RRIP quality programs have maximum penalties of 2% and maximum rewards of 1%. The sum of the hospital's quality adjustments will be multiplied by the scaled adjustment. Regardless of the quality adjustment, the maximum reward and penalty of ±1.0% will not be exceeded. The MPA reward or penalty will be incorporated in the following year through adjusted Medicare hospital payments on Maryland Medicare FFS beneficiaries.

With the maximum ±1.0% Medicare FFS hospital adjustment, staff continues to recommend that the MPA be included in the HSCRC's portfolio of value-based programs and be counted as part of the aggregate revenue at risk for HSCRC quality programs.

FINAL RECOMMENDATIONS FOR RY 2022 MPA POLICY

Based on the assessment above, staff recommends the following for RY 2022 (with details as described above).

1) Continue measuring Medicare Total Cost of Care (TCOC) by attributing Medicare fee-for-service beneficiaries to non-hospital providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships. Implement only minor changes from the RY 2021 approach.
2) Maintain the maximum penalty at 1.0% and the maximum reward at 1.0% of federal Medicare revenue with maximum performance threshold of ±3%.
3) Set the TCOC benchmark as each hospital's risk-adjusted (demographics only) TCOC from CY 2019, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2020. Exclude MDPCP Performance-based Incentive Payments and Care Management Fees, but include Comprehensive Primary Care Payments for Track 2 practices in both the base and performance period.
4) Continue to assess performance on each hospital's own improvement in its attributed population's per capita TCOC.
    a) Adjust for year-over-year changes in the demographic characteristics of the hospital's attributed population.
    b) For future years, continue to explore incorporating attainment and further risk adjustment into the MPA's performance assessment.
5) Include the MPA as part of the aggregate revenue at risk under HSCRC quality programs.
6) Focus TCOC Work Group on more comprehensive review of the MPA policy for Rate Year 2023 (Performance in calendar year 2021), including but not limited to revisiting the fundamental attribution method, coordinating with the CTI process, adding attainment with benchmarking, and considering changes to amount at risk.

7) Provide national Medicare growth rate estimates relative to Maryland throughout the year to help hospitals monitor their progress.
8) Continue to work with CMS and CRISP to provide information to hospitals so they can more effectively engage in care coordination and quality improvement activities, assess their performance, and better manage the TCOC by working in alignment with both independent and affiliated providers whose beneficiaries they serve.

APPENDIX I. BACKGROUND

The Maryland Health Services Cost Review Commission (HSCRC) is a State agency with unique regulatory authority: for all acute-care hospitals in Maryland, HSCRC sets the amount that each hospital will be reimbursed by all payers. The federal government has granted Maryland the authority for HSCRC to set hospital payment rates for Medicare as part of its all-payer hospital rate-setting system. This all-payer rate-setting approach, which has been in place since 1977, eliminates cost-shifting among payers.

Since 2014, the State and CMS have operated Maryland's unique all-payer rate-setting system for hospital services to adopt new and innovative policies aimed at reducing per capita hospital expenditures and TCOC spending, while improving health care quality, patient outcomes, and population health. Under this initiative, hospital-level global budgets are established, so that each hospital's total annual revenue is known at the beginning of each fiscal year. Annual revenue is determined from a historical base period that is adjusted to account for inflation updates, infrastructure requirements, population-driven volume increases, performance in quality-based or efficiency-based programs, changes in payer mix, and changes in levels of uncompensated care. Annual revenue may also be modified for changes in services levels, market share shifts, or shifts of services to unregulated settings.

The MPA provides a mechanism to further support aligned efforts of hospitals with other providers. This includes the opportunity for physicians who partner with hospitals under Maryland's Care Redesign Programs (i.e., Hospital Care Improvement Program (HCIP), Complex and Chronic Care Improvement Program (CCIP), and Episode Care Improvement Program (ECIP)) to be eligible for bonuses and increased payment rates under the federal MACRA law.

Although outside the scope of the MPA attribution algorithm and other aspects described in this document, the State also has the flexibility to apply an MPA Framework to adjust hospitals' Medicare payments for other purposes. There are two primary use cases for the MPA Framework. First, the MPA Framework can permit the flow of Medicare funds to hospitals based on their performance in other programs (the MPA Reconciliation Component (MPA-RC)). For example, Medicare payments to qualifying hospitals under ECIP will occur through an MPA-RC separate from the MPA's adjustment based on the hospital's performance on its attributed population. In addition, the MPA Framework may also be used to reduce hospital payments if necessary to meet Medicare financial targets that are not approved on an all-payer basis (the MPA Savings Component (MPA-SC)).

APPENDIX II. ESTIMATED TIMELINE AND HOSPITAL SUBMISSION

Estimated Timing	Action
December 2019	• *Required for ACOs:* Hospitals provide HSCRC with ACO Participant List for Performance Year 2020 (also used for Base Year 2019) • *Voluntary*: Hospitals participating in multi-hospital ACOs designate which ACO providers should be linked with which ACO hospital • *Voluntary:* Hospitals provide HSCRC with a list of full-time, fully employed providers • *Voluntary:* Hospitals wanting to be treated as a combination under the MPA submit a joint request to HSCRC
January 2020	• Performance year begins • HSCRC combines hospital lists and identifies potential overlaps • HSCRC runs attribution algorithm for Base Year 2019 and Performance Year 2020, and provides hospitals with preliminary provider-attribution lists
February 2020	• Official review period for hospitals of 2 weeks following preliminary provider-attribution lists • HSCRC reruns attribution algorithm for implementation

Maryland
Hospital Association

October 22, 2019

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

Dear Katie:

On behalf of Maryland's 61 member hospitals and health systems, the Maryland Hospital Association appreciates the opportunity to comment on the commission's proposed Medicare Performance Adjustment (MPA) changes for rate year 2022.

MHA supports the HSCRC staff's proposal
Maryland's hospitals support HSCRC staff's recommendation. The revenue at risk should remain unchanged and only minor technical adjustments should apply. The traditional MPA is an important vehicle that allows Maryland's Total Cost of Care Model to qualify as an Advanced Alternative Payment Model—making participating physicians eligible for MACRA payments.

An assessment of the attributed spend per beneficiary is needed in a comprehensive review
A main component of HSCRC staff's planned review should be an assessment of the payment per beneficiary attributed to hospitals. This assessment should include analyzing spending per beneficiary for:

- Changes in service use for beneficiaries attributed to the same hospital
- Changes for lost and new beneficiaries
- Changes for beneficiaries attributed to different hospitals in different years
- Service use at the attributed hospitals relative to service use at other hospitals
- Magnitude of payments and beneficiaries assigned to a hospital relative to its overall Medicare charges

It would be beneficial to assess the statistical validity of the measure to ensure the best and most appropriate attribution method is used and that hospitals can affect total spending per beneficiary from management's actions. If HSCRC staff propose an attainment benchmark, the methodology would require appropriate risk adjustments, including socio-economic factors that may not be present in claims data.

Thank you again for your careful consideration of these matters. If you have any questions, please contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James N. Elliott, M.D.
Adam Kane
Will Daniel, Deputy Director

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October 23, 2019

Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini:

The purpose of this letter is to provide CareFirst's comments on the HSCRC Staff's "Draft Recommendation for the Medicare Performance Adjustment (MPA) Policy for Rate Year 2022".

CareFirst supports the Staff's draft MPA recommendation that is an integral part of our waiver model and agreement with CMMI. This policy holds hospitals at risk for Medicare performance with respect to total cost of care. It allows Maryland Hospitals to meet their Medicare at-risk levels- required for our quality programs exemptions- while demonstrating performance improvement under our current model.

We understand the current use of improvement as the basis of performance evaluation under the MPA but urge the Commission to move towards incorporating attainment into this model. We also encourage the Commission to increase the maximum reward and penalty under the MPA to levels that are higher than the current +/- 1.0%. The results from payment reform models nationally (such as the Medicare Shared Savings Program) show that hospital-led and physician-affiliated Accountable Care Organizations facing more substantial levels of upside and downside risk consistently generate much larger cost savings, than those facing little or no risk.

Thank you for this opportunity to comment on the MPA Policy. We support this effort as it should help to encourage hospitals to become more efficient, reduce potentially avoidable utilization and ultimately reduce total cost of care.

Sincerely,

Maria Harris Tildon

Cc: Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
Stacia Cohen
John Colmers
James N. Elliott, M.D.
Adam Kane
Katie Wunderlich, Executive Director

Kevin W. Sowers, MSN, RN, FAAN

President
Johns Hopkins Health System

Executive Vice President
Johns Hopkins Medicine

October 23, 2019

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

Dear Ms. Wunderlich,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the draft recommendation for the Medicare Performance Adjustment (MPA) Policy for Rate Year 2022. JHHS appreciates the HSCRC staff's approach to propose only limited changes to the MPA at this time. The current attribution methodology needs to be refined in order to align with the Assessment Principles originally outlined in the development of the MPA. These principles specifically noted that the policy should, amongst other things, "monitor and minimize fluctuation over time" and "hospitals should have the ability to track their progress during the performance period and implement initiatives that affect their performance." A sound attribution methodology is critical to the success of the MPA and JHHS appreciates the willingness of the HSCRC staff and the TCOC workgroup to do a comprehensive review MPA policy for RY 2023. Taking a conservative approach to the MPA until this review is complete is both responsible and appropriate.

As part of the comprehensive review process, JHHS would appreciate the incorporation of a comprehensive analysis of the hospitals' spend per attributed beneficiary. The analysis should include a better understanding by both the HSCRC and hospitals of the intersection between attributed beneficiaries and utilization of services as well as the changes in beneficiary yields by attributed hospital year over year. The assessment would help inform the attribution methodology and ensure that hospitals can reasonably impact the total cost of care benchmark.

Additionally, as the HSCRC considers an attainment methodology under this review process, the inclusion of socio-economic risk factors must also be considered. Robust risk adjustment better reflects the resources needed to deliver quality care to high risk beneficiaries.

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JHHS requests additional clarification regarding the inclusion of the MDPCP Care Management Fees and Comprehensive Primary Care Payments in the MPA policy. JHHS recognizes that the TCOC Agreement requires the MDPCP to be included in the MPA policy; however, on June 13, 2018 the Commission issued a Resolution recognizing that "hospitals should not be held financially liable for the cost of the MDPCP Care Management Fees." At the time, there was discussion of the potential adoption of state efforts that would potentially mitigate the impact of the MDPCP on hospital performance under the TCOC policies. Any updates regarding state efforts to moderate the impact of the MDPCP would assist in the future review of the MPA policy.

JHHS also appreciates the staff recommendation to hold the revenue at risk to 1%. Again maintaining stability is critical until a comprehensive review of the MPA is complete. The revenue at risk should not be increased without confirmation that the MPA policy is functioning as intended, which is to bring direct financial accountability to individual hospitals based on the total cost of care.

Thank you to the efforts of the HSCRC staff who have been thoughtful and transparent in their efforts around this complex issue and for their commitment to improve the MPA policy. We look forward to continued collaboration in our mutual efforts to reduce Total Cost of Care.

Sincerely,

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

Peter Hill, M.D., M.S., F.A.C.E.P.
Senior Vice President, Medical Affairs, Johns Hopkins Health System
Associate Professor of Emergency Medicine

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
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John M. Colmers
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Adam Kane

Anne Arundel Medical Center | DOCTORS COMMUNITY HEALTH SYSTEM

October 23, 2019

Chris Peterson
Principle Deputy Director, Payment Reform and Provider Alignment
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Peterson:

On behalf of Anne Arundel Medical Center (AAMC) and Doctors Community Health System (DCHS), thank you for the opportunity to comment on the proposed Medicare Performance Adjustment (MPA) RY2022 policy. We recognize the importance of creating local accountability for total cost of care (TCOC) in order to meet the TCOC Model goals and appreciate the Staff's commitment to refining the MPA. We strongly urge the Staff and Commission to consider the interactions between the MPA and Care Transformation Initiatives (CTIs), particularly the double rewards and penalties hospitals may receive. As hospitals manage quality-based metrics, CTIs, the Maryland Primary Care Program (MDPCP), and many other initiatives that require upfront investment, we must prioritize areas where we have the biggest impact. The HSCRC should ensure its policies work congruently and that incentives are aligned appropriately with the highest priority areas.

In addition to the overarching concern about the MPA's interaction with other policies, we have three main issues with this draft recommendation:

(1) Since the MPA's inception, Staff has delayed incorporating attainment into the methodology. We strongly recommend the Commission **establish a clear and expedited timeline for incorporating attainment into the methodology, prior to the RY2022 performance period**. The MPA's improvement-only methodology does not acknowledge the substantial gains made to date by certain hospitals, nor does it recognize hospitals' varying degrees of cost reduction opportunity. To pressure hospitals that are already efficient to continue to decrease costs at a rate below the national growth rate threatens both quality and appropriate utilization of care for beneficiaries. The MPA methodology must include attainment so that high performing hospitals with appropriate growth are not unjustly penalized for achieving significant TCOC savings prior to the MPA. This is essential and aligns with other existing state and national policies that consider both improvement and attainment. Furthermore, until this key methodology change is made,

it is unreasonable to increase the amount of revenue at-risk above 1% of Medicare revenue.

(2) Similarly, Staff has delayed incorporating appropriate risk-adjustment into the methodology. We recommend using Hierarchical Condition Category (HCC) coding, as it is the most widely accepted risk-adjustment methodology for value-based programs, including the MDPCP, Accountable Care Organizations (ACO), and Medicare Advantage plans. The MPA should **include full risk-adjustment** to account for the various population types that hospitals serve.

(3) The Maryland Primary Care Program (MDPCP) may take years to achieve significant financial results, so there are short-term consequences for including the prospective care management funding (CMF) and comprehensive primary care payments (CPCP) in the MPA. Staff suggest that this impact will be diminished by including MDPCP funding in both the base year and performance year. However, as practices advance in the program, their amount of MDPCP funding per beneficiary almost doubles, thereby increasing the total cost of care from base year to performance year substantially. This increase is appropriate and necessary to manage practices' beneficiaries. Yet, under the MPA, this increase is accounted for in TCOC, thereby penalizing hospitals associated with the highest performing practices. We encourage Staff to **conduct an analysis on the projected impact of including MDPCP funding and consider ways to mitigate this impact** in the MPA results.

Thank you again for the opportunity to provide comments. Please let us know if we can be of assistance.

Sincerely,

Paul Grenaldo
President, DCHS

Bob Reilly
Chief Financial Officer, AAMC

Cc: Victoria Bayless, Chief Executive Officer, Luminis Health
Nelson J. Sabatini, Chairman, HSCRC
Katie Wunderlich, Executive Director, HSCRC

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Finance Shared Services

October 23, 2019

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

Dear Katie:

The University of Maryland Medical System (UMMS) appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendations on the Medicare Performance Adjustment (MPA) Rate Year (RY) 2022 Policy. UMMS supports the HSCRC's decision to make minimal changes for RY2022. At this time, we recommend that the HSCRC take the following actions to address policy overlap and provide hospitals with better opportunity to enhance total cost of care (TCOC) performance:

1. Monitor the interaction between the MPA RY2022 Policy and other policies to address payment overlap and any unintended consequences.

2. Further evaluate the stability of the attribution methodology and its plausibility in future years.

3. Share data with hospitals that will help determine additional TCOC drivers.

Address policy and payment overlap

The "Traditional MPA" was one of the initial policies the HSCRC enacted under the Total Cost of Care Agreement ("Waiver") to ensure hospital accountability in meeting Medicare cost reduction requirements. Since then, the MPA Framework has been introduced as an additional means to ensure the Waiver financial tests are met. While the methodology for calculating savings through hospital care transformation interventions (CTIs) and offsetting payments is still in development and the impacts yet to be understood, UMMS recommends that the HSCRC closely monitor the overlap between hospital penalty and reward payments under both the Traditional MPA and MPA Framework.

The introduction of CTIs may introduce unintended consequences and warrant the need for policy amendments. An example would be the scenario in which a beneficiary presents on more than one hospital CTI intervention and MPA attribution list. Such a scenario may cause confusion among hospitals in terms of patient accountability. It may also create confusion and cause patient engagement issues among beneficiaries who receive outreach from multiple hospital care management teams.

In addition to the overlap between the Traditional MPA and MPA Framework, HSCRC should evaluate the interactions between other payment methodologies and policies. HSCRC currently has several payment methodologies in place that are influenced by the Medicare population, including the Readmission Reduction Incentive Program (RRIP), Maryland Hospital Acquired Conditions (MHAC) and Potentially Avoidable Utilization (PAU).

Further evaluate the stability of the attribution methodology and its plausibility

The attribution methodology was modified in RY2021 to better link hospitals to beneficiaries they could likely impact through their relationships with primary care providers. Not changing the attribution methodology for RY2022 will provide HSCRC with an opportunity to analyze the year-over-year stability of attributed beneficiaries as a result of the linkages.

UMMS is concerned with the HSCRC analysis presented in the Draft Integrated Efficiency Recommendations, which demonstrated the geographic and MPA attributions yielded similar results. The correlation between the two methodologies calls into question the premise of the policy. If sound evidence does not exist to be able to correlate the attribution methodology, specific hospital efforts, and the rewards/penalties year-over-year, HSCRC should consider having the Traditional MPA sunset and focus on promoting policies where a quantifiable impact on TCOC can be shown as a result of hospital efforts (e.g. care transformation through CTI participation).

Share data with hospitals that will help determine additional drivers of total cost of care (TCOC)

Currently, hospitals do not receive detailed information on attributed beneficiaries to help determine additional TCOC drivers that can be impacted to enhance performance. UMMS recommends that the HSCRC perform additional analyses to evaluate the influence of other factors on TCOC, such as changes to hospital rates, volume decreases and movement of beneficiaries from regulated to unregulated settings. These analyses will help inform the HSCRC and hospitals on areas of opportunity where hospitals would be able to affect performance.

Conclusion

UMMS applauds the HSCRC for demonstrating progress in developing policies that will have a positive impact on Maryland TCOC performance. As the HSCRC continues to develop alternate solutions to ensure the requirements of the Waiver are met, the HSCRC should strive to conduct robust evaluations to reduce the potential for negative unintended consequences.

UMMS looks forward to continued collaboration with the HSCRC. If you have any questions about the proposed recommendations, please do not hesitate to contact me.

Sincerely,

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

cc: Nelson J. Sabatini, Chairman
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John Ashworth, UMMS CEO
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MedStar Health

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October 23, 2019

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
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Dear Katie:

On behalf of MedStar Health Inc., we are commenting on the HSCRC's Medicare Performance Adjustment (MPA) Draft Staff recommendation. As a participant on the HSCRC's Total Cost of Care Workgroup, we appreciate all the work to-date by HSCRC staff and others and look forward to continued collaboration between all the members.

We support Maryland Hospital Association's comment letter, but want to emphasize and add a few important points.

(1) We don't want to understate the need for industry-wide data analysis on current performance to understand what is driving change in total cost of care. We would request that the TCOC workgroup or subset be used as the venue for review of this data, which would allow stakeholders with a variety of backgrounds/knowledge to provide insights. We believe this work is critical as it will better inform future policies, including the attribution methodology.

(2) We believe that attribution methodology needs to have alignment in the future with revenue at risk. Since results are applied to Hospital's Medicare Revenue, a large hospital could perform well, but have a small population attributed to them and receive a higher payment because of their hospital revenue base. The same could be said for a small hospital that performs well on a large population attributed to them and receive a lower payment because of their hospital revenue base.

(3) Further understanding of the intersection between Care Transition Interventions (CTI), MPA, and geographical attribution in the efficiency draft and ensuring there is an alignment without competing direction/incentives. This would include striving for simplicity and therefore, developing quality metrics through CTI where appropriate, rather than included in the MPA.

We appreciate the opportunity to comment. Please reach out to me if you have any questions.

Sincerely,

Kathy Talbot
Vice President, Rates and Reimbursement
MedStar Health

cc: Nelson Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Adam Kane
Victoria W. Bayless
James Elliott, M.D.
Stacia Cohen, RN
John M. Colmers

Draft Recommendation for the Maximum Revenue Guardrail for Maryland Hospital Quality Programs

Maximum Revenue Quality Guardrail

- The maximum penalty quality guardrail protects against unforeseen financial adjustments in Maryland pay-for-performance programs.
- This years policy differs from previous iterations, in that staff is asking Commission approval to permanently adopt the previously used formula for calculating the guardrail until otherwise directed, and eliminate the need for an annual policy.
  - For reference, the RY 2020 max guardrail is 3.40 percent of total revenue; staff do not anticipate large shifts in this calculation year over year.
  - RY 2020: Maximum penalty for one hospital is estimates to be 2.00 percent of total hospital revenue (2.47 percent of IP revenue).
- Policy recommends the maximum penalty one hospital could receive in RY 2021 and beyond across QBR, MHAC, RRIP, and net PAU savings.

Draft Recommendation

- For RY 2021 and beyond, the maximum penalty guardrail should be set using the following formula:
  - Percent of Medicare revenue at-risk for quality multiplied by the percent of Maryland revenue attributable to inpatient services
- Each fiscal year staff will provide the Commissioners in a formal report the calculated maximum penalty guardrail based on the calculation described above.

Potential Revenue at Risk MD vs. Nation 2014-2021

Maryland - Potential Inpatient Revenue at Risk absolute values

% of MD All-Payer Inpatient Revenue	RY 2014	RY 2015	RY 2016	RY 2017	RY 2018	RY 2019	RY 2020	RY 2021
MHAC	2.0%	3.0%	4.0%	3.0%	3.0%	2.00%	2.00%	2.00%
RRIP			0.5%	2.0%	2.0%	2.00%	2.00%	2.00%
QBR	0.5%	0.5%	1.0%	2.0%	2.0%	2.00%	2.00%	2.00%
Subtotal	**2.5%**	**3.5%**	**5.5%**	**7.0%**	**7.0%**	**6.0%**	**6.0%**	**6.0%**
PAU Savings	0.41%	0.49%	0.46%	3.69%	1.42%	1.29%	1.13%	*1.13%*
Medicare Performance Adjustment							0.24%	*0.48%*
MD Aggregate Maximum At Risk	**2.91%**	**3.99%**	**6.0%**	**10.7%**	**8.4%**	**7.3%**	**7.4%**	**7.6%**

PAU Savings and MPA are estimated for RY 2021

National - Potential Inpatient Revenue at Risk absolute values

% of National Medicare Inpatient Revenue	FFY 2014	FFY 2015	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020	FFY2021
HAC		1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Readmissions	2.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
VBP	1.3%	1.5%	1.8%	2.0%	2.0%	2.0%	2.0%	2.0%
Medicare Aggregate Maximum At Risk	**3.25%**	**5.5%**	**5.8%**	**6.0%**	**6.0%**	**6.0%**	**6.0%**	**6.0%**
Annual MD-US Difference	**-0.34%**	**-1.51%**	**0.21%**	**4.69%**	**2.42%**	**1.29%**	**1.37%**	**1.61%**

Realized Revenue at Risk MD vs. Nation 2014-2020

Maryland - Realized Inpatient Revenue at Risk

% of MD All-Payer Inpatient Revenue	RY 2014	RY 2015	RY 2016	RY 2017	RY 2018	RY 2019	RY 2020
MHAC	0.22%	0.11%	0.18%	0.40%	0.50%	0.25%	0.33%
RRIP			0.15%	0.57%	0.61%	0.58%	0.67%
QBR	0.11%	0.14%	0.30%	0.26%	0.59%	0.64%	0.6034%
Subtotal	0.34%	0.25%	0.63%	1.23%	1.70%	1.47%	1.60%
PAU Savings	0.29%	0.34%	0.30%	1.63%	0.57%	0.61%	0.62%
Medicare Performance Adjustment*							0.18%
MD Aggregate Maximum At Risk	**0.62%**	**0.59%**	**0.93%**	**2.86%**	**2.26%**	**2.08%**	**2.40%**

*Laurel's RY 2020 MPA is not included in the Aggregate at Risk calculations due to transition to FMF

National - Realized Inpatient Revenue at Risk absolute values

% of National Medicare Inpatient Reven	FFY	FFY	FFY2016	FFY2017*	FFY2018*	FFY2019*	FFY2020*
HAC (penalty only)		0.22%	0.23%	0.24%	0.24%	0.25%	*0.25%*
Readmits (penalty only)	0.28%	0.52%	0.51%	0.61%	0.56%	0.57%	*0.57%*
VBP	0.20%	0.24%	0.40%	0.51%	0.53%	0.51%	*0.51%*
Medicare Aggregate Maximum At Risk	**0.47%**	**0.97%**	**1.14%**	**1.36%**	**1.33%**	**1.34%**	***1.34%***
Annual MD-US Difference	**0.15%**	**-0.38%**	**-0.20%**	**1.50%**	**0.93%**	**0.74%**	***1.06%***

*HSCRC estimated CMS numbers based on publicly available files and this is subject to change. FFY 2020 uses FFY 2019 estimates.

Draft Recommendation for the Maximum Revenue Guardrail for Maryland Hospital Quality Programs

November 13, 2019

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

FAX: (410) 358-6217

This document contains the draft staff recommendations for updating the Maximum Guardrail Policy. Comments on the draft policy may be submitted by email to hscrc.quality@maryland.gov and are due by Wednesday, November 27, 2019.

LIST OF ABBREVIATIONS

CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFY	Federal fiscal year
FY/RY	State fiscal year/Rate year (July-June), which signifies the timeframe in which the rewards and/or penalties would be assessed. State rate year and fiscal year are used interchangeably.
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital-Acquired Conditions Program
PAU	Potentially avoidable utilization
PQI	Prevention quality indicator
QBR	Quality-based reimbursement
RRIP	Readmissions Reduction Incentive Program
VBP	Value-based purchasing

INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) performance-based payment methodologies are important policy tools that provide strong incentives for hospitals to improve their quality performance over time. These performance-based payment programs hold amounts of hospital revenue at-risk directly related to specified performance benchmarks. Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system, special considerations were given to Maryland, including exemption from the federal Medicare quality-based programs. Instead, the HSCRC implements various Maryland-specific quality-based payment programs, which are discussed in further detail in the background section of this report.

Maryland entered into an All-Payer Model Agreement with the Centers for Medicare & Medicaid Services (CMS) on January 1, 2014 and entered into a Total Cost of Care Model Agreement on January 1, 2019. One of the requirements under both agreements is that the proportion of hospital revenue that is held at-risk under Maryland's quality-based payment programs must be greater than or equal to the proportion that is held at-risk under national Medicare quality programs. Given Maryland's programs are fundamentally different from the nation in how revenue adjustments are determined (e.g., most Maryland programs have prospective incremental revenue adjustment scales with both rewards and penalties), the at-risk is measured both as potential risk (i.e., highest maximum penalty per program) and realized risk (absolute average of adjustments per program).

The purpose of this report is to make a recommendation for the maximum amount one hospital can be penalized during a rate year, otherwise known as the maximum revenue guardrail. The recommendations for the maximum penalties and rewards for each quality program are set forth in the individual policies rather than in an aggregate at-risk policy. In prior iterations of this policy, staff has recommended an overall guardrail amount based on the same calculation, i.e. percent at-risk under Medicare multiplied by the percent of Maryland revenue attributable to inpatient services. Moving forward staff proposes to use this formula unless otherwise directed, thereby eliminating the need for an annual policy recommendation. Staff will continue to provide Commissioners the calculated maximum penalty guardrail each fiscal year in a formal report.

BACKGROUND

1. Federal Quality Programs

In developing the recommendation for the maximum revenue guardrail, the staff first analyzed the aggregate revenue at-risk for Maryland's quality-based payment programs compared to the amount at-risk for the following national Medicare quality programs:

- The Medicare Hospital Readmissions Reduction Program (HRRP), which reduces payments to inpatient prospective payment system hospitals with readmissions in

excess of peer group.[1]

- The Medicare Hospital-Acquired Condition Reduction Program (HACRP), which ranks hospitals according to performance on a list of hospital-acquired conditions and reduces Medicare payments to the hospitals in the lowest performing quartile.[2]
- The Medicare Value Based Purchasing (VBP) Program, which adjusts hospitals' payments based on their performance on the following four hospital quality domains: clinical care, patient experience of care, safety, and efficiency.[3]

2. Maryland's Quality-Based Programs

As discussed in the introduction section of this report, Maryland is exempt from the federal Medicare hospital quality programs. Instead, Maryland implements the following quality-based payment programs:

- The Quality Based Reimbursement (QBR) program employs measures in several domains, including clinical care, patient experience, and safety. Starting in FY 2019, the QBR program revenue adjustments were linked to a preset scale instead of relatively ranking hospitals, which was designed to provide hospitals with more predictable revenue adjustments. For additional discussion on the QBR program, please refer to the RY 2021 QBR policy posted to the HSCRC website.

- The Maryland Hospital Acquired Conditions (MHAC) program measures hospital performance using 3M's potentially preventable complications. HSCRC calculates observed-to-expected ratios for each complication and compares them with statewide benchmarks and thresholds. As with the QBR program, the MHAC program uses a pre-set scale to provide hospitals with the ability to prospectively estimate revenue adjustments. For additional discussion on the MHAC program, please refer to the RY 2021 MHAC Policy posted to the HSCRC website.

- The Readmission Reduction Incentive Program (RRIP) establishes a readmissions reduction target, an attainment target, and a scale for rewards/penalties for hospitals. The statewide minimum improvement target is established to ensure the Medicare readmission rate remains below the national Medicare readmission rate. For additional discussion on the RRIP program, please refer to the RY 2021 Readmission policy posted to the HSCRC website.

- The Potentially Avoidable Utilization (PAU) Savings Program reduces each hospital's approved revenues prospectively based on performance associated with avoidable

[1] For more information on the Medicare Hospital Readmissions Reduction Program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction- Program.html.

[2] For more information on the Medicare Hospital-Acquired Condition Reduction program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction- Program.html.

[3] For information on the Medicare VBP program, see https://www.medicare.gov/hospitalcompare/Data/hospital- vbp.html.

admissions and readmissions. This adjustment is tied to hospital inpatient revenues prospectively as part of the annual update factor. For additional discussion on PAU Savings, please refer to the RY 2020 Update Factor posted to the HSCRC website.

ASSESSMENT

In order to develop the maximum revenue at-risk guardrail for quality programs, HSCRC staff considered CMS relevant policies, conducted analyses, and solicited input from the Performance Measurement Workgroup.[4]

Maximum Revenue at-risk Hospital Guardrail

As the HSCRC increases the maximum revenue adjustments statewide, the potential for a particular hospital to receive significant revenue reductions has raised concerns that such penalties may generate unmanageable financial risk. Similar to the risk corridors in other VBP programs, a maximum penalty guardrail may be necessary to mitigate the detrimental financial impact of unforeseen large adjustments in Maryland programs. Given the increases in risk levels in other programs, a hospital-specific guardrail will provide better protection than a statewide limit. Moving forward staff propose using the inpatient Medicare aggregate amount at-risk total as the benchmark to calculate the hospital maximum penalty guardrail (i.e., percent at-risk under Medicare multiplied by the percent of Maryland revenue attributable to inpatient services). This maximum revenue guardrail will apply to QBR, MHAC, RRIP, and net PAU Savings. The maximum guardrail calculation will not include the Medicare Performance Adjustment (MPA), as this is payer specific adjustment and if the MPA adjustment caused a hospital to exceed the quality guardrail that capping of revenue adjustment could reduce adjustments for other payers. Furthermore, to date no hospital penalties have reached the maximum revenue guardrail, and the MPA when expressed as a percent of all-payer revenue is relatively small. For reference, in RY 2020 the quality guardrail was 3.40 percent of total hospital revenue and the highest negative revenue adjustment was a 2.00 percent total revenue reduction or 2.47 percent of inpatient revenue (with the MPA this hospital maintains the highest reduction at 2.03 percent of total revenue). See Appendix B for hospital-specific net revenue adjustments across quality programs included in the maximum guardrail calculation.

[4] For more information on the Performance Measurement Workgroup, see https://hscrc.maryland.gov/Pages/hscrc-workgroup-performance-measurement.aspx

RECOMMENDATION

1. For RY 2021 and beyond, the maximum penalty guardrail should be set using the following formula:

   Percent of Medicare revenue at-risk for quality multiplied by the percent of Maryland revenue attributable to inpatient services[5]

2. Each fiscal year staff will provide the Commissioners in a formal report the calculated maximum penalty guardrail based on the calculation described above.

[5] The percent inpatient is determined based on data from historical time period

Appendix A. Comparison of the Aggregate Revenue At-Risk for Maryland and Medicare Quality Programs

After discussions with CMS, HSCRC staff performed analyses of both "potential" and "realized" revenue at-risk. Potential revenue at-risk refers to the maximum amount of revenue that is at-risk in the measurement year. Realized risk refers to the actual amounts imposed by the programs. The comparison with the national amounts is calculated on a cumulative basis. Exhibit 1 compares the potential amount of revenue at-risk in Maryland with the amount at-risk in the national programs. The difference between the national Medicare and Maryland all-payer annual amounts are summed after each year's experience to compare the annual difference.

The top half of Exhibit 1 displays the percentage of potential inpatient revenue at-risk in Maryland for all payers for each of Maryland's quality-based payment programs for RYs 2014 through 2021. The bottom half of the figure displays the percentage of potential national Medicare inpatient revenue at-risk for quality-based payment programs for FFYs 2014 through 2021. These potential at-risk numbers are the absolute values of the maximum penalty or reward.

Exhibit 1. Potential Revenue at-risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2021

Maryland - Potential Inpatient Revenue at Risk absolute values

% of MD All-Payer Inpatient Revenue	RY 2014	RY 2015	RY 2016	RY 2017	RY 2018	RY 2019	RY 2020	RY 2021
MHAC	2.0%	3.0%	4.0%	3.0%	3.0%	2.00%	2.00%	2.00%
RRIP			0.5%	2.0%	2.0%	2.00%	2.00%	2.00%
QBR	0.5%	0.5%	1.0%	2.0%	2.0%	2.00%	2.00%	2.00%
Subtotal	**2.5%**	**3.5%**	**5.5%**	**7.0%**	**7.0%**	**6.0%**	**6.0%**	**6.0%**
PAU Savings	0.41%	0.49%	0.46%	3.69%	1.42%	1.29%	1.13%	*1.13%*
Medicare Performance Adjustment							0.24%	*0.48%*
MD Aggregate Maximum At Risk	**2.91%**	**3.99%**	**6.0%**	**10.7%**	**8.4%**	**7.3%**	**7.4%**	**7.6%**

PAU Savings and MPA are estimated for RY 2021

National - Potential Inpatient Revenue at Risk absolute values

% of National Medicare Inpatient Revenue	FFY 2014	FFY 2015	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020	FFY2021
HAC		1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Readmissions	2.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
VBP	1.3%	1.5%	1.8%	2.0%	2.0%	2.0%	2.0%	2.0%
Medicare Aggregate Maximum At Risk	**3.25%**	**5.5%**	**5.8%**	**6.0%**	**6.0%**	**6.0%**	**6.0%**	**6.0%**
Annual MD-US Difference	**-0.34%**	**-1.51%**	**0.21%**	**4.69%**	**2.42%**	**1.29%**	**1.37%**	**1.61%**

Exhibit 2. Realized Revenue at-risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2020

Maryland - Realized Inpatient Revenue at Risk

% of MD All-Payer Inpatient Revenue	RY 2014	RY 2015	RY 2016	RY 2017	RY 2018	RY 2019	RY 2020
MHAC	0.22%	0.11%	0.18%	0.40%	0.50%	0.25%	0.33%
RRIP			0.15%	0.57%	0.61%	0.58%	0.67%
QBR	0.11%	0.14%	0.30%	0.26%	0.59%	0.64%	0.6034%
Subtotal	0.34%	0.25%	0.63%	1.23%	1.70%	1.47%	1.60%
PAU Savings	0.29%	0.34%	0.30%	1.63%	0.57%	0.61%	0.62%
Medicare Performance Adjustment*							0.18%
MD Aggregate Maximum At Risk	**0.62%**	**0.59%**	**0.93%**	**2.86%**	**2.26%**	**2.08%**	**2.40%**

*Laurel's RY 2020 MPA is not included in the Aggregate at Risk calculations due to transition to FMF

National - Realized Inpatient Revenue at Risk absolute values

% of National Medicare Inpatient Reven	FFY	FFY	FFY2016	FFY2017*	FFY2018*	FFY2019*	FFY2020*
HAC (penalty only)		0.22%	0.23%	0.24%	0.24%	0.25%	*0.25%*
Readmits (penalty only)	0.28%	0.52%	0.51%	0.61%	0.56%	0.57%	*0.57%*
VBP	0.20%	0.24%	0.40%	0.51%	0.53%	0.51%	*0.51%*
Medicare Aggregate Maximum At Risk	**0.47%**	**0.97%**	**1.14%**	**1.36%**	**1.33%**	**1.34%**	***1.34%***
Annual MD-US Difference	**0.15%**	**-0.38%**	**-0.20%**	**1.50%**	**0.93%**	**0.74%**	***1.06%***

*HSCRC estimated CMS numbers based on publicly available files and this is subject to change. FFY 2020 uses FFY 2019 estimates.

In summary, staff estimate that Maryland outperformed the national programs in the potential and realized aggregate payment amounts for RY 2020. Maryland hospitals continued to improve their performance in reducing complications and readmissions. However, further reductions in revenue associated with PAU will be important for financial success under the Total Cost of Care model. Staff will continue to discuss the appropriate amounts for performance-based payment programs with the workgroups and other stakeholders.

Appendix B. Consolidated Net Revenue Adjustments for All Quality-Based Payment Programs for Rate Year 2020, by Hospital

Hospital ID	Hospital Name	RY2019 Total Permanent Revenue	MHAC % Inpatient	MHAC $	RRIP % Inpatient	RRIP $	QBR % Inpatient RY2020	QBR $ RY2020	PAU Savings % Inpatient	PAU Savings $ (net)	Net Dollar Impact	Total Impact % Total Revenue
		A									B	C=B/A
210064	LEVINDALE	$59,867,175	0.29%	$166,142	1.00%	$575,107			-0.19%	-$107,761	$633,488	1.06%
210058	UMROI	$120,383,835	0.44%	$321,557	1.00%	$723,503			0.00%	$0	$1,045,060	0.87%
210030	CHESTERTOWN	$53,535,766	0.27%	$47,627	1.00%	$178,599	0.62%	$110,732	-0.57%	-$101,718	$235,240	0.44%
210061	ATLANTIC	$107,225,177	0.38%	$139,521	1.00%	$369,319	0.54%	$199,432	-0.78%	-$289,508	$418,764	0.39%
210005	FREDERICK	$345,157,181	0.33%	$775,553	1.00%	$2,326,658	-0.23%	-$535,131	-0.55%	-$1,277,082	$1,289,998	0.37%
210051	DOCTORS	$247,543,706	0.62%	$877,920	1.00%	$1,410,943	-0.16%	-$225,751	-0.82%	-$1,163,455	$899,657	0.36%
210010	DORCHESTER	$46,645,024	0.62%	$140,957	1.00%	$226,538	-0.37%	-$83,819	-0.74%	-$167,922	$115,754	0.25%
210037	EASTON	$214,261,973	0.29%	$298,945	1.00%	$1,034,811	-0.43%	-$444,969	-0.41%	-$428,524	$460,263	0.21%
210035	CHARLES REGIONAL	$153,867,989	0.38%	$290,625	0.41%	$315,413	0.07%	$53,851	-0.70%	-$538,538	$121,351	0.08%
210063	UM ST. JOSEPH	$375,488,512	0.20%	$446,800	0.06%	$134,040	0.27%	$603,180	-0.40%	-$901,172	$282,848	0.08%
210043	BWMC	$432,711,982	0.11%	$278,019	0.87%	$2,176,891	-0.33%	-$825,717	-0.67%	-$1,687,577	-$58,384	-0.01%
210008	MERCY	$536,545,951	0.16%	$352,321	0.63%	$1,426,900	-0.46%	-$1,041,863	-0.47%	-$1,073,092	-$335,734	-0.06%
210040	NORTHWEST	$262,648,422	0.38%	$524,053	1.00%	$1,387,199	-0.71%	-$984,911	-0.81%	-$1,129,388	-$203,047	-0.08%
210057	SHADY GROVE	$436,099,746	0.00%	$0	0.90%	$2,265,734	-0.60%	-$1,510,489	-0.47%	-$1,177,469	-$422,224	-0.10%
210039	CALVERT	$146,163,780	0.40%	$268,448	-0.80%	-$536,896	0.86%	$577,163	-0.68%	-$453,108	-$144,393	-0.10%
210013	BON SECOURS	$112,784,456	0.22%	$143,030	1.00%	$643,633	-0.63%	-$405,489	-0.84%	-$541,365	-$160,191	-0.14%
210028	ST. MARY	$185,289,624	0.58%	$457,259	0.29%	$229,509	-0.41%	-$324,478	-0.80%	-$629,985	-$267,695	-0.14%
210012	SINAI	$764,180,996	0.13%	$533,090	1.00%	$3,998,177	-0.98%	-$3,918,213	-0.46%	-$1,834,034	-$1,220,980	-0.16%
210006	HARFORD	$104,913,929	0.44%	$240,805	-0.13%	-$70,436	0.28%	$151,707	-0.91%	-$493,095	-$171,019	-0.16%
210060	FT. WASH.	$50,264,400	0.78%	$154,703	1.00%	$198,904	-1.16%	-$230,728	-1.06%	-$211,110	-$88,231	-0.18%
210027	W. Maryland	$325,414,055	0.16%	$263,608	0.37%	$627,009	-0.46%	-$779,525	-0.56%	-$943,701	-$832,609	-0.26%
210044	GBMC	$460,191,024	-0.18%	-$422,733	0.46%	$1,093,822	-0.36%	-$856,034	-0.46%	-$1,104,458	-$1,289,403	-0.28%

Hospital ID	Hospital Name	RY2019 Total Permanent Revenue	MHAC % Inpatient	MHAC $	RRIP % Inpatient	RRIP $	QBR % Inpatient RY2020	QBR $ RY2020	PAU Savings % Inpatient	PAU Savings $ (net)	Net Dollar Impact	Total Impact % Total Revenue
		A									B	C=B/A
210018	MONTGOMERY GENERAL	$176,329,979	0.49%	$414,195	0.12%	$101,666	-0.51%	-$432,080	-0.71%	-$599,522	-$515,741	-0.29%
210023	ANNE ARUNDEL	$617,272,369	0.56%	$1,636,358	-0.42%	-$1,237,087	-0.25%	-$736,361	-0.50%	-$1,481,454	-$1,818,544	-0.29%
210045	MCCREADY	$14,249,481			-0.75%	-$17,024			-1.13%	-$25,649	-$42,673	-0.30%
210009	JOHNS HOPKINS	$2,422,312,771	0.33%	$4,855,625	0.07%	$1,019,681	-0.57%	-$8,303,118	-0.37%	-$5,329,088	-$7,756,900	-0.32%
210038	UMMC MIDTOWN	$223,331,473	0.44%	$493,960	0.20%	$222,282	-0.53%	-$589,047	-0.78%	-$870,993	-$743,798	-0.33%
210016	WASHINGTON ADVENTIST	$275,917,609	0.18%	$291,906	0.17%	$279,135	-0.35%	-$574,690	-0.59%	-$965,712	-$969,361	-0.35%
210049	UPPER CHESAPEAKE	$311,867,570	0.49%	$629,132	-0.61%	-$784,985	0.14%	$180,161	-0.87%	-$1,122,723	-$1,098,415	-0.35%
210048	HOWARD	$299,669,481	0.33%	$609,570	-0.30%	-$548,613	-0.20%	-$365,742	-0.54%	-$988,909	-$1,293,694	-0.43%
210017	GARRETT	$60,636,352	0.80%	$189,715	-0.91%	-$215,801	-0.66%	-$156,515	-0.61%	-$145,527	-$328,128	-0.54%
210029	HOPKINS BAYVIEW	$671,715,144	0.40%	$1,466,431	-0.10%	-$366,608	-0.91%	-$3,336,129	-0.59%	-$2,149,488	-$4,385,794	-0.65%
210015	FRANKLIN SQUARE	$545,849,179	-0.13%	-$409,198	-0.80%	-$2,455,188	0.38%	$1,166,214	-0.73%	-$2,237,982	-$3,936,154	-0.72%
210062	S. MARYLAND	$270,197,319	-0.49%	-$792,430	0.77%	$1,248,076	-0.81%	-$1,312,912	-0.68%	-$1,107,809	-$1,965,075	-0.73%
210011	ST. AGNES	$414,960,504	0.16%	$371,401	0.08%	$191,006	-0.84%	-$2,005,565	-0.73%	-$1,742,834	-$3,185,992	-0.77%
210033	CARROLL	$227,083,963	0.22%	$311,760	-0.48%	-$673,401	-0.24%	-$336,700	-0.76%	-$1,067,295	-$1,765,636	-0.78%
210024	UNION MEMORIAL	$414,187,673	0.00%	$0	0.66%	$1,604,834	-1.39%	-$3,379,878	-0.61%	-$1,491,076	-$3,266,120	-0.79%
210002	UMMS	$1,728,168,161	0.27%	$3,209,797	-0.03%	-$361,102	-1.09%	-$13,120,045	-0.30%	-$3,629,153	-$13,900,503	-0.80%
210065	HOLY CROSS GERMANTOWN	$103,680,716	0.67%	$393,749	-0.81%	-$478,405	-0.82%	-$484,311	-0.58%	-$342,146	-$911,113	-0.88%
210019	PENINSULA	$440,472,737	-0.04%	-$110,768	-0.86%	-$2,143,363	-0.24%	-$598,148	-0.55%	-$1,365,465	-$4,217,744	-0.96%

Hospital ID	Hospital Name	RY2019 Total Permanent Revenue	MHAC % Inpatient	MHAC $	RRIP % Inpatient	RRIP $	QBR % Inpatient RY2020	QBR $ RY2020	PAU Savings % Inpatient	PAU Savings $ (net)	Net Dollar Impact	Total Impact % Total Revenue
		A									B	C=B/A
210022	SUBURBAN	$323,715,549	0.38%	$789,383	-0.44%	-$919,399	-1.13%	-$2,361,183	-0.43%	-$906,404	-$3,397,603	-1.05%
210056	GOOD SAM	$258,484,446	0.00%	$0	-0.39%	-$572,916	-0.68%	-$998,931	-0.83%	-$1,214,877	-$2,786,724	-1.08%
210032	UNION OF CECIL	$160,537,054	0.40%	$261,708	-1.64%	-$1,073,001	-0.65%	-$425,275	-0.76%	-$497,665	-$1,734,233	-1.08%
210004	HOLY CROSS	$500,698,497	0.67%	$2,370,725	-1.17%	-$4,160,622	-1.03%	-$3,662,770	-0.39%	-$1,401,956	-$6,854,623	-1.37%
210001	MERITUS	$362,368,543	-0.27%	-$585,471	-0.41%	-$900,162	-1.06%	-$2,327,249	-0.58%	-$1,268,290	-$5,081,172	-1.40%
210034	HARBOR	$187,602,544	0.00%	$0	-1.69%	-$1,865,625	-0.61%	-$673,391	-0.73%	-$806,691	-$3,345,707	-1.78%
210003	PG	$348,438,485	0.00%	$0	-0.47%	-$1,329,767	-1.53%	-$4,328,817	-0.47%	-$1,324,066	-$6,982,650	-2.00%
State	**Statewide**	**$16,900,932,303**	**0.23%**	**$22,695,798**	**0.05%**	**$5,298,988**	**-0.61%**	**-$59,633,534**	**-0.52%**	**-$50,336,836**	**-$81,975,584**	**-0.49%**

Quality Based Reimbursement Policy RY2022 Draft Recommendation

November 13, 2019

HSCRC
Health Services Cost Review Commission

Proposed Commission Action

- This is a draft recommendation

- Staff proposes minimal changes for FY 2022
  - Maintain RY 2021 QBR scoring and revenue adjustment methodology
  - For ED wait time measures, remove ED-2b (with removal from CMS mandatory reporting) and consider option for adding OP-18b
- Staff will convene a QBR redesign sub-group during CY 2020 for the FY 2023 policy

Quality Based Reimbursement (QBR) Program Measures and Domains

- The QBR program measures and domains are similar to those of the VBP program, with some differences, most notably:
  - Does not include an Efficiency domain (efficiency measured in other HSCRC methodologies, including, the Potentially Avoidable Utilization program, the Medicare Performance Adjustment, and the Integrated Efficiency policy.).
  - Assigns higher weight on the Person and Community Engagement and Safety domains to encourage improvement on these measures.

Figure 1. RY 2021 QBR Measures with Changes from RY 2020, Domain Weights Compared with CMS VBP Programs

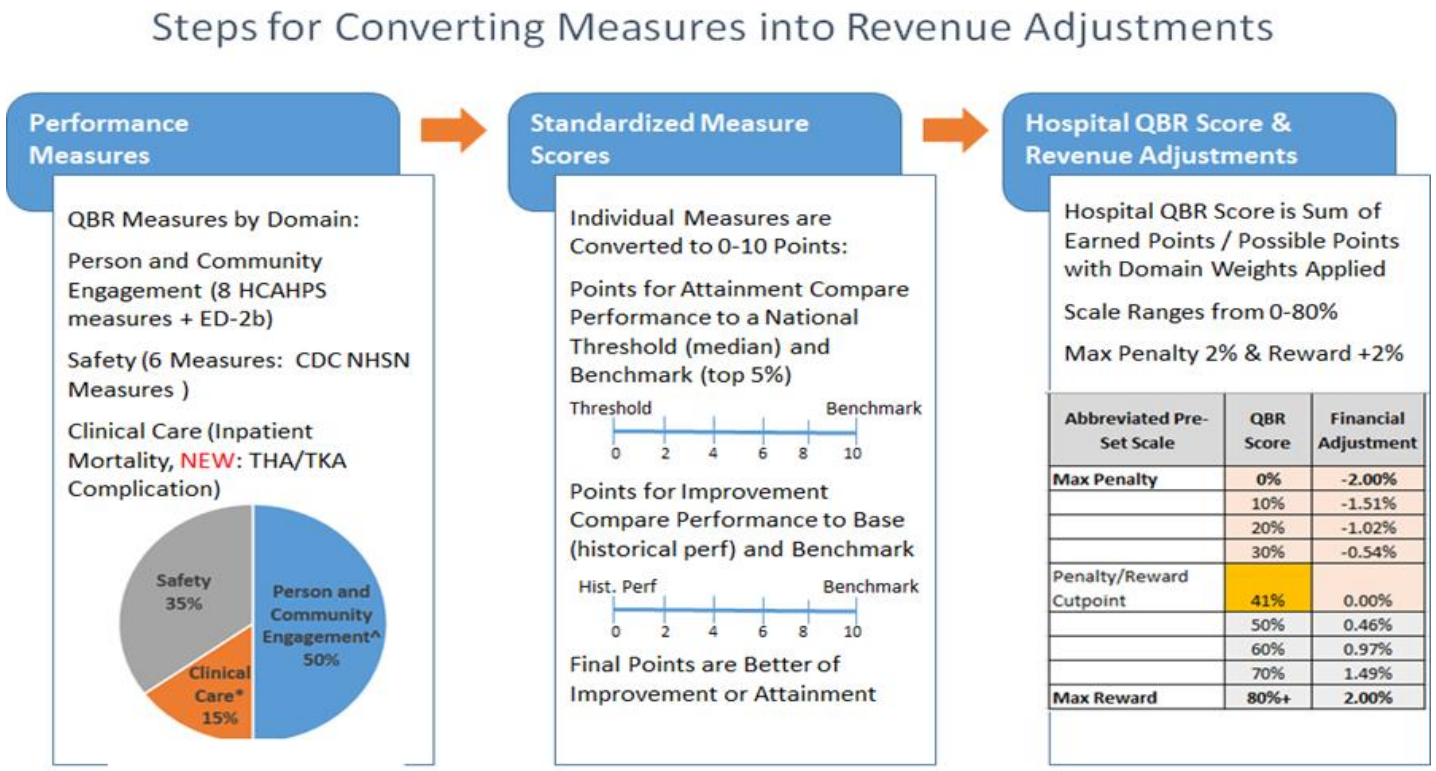
	Maryland QBR Domain Weights and Measures	CMS VBP Domain Weights and Measures
Clinical Care	15 percent -2 measures: all cause inpatient Mortality, THA/TKA complications measure (newly adopted RY 2021)	25 percent -5 measures: 4 condition-specific Mortality, THA/TKA complications measure
Person and Community Engagement	50 percent- 9 measures: 8 HCAHPS measures; ED-2b wait time measure (ED-1b removed after RY 2020)	25 percent- 8 HCAHPS measures (no ED wait time measures)
Safety	35 percent -5 measures: CDC NHSN HAI	25 percent 5 measures: CDC NHSN HAI
Efficiency	N/A	25 percent-Medicare Spending Per Beneficiary measure

No Major Methodology Changes from Current Policy as QBR is Slated for Redesign During CY 2020.

Steps to calculate hospital QBR scores and associated inpatient revenue adjustments:

1. Assess performance on each measure in the domain;
2. Standardize measure scores relative to performance standards;
3. Calculate the total points a hospital earned divided by the total possible points for each domain;
4. Finalize the total hospital QBR score (0-100 percent) by weighting the domains based on the overall percentage or importance the Commission has placed on each domain; and
5. Convert the total hospital QBR scores into revenue adjustments using the preset scale that ranges from 0 to 80 percent.

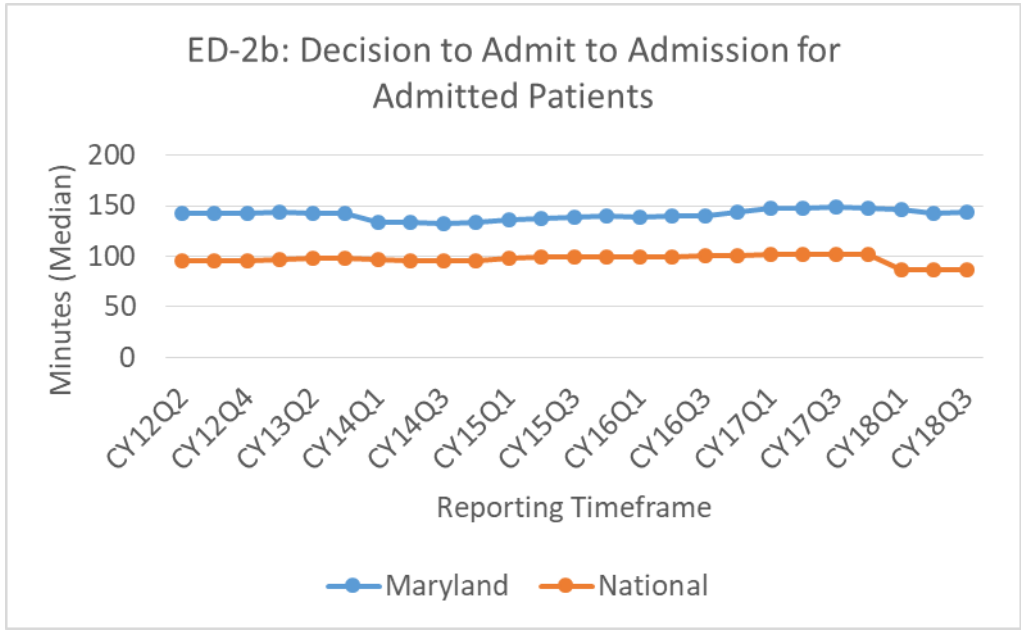
Figure 2. Process for Calculating RY 2021 QBR Scores

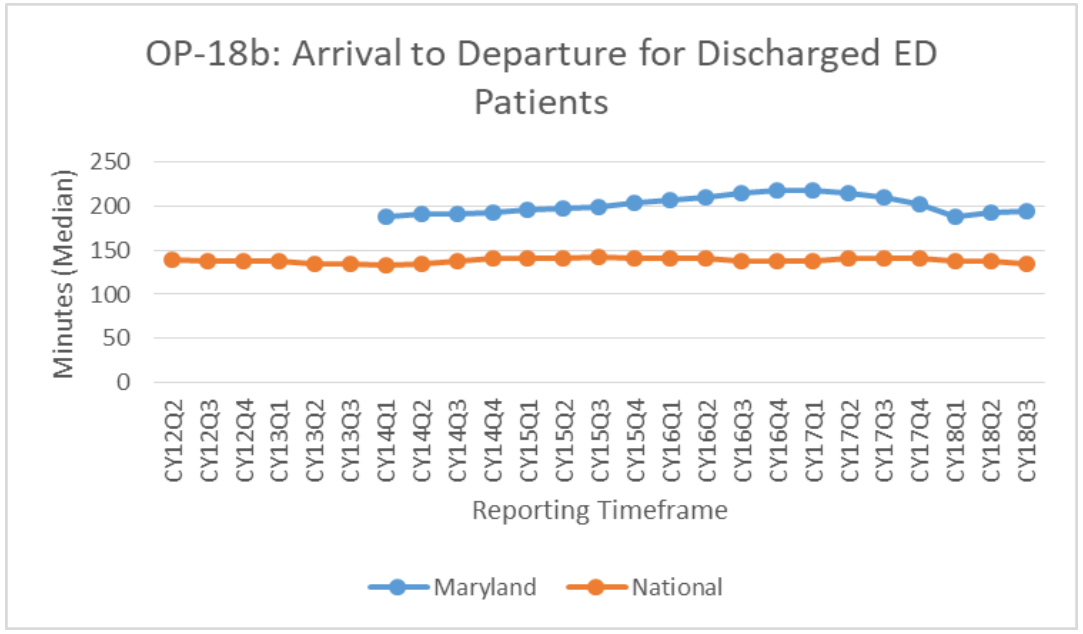


Staff Assessed Performance on State Performance Over Time, and Compared to National Trends Where Data Was Available

- Summary of Maryland Performance:
  - Safety Domain- Consists of five CDC National Health Safety Network (NHSN) healthcare associated infection (HAI) measures.
    - Average hospital standardized infection ratios (SIRs) for five of the six HAI categories improved for both for Maryland and nationally from the base.
    - Maryland performs essentially on par with the nation, with exception of SSI Hysterectomy where Maryland is markedly worse.
  - Clinical Care Domain- Consists of inpatient mortality measure, hip/knee complication measure
    - On CMS and VBP condition-specific mortality measures and hip/knee complication measure, Maryland performs on par with the nation.
    - On Maryland all condition, all payer inpatient mortality measure, Maryland has improved slightly from the base.
  - Person and Community Engagement Domain- Consists of HCAHPS ED wait time measures.
    - On HCAHPS, Maryland continues to make some modest improvements, continues to lag behind the nation.
    - On ED wait time measures, Maryland has not shown improvement in decreasing the wait times and performs worse than the nation.

ED Wait Time Measure Trends Compared to the Nation Over Time





RY 2022 Draft QBR Recommendations

1. Implement the following measure updates:
   A. Remove the ED-2b measure commensurate with its removal from the CMS IQR program.
   B. Consider adding OP-18b to the Person and Community Engagement domain.
2. Continue Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement - 50 percent, Safety (NHSN measures) - 35 percent, Clinical Care - 15 percent.
3. Maintain the pre-set scale (0-80 percent with cut-point at 41 percent), and continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) for the QBR program.

QBR Redesign Sub-group FY 2023: Topic Examples

- Strengthen the current incentives to improve patient experience, safety, and clinical outcomes.
- Explore potential new QBR measures from those already in the CMS inpatient hospital reporting pipeline but not currently used in pay for performance, such as the Severe Sepsis and Septic Shock: Management Bundle measure (SEP-1).
- Explore other available measures using measure catalogues such as the CMS's Measure Inventory Tool and the National Quality Forum's Quality Positioning System.
- Evaluate additional data sources needed for performance measurement under the TCOC model.
- Evaluate new opportunities for performance measurement as care is moved from the inpatient setting to other settings of care (e.g., outpatient hospital measures).
- Consider options for re-adoption of ED wait time measure(s)
- Ensure that financial incentives under the population-based revenue system are aligned.
- Identify or develop holistic and patient-centered measures.
- Develop hospital pay-for-performance programs that foster; specifically, consider options for utilizing the QBR program to support goals developed for the State Integrated Health Improvement Strategy (SIHIS) that do not fit under other quality programs.

Draft Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2022

November 13, 2019

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

This document contains the draft staff recommendations for updating the Quality Based Reimbursement Program for RY 2022.Comments on the draft policy may be submitted by email to hscrc.quality@maryland.gov and are due by Wednesday, November 27, 2019.

Table of Contents

List of Abbreviations

CDC	Centers for Disease Control & Prevention
CAUTI	Catheter-associated urinary tract infection
CDIFF	Clostridium Difficile infection
CLABSI	Central Line-Associated Blood Stream Infection
CMS	Centers for Medicare &e Medicaid Services
DRG	Diagnosis-Related Group
ED	Emergency Department
FFY	Federal Fiscal Year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
MRSA	Methicillin-Resistant Staphylococcus Aureus
NHSN	National Health Safety Network
PQI	Prevention Quality Indicators
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year (Coincides with State Fiscal Year (SFY) July-Jun; signifies the timeframe in which the rewards and/or penalties would be assessed)
SIR	Standardized Infection Ratio
SSI	Surgical Site Infection
THA/TKA	Total Hip and Knee Arthroplasty Risk Standardized Complication Rate
VBP	Value-Based Purchasing

EXECUTIVE SUMMARY

This document puts forth the RY 2022 Quality-Based Reimbursement (QBR) draft policy recommendations that include maintaining the RY 2021 quality domains, scoring approach, and pre-set revenue adjustment scale. This draft recommendation also proposes minimal changes to the program measures, as outlined below.

Draft Recommendations for RY 2022 QBR Program

1. Implement the following measure updates:
    A. Remove the ED-2b measure commensurate with its removal from the CMS IQR program.
    B. Consider adding OP-18b to the Person and Community Engagement domain.
2. Continue Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement - 50 percent, Safety (NHSN measures) - 35 percent, Clinical Care - 15 percent.
3. Maintain the pre-set scale (0-80 percent with cut-point at 41 percent), and continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) for the QBR program.

INTRODUCTION

Since 2014, Maryland hospitals are funded under Population-Based Revenue, a fixed annual revenue cap that is adjusted for inflation, quality performance, reductions in potentially avoidable utilization, market shifts, and demographic growth. Under the Population-Based Revenue system, hospitals are incentivized to transition services to the most appropriate setting within the continuum of care, and may keep savings that they achieve via improved quality of care (e.g., reduced avoidable utilization, readmissions, hospital-acquired infections). It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Quality programs reward quality improvements that reinforce the incentives of the Population-Based Revenue system, while guarding against unintended consequences and penalizing poor performance.

The HSCRC's Quality Based Reimbursement (QBR) program is one of several pay-for-performance initiatives that provide incentives for hospitals to improve patient care and value over time. Under the current Total Cost of Care (TCOC) Model Agreement between Maryland and the Centers for Medicare & Medicaid Services (CMS), Maryland's QBR program has no stated performance requirements. However, the Commission has prioritized aligning the QBR program with the federal Value Based Purchasing (VBP) program, and has attempted to encourage improvement in areas where Maryland has exhibited poor performance relative to the nation.

Under the TCOC Model, the State must request exemptions from the CMS Hospital Acquired Conditions (HAC) program, Hospital Readmission Reduction program (HRRP), and Hospital Value-Based Purchasing (HVBP) program based on annual reports to CMS that demonstrate that Maryland's program results continue to be aggressive and progressive, i.e. meeting or surpassing those of the nation. HSCRC submitted a report this year with its exemption request and received notification from CMS on August 29, 2019 that the exemptions were granted for Federal Fiscal Year 2020.[1] With Maryland's continued exemption from the federal VBP program, the State (via the HSCRC) can continue to generate autonomous, quality-based measurement and payment initiatives that set consistent all-payer quality incentives.[2] .

The QBR program measures and domains are similar to those of the VBP program, but there are a few differences. Most notably, QBR does not include an Efficiency domain, as efficiency is more directly measured in other HSCRC methodologies, including, the Potentially Avoidable Utilization program, the Medicare Performance Adjustment, and the Integrated Efficiency policy. Another key difference is that the HSCRC has put higher weight on the Person and Community Engagement and Safety domains to encourage improvement on measures of patient experience.

[1] The notification of exemption may be found in Appendix I

[2] For more information on the VBP Exemption (granted annually by CMMI), please see Appendix I.

Generally though the HSCRC tries to align the QBR program to measures of national import, and where feasible the Commission incorporates more comprehensive measurement relative to the VBP program,[3] most notably an all-cause, inpatient Maryland mortality measure versus VBP's condition-specific 30-day mortality measures.[4]

Finally, it is important to note that Maryland has begun the work to update performance standards and targets in HSCRC's portfolio of quality and value-based payment programs with the onset of the Total Cost of Care (TCOC) Model Agreement with CMS. Per directives from HSCRC Commissioners,[5] staff worked with stakeholders last year to revise two of the Commission's Quality programs, the Maryland Hospital Acquired Complications program and the Potentially Avoidable Utilization program.[6] This year, staff is working with stakeholders to redesign the Readmissions Reduction Incentive Program for RY 2022 (Performance Period - CY 2020). The QBR program will include minor updates this year, but will largely remain similar to prior iterations of the policy, as it is slated for redesign for next year. For more information on suggested areas of analysis for the future QBR redesign, please see "QBR Future Updates" or follow along with our work over the coming calendar year.

This report provides draft recommendations for updates to Maryland's QBR program for Rate Year (RY) 2022, with minimal updates from RY 2021.

BACKGROUND

The Affordable Care Act established the hospital Medicare Value-Based Purchasing (VBP) program,[7] which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. Figure 1 below compares the RY 2021 QBR measures--with changes noted from RY 2020— and domain weights to those used in the CMS VBP program.

[3] For more information on the VBP program, see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html, last accessed 10/28/19.
[4] During the coming year, staff will work with contractor support to continue developing an all-cause, all-condition 30-day mortality measure applicable to all payers, expanding further the QBR mortality measure's potential to incentivize better outcomes outside the hospital walls.
[5] In the fall of 2017, HSCRC Commissioners and staff support conducted several strategic planning sessions to outline priorities and guiding principles for the upcoming Total Cost of Care Model. Based on these sessions, the HSCRC developed a Critical Action Plan that delineates timelines for review and possible reform of financial and quality methodologies, as well as other staff operations.
[6] Maryland has implemented an efficiency measure in the Population-Based Revenue system, based on a calculation of potentially avoidable utilization (PAU), but it has not made efficiency part of its core quality programs as a domain because the revenue system itself incentivizes improved efficiency. PAU is currently defined as the costs of readmissions and a subset of admissions defined by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs).
[7] Details of CMS VBP measures may be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

Figure 1. RY 2021 QBR Measures with Changes from RY 2020, Domain Weights Compared with CMS VBP Programs

	Maryland QBR Domain Weights and Measures	CMS VBP Domain Weights and Measures
Clinical Care	15 percent -2 measures: all cause inpatient Mortality, THA/TKA complications measure (newly adopted RY 2021)	25 percent -5 measures: 4 condition-specific Mortality, THA/TKA complications measure
Person and Community Engagement	50 percent- 9 measures: 8 HCAHPS measures; ED-2b wait time measure (ED-1b removed after RY 2020)	25 percent- 8 HCAHPS measures (no ED wait time measures)
Safety	35 percent -5 measures: CDC NHSN HAI	25 percent 5 measures: CDC NHSN HAI
Efficiency	N/A	25 percent-Medicare Spending Per Beneficiary measure

With the selected measures from above, the QBR program assesses hospital performance on an all-payer basis. Performance standards are based on the national average (threshold) and the top performance values (benchmark) for all measures, with the exception of HSCRC calculated in-hospital mortality rate, which uses State data to calculate performance standards. Thus, a score of 0 percent means that performance on all measures is below the national average or not improved, while a score of 100 percent means performance on all measures is at or better than the top 5 percent best performing hospitals. This scoring methodology is the same as the national VBP program. However, unlike the VBP program that then relatively ranks all hospitals, the QBR program uses a preset scale to determine each hospitals revenue adjustment.

In the RY 2019 QBR recommendation, the Commission approved using a preset scale based on national performance to ensure that QBR revenue adjustments are linked to Maryland hospital performance relative to the nation. Prior to RY 2019, Maryland hospitals were evaluated by national thresholds and benchmarks, but their scores were then scaled in accordance with Maryland performance, resulting in Maryland hospitals receiving financial rewards despite falling behind the nation in performance. Consequently, the scale is now 0 to 80 percent regardless of the score of the highest performing hospital in the State, and the cut-point at which a hospital earns rewards in RY 2021 is 41 percent. This reward and penalty cut-point was based on an analysis of FFY16-FFY18 National Value-Based Purchasing scores, which indicated the average national score using Maryland domain weights (i.e., without the Efficiency domain) was around 41 percent (range 39.9 to 42.7).

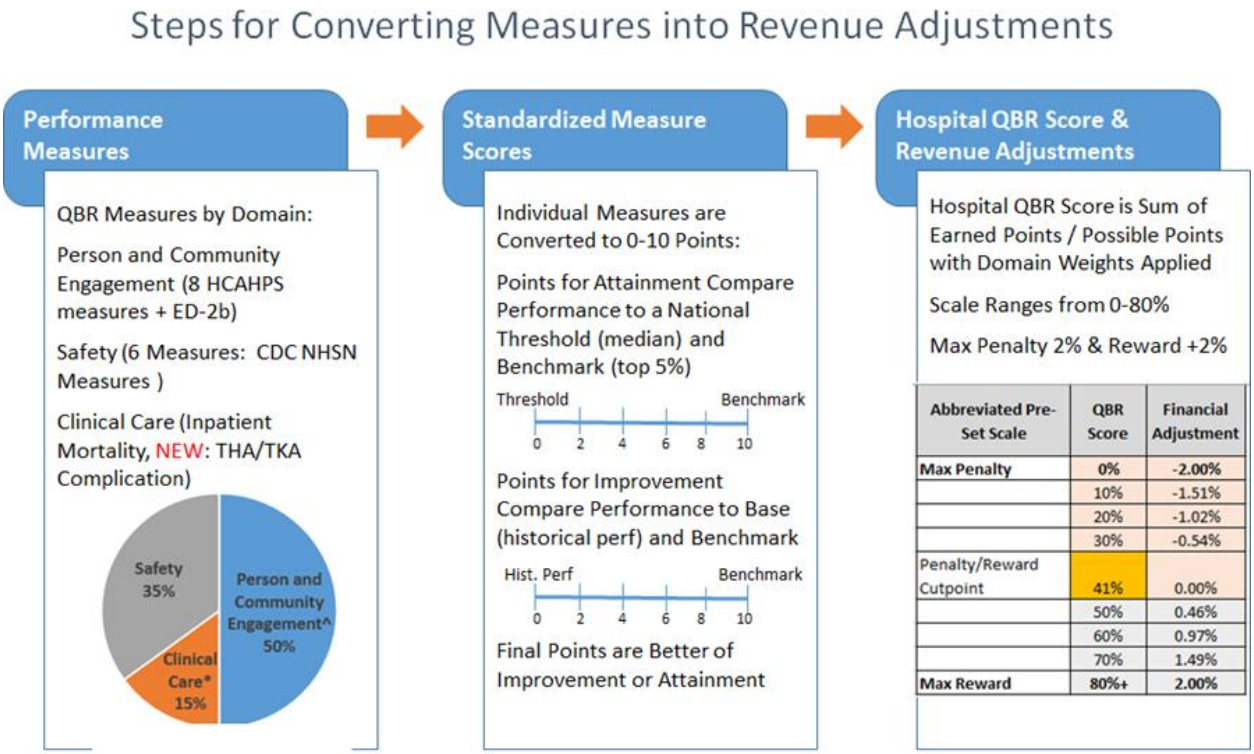
As a recap, the methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019, and involves:

1) assessing performance on each measure in the domain;
2) standardizing measure scores relative to performance standards;
3) calculating the total points a hospital earned divided by the total possible points for each domain;

4) finalizing the total hospital QBR score (0-100 percent) by weighting the domains based on the overall percentage or importance the Commission has placed on each domain; and
5) converting the total hospital QBR scores into revenue adjustments using the preset scale that ranges from 0 to 80 percent.

The methodology is illustrated in Figure 2 below.

Figure 2. Process for Calculating RY 2021 QBR Scores



Appendix II contains further background and technical details about the QBR and VBP programs.

ASSESSMENT

The purpose of this section is to present an assessment, using the most current data available, of Maryland's performance on measures used in QBR as well as other measures where national comparisons are available. The assessment, together with the deliberations of the Performance Measurement Workgroup (PMWG), serve as the basis for the draft recommendations for the RY 2022 QBR program. In addition, staff has modeled the QBR revenue adjustments with the recommended changes.

Maryland Performance by QBR Domain

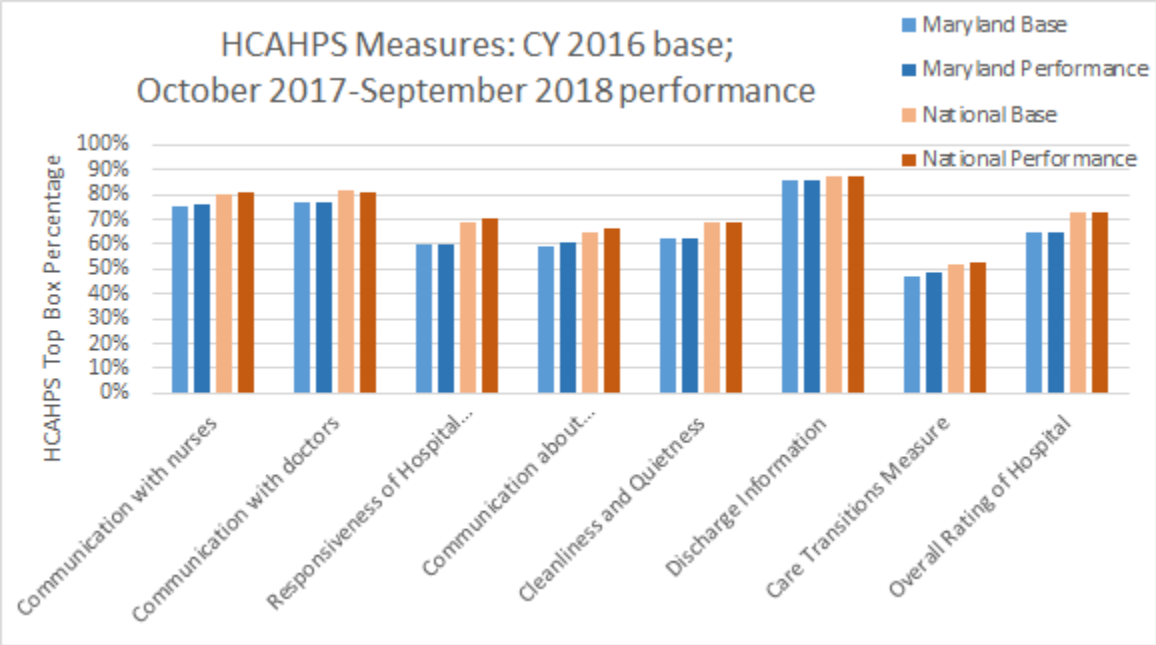
Person and Community Engagement Domain

During RY 2020, the **Person and Community Engagement** domain measured performance using the HCAHPS patient survey, as well as two emergency department wait time measures for admitted patients. The addition of the emergency department wait time measures was an example of Maryland's quality programs differing from the nation to target an area of concern.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Figure 3 below provides a graphic representation of the HCAHPS measure results for the RY 2020 base and performance periods for Maryland compared to the Nation, revealing that Maryland continues to lag behind the Nation, but both the Nation and Maryland are improving at similar rates overall.

Figure 3. HCAHPS Results: Maryland Compared to the Nation for RY 2020



For each HCAHPS measure, the changes over time from the base to the performance period for Maryland and the Nation, and the gaps in performance between Maryland and the Nation, are provided below.

- **Communication with nurses**- Maryland and the Nation both improved by 1 percent, and the gap remained the same with Maryland -5 percent below (worse than) the Nation.
- **Communication with doctors**- Maryland remained the same, while the Nation decreased by 1 percent, and the gap lessened for Maryland from -5 percent to -4 percent below the Nation.

- **Responsiveness of hospital staff-** Maryland remained the same while the Nation improved by 1 percent, and the gap widened for Maryland from -9 percent to -10 percent below the Nation.
- **Communication about medicine** Maryland improved by 1 percent and the Nation remained the same, and the gap decreased for Maryland from -6 percent to -5 percent below the Nation.
- **Cleanliness and quietness-** Maryland and the Nation remained the same, and the gap remained the same for Maryland at -6 percent below the Nation.
- **Discharge information-** Maryland and the Nation remained the same, and the gap remained the same for Maryland at -1 percent below the Nation.
- **Care transition measure-** Maryland improved by 2 percent and the Nation improved by 1 percent, and the gap decreased for Maryland from -5 percent to -4 percent below the Nation.
- **Overall rating of hospital-** Maryland and the Nation remained the same, and the gap remained the same for Maryland at -8 percent below the Nation.

While the statewide data suggests that Maryland continues to lag behind the Nation on HCAHPS measures, there is variability in performance across individual hospitals, with some performing better than the national average on each measure. Furthermore, while the statewide improvements were modest, there were individual hospitals with significant improvements on each measure (Appendix III). Nevertheless, staff remains concerned about overall statewide performance relative to the Nation and will continue to consider additional incentive structures to improve performance as part of the QBR redesign.

An additional concern raised by hospitals is the potential impact of the HCAHPS patient mix adjustment changes between the base and performance periods at the federal level This adjustment, which accounts for the probability of a patient's positive response on a survey relative to other sets of patients, e.g. 55-64 year olds versus individuals over 85, should ideally be consistent in the base and performance periods. However, CMS has advised staff that these changes occur on an ongoing basis and are not considered materially significant for the VBP program. Further, staff believes that the changes in any given year may slightly benefit or disadvantage each hospital on their respective QBR scores, but recognizes that the use of the prospective preset scale may make this issue more of a concern in Maryland. [8] Therefore, staff proposes again to work with QBR redesign subgroup to be convened in CY 2020 and the PMWG to evaluate the impact, if any, of the patient mix adjustment changes for RYs 2019 through 2021, but does not believe retrospective revenue adjustments are warranted at this time. Staff may re-visit this position with the Commission should analysis determine the patient mix adjustment changes are materially significant.

[8]The Patient-Mix Adjustment document for the July 2019 Public Report period can be found at: : https://hcahpsonline.org/globalassets/hcahps/mode-patient-mix-adjustment/july_2019_mode--patient-mix-adj_pma.pdf.
The HCAHPS PMA model was updated to add Question 28, patient's self-reported overall mental or emotional health, beginning with July 1, 2018 discharges. The new PMA variable is called Self-Rated Mental Health. In addition, the label for overall health has been changed to "Self-Rated Overall Health."
Self-Rated Mental Health follows the same linear parameterization as Self-Rated Overall Health: patient responses are coded as 1 ("Excellent") through 5 ("Poor"). The patient-mix adjustment model will thus include both Self-Rated Overall Health and Self-Rated Mental Health.

Emergency Department Wait Times

Emergency Department wait time measures have been publicly reported nationally on Hospital Compare since 2012 for patients admitted (ED-1b and ED-2b), and since 2014 for patients treated and released (OP-18b). The measure definitions are provided below in Figure 4. Based upon Maryland's sustained poor performance on these ED throughput measures, the Commission voted to include the two ED Wait Time measures for admitted patients as part of the QBR program for RY 2020.[9] As CMS has discontinued mandatory data collection for ED-1b after CY 2018, this measure was removed from QBR for the RY 2021 policy; further, the ED-2b measure will be removed from CMS mandatory data submission requirements after CY 2019, necessitating its removal from the RY 2022 QBR program.

Figure 4. CMS ED Wait Time Measures

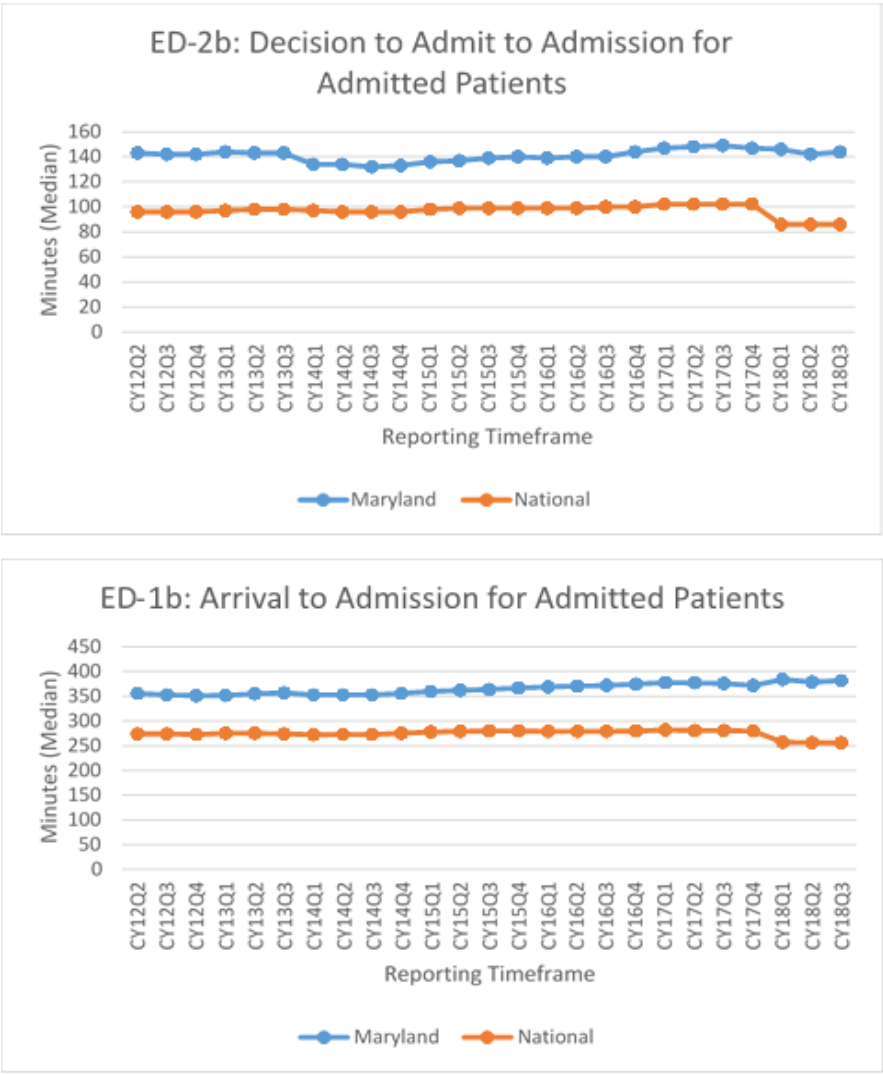
Measure ID	Measure Title
ED-1b	Median time from emergency department arrival to emergency department departure for admitted emergency department patients
ED-2b	Admit decision time to emergency department departure time for admitted patient
OP-18b*	Emergency department arrival time to departure time for discharged patients.

*OP-18 was not included in the RY 2021 Program. OP-18b strata includes non-psychiatric patients and OP-18c strata includes psychiatric patients.

Staff notes that the data trends to date do not reveal any positive impact since adding the measures to the QBR program. Based upon analysis of the RY 2020 QBR performance period (October 2017 through September 2018), Maryland continues to perform poorly on the ED wait time measures compared to the nation, as illustrated in Figure 5 below. At the hospital level, the most recent data show approximately 86 percent of Maryland hospitals perform worse than the national median in ED wait times, as compared to 85.7 percent of hospitals performing worse on ED-1b and 78.6 percent performing worse on ED-2b when these measures were first put in pay for performance programs two years ago.

[9] 91 percent of Maryland hospitals perform worse than the nation in ED-1b, 77 percent perform worse than the nation in ED-2b, and 91 percent perform worse on OB-18b. The median wait times are adjusted based upon ED volume. These results are similar to the 85 percent average reported in RY2021 policy.

Figure 5. Maryland Statewide ED Wait Time Trends for Admitted Patients Compared to the Nation, Q2 2012 to Q32018.

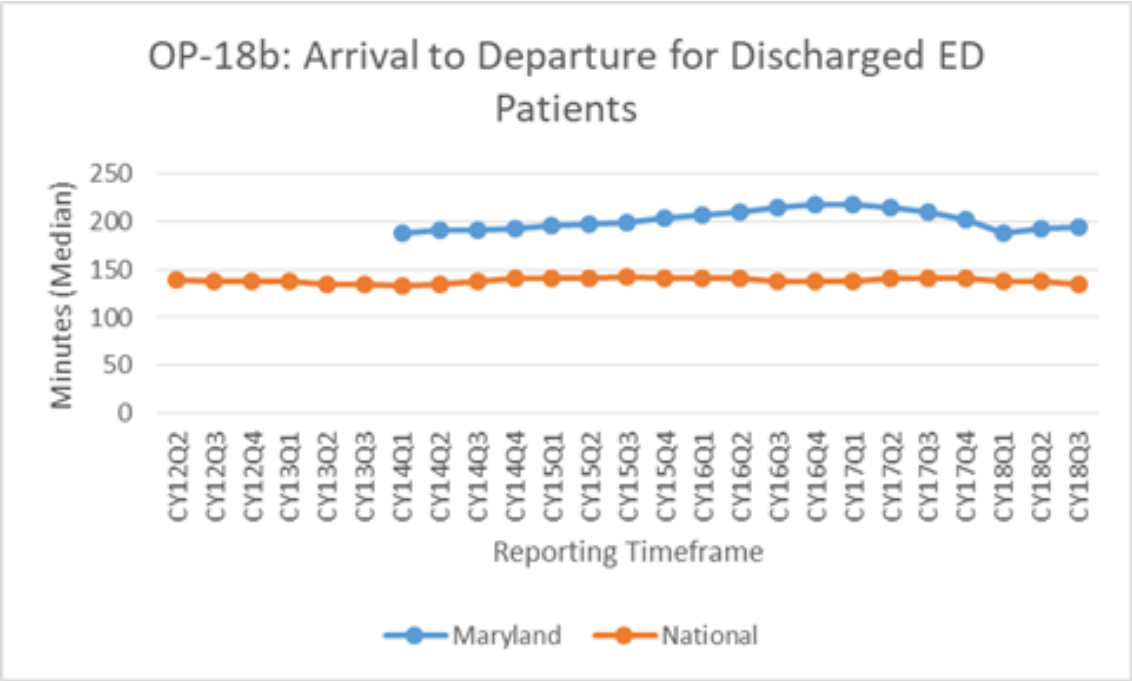


As staff notes above, for the RY 2022 QBR program, since CMS has discontinued mandatory reporting of the ED-2b measure after CY 2019, this measure will no longer be available on Hospital Compare for use. With the redesign of the QBR program for RY 2023, staff proposes to consider alternative data source options for re-adoption of ED Wait Time measures for admitted patients.

With stakeholder interest continuing this year to retain ED wait time measures, particularly payer and consumer stakeholders, staff and the PMWG reconsidered whether to propose inclusion of OP-18b (non-admitted patients) for RY 2022. Maryland has performed poorly compared to the nation on the wait time for non-admitted/discharged patients as illustrated in Figure 6. While some stakeholders voiced support for inclusion of the OP-18b measure last year, others

suggested the measure is at odds with hospitals' efforts to reduce inpatient admissions and the time needed for care coordination in the ED.

Figure 6. Maryland Performance Compared to the Nation on OP-18b, CY 2014 Qtr 1-CY 2018 Qtr 3



Last year, staff noted its intent to monitor performance on the OP-18b measure over the coming program year. Staff noted it would reconsider inclusion of OP-18b in the future if "spillover" improvements from implementing the wait time measures for admitted patients were not seen in outpatient/non-admitted ED wait times, particularly in light of the fact that Maryland's higher wait times are paired with declining statewide ED visits. Conversely, staff acknowledged that a factor impacting the measure is related to difficulties with the behavioral health system in the State, such as the need for improvement in the behavioral health system infrastructure and labor shortages, which exacerbate emergency department throughput problems; however these issues are not unique to Maryland. Staff, therefore, proposes to reconsider adoption of the OP-18b measure as part of the process to redesign the QBR program during CY 2020 and to continue to monitor performance on this measure. With the data lag time, this will allow for two years of data to be analyzed where at least one ED wait time measure for admitted patients was included in the program; however, staff will consider stakeholder feedback on the draft policy and may recommend adopting the OP-18b measure for RY 2022.

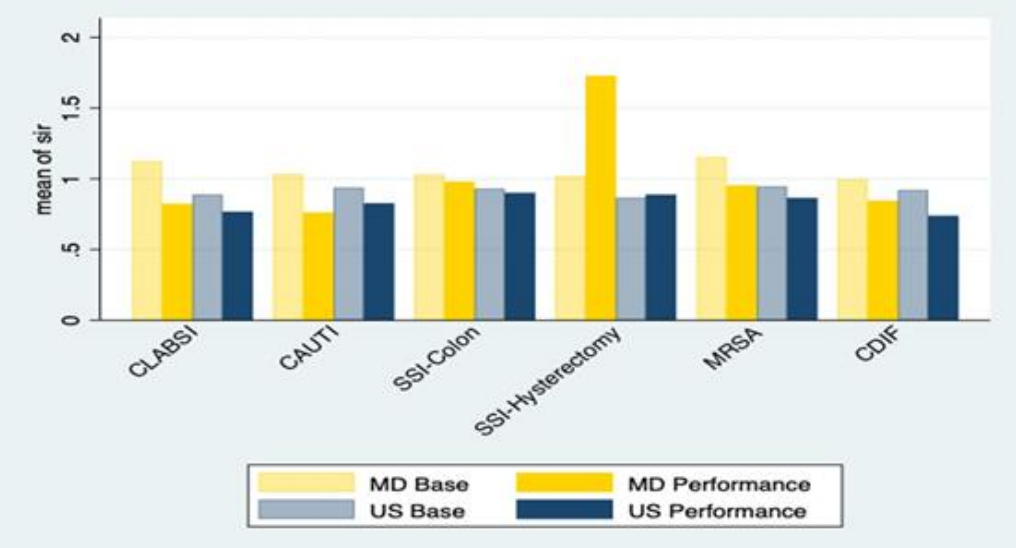
Finally, staff notes that, in the FFY 2020 notification of exemption from CMS quality programs, CMS acknowledged the challenges around improving patient experience, and were supportive of "...maintaining the highest weight for the person and community engagement component along with the one emergency department wait time measure (ED-2b) if publicly reported."

Based on the analysis of the Person and Community Engagement domain, HSCRC staff recommends continuing to weight this domain at 50 percent of the QBR score, with the HCAHPS measures remaining in the domain. Staff proposes to consider ED wait time measure options as part of the QBR redesign during CY 2020 with potential re-adoption of measures for RY 2023; alternatively, based on feedback on the draft policy the staff may propose adopting the OP-18b -- Arrival to Departure measure for Patients not Admitted-- for the RY 2022 QBR program.

Safety Domain

The **Safety** domain consists of five CDC National Health Safety Network (NHSN) healthcare associated infection (HAI) measures. As illustrated in Figure 7 below, Maryland's performance on the NHSN measures has been mixed (lower scores are better). Average hospital standardized infection ratios (SIRs) for five of the six HAI categories declined (improved) both nationally and for Maryland in the performance period compared to the base.[10] Maryland's improvement from the base was better than that of the nation for three of the six infection categories (Central Line Associated Blood Stream Infection-CLABSI, Catheter Associated Urinary Tract Infection-CAUTI, Methicillin Resistant Staph aureus- MRSA) and on par with the nation for two measures (Clostridium difficile-CDIFF, Surgical Sight Infection Colon- SSI Colon). Additionally, in the performance period, Maryland's infection rates were better (lower) for CAUTI; slightly worse (higher) for CLABSI, SSI colon, MRSA, and CDIFF; and, markedly worse for Surgical Sight Infection hysterectomy.

Figure 7. Maryland vs. National Median Hospital SIRs on NHSN HAI Safety Measures (Base period Calendar Year 2016, Performance period October 1, 2017 to September 30, 2018)



[10] While there are six Healthcare Associated Infection categories, the two SSI colon and hysterectomy categories are combined resulting in five Safety domain measures.

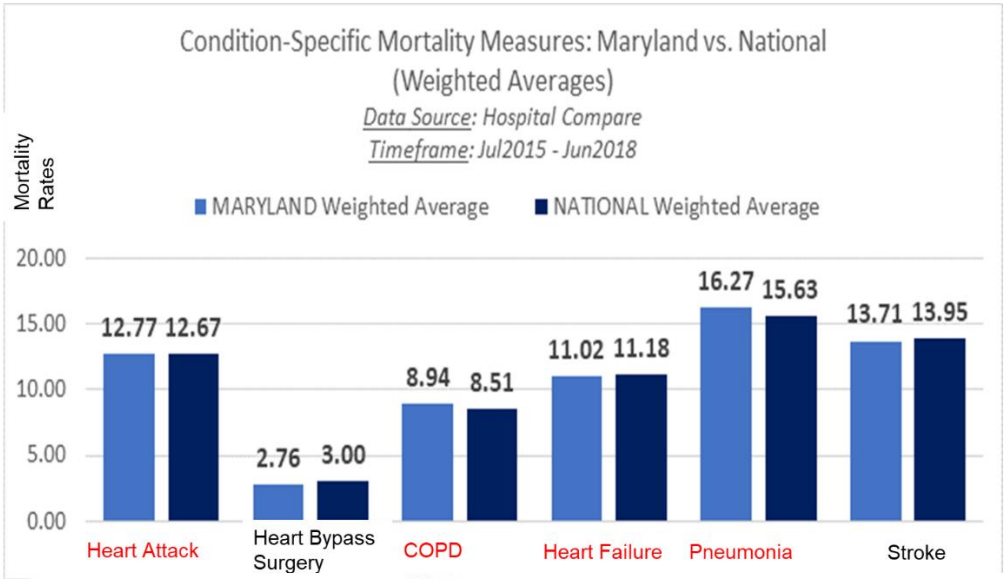
Staff recommends continuing to weight the Safety domain at 35 percent of the total QBR score (10 percent greater than the 25 percent in CMS VBP).

Clinical Care Domain

The QBR **Clinical Care** domain consists of one all-payer, all-cause, all-condition inpatient mortality measure, while the Medicare VBP program includes four 30-day condition-specific mortality measures (Heart Attack, Heart Failure, Pneumonia, and COPD). Medicare also monitors two additional 30-day mortality measures for Coronary Artery Bypass Graft and Stroke, but does not include these measures in VBP. Both QBR and VBP include the Total Hip and Knee Arthroplasty (THA/TKA) complication measure on Medicare patients with elective primary procedures.

Based on the analysis of the weighted average rates for Maryland versus the nation for the condition specific mortality measures provided by Health Quality Innovators, Maryland performs similarly to the nation for all condition-specific measures of 30-day mortality (Figure 8).

Figure 8. Maryland Hospital Performance Compared with the nation on CMS Condition-Specific Mortality Measure Rates



For the QBR all-payer inpatient mortality measure for RY 2020, statewide survival rate increased (improved) from 0.9553 in the base period to 0.9617 in the performance period. As illustrated in Figure 9 below, all but three hospitals earned points for either attainment or

improvement on the mortality measure; 33 hospitals performed better than the statewide benchmark (50th percentile) as they earned at least one attainment point.

Figure 9. Maryland Hospital Performance, FY 2020 QBR Inpatient All Condition, All Payer Mortality Measure

Number of Hospitals Scoring Points		Attainment Points	
		Yes	No
Improvement Points	Yes	24	9
	No	9	3

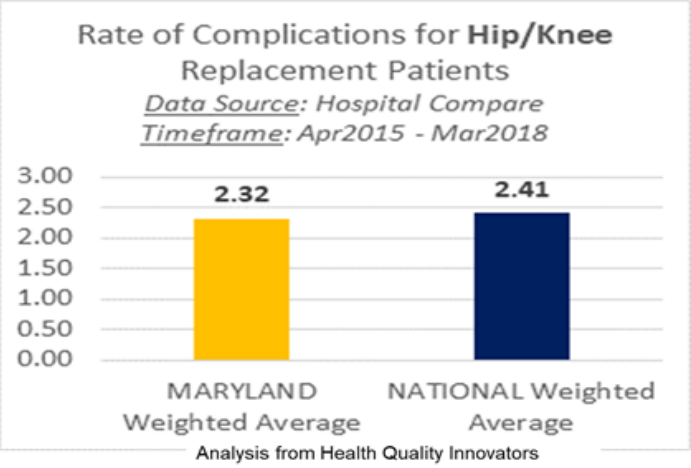
Attainment summary:
6 Hospitals better than benchmark (statewide 95th percentile)
12 Hospitals worse than threshold (statewide median)

For RY 2022, staff are not proposing any significant methodology changes to the inpatient mortality measure. However, Johns Hopkins and University of Maryland have brought to our attention two technical adjustments that the staff will implement - these are minor adjustments to align the measure with the original intent of the 80 percent DRG inclusion, and to update the exclusions to accommodate recent ICD-10 updates.[11] Other stakeholder comments on the inpatient measure will be considered during the QBR redesign, and as part of the development of the 30-day all-payer, all-condition mortality measure. Staff have been working with contractor support to develop the new mortality measure and will vet the measure with the QBR redesign subgroup and the PMWG during the course of the coming year, with potential plans for inclusion of the measure in the RY 2023 QBR program.

For the hip and knee complication rate measure for RY 2020, Figure 10 illustrates that, based on analysis of the weighted average rates for Maryland and the nation, Maryland performed on par with the nation.

[11] Two technical changes to the mortality measure are: 1. adding the procedure code for removing ECMO patients previously identified only by DRG (under ICD-10 ECMO patients are now in multiple DRGs); 2. adjusting the process for selecting the included DRGs to ensure all DRGs with same number of observed deaths at the cut-point are included.

Figure 10. Maryland THA/TKA Measure Performance Compared to the Nation



Since this measure is calculated by Hospital Compare using Medicare claims data and includes only Medicare patients, payer stakeholders of the PMWG have voiced support for expanding this measure to the commercial population and other payers if feasible. In addition, staff notes that this measure is applicable only to patients in the inpatient setting. With the removal of hip and knee replacement procedures from the Medicare "inpatient only" list--procedures for which Medicare will reimburse only if performed in the inpatient setting--, and the shift of these procedures to the outpatient setting, staff believes the QBR re-design subgroup should consider both payer and care setting applicability options for measure expansion.

Staff recommends continuing to include the inpatient mortality measure and hip and knee replacement complication measure in the Clinical Care domain consistent with the VBP program, and continuing to weight the Clinical Care domain at 15 percent.

Appendix IV details the available published performance standards (for VBP measures) for each measure by domain for RY2022; staff will calculate and disseminate the inpatient mortality standards when Version 37 of the 3M APR DRG grouper is implemented.

Revenue Adjustment Modeling

HSCRC staff modeled hospital QBR scores and revenue adjustments using the methodology approved for RY 2021. This includes maintaining the reward/penalty cut-point at 41 percent, which is consistent with updated analyses showing that the FFY19 national average score using QBR weights is 41 percent. The only changes in calculating the modeled QBR scores were the removal of the ED wait time measure and technical updates to the inpatient mortality measure.

Hospital-specific domain scores and total QBR scores are included in Appendix V. Statewide, the average hospital score is 35 percent; with a range from 13 to 59 percent. The modeled hospital-specific and statewide revenue impacts are found in Appendix VI. Figure 11 provides the estimated statewide revenue adjustments and counts of hospitals receiving a reward and

penalty and compares to the final RY 2020 QBR revenue adjustments. Overall, the estimated revenue adjustments are significantly less than the net RY 2020 due to the lower cut-point (RY 2020 cut-point was 45 percent) and measure changes (ED wait time removal, addition of hip and knee measure).

Figure 11. Maryland THA/TKA Measure Performance Compared to the Nation

Statewide Revenue Adjustments	RY2020 Actual		RY2020 with 41% cutpoint		RY2022 Modeling with 41%	
	$	%	$	%	$	%
Net	-$59,633,534	-0.62%	-$47,350,623	-0.49%	-$40,033,022	-0.42%
Penalties	-62,675,974	-0.65%	-51,979,616	-0.54%	-44,513,968	-0.46%
Rewards	3,042,440	0.03%	4,628,993	0.05%	4,480,946	0.05%
# Hospitals Penalized	36		35		31	
# Hospitals Rewarded	8		9		13	

QBR Future Updates

As previously mentioned, staff intends to convene a sub-group of the Performance Measurement Work Group, comprised of key stakeholders and subject-matter experts, to consider an overhaul of the QBR program in CY 2020. This group will review the existing QBR policy and goals of the TCOC model, and develop recommendations to modify the QBR program for the RY 2023 QBR Policy and beyond. Because the QBR policy assesses multiple domains of hospital quality (as opposed to the complications or readmissions program), this program is particularly well suited for expanding into new areas that are relevant under the TCOC model. To accomplish this redesign, which will necessitate consideration of measures and domains outside of those in the current program, the sub-group will consider 1) measurement selection, which will include evaluating the feasibility of including other CMS inpatient and outpatient measures, as well as retaining measures currently used, or adopting other measures that cover important all-payer clinical areas that may not be addressed by CMS measurement and reporting; and 2) methodological concerns, which will include appropriate risk adjustment, scoring, and scaling, and establishing reasonable performance targets.

Among the topics the sub-group may consider are the following:

- Strengthen the current incentives to improve patient experience, safety, and clinical outcomes.
- Explore potential new QBR measures from those already in the CMS inpatient hospital reporting pipeline but not currently used in pay for performance, such as the Severe Sepsis and Septic Shock: Management Bundle measure (SEP-1).
- Explore other available measures using measure catalogues such as the CMS's Measure Inventory Tool and the National Quality Forum's Quality Positioning System.

- Evaluate additional data sources needed for performance measurement under the TCOC model.
- Evaluate new opportunities for performance measurement as care is moved from the inpatient setting to other settings of care (e.g., outpatient hospital measures).
- Consider re-adoption of ED wait time measures
- Ensure that financial incentives under the population-based revenue system are aligned.
- Identify or develop holistic and patient-centered measures.
- Develop hospital pay-for-performance programs that foster accountability for broader care transformation and population health initiatives; specifically, the QBR program could be utilized to support goals developed for the State Integrated Health Improvement Strategy (SIHIS) that do not fit under other quality programs.

Staff acknowledges that this redesign will require substantial work in concert with industry and a broad array of other stakeholders, including consumers, payers, cross-continuum providers, quality measurement experts, and government agencies (local, state, and federal). Staff welcomes additional topics for consideration related to the QBR sub-group, and encourages those interested in participating in the sub-group to contact the Quality team at hscrc.quality@maryland.gov.

DRAFT RECOMMENDATIONS FOR RY 2022 QBR PROGRAM

1. Implement the following measure updates:
    A. Remove the ED-2b measure commensurate with its removal from the CMS IQR program.
    B. Consider adding OP-18b to the Person and Community Engagement domain.
2. Continue Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement - 50 percent, Safety (NHSN measures) - 35 percent, Clinical Care - 15 percent.
3. Maintain the pre-set scale (0-80 percent with cut-point at 41 percent), and continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) for the QBR program.

APPENDIX I. CMS NOTIFICATION OF QUALITY PROGRAM EXEMPTIONS, FFY 2020

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

August 29, 2019

Katie Wunderlich
Executive Director, HSCRC
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Maryland's Request for Hospital Quality Program Exemption for Federal Fiscal Year 2020

Dear Ms. Wunderlich:

Thank you for your letter on behalf of the State of Maryland requesting an exemption from the national hospital quality and value-based payment programs for federal fiscal year (FFY) 2020, which include the Hospital Value-Based Purchasing (HVBP) program, Hospital Acquired Conditions Reduction (HAC) program, and the Hospital Readmissions Reduction program (HRRP). Under Section 8.d.iii. of the Maryland Total Cost of Care Model (MDTCOC model) Agreement, the Centers for Medicare & Medicaid Services (CMS) will waive Maryland from participating in the national hospital quality and value-based payment programs as long as the State implements hospital quality and value-based payment programs that achieve or surpass the measured results in terms of patient outcomes and cost savings in HVBP, HAC, and HRRP.

CMS has reviewed your exemption request and supporting documentation. We officially grant the State of Maryland's exemption from HVBP, HAC, and HRRP based on the fact that Maryland under their state-based quality and value-based payment programs achieved performance results in terms of patient outcomes and cost savings that were as good as or better than if Maryland was participating in the national hospital quality and value-based payment programs.

Below are a few requests for the State regarding their state-based hospital quality and value-based payment programs:

- *Quality Based Reimbursement*. CMS reviewed each component of the State's version of HVBP, the Quality Based Reimbursement (QBR) program, which includes three components: clinical care, safety measures, and person and community engagement. While the State is performing well in clinical care and safety measures, Maryland's performance continues to lag behind the nation in patient experience of care under person and community engagement. We acknowledge the challenges around improving patient experience, and we are supportive of maintaining the highest weight for the person and community engagement component along with the one emergency

department wait time measure (ED-2b) if publicly reported. Furthermore, with CMS removing the early elective delivery measure (PC-01) from the HVBP due to performance topping off plus the State's focus on improving maternal mortality and morbidity, we request that the State continue to monitor this measure under QBR if it is publicly reported in the Hospital Inpatient Quality Reporting Program. We would like to see hospitals continue to be held accountable for obstetric care to help move the needle on improving maternal health outcomes in the state. We are hopeful that these modifications will incentivize hospitals to improve the patient care experience and maternal health in Maryland hospitals, and we are eager to assist in helping hospitals improve in these areas in any way possible.

- *PAU Savings*. CMS is in favor of the State evaluating PQIs on a per capita basis for the PAU Savings program starting in RY2021. We believe this aligns with the population health goals of the MDTCOC model by encouraging hospital accountability for the broad community it serves, e.g., including avoidable pediatric admissions. CMS requests the State set a concrete per capita PQI reduction target within a certain timeframe to help facilitate this transition. We expect the State to make progress on avoidable utilization since the potential for population health impact is much greater under the MDTCOC model given the wider range of tools available to Maryland providers.

- *Medicare Performance Adjustment*. CMS supports the addition of measures to the quality adjustment component of the Medicare Performance Adjustment (MPA) that align with the goals of the MDTCOC model and support the Statewide Integrated Health Improvement Strategy (SIHIS). We are also in favor of the State continuing to refine the MPA scoring methodology, such as considering incorporating attainment in the future as needed to ensure a fair threshold for well-performing hospitals under the MPA. Additionally, CMS requests the State to consider increasing the amount of revenue at risk under the MPA. It is not clear whether a Medicare Performance Adjustment to hospitals that is capped at 1% (or less than 0.35% as a share of hospitals' all-payer revenue) is adequate to ensure hospitals' focus on the Medicare TCOC of their MPA-attributed populations.

- *Improvement Strategy*. The State proposes a comprehensive strategic plan for improving the hospital quality programs under the MDTCOC model. We are supportive of the State's efforts to include population health measures in the hospital pay for performance quality programs. Furthermore, we are excited to continue working with the State to create a vision for Maryland's quality and population health priorities and goals under the TCOC Model, in particular developing a framework for the Statewide Integrated Health Improvement Strategy (SIHIS). CMS requests the State to have the broad framework for SIHIS to be in place by December 2019 and the goals with measures and targets finalized as soon as possible in 2020.

In regards to the State's Revenue at Risk for RY2019, thank you for including this preliminary information in your request for exemption from the national hospital quality programs. It is helpful to see an initial comparison of the percentage of hospital regulated revenue is at risk under the state-based programs versus the national programs. We look forward to receiving the final data in October 2019, and plan to provide our review shortly thereafter.

Thank you for your continued efforts to improve the hospital quality programs within the State of Maryland. Should you have any questions, please do not hesitate to contact the MDTCOC model team.

Sincerely,

Dawn Alley, PhD
Acting Director, State Innovations Group

APPENDIX II. HSCRC QBR PROGRAM BACKGROUND, DETAILED OVERVIEW

The Affordable Care Act established the hospital Medicare Value-Based Purchasing (VBP) program,[12] which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. The program assesses hospital performance on a set of measures in Clinical Care, Person and Community Engagement, Safety, and Efficiency domains. The incentive payments are funded by reducing the base operating diagnosis-related group (DRG) amounts that determine the Medicare payment for each hospital inpatient discharge.[13] The Affordable Care Act set the maximum penalty and reward at 2 percent for federal fiscal year (FFY) 2017 and beyond.[14]

Maryland's Quality-Based Reimbursement (QBR) program, in place since July 2009, employs measures that are similar to those in the federal Medicare VBP program, under which all other states have operated since October 2012. Similar to the VBP program, the QBR program currently measures performance in Clinical Care, Safety, and Person and Community Engagement domains, which comprise 15 percent, 35 percent, and 50 percent of a hospital's total QBR score, respectively. For the Safety and Person and Community Engagement domains, which constitute the largest share of a hospital's overall QBR score (85 percent), performance standards are the same as those established in the national VBP program. The Clinical Care Domain, in contrast, uses a Maryland-specific mortality measure and benchmarks. In effect, Maryland's QBR program, despite not having a prescribed national goal, reflects Maryland's rankings relative to the nation by using national VBP benchmarks for the majority of the overall QBR score.

In addition to structuring two of the three domains of the QBR program to correspond to the federal VBP program, the Commission has increasingly emphasized performance relative to the nation through benchmarking, domain weighting, and scaling decisions. For example, beginning in RY 2015, the QBR program began utilizing national benchmarks to assess performance for the Person and Community Engagement and Safety domains. Subsequently, the RY 2017 QBR policy increased the weighting of the Person and Community Engagement domain, which was measured by the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey instrument to 50 percent. The weighting was increased in order to raise incentives for HCAHPS improvement, as Maryland has consistently scored in the lowest decile nationally on these measures. In RY 2020, ED-1b, and ED-2b wait time measures for admitted patients were added to this domain with the domain weight remaining at 50 percent; in RY 2021, the domain weight remained constant but the ED-1b measure was removed from the program.

While the QBR program has many similarities to the federal Medicare VBP program, it does differ because Maryland's unique Model Agreements and autonomous position allow the State to be innovative and progressive. Figure 12 below compares the RY 2021 QBR measures and domain weights to those used in the CMS VBP program.

[12] 42 USC § 1395ww(o)(7).

[13] 42 USC § 1395ww(o)(7)(C).

[14] The HCAHPS increase reduced the Clinical Care domain from 20 percent to 15 percent.

Figure 12. RY 2021 QBR Measures and Domain Weights Compared with CMS VBP Program[15]

	Maryland QBR Domains and Measures	CMS VBP Domain Weights and Measure Differences
Clinical Care	15 percent (2 measures: all cause inpatient Mortality; THA/TKA Complication)	25 percent (4 measures: condition-specific Mortality, THA/TKA Complication)
Person and Community Engagement	50 percent (8 HCAHPS measures, ED-2b wait time measure)	25 percent Same HCAHPS measures, no ED wait time measures
Safety	35 percent (5 measures: CDC NHSN)*	25 percent (5 measures: CDC NHSN)*
Efficiency	N/A	25 percent (Medicare Spending Per Beneficiary measure)

*While there are six Healthcare Associated Infection categories, the two SSI colon and hysterectomy categories are combined resulting in five Safety domain measures.

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019, and involves: 1) assessing performance on each measure in the domain; 2) standardizing measure scores relative to performance standards; 3) calculating the total points a hospital earned divided by the total possible points for each domain; 4) finalizing the total hospital QBR score (0-100 percent) by weighting the domains based on the overall percentage or importance the Commission has placed on each domain; and 5) converting the total hospital QBR scores into revenue adjustments using the preset scale that ranges from 0 to 80 percent.

Domain Weights and Revenue At-Risk

As illustrated in the body of the report, for the RY 2021 QBR program, the policy weighted the clinical care domain at 15 percent of the final score, the Safety domain at 35 percent, and the Person and Community Engagement domain at 50 percent.

The HSCRC sets aside a percentage of hospital inpatient revenue to be held "at-risk" based on each hospital's QBR program performance. Hospital performance scores are translated into rewards and penalties in a process that is referred to as scaling.[16] Rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered

[15] Details of CMS VBP measures may be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html ; last accessed 10./28/19.

[16] Scaling refers to the differential allocation of a pre-determined portion of base-regulated hospital inpatient revenue based on assessment of the quality of hospital performance.

permanent revenue. The Commission previously approved scaling a maximum reward of 2 percent and a penalty of 2 percent of total approved base inpatient revenue across all hospitals.

HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the CMS VBP program where feasible,[17] allowing the HSCRC to use data submitted directly to CMS. As mentioned above, Maryland implemented an efficiency measure in relation to population based revenue budgets based on potentially avoidable utilization outside of the QBR program. The potentially avoidable utilization (PAU) savings adjustment to hospital rates is based on costs related to potentially avoidable admissions, as measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs) and avoidable readmissions. HSCRC staff will continue to work with key stakeholders to complete development of an efficiency measure that incorporates population-based cost outcomes.

QBR Score Calculation

QBR Scores are evaluated by comparing a hospital's performance rate to its base period rate, as well as the threshold (which is the median, or 50th percentile, of all hospitals' performance during the baseline period), and the benchmark, (which is the mean of the top decile, or approximately the 95th percentile, during the baseline period).

Attainment Points: During the performance period, attainment points are awarded by comparing an individual hospital's rates with the threshold and the benchmark. With the exception of the MD Mortality measure and ED Wait Time measures, the benchmarks and thresholds are the same as those used by CMS for the VBP program measures.[18] For each measure, a hospital that has a rate at or above benchmark receives 10 attainment points. A hospital that has a rate below the attainment threshold receives 0 attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1-9 attainment points

Improvement Points: The improvement points are awarded by comparing a hospital's rates during the performance period to the hospital's rates from the baseline period. A hospital that has a rate at or above the attainment benchmark receives 9 improvement points. A hospital that has a rate at or below baseline period rate receives 0 improvement points. A hospital that has a rate between the baseline period rate and the attainment benchmark receives 0-9 improvement points.

Consistency Points: The consistency points relate only to the experience of care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in all of the eight HCAHPS dimensions. If they do, they receive the full 20 points. If they do not, the dimension for which the hospital received the lowest score is compared to the range between

[17] VBP measure specifications may be found at: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html

[18] As an exception, for the ED wait time measures, attainment points are not calculated; instead full 10 points are awarded to hospitals at or below (more efficient) than the national medians for their respective volume categories in the performance period.

the national 0 percentile (floor) and the 50th percentile (threshold) and is awarded points proportionately.

Domain Denominator Adjustments: In particular instances, QBR measures will be excluded from the QBR program for individual hospitals. In the Person and Community Engagement domain, ED wait time measures (if included in the RY 2020 program) will be excluded for protected hospitals. As described in the body of the report, a hospital may exclude the ED-2b measure if it has earned at least one improvement point and if its improvement score would reduce its overall QBR score. If this measure is excluded, the Person and Community Engagement domain will reduce from 110 total points to 100 points.

Similarly, hospitals are exempt from measurement for any of the NHSN Safety measures for which there is less than 1 predicted case in the performance period. If a hospital is exempt from an NHSN measure, its Safety domain score denominator reduces from 50 to 40 points. If it is exempt from two measures, the Safety domain score denominator would be 30 total possible points. Hospitals must have at least 2 of 5 Safety measures in order to be included in the Safety domain.

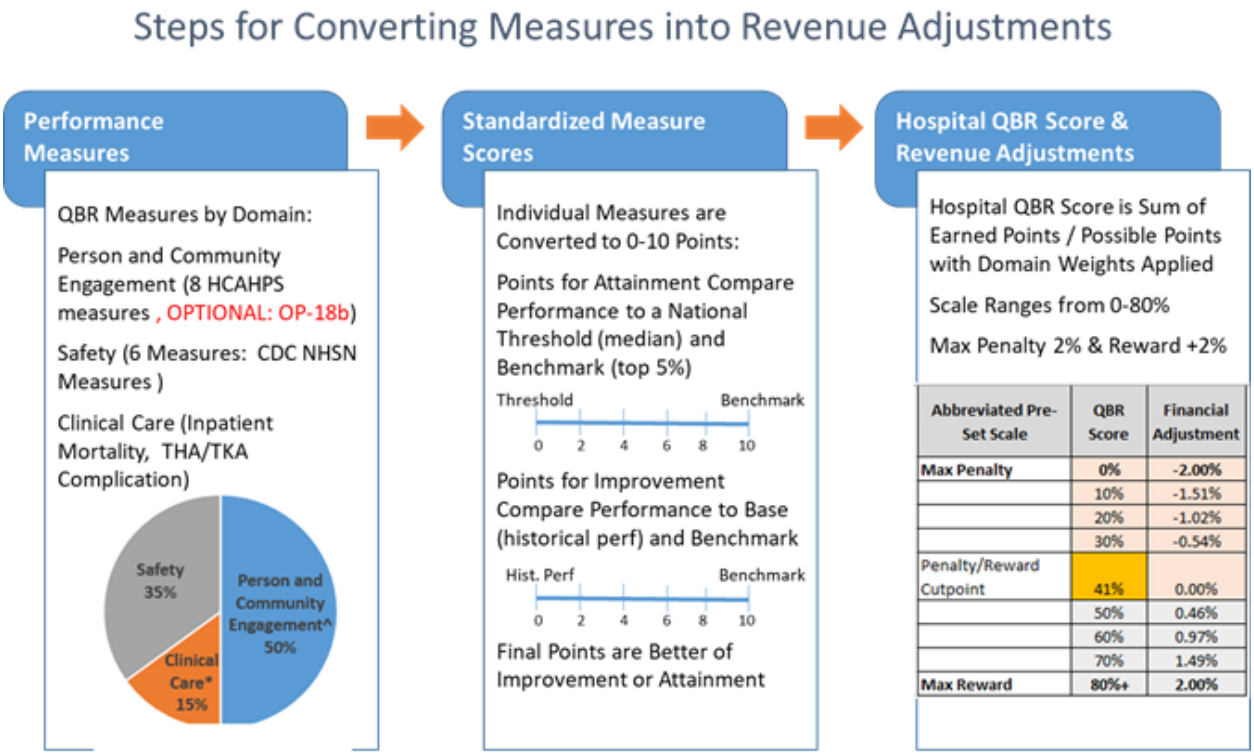
Domain Scores: The better of attainment and improvement for each measure is used to determine the measure points for each measure, which are then summed and divided by the total possible points in each domain and multiplied by 100.

Total Performance Score*:* The total Performance Score is computed by multiplying the domain scores by their specified weights, then adding those totals The Total Performance Score is then translated into a reward/ penalty that is applied to hospital revenue.

Proposed RY 2022 QBR Program Updates

For RY 2022, no fundamental changes to the methodology or measures are proposed. Figure 13 below depicts the steps for converting the measure scores to standardized scores for each measure, and then to rewards and penalties based upon total scores earned, with the proposed updates for RY 2022.

Figure 13. Proposed RY 2022 Process for Calculating QBR Scores



Similarly with the scoring and incentive methodology, there are no fundamental changes proposed for the measures and domain weighting for RY 2022, as illustrated in Figure 14 below.

Figure 14. Proposed RY 2022 QBR Domains, Measures and Data Sources

	Clinical Care	Person and Community Engagement	Safety
Proposed QBR RY 2022	15 percent 2 measures • Inpatient Mortality (HSCRC case mix data) • THA TKA (CMS Hospital Compare, Medicare claims data)	50 percent 8 or 9 measures • 8 HCAHPS domains (CMS Hospital Compare patient survey) • OPTIONAL: OP 18-b (CMS IQR chart abstracted)	35 percent 5 measures • 6 CDC NHSN HAI categories (CMS Hospital Compare chart abstracted)

Figure 15 illustrates the base and performance period timeline for the RY 2022 QBR program.

Figure 15. RY 2022 Proposed Timeline (Base and Performance Periods; Financial Impact)

Rate Year (Maryland Fiscal Year)	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20	Q1-21	Q2-21	Q3-21	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22
Calendar Year	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20	Q1-21	Q2-21	Q3-21	Q4-21	Q1-22	Q2-22
Rate Year 2022																						
Quality Based Reimbursement (QBR) Base and Performance Periods					Hospital Compare Base Period (HCAHPS measures, All NHSN Measures, optional OP-18)																Rate Year Impacted by QBR Results	
												Hospital Compare Performance Period (HCAHPS measures, All NHSN measures, optional 18-b)										
							QBR Maryland Mortality Base Period															
													QBR Maryland Mortality Performance Period								
		Hospital Compare THA/TKA Performance Period**																				

**Hospital Compare THA /TKA Complications Base Period April 1, 2012-March 31, 2015

APPENDIX III. RY 2020 HCAHPS MEASURE RESULTS BY HOSPITAL

	HCAHPS Measure	Clean/Quiet		Nurse Commun-ication		Doctor Commun-ication		Staff Respon-siveness		Understood Medications		Discharge Information		Care Transitions Measure		Top-Rated Hospital	
HospID	HospName	Perf	Change from Base	Perf	Change from Base	Perf	Change from Base	Perf	Change from Base	Perf	Change from Base	Perf	Change from Base	Perf	Change from Base	Perf	Change from Base
210001	MERITUS MEDICAL CENTER	63.5	1	79	2	76	0	64	3	60	-2	89	1	48	3	64	-4
210002	UNIVERSITY OF MARYLAND MEDICAL CENTER	57	-1.5	78	0	79	1	60	0	62	4	89	4	51	-1	67	-4
210003	UM-PRINCE GEORGE'S HOSPITAL CENTER	51.5	-2.5	64	1	73	-1	44	2	52	4	80	3	38	4	48	3
210004	HOLY CROSS HOSPITAL	64	-1	73	3	75	1	57	2	54	0	81	1	43	-2	66	4
210005	FREDERICK MEMORIAL HOSPITAL	69	-0.5	78	-2	77	-2	59	-1	63	1	88	-1	49	-2	68	-2
210006	UM-HARFORD MEMORIAL HOSPITAL	58.5	8	81	8	80	6	59	7	60	-1	87	3	53	3	67	7
210008	MERCY MEDICAL CENTER	70	1	79	-1	78	-4	65	0	69	3	89	0	56	2	78	0
210009	JOHNS HOPKINS HOSPITAL	70	2	82	2	81	0	61	0	65	3	88	0	59	1	82	1
210011	ST. AGNES HOSPITAL	59	-1	75	0	79	1	61	4	62	3	84	-2	49	5	66	2
210012	SINAI HOSPITAL	61	-7	77	0	76	-1	59	-2	57	-7	85	0	50	-1	70	1
210013	BON SECOURS HOSPITAL	66.5	8.5	74	11	80	5	66	15	64	16	87	5	45	9	48	7
210015	MEDSTAR FRANKLIN SQUARE	62	7	76	2	77	3	60	7	63	8	87	2	48	6	66	5
210016	WASHINGTON ADVENTIST HOSPITAL	62	-0.5	75	2	78	1	62	6	61	3	83	-2	44	4	70	3
210017	GARRETT COUNTY MEMORIAL HOSPITAL	67	5.5	80	0	84	0	70	1	65	-3	90	0	52	7	75	6
210018	MEDSTAR MONTGOMERY MEDICAL CENTER	56.5	-6.5	73	1	75	0	55	1	57	1	88	0	44	1	64	4
210019	PENINSULA REGIONAL MEDICAL CENTER	62.5	-0.5	79	3	77	3	60	-1	58	-5	89	-1	55	6	73	4
210022	SUBURBAN HOSPITAL	64	-2.5	78	-1	81	0	64	-1	59	-1	85	1	53	1	71	0
210023	ANNE ARUNDEL MEDICAL CENTER	67	2	81	1	82	0	69	-1	61	-2	87	0	55	-1	78	-1
210024	MEDSTAR UNION MEMORIAL HOSPITAL	64	-4.5	76	-3	79	-5	61	0	65	2	89	-1	49	0	67	-7
210027	WESTERN MARYLAND REGIONAL MEDICAL CENTER	66.5	1	79	-2	77	-2	64	0	64	-2	90	-2	49	-2	70	1
210028	MEDSTAR ST. MARY'S HOSPITAL	66	2	78	-1	78	-1	60	-2	64	4	91	2	50	1	67	-3
210029	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	58.5	1	78	1	80	2	61	-2	62	1	89	1	53	2	71	4
210030	UM-SHORE REGIONAL HEALTH AT CHESTERTOWN	64	5.5	81	6	81	5	73	8	66	13	88	3	48	6	67	12
210032	UNION HOSPITAL OF CECIL COUNTY	57	-3.5	76	-1	75	-5	61	-1	55	-5	88	-3	43	-3	62	-6
210033	CARROLL HOSPITAL CENTER	65.5	2.5	79	1	75	2	64	3	62	3	87	1	51	2	64	-5
210034	MEDSTAR HARBOR HOSPITAL CENTER	64	-2	76	2	80	1	62	2	61	3	85	-2	46	1	63	-3
210035	UM-CHARLES REGIONAL MEDICAL CENTER	64	6	78	7	77	3	62	3	61	3	86	-1	48	4	63	3
210037	UM-SHORE REGIONAL HEALTH AT EASTON	66.5	7.5	79	1	77	-2	67	0	60	1	85	3	50	3	64	6
210038	UMMC MIDTOWN CAMPUS	65.5	-0.5	72	1	76	-2	61	1	61	10	84	-3	46	3	58	1
210039	CALVERT HEALTH MEDICAL CENTER	62.5	0	82	5	79	1	64	4	63	0	85	-3	52	4	66	-1
210040	NORTHWEST HOSPITAL CENTER	65	-1.5	76	-4	76	-2	65	-4	62	2	86	-2	49	0	65	-2
210043	UM-BALTIMORE WASHINGTON MEDICAL CENTER	65	6	79	2	78	3	63	4	62	0	87	2	52	3	73	6
210044	GREATER BALTIMORE MEDICAL CENTER	57.5	-2	80	4	82	1	58	-7	62	3	87	2	51	2	72	2
210048	HOWARD COUNTY GENERAL HOSPITAL	65	3	81	4	78	1	62	3	63	2	87	2	52	3	70	0
210049	UM-UPPER CHESAPEAKE MEDICAL CENTER	63	2	82	4	78	4	57	-6	64	4	88	6	52	2	70	4
210051	DOCTORS COMMUNITY HOSPITAL	61	-1.5	73	0	72	-5	61	8	54	-2	85	-2	46	1	62	-1
210055	UM-LAUREL REGIONAL HOSPITAL	59	0.5	61	-2	65	-8	54	10	48	-12	79	0	41	1	52	6
210056	MEDSTAR GOOD SAMARITAN	61.5	4	74	2	79	3	55	-1	61	3	86	-1	46	1	62	1
210057	SHADY GROVE ADVENTIST HOSPITAL	62	3	75	0	76	0	56	3	58	0	87	-1	48	3	70	5
210060	FORT WASHINGTON MEDICAL CENTER	56	-3	70	1	74	-2	56	7	61	4	81	-5	45	7	51	-8
210061	ATLANTIC GENERAL HOSPITAL	59	3.5	82	4	82	5	67	3	61	2	91	0	51	0	71	4
210062	MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	61	2.5	71	-1	77	2	59	5	57	2	83	-3	44	7	57	4
210063	UM-ST. JOSEPH MEDICAL CENTER	62.5	-6	80	-1	80	-2	65	-2	61	1	89	0	57	-2	76	1
210065	HOLY CROSS HOSPITAL-GERMANTOWN	68	3	67	-2	75	-1	54	2	55	-3	84	0	46	-3	69	2

APPENDIX IV. RY 2020 QBR PERFORMANCE STANDARDS

Person and Community Engagement Domain*

Dimension	Benchmark	Achievement Threshold (50th percentile)	Floor (Minimum)
Communication with Nurses	87.53 percent	79.18 percent	15.73 percent
Communication with Doctors	87.85 percent	79.72 percent	19.03 percent
Responsiveness of Hospital Staff	81.29 percent	65.95 percent	25.71 percent
Communication about Medicines	74.31 percent	63.59 percent	10.62 percent
Cleanliness and Quietness of Hospital Environment	79.41 percent	65.46 percent	5.89 percent
Discharge Information	91.95 percent	87.12 percent	66.78 percent
3-Item Care Transition	63.11 percent	51.69 percent	6.84 percent
Overall Rating of Hospital	85.18 percent	71.37 percent	19.09 percent

*The Person and Community Engagement performance standards displayed in this table were calculated using four quarters of calendar year 2018 data, and published in the CMS Inpatient Prospective Payment System FFY 20 Final Rule.

Safety Domain*

Measure Short ID	Measure Description	Benchmark	Achievement Threshold
CAUTI	Catheter-Associated Urinary Tract Infection	0.00	0.727
CDI	Clostridium *difficile* Infection	0.047	0.646
CLABSI	Central Line-Associated Blood Stream Infection	0.00	0.633
MRSA	Methicillin-Resistant Staphylococcus *aureus*	0.00	0.748
SSI	SSI - Abdominal Hysterectomy	0.00	0.727
	SSI - Colon Surgery	0.00	0.749

*The Safety Domain performance standards were published in the CMS Inpatient Prospective Payment System FFY 20 Final Rule.

Clinical Care Domain

Measure Short ID	Measure Description	Benchmark	Achievement Threshold
Mortality	All Condition Inpatient Mortality	TBD*	TBD*
THA/TKA RSCR**	Total Hip/Knee Arthroplasty Risk Standardized Complication Rate	0.021493	0.029833

*Mortality standards will be calculated by HSCRC staff and disseminated with implementation of v. 37 of the APR DRG grouper.
**THA/TKA standards were published in the CMS Inpatient Prospective Payment System FFY 20 Final Rule.

APPENDIX V. MODELING OF SCORES BY DOMAIN: RY 2020 QBR DATA WITH RY 2022 MEASURE UPDATES

This appendix includes modeled QBR scores with ED wait times removed, THA-TKA measure included, and technical changes to the mortality measure.

Hospital ID	Hospital Name	HCAHPS Score	Mortality Score	THA-TKA Score	Safety Score	Total Score
		50%	10%	5%	35%	
210001	Meritus	23%	10%	60%	33%	27.17%
210002	UMMC	19%	0%	100%	32%	25.58%
210003	UM-PGHC	8%	20%		17%	12.83%
210004	Holy Cross	15%	40%	0%	18%	17.92%
210005	Frederick	20%	100%	0%	35%	32.25%
210006	UM-Harford	33%	50%	70%	70%	49.50%
210008	Mercy	39%	60%	90%	23%	38.17%
210009	Johns Hopkins	43%	30%		23%	34.17%
210010	UM-Dorchester	27%	50%	90%	45%	38.75%
210011	St. Agnes	19%	40%	90%	35%	30.25%
210012	Sinai	15%	20%	100%	33%	26.17%
210013	Bon Secours	36%	50%		23%	33.67%
210015	MedStar Fr Square	33%	70%	100%	62%	50.08%
210016	Washington Adventist	21%	40%	90%	60%	40.00%
210017	Garrett	47%	10%	90%		44.89%
210018	MedStar Montgomery	15%	30%	70%	60%	35.00%
210019	Peninsula	30%	70%	100%	27%	36.33%
210022	Suburban	21%	20%	100%	18%	23.80%
210023	Anne Arundel	36%	40%	100%	42%	41.58%
210024	MedStar Union Mem	23%	30%	100%	8%	22.13%
210027	Western Maryland	24%	20%	10%	38%	27.92%
210028	MedStar St. Mary's	26%	90%	100%	17%	32.83%
210029	JH Bayview	22%	30%	100%	28%	28.92%
210030	UM-Chestertown	47%	100%	100%		59.19%
210032	Union of Cecil	14%	40%	50%	58%	33.63%
210033	Carroll	24%	100%	100%	42%	41.58%
210034	MedStar Harbor	18%	90%	10%	23%	26.67%
210035	UM-Charles Regional	28%	80%	100%	48%	43.92%
210037	UM-Easton	27%	40%	90%	45%	37.75%
210038	UMMC Midtown	18%	100%	80%	30%	33.50%
210039	Calvert	24%	100%	100%	80%	55.00%
210040	Northwest	17%	90%	70%	20%	28.00%

Hospital ID	Hospital Name	HCAHPS Score	Mortality Score	THA-TKA Score	Safety Score	Total Score
		50%	10%	5%	35%	
210043	UM-BWMC	31%	80%	0%	32%	34.58%
210044	GBMC	24%	90%	40%	43%	38.17%
210048	Howard County	27%	70%	50%	53%	41.67%
210049	UM-Upper Chesapeake	31%	60%	100%	57%	46.33%
210051	Doctors	16%	40%	60%	82%	43.70%
210056	MedStar Good Sam	18%	70%	20%	38%	30.30%
210057	Shady Grove	18%	10%	70%	45%	29.25%
210060	Ft. Washington	15%	60%	40%		23.75%
210061	Atlantic General	35%	70%	10%	60%	46.00%
210062	MedStar Southern MD	19%	20%	100%	45%	32.25%
210063	UM-St. Joe	31%	90%		63%	51.17%
210065	HC-Germantown	14%	80%		10%	22.50%

Appendix VI. Modeling of QBR Program Revenue Adjustments

HOSPID	HOSPITAL NAME	RY19 Permanent Inpatient Revenue	RY 2022 Modeled QBR Points	% Revenue Impact	$ Revenue Impact
210001	MERITUS	$219,551,750	27.17%	-0.67%	-$1,470,997
210002	UNIVERSITY OF MARYLAND	$1,203,673,856	25.58%	-0.75%	-$9,027,554
210003	PRINCE GEORGE	$282,929,188	12.83%	-1.37%	-$3,876,130
210004	HOLY CROSS	$355,608,692	17.92%	-1.13%	-$4,018,378
210005	FREDERICK MEMORIAL	$232,665,827	32.25%	-0.43%	-$1,000,463
210006	HARFORD	$54,181,186	49.50%	0.44%	$238,397
210008	MERCY	$226,492,002	38.17%	-0.14%	-$317,089
210009	JOHNS HOPKINS	$1,456,687,424	34.17%	-0.33%	-$4,807,068
210010	DORCHESTER	$22,653,845	38.75%	-0.11%	-$24,919
210011	ST. AGNES	$238,757,730	30.25%	-0.52%	-$1,241,540
210012	SINAI	$399,817,673	26.17%	-0.72%	-$2,878,687
210013	BON SECOURS	$64,363,349	33.67%	-0.36%	-$231,708
210015	FRANKLIN SQUARE	$306,898,504	50.08%	0.47%	$1,442,423
210016	WASHINGTON ADVENTIST	$164,197,283	40.00%	-0.05%	-$82,099
210017	GARRETT COUNTY	$23,714,400	44.89%	0.20%	$47,429
210018	MONTGOMERY GENERAL	$84,721,645	35.00%	-0.29%	-$245,693
210019	PENINSULA REGIONAL	$249,228,264	36.33%	-0.23%	-$573,225
210022	SUBURBAN	$208,954,270	23.80%	-0.84%	-$1,755,216
210023	ANNE ARUNDEL	$294,544,506	41.58%	0.03%	$88,363
210024	UNION MEMORIAL	$243,156,679	22.13%	-0.92%	-$2,237,041
210027	WESTERN MARYLAND	$169,462,000	27.92%	-0.64%	-$1,084,557
210028	ST. MARY	$79,141,046	32.83%	-0.40%	-$316,564
210029	HOPKINS BAYVIEW MED CTR	$366,607,627	28.92%	-0.59%	-$2,162,985
210030	CHESTERTOWN	$17,859,942	59.19%	0.93%	$166,097
210032	UNION HOSPITAL OF CECIL	$65,426,887	33.63%	-0.36%	-$235,537
210033	CARROLL COUNTY	$140,291,849	41.58%	0.03%	$42,088
210034	HARBOR	$110,392,040	26.67%	-0.70%	-$772,744
210035	CHARLES REGIONAL	$76,930,098	43.92%	0.15%	$115,395
210037	EASTON	$103,481,053	37.75%	-0.16%	-$165,570
210038	UMMC MIDTOWN	$111,141,002	33.50%	-0.37%	-$411,222
210039	CALVERT	$67,111,996	55.00%	0.72%	$483,206
210040	NORTHWEST	$138,719,920	28.00%	-0.63%	-$873,935
210043	BALTIMORE WASHINGTON	$250,217,336	34.58%	-0.31%	-$775,674

HOSPID	HOSPITAL NAME	RY19 Permanent Inpatient Revenue	RY 2022 Modeled QBR Points	% Revenue Impact	$ Revenue Impact
210044	G.B.M.C.	$237,787,317	38.17%	-0.14%	-$332,902
210048	HOWARD COUNTY	$182,870,977	41.67%	0.03%	$54,861
210049	UPPER CHESAPEAKE HEALTH	$128,686,091	46.33%	0.27%	$347,452
210051	DOCTORS COMMUNITY	$141,094,311	43.70%	0.14%	$197,532
210056	GOOD SAMARITAN	$146,901,579	30.30%	-0.52%	-$763,888
210057	SHADY GROVE	$251,748,234	29.25%	-0.57%	-$1,434,965
210060	FT. WASHINGTON	$19,890,383	23.75%	-0.84%	-$167,079
210061	ATLANTIC GENERAL	$36,931,910	46.00%	0.26%	$96,023
210062	SOUTHERN MARYLAND	$162,087,856	32.25%	-0.43%	-$696,978
210063	UM ST. JOSEPH	$223,399,907	51.17%	0.52%	$1,161,680
210065	HC-GERMANTOWN	$59,062,315	22.50%	-0.90%	-$531,561
	Statewide Total	**$9,620,041,749**			**-$40,033,022**
		Average			-0.42%

Scaling Components	Values
QBR Lowest Score	0
QBR Max Penalty	-2%
QBR Highest Score	80%
QBR Max Reward	2%
QBR Threshold	41%

Total Penalties	-44,513,968
% Inpatient Revenue	-0.46%
Total rewards	4,480,946
% Inpatient revenue	0.05%

November 13, 2019

Nurse Support Program II: 5 Year Evaluation and Draft Recommendations for Future Funding

Oscar Ibarra, HSCRC
Peg Daw, MHEC

Nurse Support Program II : An Overview

- Established in 2005 to increase Maryland's academic capacity for nursing education
- Administered by the Maryland Higher Education Commission (MHEC)
- Funded through pooled assessments totaling up to 0.1% of hospital regulated gross patient revenue
- Goal: to increase nursing graduates and mitigate barriers to nursing education through institutional and faculty focused initiatives.

Major Achievements By Initiative

Initiative #1: Ensuring educational capacity for nursing pre-licensure enrollments and graduates

- Increased the first time pass rate for NCLEX-RN nursing licensure by 8.51%
- Recruited 162 new nurse faculty into full-time positions, maintaining 93% retention rate.

Initiative #2: Advancing academic preparation of entry-level nurses and existing nurses to meet the needs of hospitals and health systems (80 percent BSN)

- Improved time to completion of Associate to Bachelors in Nursing (ATB) by 50%; estimated cost saving of $13K per new nurse graduate
- Increased proportion of BSN nurses to 60% to meet hospital skill mix.

Major Achievements By Initiative

Initiative #3: Doubling the number of nurses and nurse faculty with doctoral degrees

- Increased the number of doctoral degree completions by 78%
- Provided funding for 63 full-time nurse faculty to complete terminal doctoral degree while maintaining a 89% retention rate

Initiative #4: Promoting academic/practice partnerships

- Expanded NSP II opportunities to 558 hospital-based nurses across 7 programs.
- Provided focused leadership development for 48 nurse faculty and 89 hospital emerging and existing nurse leaders through the Nurse Leadership Institute
- Expanded training for 343 nurse faculty and 51 hospital educators; increasing by 12% the use of clinical simulation in lieu of clinical sites.

Major Achievements By Initiative

Initiative #5: Developing statewide resources and models for inter-professional education, alternative clinical practice sites, and clinical faculty preparation

- Established the Maryland Nursing Workforce Center and joined 34 other states in the National Forum of State Nursing Workforce Centers
- Updated the Maryland Nursing Articulation Education Agreement (originally established in 1985) for seamless academic progression from Associate Degree Nursing to BSN for Licensed Practical Nurses in 2017.

Draft Staff Recommendations

- **Recommendation 1**: Renew NSP II funding for next five years, FY 2021 through FY 2025
- **Recommendation 2**: Establish a Workgroup to Recommend Updates to Statewide Initiatives
- **Recommendation 3**: Continue Established Competitive Institutional Grants Initiatives #1-5
- **Recommendation 4**: Form NSP I and NSP II Advisory Board to Address Common Issues Between Academia and Practice
- **Recommendation 5**: Improve Infrastructure for Nursing Workforce Data

Nurse Support Program II (NSP II)

Outcomes Evaluation FY 2016–FY 2020 and

Draft Recommendations for Future Funding

November 13, 2019

Health Services Cost Review Commission

4160 Patterson Avenue Baltimore, Maryland 21215

(410) 764-2605

FAX: (410) 358-6217

This recommendation is a draft proposal. No Commission action is required at this time. Public comment should be sent to Oscar Ibarra at the above address or by e-mail at Oscar.Ibarra@maryland.gov. For full consideration, comments must be received by **December 1, 2019.**

Nurse Support Program II (NSP II) Outcomes Evaluation FY 2016-FY 2020 and Recommendations for Future Funding

Background

The registered nurse (RN) workforce is the single largest group of health professionals, with more than three million nationally and 54,000 employed in the State of Maryland (DLLR, 2018). Changes in the nursing workforce and profession invariably impact health care systems. The Maryland Health Services Cost Review Commission (HSCRC) recognized the importance of nursing to the health of the State when it created the first Nurse Education Support Program in 1986, followed by implementation of the first phase of the Nurse Support Program I (NSP I) in June 2001, to address the short and long-term issues of recruiting and retaining nurses in Maryland hospitals. NSP I has been funded over 19 years with the most recent program evaluation and renewal in 2017. The HSCRC established the Nurse Support Program II (NSP II) on May 4, 2005, to increase Maryland's academic capacity to educate nurses [2006, chs. 221, 222]. The NSP II, administered by the Maryland Higher Education Commission (MHEC) in collaboration with the HSCRC, has been funded for 15 years and is complementary to the NSP I, the hospital-based program. The NSP I and NSP II are each funded through pooled assessments totaling up to 0.1 percent of hospital regulated gross patient revenue for the NSP I noncompetitive hospital requests and the NSP II competitive institutional grants with faculty-focused statewide initiatives. In 2016, Senate Bill (SB) 108 was passed to remove the term "bedside" nurse from the statute to allow NSP I and II to focus on improving the pipeline of nurses with the skills necessary to keep pace with a rapidly changing health care delivery system.

NSP II is designed to increase nursing graduates and mitigate barriers to nursing education through institutional and faculty focused initiatives. The program employs an effective three-prong strategy to increase the number of nurses, improve quality of care, and reduce hospital costs. These goals are achieved by 1) growing the number of nursing lecture and clinical faculty, 2) supporting schools and departments of nursing in strengthening academic capacity and curriculum, and 3) providing support to enhance nursing enrollments and graduation for an adequate supply of nurses to meet the demands of Maryland's hospitals and health systems. NSP II has been funded over the past five years, including a carryover balance from FY 2015, with approximately $90 million for FY 2016 – FY 2020.

In 2012, the Nurse Support Program I and II initiatives were aligned with the Institute of Medicine (IOM) recommendations in its *Future of Nursing* report and included the following aims:

1. Ensuring nursing educational capacity for Nursing Pre-Licensure Enrollments and Graduates, including Associate Degree in Nursing, Bachelor of Science in Nursing (BSN), Master of Science Entry and Second Degree BSN Entry preparation for licensure

by the National Council Licensure Examination for Registered Nurses (NCLEX-RN) to determine safety of new graduate nurses to enter practice.

2. Advancing academic preparation of entry-level nurses and experienced nurses to meet the needs of hospitals and health systems for a higher proportion of registered nurses with a Baccalaureate (BSN) or higher degree in Nursing.
3. Increasing the number of nurses and nurse faculty with graduate education and doctoral degrees to prepare them as leaders, researchers, and educators in academic and clinical settings, and advanced practice nurses.
4. Building collaborations between nursing education and practice for improved nursing competency through seamless academic progression and lifelong learning to improve patient outcomes and satisfaction.
5. Developing statewide resources and models for clinical simulation, leadership, inter-professional education, alternative clinical practice sites, and clinical faculty preparation.
6. Ensuring a cadre of qualified faculty and clinical nursing instructors with efforts to provide graduate educational support, recruit new faculty, retain experienced educators, and increase the number of certified nurse faculty in the specialty practice of nursing education.
7. Advancing the practice of nursing in provision of primary services as nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists.
8. Providing for the nursing workforce data infrastructure for future workforce analysis.

This investment has resulted in Maryland being recognized as a leader in advancing practice and educational initiatives for improved nurse competency and better patient outcomes. This report will update the Commission on the current state of nursing, the progress of the NSP II, and provide recommendations for the future of the program.

Major NSP II Achievements

This report contains the analysis of nursing program outcome data using the revised nursing and organizational metrics instituted in 2015 to assess progress in achieving these NSP II aims. Program achievements and areas for continued guidance and improvement are highlighted below and in the following sections of this report.

1. Expanded NSP II opportunities to 558 hospital-based nurses across seven programs.
2. Increased the first time pass rates for NCLEX-RN nursing licensure by 8.51 percent.
3. Increased the number of doctoral degree completions by 78 percent, exceeding the goal of 50 percent set by IOM.
4. Improved time to completion of Associate to Bachelors in Nursing (ATB) by 50 percent, with an estimated cost saving of approximately $13K per new nurse graduate.
5. Between FY 2018 and FY 2019, increased number of nurse faculty with Certified Nurse Educator credentials by 55 percent.

6. Provided graduate degree tuition support for 26 hospital-based professional development specialist nurse educators and 224 new nursing program instructors.
7. Expanded training for 343 nurse faculty and 51 hospital educators; increasing by 12 percent the number of nurses accessing clinical simulation lieu of clinical sites.
8. Increased by 60 percent the proportion of BSN-prepared nurses with the skills to meet hospital needs.
9. Provided focused leadership development for 48 nurse faculty and 89 hospital emerging and existing nurse leaders through a year-long leadership program.
10. Provided tuition support and course release time for 63 full time nurse faculty to complete the terminal doctoral degree, resulting in an 89 percent retention rate for teaching positions.
11. Recruited 162 new nurse faculty into full-time positions, with 93 percent retention rate.
12. Maryland Nursing Articulation Education Agreement (originally established in 1985) for seamless academic progression for Licensed Practical Nursing to Associate Degree Nursing to BSN was revised and updated in 2017.
13. Maryland Nursing Workforce Center was formally established and joined 34 other states in the National Forum of State Nursing Workforce Centers.

Maryland is a Leader in Nursing Education and Practice

The *U.S. News and World Report* (2019) recognized Maryland with two nursing graduate programs in the top 10 in the United States for *Best Nursing Schools*. Johns Hopkins University School of Nursing (JHUSON) was recognized for being #1 for Doctor of Nursing Practice and Master of Science in Nursing. The University of Maryland School of Nursing (UMSON) and JHUSON were also recognized repeatedly in the top 10 for Clinical Nurse Leader, Nurse Practitioners in Family Care, Adult Acute, Adult Primary Care and Psychiatric Mental Health; along with *Best Nursing Schools* in the areas of Nurse Anesthesia, Nursing Informatics, and Nursing Administration.

The Maryland Nurse Residency Collaborative (MNRC) was recognized as a leader under the auspices of the Maryland Organization of Nurse Leaders (MONL) in 2019 when all 40 hospitals and health systems in the state required a nurse residency program for all new graduate nurses. Maryland is the first state in the nation to meet this *Future of Nursing* (IOM, 2010) recommendation and goal of the American Academy of Nursing. All of Maryland's acute care hospitals now fund and offer a 12-month statewide standardized nurse residency program.

The National League for Nursing (NLN) recognized Maryland for statewide leadership through NSP II, at the direction of the Maryland Council of Deans and Directors of Nursing Programs, for focused efforts and incentives to increase the number of certified nurse educators (CNE®) across all nursing education programs. Recent figures indicate Maryland has twice the number of new CNEs completing the credentialing process as any other state.

Excellence in education and practice are the two primary overarching goals of the Nurse Support Program. Programs are directed at building educational capacity and strengthening nurse educators for an adequate supply of well-prepared nurses for the hospitals and health systems.

Nursing Workforce Projections

Nursing workforce shortage estimates vary widely. Reports range from the worst nursing shortage since the 1960's initiation of Medicare and Medicaid by 2025 (Buerhaus, et al., 2009); to regional RN shortages of about 500K across the country between 2016 and 2030, with the most intense shortfalls in open positions occurring in the South (about 250K) and West (about 240K) (Zhang, X, et al., 2018). Five years ago, a U.S. Health Resources and Services Administration (HRSA) report projected that Maryland would be the only state among its geographic neighbors to experience a shortfall of 12,000 RNs (HRSA, 2014) while another more recent report published two years ago predicted a surplus of 12,100 RNs in Maryland (HRSA, 2017). Although progress has been made, efforts need to be continued to ensure a strong pipeline of entry level nurses.

A leading national nursing workforce researcher, Dr. Peter Buerhaus, and his team of economists found a near balance in supply and demand for RNs nationally, but advised that there are many variables that impact these figures, including nursing career decisions of the youngest nurses; the uncertainty of regional forecasts as nurses move between regions; and the effects of RNs joining temporary staffing agencies (Buerhaus, et al., 2017). HRSA continues to explore systematic differences in state-based administrative data and analyze how each model handles entry to practice output. In fact, all researchers agree that "co-monitoring changes in RN entry is the single most important factor that affects each model and hence accuracy of its projections" (Auerbach, et al., 2017, pg. 294). Researchers are encouraging caution when using forecast models for policy and decision-making, as nursing shortages are highly sensitive to multiple variables and difficult to pinpoint beyond regional trends.

Many of the national data models utilize surveys, while state-level data is more granular; it includes the actual number of nurse graduates, the number of newly licensed nurses entering the profession, and changes in the educational skill level of the nursing workforce. The number of first-time NCLEX-RN testers may be a better reflection of the number of new nurses in Maryland, since RN entry to practice is the most important factor affecting projections of the nursing workforce supply (Figure 1). Testing candidates may be graduates of an Associate Degree in Nursing, Bachelor of Science in Nursing (BSN), second degree BSN, or entry-level Master of Science in Nursing program.

Over the past five years, from FY 2015 to FY 2019, the number of first-time testers has declined, possibly due to factors such as program changes, an improved economy, or the focus on increasing the BSN or higher entry-level nurse. However, the percent of first-time testers passing the licensure examination has improved. The Maryland Board of Nursing (MBON) scores for NCLEX-RN pass rates indicate the proportion of first-time testers who passed on the

first attempt increased by 8.51 percentage points for all MD programs, compared to 5.82 percentage point increase nationally (Table 1).

Figure 1. Maryland vs US for First-Time NCLEX-RN Candidates, FY 2015-FY 2019

Graduated Program		FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
MD BSN and Master's Entry Programs	# Tested	1,277	1,202	1,124	1,034	1,172
	# Passed	994	994	956	916	1,018
MD ADN Programs	# Tested	1,658	1,557	1,457	1,316	1,375
	# Passed	1,355	1,291	1,252	1,145	1,245
Total for MD Programs	# Tested	2,935	2,759	2,581	2,350	2,339
	# Passed	2,349	2,285	2,208	2,061	2,071
Total for U.S. Programs	# Tested	159,528	161,156	159,419	157,001	168,277
	# Passed	131,666	135,276	137,446	137,865	148,688

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

In 2018, *American Journal of Medical Quality* article reevaluated a previous supply and demand methodology using more recent workforce data and ranked states on projected RN shortages in 2030. In the article, Maryland was ranked 32 out of 50, and the nursing workforce shortage projected for 2030 was 9,745 nurses (Zhang, X, et al., 2018). The State cited with the nation's best nursing supply vs. demand balance utilized three best practices: 1) funding a permanent nursing workforce center to study the state level dynamics, 2) expanding enrollments in nursing programs and, 3) providing incentives for newly licensed nurses who practice in facilities for more than two years after graduation. Of those three best practices listed, NSP II has achieved measures to support two areas: increased enrollments, and a nursing workforce center. NSP I provides funding support for the nurse residency program as an incentive for newly licensed nurses.

Over the past two years, the University System of Maryland (USM) Health Care Workforce Working Group convened subgroups to examine four areas of urgency in health care education: 1) nursing articulation and collaboration, 2) clinical partnerships and placements, 3) inter-professional education, and 4) simulation facilities. The NSP II program evaluation committee agreed that the program is aligned with the recommendations in the USM report, *Strengthening Maryland's Health Care Workforce*. To address concerns in the nursing articulation and collaboration area, the Maryland Nursing Education Articulation agreement was updated in a collaborative effort in 2017. The NSPII program address the concerns regarding inter-professional education and simulation resources, as both are provided to all nursing programs and hospital educators. The remaining area of concern is the shortage of clinical placements, particularly the increased numbers of out-of-state nursing programs utilizing Maryland's clinical sites, and changes in student's clinical training opportunities at hospitals.

Competitive Institutional Grant Program and Statewide Initiatives

The NSP II supports two types of programs: Competitive Institutional Grants Program and Statewide Initiatives. Fifteen community colleges and thirteen universities across all geographic regions and types of programs in Maryland were encouraged to participate in the NSP II-funded initiatives. A brief description of each type of program follows.

Competitive Institutional Grant Program

These grants are designed to increase the structural capacity of Maryland nursing schools through shared resources, innovative educational designs, and streamlined processes to produce more nurse faculty, and undergraduate and graduate nurses. Activities may include the establishment of new degree programs, curriculum enhancement and redesign, simulation and other productivity-enhancing instructional technologies. These grants also contribute to the creation of a more diverse nursing faculty and workforce as well as preparing graduate-level nurses to serve as lecturers and/or clinical faculty at Maryland's higher education institutions. All grant recipient project directors are required to disseminate their work through publications in peer-reviewed journals or presentations to fellow nurses in Maryland and nationally. NSP II presentations have been made to organizations such as the Maryland Nurses Association (MNA), MONL, Maryland Action Coalition (MDAC), MNRC, NSP II project director meetings, or other professional nursing conferences. Each year, program updates from grant recipients and publication citations are added to the Nurse Support Program website.

Statewide Initiatives Program

These initiatives include the New Nurse Faculty Fellowships (NNFF), the Nurse Educator Doctoral Grants for Practice and Dissertation Research (NEDG), the Hal and Jo Cohen Graduate Nursing Faculty Scholarship (GNF) and the Academic Nurse Educator Certification (ANEC). The NNFF provides funding for newly hired nursing faculty to support their research and teaching. The funds are used to assist faculty in acclimating to the academic culture, developing in their new role, and supporting their retention. Research suggests that lack of time and money are key barriers to doctoral degree completion. The NEDG address this barrier by providing funds to support current faculty who are enrolled in their final phase of doctoral study (completing their dissertation or capstone project to facilitate degree completion). NEDG has positively impacted the number of nurse faculty with terminal degrees. The GNF scholarship provides powerful incentives to pursue graduate-level education and teach in the classroom and/or clinical settings for nursing education programs, or within healthcare organizations as hospital educators or professional development specialists.

Program Evaluation Methodology

The NSP II completed a program evaluation in 2014 after the first 10 years of funding and was approved for an additional five years of funding through FY 2020. At the request of the HSCRC, MHEC and HSCRC staff initiated a comprehensive program review in January 2019.

Assistance was provided by an experienced NSP II Program Evaluation committee with representatives from all geographic regions and types of nursing programs. This group met over a nine month period culminating with strategic planning sessions in September and October that included the following organizations:

- Maryland Hospital Association,
- Maryland Action Coalition,
- Maryland Organization of Nurse Leaders,
- Maryland Nurse Residency Collaborative,
- Maryland Nurses Association,
- Maryland Council of Deans and Directors of Nursing Programs,
- Maryland Nursing Workforce Center,
- Maryland Board of Nursing,
- Statewide Academic - Hospital Practice Partnership Committee, and
- HSCRC NSP I Advisory Board

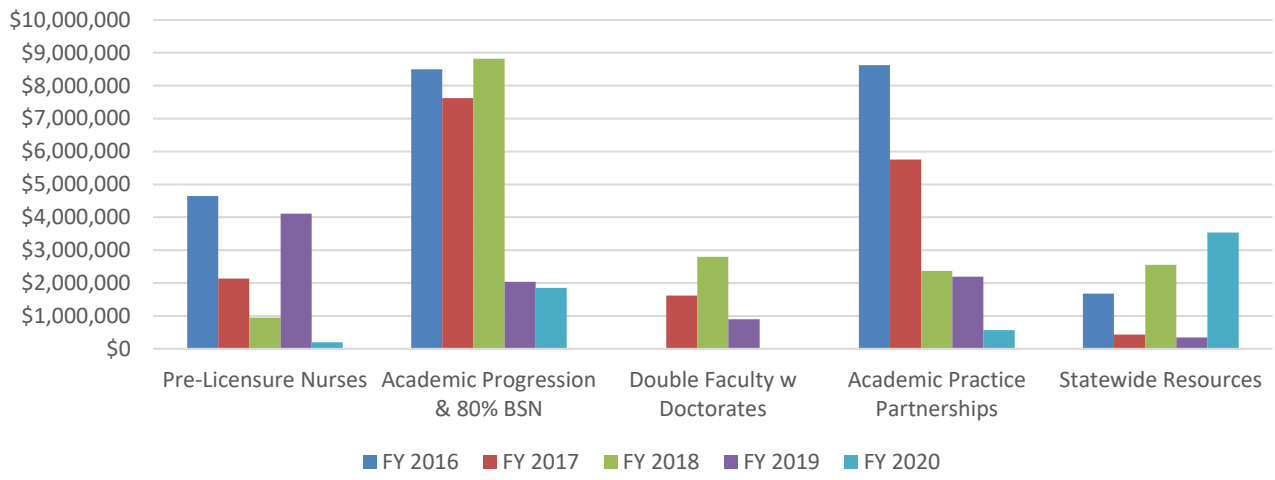
NSP II competitive institutional grant recipients were instrumental in the collection of project outcomes data and collaborated with nurse executive leaders on hospital-based measures. Data were collected and compiled for all NSP II funded projects for all years of activity for which data were available. Both quantitative and qualitative analyses were conducted, most notably, descriptive statistics, case study, and thematic analysis. Outcomes were compared to project goals. A summary of important outcomes is discussed in the following section. Findings on the most successful strategies utilized by NSP II and suggested revisions for improvement are included in the review of activities.

NSP II PROGRAM EVALUATION AND OUTCOMES 2016-2020

Competitive Institutional Grants Awards: by Geographic Location, Amount, and Project Type

Five rounds of competitive institutional grants were conducted since July 2015. A total of $74 million was awarded through a competitive review process for 106 multi-year projects. Thirteen community colleges and eleven universities received these funds. Grant recipients included schools or departments of nursing at public universities, including the State's historically black institutions, independent colleges, universities and community colleges. The distribution of awards was geographically diverse: Western Maryland (3), Eastern Shore (3), Northern Maryland (3), and Southern Maryland (1). The remaining institutions are located in the central region of the State and Baltimore City. Figure 2 displays the amount funded over the last five fiscal years by project type.

Figure 2: NSP II Competitive Institutional Grants by Initiatives Awarded FY 2016 - 2020



Source: NSP II Competitive Institutional Grant Project Budgets, 2019

The funds were released to recipients in installments over the life of the grant, contingent upon adequate yearly progress. Of the 106 projects funded since FY 2016, 47 have concluded, allowing for a detailed analysis of the strategies used by the most successful awardees. Fifty-nine (59) awards remain open, some with annual payments extending into FY 2022 (with funds accrued through FY 2020). While these projects have not yet concluded, annual outcomes to-date are included in the data analysis.

Competitive Institutional Grants: Progress by Initiative

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

1) Ensuring nursing educational capacity for nursing pre-licensure enrollments and graduates,
2) Advancing academic preparation of entry-level nurses and existing nurses to meet the needs of hospitals and health systems (80 percent BSN),
3) Doubling the number of nurses and nurse faculty with doctoral degrees,
4) Academic/practice partnerships, and
5) Developing statewide resources and models for clinical simulation, leadership, inter-professional education, alternative clinical practice sites, and clinical faculty preparation.

Progress on each initiative are presented in the paragraphs below.

Initiative #1: Pre-Licensure Nursing Graduates

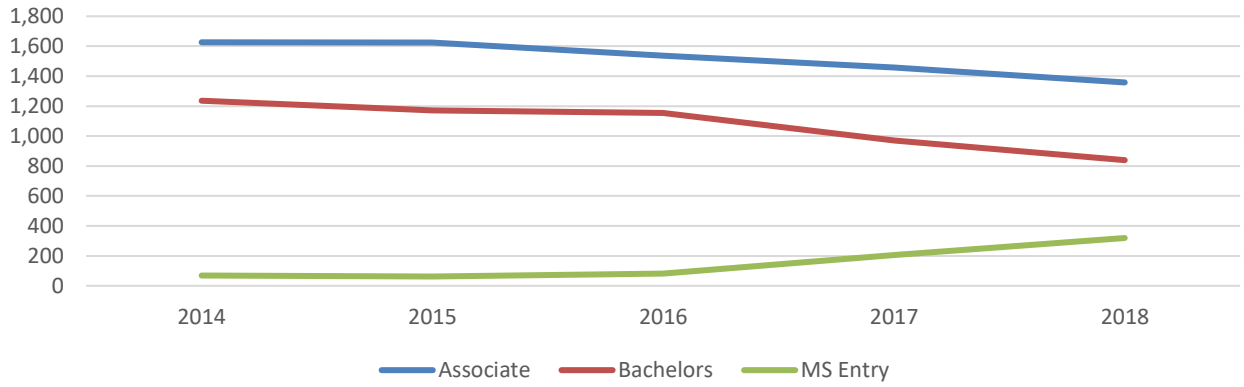
Over the last five years, a little over $12 million have been funded to support pre-licensure nursing education. Maryland's nursing graduate data demonstrates an increase in the overall

education of the nursing workforce, which is consistent with national trends. Declines in enrollments and graduations from Associate Degree Programs may reflect alignment with IOM initiatives and changing hiring practices of hospitals and healthcare organizations.

However, enrollments in BSN and MS Entry nursing programs have been steadily rising. There are several factors behind this movement in RN education: 1) hospitals are aware of better patient outcomes associated with BSN or higher prepared RNs; 2) economic incentives reward hospitals for improved quality and outcomes; 3) requirements to have a higher proportion of BSN-educated RNs for the Magnet Recognition Program®, and 4) recommendation by the Institute of Medicine (2010) that 80 percent of nurses be BSN-prepared by 2020 (Buerhaus, et al., 2017).

New pre-licensure programs, called Master of Science (MS) Entry, address the needs for well-prepared professional nurses who can advance more quickly into leadership roles and advanced practice. There are currently two MS entry programs, with another in the planning stages. The second MS Entry program replaced an undergraduate BSN program. With full transition from undergraduate BSN to MS Entry, the pre-licensure graduate data will continue to increase (Figure 3).

Figure 3: Maryland Pre-licensure Nurse Graduates, FY 2014 -2018



Source: Maryland Higher Education Commission, Enrollments and Graduates for all pre-licensure programs-Associate, Baccalaureate of Science and Master's Entry in Nursing Degrees

Initiative #2: Academic Progression through Associate to Bachelors (ATB) and Graduate Education

Alternative academic progression models have been among the top-funded ($28.8 million) competitive institutional grant projects. In the Associate to Bachelor's (ATB) model, a student nurse enrolled at a community college can concurrently enroll in a university, allowing completion of both an Associate and BSN degree within three years. This minimizes educational costs and time to degree completion. Integrating nursing curricula for community college and university programs without redundancy is a major challenge. Since 2015, 12 nursing programs

have received approximately $14 million for a variety of competitive institutional grants to implement the ATB partnership concurrent enrollment model, dual enrollment, or alternate routes to the BSN with good results.

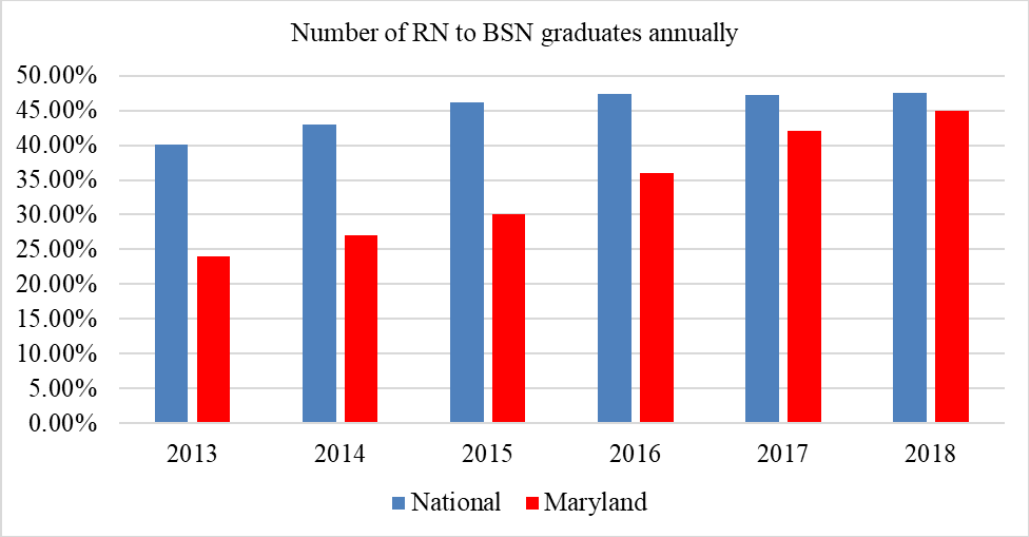
Across Maryland, universities and community colleges are working together through funded projects to promote the BSN with Associate to Bachelor's (ATB) agreements for seamless academic progression. A concerted effort was necessary to ensure access to BSN education through targeted strategies, streamlined financial aid processes, and a unified message with hospital leaders that newly licensed nurses should make every effort to complete the BSN within 3-5 years of employment at a Maryland hospital. In 2017, MHEC with the Maryland Council of Deans and Directors of Nursing Programs (MCDDNP), revised and updated the Maryland Nursing Articulation Education Agreement (1985) for seamless academic progression for Licensed Practical Nursing to Associate Degree Nursing to BSN.

NSP II staff worked with the Maryland Longitudinal Data System (MLDS) at MHEC to measure ATB completions and determine time and cost savings to the individual nursing student. Early data are encouraging. Approximately one in five pre-licensure nurses graduate from community college with Associate Degree in Nursing and completes the BSN within one year. Using the ATB model has shown a 50 percent improvement in the time to completion of the Associate to Bachelor degree and an approximate cost saving in tuition of $13,000 per student.

The seamless transition is expected to result in cost savings to newly licensed registered nurses and the hospital where they work; fewer courses will be needed to complete the BSN, thereby reducing the amount of tuition reimbursement. Cost savings are much higher for ATB students enrolled in a private university partnering with a community college, compared with attending the private university's traditional BSN program. This cost saving is transferred to hospitals in reduced tuition expenses for newly hired nurses. Along with cost savings, the ATB model is providing much needed access to BSN programs for those qualified applicants who were not accepted to traditional BSN programs for lack of space. Statewide dissemination of best practices in the ATB Model is continuing through ongoing ATB Coordinator meetings.

Maryland has made significant progress toward increasing the proportion of nurses with a BSN working in hospitals and healthcare organizations to 80 percent (Figure 4). The Campaign for Action Maps, funded through the AARP and Robert Wood Johnson Foundations, used American Community Survey data to display national trends in BSN-prepared nurses. Maryland's average was about 60 percent and is among 12 states with over 60 percent BSN prepared nurses, outpacing the national average (55.9 percent) and neighboring states Virginia, West Virginia, and Pennsylvania (Courville & Green, 2019).

Figure 4: Comparison of Number of RN to BSN Graduates Annually for Maryland and U.S.



Sources: Maryland Higher Education Commission, Maryland Council of Deans and Directors of Nursing Programs, Campaign for Action, American Association of Colleges of Nursing

Along with this promising trend, hospitals are reiterating this message with their hiring practices. In a survey of Maryland hospital nursing leaders (MCSRC, 9/10/19), most Maryland hospitals (54 percent) require the newly hired nurse to be enrolled in a BSN program prior to or within 6-12 months of starting work and complete it within three years. Another 21 percent are developing similar policies, and 25 percent do not have a policy on BSN completion.

Research on healthcare quality also indicate that BSN-prepared nurses improve patient outcomes. A recent study involving five states (including New Jersey and Pennsylvania) found that for each 10 percent increase in a hospital's proportion of BSN prepared nurses, there was a 24 percent increase in the odds of surviving a cardiac arrest to discharge with good cerebral performance (Harrison, et al., 2019). The findings indicated that a higher level of surveillance, quicker recognition of a deteriorating condition, and intervention with life-saving measures were important indicators to minimizing potential neurologic damage (Harrison, et al., 2019).

The American Nurses Credentialing Center's Magnet Recognition Program is acknowledged as the premier international recognition of organizations that were able to attract and retain nurses, keeping nurse vacancy and turnover rates low, and improving patient outcomes. Magnet® designation validates the highest-level nursing standards within the hospital (Graystone, 2018). Preliminary research has shown improved patient experiences in Magnet® designated hospitals compared to non- Magnet. The Magnet® designation is also associated with hospitals that can attract and retain high-quality nurses who are more satisfied and committed to their work environments (McCaughey, et al., 2018). In 2019, eight (8) hospitals in Maryland have successfully achieved Magnet® and one has achieved Pathway to Excellence® designation with funding from the NSP I. Of those hospitals, four newly achieved Magnet® or Pathway to

Excellence® designation and three were re-designated. Seventeen hospitals are pursuing either Magnet® or Pathway to Excellence® designation. The Pathway to Excellence® designation was achieved by UM Upper Chesapeake Health Medical Center. The ANCC Magnet® designated hospitals are listed below:

- Anne Arundel Medical Center,
- MedStar Franklin Square Medical Center,
- Mercy Medical Center,
- Meritus Medical Center,
- Suburban Hospital,
- The Johns Hopkins Hospital,
- University of Maryland (UM) Medical Center, and
- UM Shore Regional Health.

An examination of the U.S. Agency for Healthcare Assessment of Healthcare Providers and Systems (HCAHPS) scores found overall hospital ratings were significantly higher in Maryland hospitals with Magnet or Pathway designation. In addition, the Maryland Hospital Acquired Conditions Potentially Preventable Complications (PPC) differences were statistically significant (Figure 5 and 6).

Figure 5: Magnet® vs Non-Magnet vs Journey to Magnet Hospitals: HCAHPS, CY 2017

					ANOVA Tests	*Post Hoc Tests*		
HCAHPS	**Total (n=46)**	**Magnet (n=9)**	**Non-Magnet (n=26)**	**Journey (n=11)**	**p-value**	**Magnet vs. Non-Magnet**	**Magnet vs. Journey**	**Non-Magnet vs. Journey**
Cleanliness of Hospital Environment	68.4 (6.7)	69.9 (5.8)	68.3 (7.6)	67.5 (5.3)	0.724	0.8391	1.2611	0.4221
Communication with Nurses	76.3 (5.3)	79.3 (2.4)	75.7 (5.8)	75.2 (5.2)	0.149	2.5027	2.8237	0.3211
Communication with Doctors	77.6 (3.7)	79.3 (2.3)	77 (4.3)	77.5 (2.7)	0.284	2.1925	1.795	0.3975
Responsiveness of Hospital Staff	61.4 (6.3)	63.9 (4.5)	61.8 (6.8)	58.5 (5.6)	0.151	1.2204	3.0765	1.8561
Communication about Medicines	60.3 (5.2)	63.4 (3.1)	59.8 (5.7)	58.8 (4.3)	0.102	2.5968	3.2688	0.672
Discharge Information	86.5 (3.1)	86.9 (1.2)	86.6 (3.1)	85.8 (4.2)	0.72	0.3505	1.2031	0.8525
Transition of Care	48.8 (4.3)	51.2 (3.8)	48.7 (4.2)	46.9 (4.2)	0.076	2.1747	**3.7075***	1.5328
Overall Rating of this Hospital	66.7 (6.7)	71.4 (5.8)	66.2 (5.7)	64 (8)	**0.037**	2.916	**4.1331***	1.2172
Quietness of Hospital Environment	56.2 (6.6)	57.7 (7.2)	55 (6.8)	57.9 (5.3)	0.356	1.4551	0.1304	1.5855
Willingness to Recommend this Hospital	65.2 (12.7)	71.8 (8.1)	63.6 (14.6)	63.5 (9.8)	0.224	2.3012	2.3355	0.0343

*Note: * indicates p-value <.05; Tukey's HSD tests were reported in post hoc tests*
Source: HSCRC HCAHPS data with SPSS by M. E. Mills, 9/10/19

Figure 6: Magnet® vs Non-Magnet vs Journey to Magnet Hospitals: PPC, FY 2017 & 2018

					ANOVA Tests	*Post Hoc Tests*		
PPC	**Total (n=48)**	**Magnet (n=9)**	**Non-Magnet (n=22)**	**Journey (n=17)**	**p-value**	**Magnet vs. Non-Magnet**	**Magnet vs. Journey**	**Non-Magnet vs. Journey**
Total Observed PPC in 2017	18.5 (14.7)	29.6 (24.1)	14.5 (8.8)	17.8 (12.2)	0.030	4.0597*	3.154	0.9057
Total Case-mix Adjusted Rate in 2017	5.1 (6.6)	3 (0.6)	4.8 (5.1)	6.5 (9.5)	0.425	1.0335	1.9945	0.9611
Total Observed PPC in 2018	15 (12.1)	23.8 (16)	11.1 (8.9)	15.4 (11.5)	0.026	4.1492*	2.7652	1.384
Total Case-mix Adjusted Rate in 2018	4.6 (5.9)	3.1 (1.8)	3.5 (2.9)	6.9 (9.1)	0.136	0.2294	2.458	2.2286

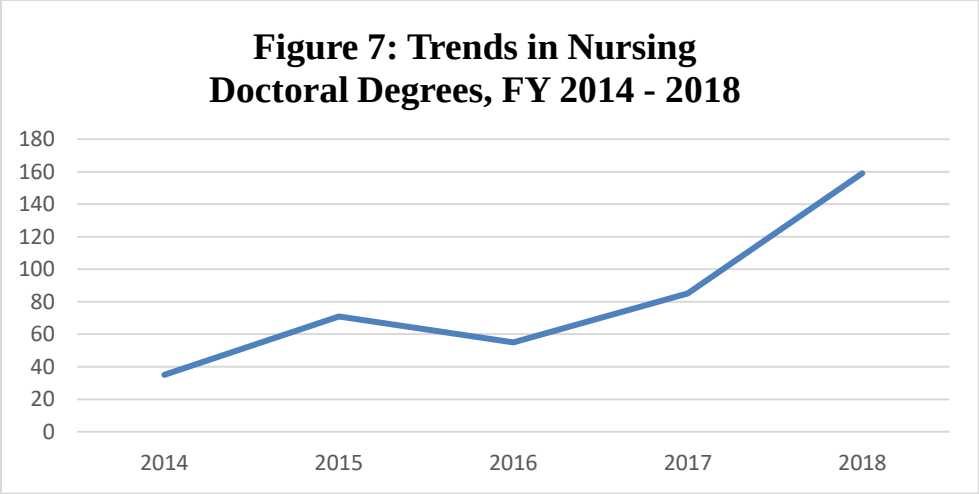
*Note: * indicates p-value <.05; Tukey's HSD tests were reported in post hoc tests*
Source: HSCRC PPC data with SPSS by M. E. Mills, 9/10/19

Initiative #3: Doubling the Number of Nurses and Nurse Faculty with Doctoral Degrees

NSP II funded $5.3 million for projects focused on doubling the number of nurses with doctoral degrees. The planning committee for the National Academy of Medicine (formerly IOM) convened a public session on March 22, 2019, for the upcoming study, *The Future of Nursing 2020-2030*. Researchers reported that the national goal set in 2010 to double the number of nurses with a doctoral degree had been met. Maryland data supports this increase in doctoral degrees for both Doctor of Philosophy in Nursing (Ph.D.) and Doctor of Nursing Practice (DNP). The DNP curriculum focuses on the preparation of nurses for advanced practice roles, while the Ph.D. is a research-focused degree. The number of nursing doctoral degrees (Ph.D. and DNP) awarded by Maryland schools has grown exponentially in the last five years to a high of 159 in 2018. Demands for those with doctoral degrees in both academic and practice settings will continue to rise. Although doctoral degree enrollments are at an all-time high, there is variation between the types. Consistent with national trends, there is high interest in the practice-focused DNP, and declining interest in the research-focused Ph.D. (AACN, 2019).

A study by Fang and Bednash (2017) found that 56.8 percent of DNP students were already full-time or part-time faculty members. Nurse faculty with dual clinical and academic appointments as advanced practice registered nurses (APRNs) maintain clinical credentials and provide primary care while preparing the next generation of new pre-licensure nurses or serving as preceptors for new APRNs at hospitals and clinical sites.

NSP II met and exceeded the goal of doubling the number of doctoral degree completions from 35 Ph.D. or DNP graduates in 2014 to 159 Ph.D. or DNP graduates in 2018, a 78 percent increase (Figure 7).



Source: Trends in Doctoral: PhD and DNP Graduates through 2018, Maryland Higher Education Commission, Enrollments and Graduate Data

Initiative #4: Academic and Practice Partnerships

The second largest portion ($19.5 million) of NSP II competitive grant funding was awarded to programs for Initiative #4. NSP II programs under this initiative were intended to meet the needs of hospital practice nurses, as well as nurses in academic settings, and include:

- Academic-Practice Partnership Model for graduate degree completion by clinical staff nurses,
- Nurse Leadership Institute (NLI),
- Maryland Clinical Simulation Resource Consortium (MCSRC),
- Eastern Shore Faculty Academy and Mentoring Initiative (ES-FAMI),
- Advanced Practice Nurse Preceptor (APRN) modules, and
- Inter-professional Education (IPE) hospital bedside rounds modules

Descriptions of these programs are described below.

Academic -Practice Partnership Model. A total of 558 hospital registered nurses participated across seven NSP II academic-practice partnership projects. This movement aligns with the recommendations of a study commissioned by the AACN, which examined the potential for enhanced partnerships between academic nursing and academic health centers (AACN, 2016). These new programs were created to provide opportunities across settings for academic nurse faculty and clinical practice nurses to work more closely together. These programs are open to all hospitals, health systems, and schools of nursing through an annual nomination process. Nurses from academia and practice were nominated by health systems at 39 (out of 46) hospitals and 24 (out of 28) nursing programs (Figure 8). At present, nurse leaders in academia and hospital practice are collaborating to develop a set of universal student requirements accepted by all organizations for student clinical site rotation. The intention is to reduce duplication in

time and effort by both the hospital education and academic coordinators. Twenty-six nurses in Professional Development Specialist positions at hospitals across the State have received full tuition and fees at an in-state nursing graduate degree program with the opportunity to complete their service obligation in their current educator role at the employing hospital.

Figure 8: Hospital Nurse Participants across Academic Practice Programs

Hospital Region	Acute Care Beds	Total Hospital RN Participants
Western Maryland	729	16
Montgomery County	1,249	19
Southern Maryland	951	16
Central Maryland	2,243	151
Baltimore City	3,609	262
Eastern Shore	574	90
Maryland Total	9,355	558

Source: Maryland Health Care Commission Hospital Acute Beds and NSP II Annual Reports Outcomes Evaluation

NSP II recognized the importance of the academic-practice partnership programs early on through an NSP II funded competitive grant program that expanded from six hospitals to 18 partner hospitals over the multiple year grants. This working relationship is a model for expanding the roles of Clinical Instructors, Faculty and Preceptor resources. The academic-practice partnership model funded at the University of Maryland, School of Nursing includes 18 hospitals located across all five regions of Maryland. Collaboration between the nursing program, Chief Nurse Officer and Nurse Education Coordinators at each partner hospital provided the structure for 235 staff nurses in a combination of RN-BSN, RN-MS and MSN programs for preparation as hospital-based clinical instructors, preceptors and mentors. The program prepares the students for a culture of learning and career advancement in leadership, as well as quality and safety of patient care at the partner hospitals. NSP II proposed two new statewide programs in 2015 to serve nurses in both academic and practice settings across the state. Nurse faculty with expertise in the areas of leadership and clinical simulation led these initiatives based on the *Future of Nursing* recommendations.

Nurse Leadership Institute (NLI). The NLI was formed to promote innovative opportunities to meet the Future of Nursing's recommendation for nurses to lead changes in health delivery and drive patient care solutions. The concept was expanded beyond academic leaders to hospital nurse managers and executives in 2015. To date, 48 nurse faculty and 89 hospital emerging and existing nurse leaders completed a year-long leadership program. Through mentorship, reflective exercises, and a leadership project, nurses develop the skills to lead change and advance health.

Maryland Clinical Simulation Resource Consortium (MCSRC). The MCSRC increases the quality and quantity of clinical simulation used in nursing education. The on-site Train-the-Trainer sessions for faculty and hospital-based nurses are coordinated with an expert panel guiding simulation equipment resources allocated to all programs across the state based on nationally recognized benchmarking measures. To date, 394 Simulation Education Leaders (SEL) and Advanced Simulation Education Leaders (ASEL) participated in the three-day sessions with 343 nurse faculty and 51 hospital educators. Faculty achieved levels of preparation from Simulation Education Leaders (SEL 1-3) to the more Advanced Simulation Education Leaders (ASEL). Nine ASEL educators completed the Society for Simulation in Healthcare's Certified Healthcare Simulation Educator (CHSE) credential demonstrating excellence and expertise in multi-modal simulation methodologies including task trainers, high and low-fidelity patient simulators, virtual reality, screen-based simulators, and standardized patients. Utilizing technology and tools, the goals of simulation are threefold: 1) to improve student nurse performance by providing experience working with highly technical equipment in a virtual environment prior to actual clinical experience in a patient care setting; 2) to promote competent care by ensuring comprehensive practice in critical thinking and clinical judgement; and 3) to substitute the number of clinical hours required in active patient care settings, thereby easing the shortage of clinical access opportunities. On average, clinical simulation was used to replace approximately 12 percent of total clinical practice time, with many schools having increased the percent of simulation used in place of clinical hours as they acquired simulation resources and experience in utilizing this educational technology.

Eastern Shore Faculty Academy and Mentoring Initiative (ES-FAMI). The ES-FAMI increases the preparation and availability of clinical instructors to teach in nursing programs by providing a foundation in learning theory and assessment. Established on the Eastern Shore in 2011 as a collaboration between Salisbury University, Chesapeake College, and Wor-Wic Community College, the ES-FAMI has expanded to central and western Maryland to prepare a pool of clinical faculty across the state. The program is delivered online, face-to-face, and in simulated teaching experiences.

Inter-professional Education Resources (IPE). Collaborative practice has been identified as a solution to current challenges of health care, including improving patient safety, quality and outcomes of care; minimizing/decreasing cost; and improving the patient experience. Most accrediting bodies of health professions today require learners to be prepared for IPE practice, yet barriers often exist for teaching multiple disciplines together in IPE settings. The Johns Hopkins University School of Nursing program addresses these barriers through simulations. The Core Competencies for IPE Collaborative Practice, which include 1) shared values/ethics, 2) roles and responsibilities, 3) communication, and 4) teamwork with bedside rounds, provided the

framework for developing four simulations, with actors playing roles to deliver the IPE simulations via video vignettes.

Initiative #5: Developing Statewide Resources

The intent of Initiative #5 is to provide resources for potentially successful projects or concepts that were embedded in the Future of Nursing report that would be available for all nurses in both academic and practice environments. The funding support for Initiative #5 was $8.6 million and provided resources for accreditation, instructional technology, and preparation of clinical instructors, preceptors, and mentoring nursing faculty in multiple in-state settings. In addition, a nurse residency toolkit as developed to provide guidance for all programs to enhance newly licensed nurses' academic progression. Some of the more widely available opportunities are described below.

Nurse Managed Wellness Center for Student Clinical Opportunities (NMWC). The NMWC at Allegany College of Maryland in Western Maryland provides nursing students with opportunities to improve their essential skills and competencies for transitioning to the role of the nurse. In anticipation of decreased inpatient clinical pediatric opportunities, students work with the local Head Start to provide pediatric assessments, including vision, hearing, developmental and physical screenings. Providing the template for the experiences (objectives, learning activity, and evaluation tools), in addition to an opportunity to see it in action (on-site or webinar) makes this a replicable model with the preceptor clinical training. The intent is to reduce the stress on hospital clinical sites and increase enrollments based on creating alternate clinical site options.

Lead Nursing Forward Educator Career Portal (LNF). Salisbury University School of Nursing (SUSON), in collaboration with UMSON, developed a free web resource that connects interested educators with clinical instructor, preceptor, part-time adjunct, and full time faculty opportunities across hospitals and nursing programs. The site (leadnursingforward.org) provides information for nurses and career explorers to learn more about the educator role, different pathways to becoming an educator, and continuing their education. The site also promotes the nurse educator career with photos and videos featuring current nurse educators across Maryland. Through the portal, users can register a profile and also gain access to postings for events such as seminars, job fairs, and conferences.

Maryland Nursing Workforce Center (MNWC). The MNWC was established in July 2018 and became an officially recognized Center at the University of Maryland, Baltimore in November, 2018. The following May, the MNWC was accepted into membership in the National Forum of State Nursing Workforce Centers. The MNWC is intended to improve collaboration among stakeholders and enhance data infrastructure as recommended by the *Future of Nursing* (2010) report and reinforced at the National Academies of Medicine *Future of Nursing 2020-2030* public sessions in 2019. The

MNWC Advisory Committee determined that the top priority is to secure accurate, and timely nursing workforce data from the Maryland Board of Nursing. The MNWC filed a Public Information Act request in March of 2019 to gain access to the data. Unfortunately, this information has not been provided at the time of this report and state-level data regarding the nursing workforce remains incomplete. MNWC will analyze and report on the nurse workforce data with stakeholders once it's received.

Statewide Initiatives Awards: by Program

There were four funding cycles for the nurse faculty focused programs, totaling $16 million. As a requirement of the programs, recipients commit to becoming nursing faculty upon completion of their graduate education; advancing their careers through earning doctoral degrees; joining an institution as a new faculty member; or demonstrating expertise in the specialty practice of nursing education through national certification. Across the State, nurse faculty were awarded $5 million for fellowships, grants and professional development between FY 2016 and FY 2019. Approximately $11 million over the same period was awarded to 250 nurses who enrolled in the graduate degree programs, a requirement for becoming a faculty or hospital-based educator. A description of the outcomes for each program follows.

New Nursing Faculty Fellowships (NNFF). These fellowships assist Maryland nursing programs with recruiting and retaining newly hired faculty by providing funding to pay student loans, attend and present at professional conferences, conduct research, publish work in peer-reviewed journals, and other professional development activities. Each fellowship is funded for three years. Since 2015, 162 new faculty members have been recruited through this program and received a total of $3 million. The retention rate for faculty for the last 3 years is 93 percent; clear evidence of the program's value.

Nurse Educator Doctoral Grants for Practice and Dissertation Research (NEDG). This program provides grants to current nursing faculty (typically instructors or assistant professors) enrolled in doctoral study, who are completing their final scholarly work through a dissertation (Ph.D. or Doctor of Education, Ed.D) or a capstone/scholarly project (DNP). Faculty who have recently completed a doctoral degree are also eligible for this award. Funds may be used to offset research, tuition, student loans, course release time, and other educational costs related to expediting degree completion. Since July 2015, there have been 63 awards totaling $1.6 million. Of these awards, 28 faculty were receiving a Ph.D. (22 PhDs in Nursing and 6 PhDs in other related fields), 28 were receiving a DNP and 7 were completing an Ed.D. This represents approximately 10 percent of the total full-time faculty employed in nursing degree programs, based on NSP II outcomes data. Upon degree completion, recipients are required to provide the abstracts and citations of their dissertation, capstone project paper, and any other published work or scholarly project. Many doctoral projects focused on educational issues in nursing that inform best practices in both academia and clinical practice.

Examples include simulation, faculty shortage, teaching modalities, medication errors, mentoring models, civility, and student retention. Maryland Deans and Directors indicate that 9 out of 10 nursing faculty who received the NEDG award remained employed in good standing; an indication of the program's effectiveness in advancing the number of nursing faculty with doctoral degrees and retaining highly qualified faculty.

Hal and Jo Cohen Graduate Nurse Faculty Scholarship (GNF). This program supports registered nurses in completion of their Master's and Doctoral degrees, post-graduate teaching certificate, and coursework to become nurse faculty. The scholarship is for full tuition and fees for Maryland residents to go to a Maryland program, with a service obligation to teach in an in-state nursing program or hospital education department. Recipients who are unable to meet the service obligation must repay the GNF through a bond repayment plan. Since July 2015, approximately 250 recipients have been awarded $11.2 million in scholarships. Most were pursuing Master's Degrees, a pre-requisite for doctoral level study and a minimum requirement of the Maryland Board of Nursing for nursing faculty. Since the GNF's inception in 2007, over 175 recipients have completed their service obligation; 244 are working as Maryland nursing faculty or hospital-based nurse educators in fulfillment of the service obligation; and 68 recent graduates are in an approved deferment or seeking teaching positions at a school or hospital. The remaining students are enrolled in Master's and Doctoral level degree programs. In 2015, based on feedback from Chief Nursing Officers at Maryland hospitals, the guidelines and service commitment for the GNF were revised to include hospital-based nurse educators to attract nursing professional development specialists. At least 26 hospital nurse educators have received GNF funds for tuition and are completing their service at their hospital's education departments at The Johns Hopkins Hospital, Greater Baltimore Medical Center, Howard County General Hospital, Johns Hopkins Bayview Medical Center, University of Maryland St. Joseph Medical Center, Sinai Hospital, and Mercy Medical Center.

Academic Nurse Educator Certification (ANEC) award The ANEC provides recognition and professional development support for full-time nurse faculty across the state who achieved the National League for Nursing's Certified Nurse Educator (CNE) credential or renewed the CNE they already held as required every five years. The CNE certification is a mark of excellence and expertise in the specialty practice of nursing education. A total of 57 faculty received $285,000 across 12 community colleges and 9 universities. To assist faculty in preparing for the CNE examination, NSP II partnered with the NLN to host CNE Workshops taught by Dr. Diane Billings, a national leader in faculty development. Workshop attendees are expected to take the CNE examination within a year. The goal is to double the number of full-time nurse faculty with the CNE credential, a mark of excellence in teaching, pedagogy, curriculum design, and student learning. At the inception of the program, there were 65 certified nurse educators. Since

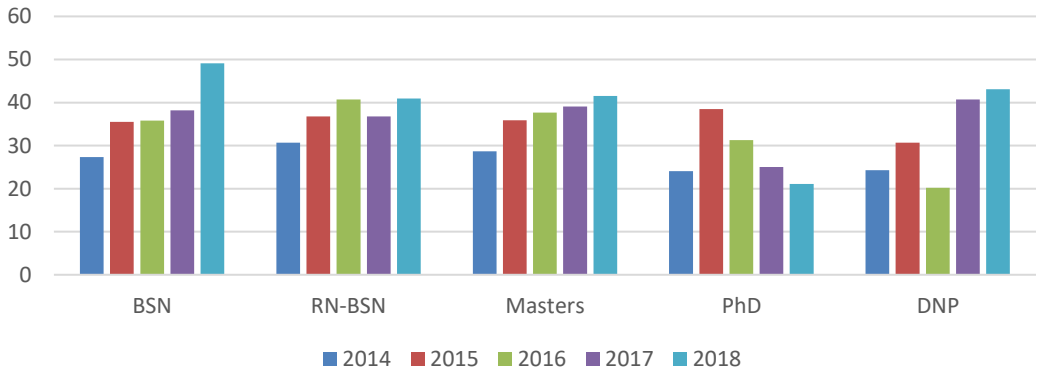
2017, 36 additional full-time nurse faculty were awarded the CNE and 21 full-time faculty completed the requirements to renew the CNE credential. This demonstrated an increase of 55 percent newly credentialed CNEs.

Diversity of the Maryland Nursing Workforce

In accordance with the Education Article § 11-405, Annotated Code of Maryland, the Nurse Support Program Assistance Fund statute states, "the guidelines established under subsection (e) of this section shall provide that a portion of the competitive grants and statewide grants be used to attract and retain minorities to nursing and nurse faculty careers in Maryland." The NSP II program has impacted the diversity in the nursing workforce in several ways. Over the past five years, NSP II has awarded $3.6 million in competitive grants to support diverse students at Historically Black Colleges and Universities, including Bowie State University, Coppin State University, and Morgan State University. The programs were designed to increase student retention, graduation rates, and licensure first-time pass rates.

Based on diversity data provided by the Maryland Longitudinal Data System, 73 percent of recipients of the Hal and Jo Cohen Graduate Nurse Faculty Scholarship program were underrepresented racial and ethnic minorities. Additionally, a report prepared in 2019 for Maryland by the AACN Research and Data Services indicated that the percentage of racial or ethnic minority nursing graduates in Maryland has increased or held steady across all degree programs. Forty-nine percent of Maryland nurse graduates at BSN programs and a little over 40 percent of RN-BSN, Master's and DNP graduates were racial or ethnic minorities in 2018 (Figure 9).

Figure 9: Percentage of Underrepresented Racial and Ethnic Minority Nursing Graduates in Maryland

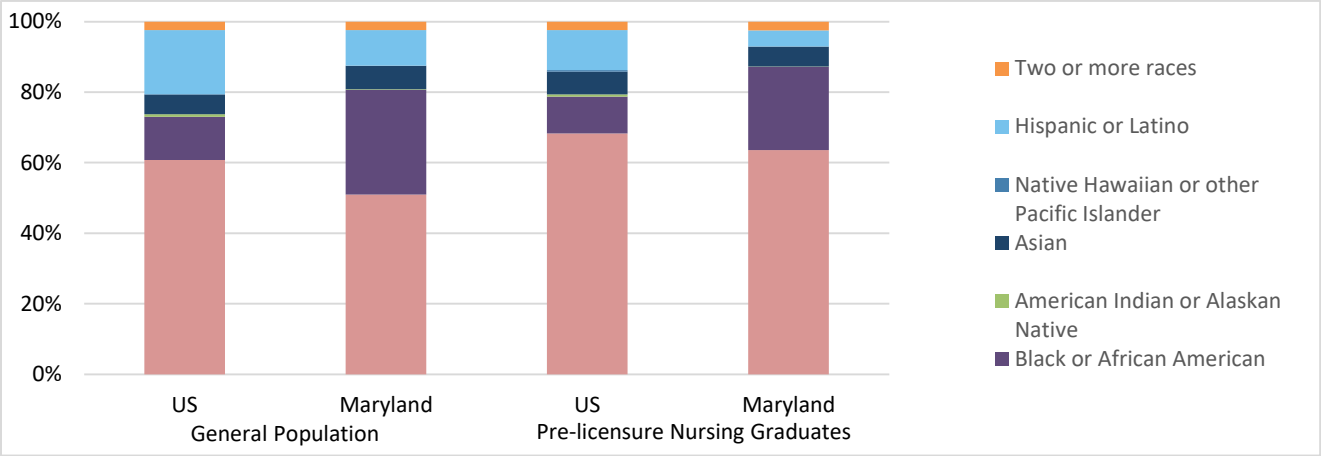


Source: American Association of Colleges of Nursing, Research and Data Services, 2019

The diversity among pre-licensure graduates from all entry-level nursing programs is consistent with the State and national population demographics. This demonstrates that progress is being made to make Maryland's nursing workforce more closely reflect the population they

serve (Figure 10). The National League for Nursing's *Biennial Survey of Nursing Schools Academic Year 2017-2018* indicates an increase in enrollment for underrepresented populations, from 27 percent in 2016 to 31 percent in 2018; the highest increases were among African American and Hispanic students.

Figure 10: Comparison of the diversity of pre-licensure RNs in Maryland and US



Source: Campaign for Action, Maryland's RN Graduates Reflect State's Diversity, 2019

The State of Nursing and Future Issues

There are significant challenges facing the nursing workforce (Buerhaus, et al., 2017). First, is the aging RN workforce and projected retirements. According to a 2018 National Council of State Boards of Nursing and the Forum of State Nursing Workforce Centers report, nearly 51 percent of the RN workforce is 50 years of age or older. One million RNs will retire by 2030 and with their departure, the patient care settings face a significant loss of knowledge and expertise that will be felt for years to come.

Second, aging baby boomers will continue to increase the demand for health care over longer life expectancies. According to the U.S. Census Bureau, the nation's population is estimated to grow by more than 10 percent by 2032, with those over age 65 increasing by 48 percent. Consistent with this trend, Medicare enrollments are projected to grow to 80 Million beneficiaries by 2030.

Third, physician shortages will create the need for more advanced practice nurses to provide primary and rural care within their full scope of practice. There is a projected shortage of between 46,900 and 121,900 physicians by 2032, which includes both primary care (between 21,100 and 55,200) and specialty care (between 24,800 and 65,800). Among specialists such as pathologists, neurologists, radiologists, and psychiatrists, the data projects a shortage of between 1,900 and 12,100 medical specialists, 14,300 and 23,400 surgical specialists, and 20,600 and 39,100 other specialists. One-third of all currently active doctors will be older than 65 in the next

decade. There is potential for nurse practitioners prepared in primary care, psychiatric and pediatric specialties that can help ease this shortage, especially in rural areas.

Fourth, we are entering a new era of health reform where hospitals face financial incentives to be accountable for the quality and the total cost of care. This will increase care management activities to avoid readmissions and costly unnecessary use of the emergency departments. RNs with experience in care management, public health, and partnership building will be needed. In addition to these overarching national concerns, there are several other pressing issues of concern in Maryland.

Maryland's nursing programs have responded to industry changes in hospitals and health systems. The Maryland Hospital Association (MHA) concurs with the American Hospital Association (AHA, 2019) citing the aging population, higher complexity of care, improved care coordination, integration of behavioral healthcare with physical healthcare, and improved methods of delivery of care will jointly impact workforce dynamics, access to care, and the clinical work environment. The MHA is in the process of prioritizing the nursing workforce, along with their focus on the health care work environment and violence in the workplace.

Lack of Qualified Nursing Faculty Leads to Limits on Enrollment

Despite this progress, nursing schools continue to turn away qualified students due to shortages in faculty. According to the AACN's *Special Survey on Vacant Faculty Positions* (2018), 1,715 faculty vacancies were identified, an eight (8) percent faculty vacancy rate. In the AACN's *2018-2019 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*, nursing schools across the nation turned away approximately 75,029 qualified applicants to baccalaureate and graduate degree programs in 2018, due to insufficient numbers of faculty, classroom space, clinical sites, clinical preceptors, and shrinking budgets (AACN, 2017 a, 2017 b). Compounding the faculty shortage is the "gray tsunami;" the average faculty member is between 51 and 62 years old and more than a third are expected to retire by 2025 (Fang & Kesten, 2017). Annually, Maryland is expected to have 60 full-time faculty vacancies. Despite resources to recruit and retain faculty, the most recent reports indicate 40 full-time vacancies. Each vacancy potentially decreases the capacity to enroll ten additional students. This comes at a time when the number of nurses retiring or leaving the workforce is expected to double over the decade the next decade to 80,000 per year, and reduced capacity is not going to address the problem.

Advancing the Practice of Nursing

According to the American Association of Medical Colleges (2019), there is a shortfall of primary and specialty care physicians. Advanced Practice Registered Nurses (APRNs) are positioned to help meet the demand for these types of healthcare providers. The U.S. Bureau of Labor Statistics (BLS) Occupational Outlook Handbook (OOH) predicts that every state in the U.S. will see an increase in nurse practitioner (NP) position openings, forecasting a 36 percent

increase in the need for NPs between 2016 and 2026 (BLS OOH, 2019). The need for NPs in Maryland is estimated to increase by 31 percent over the same period. This remarkable growth in the workforce will continue for a number of years with current rates of nurse practitioner training (BLS OOH, 2019). Current projections indicate a shortage of 122,000 physician providers by 2032. This is a growing concern, especially in the area of primary care and for medically underserved areas and populations (AAMC, 2019).

RN Vacancy Rates

The RN vacancy rate is trending up across the nation but is holding fairly steady in Maryland. The hospital nurse vacancy rates for Maryland (averaging about eight (8) percent over the last four years) is comparable with 28 percent of other U.S. hospitals, higher than 46 percent of other U.S. hospitals, and lower than 25 percent of other U.S. hospitals. In 2015, sixty percent (60%) of hospitals reported a vacancy rate below 7.5 percent. By 2018, the rate declined to 46 percent. This downward shift, along with rising RN recruitment difficulty (close to 3 months to hire an RN), is a clear indication that the RN labor shortage has arrived (NSU, 2019) (Figure 11).

Figure 11: Comparison of RN Vacancy Rates: US vs Maryland Hospitals

	2015	2016	2017	2018
US RN Vacancy Rates: *Less than 7.5%*	60%	52%	50%	46%
US RN Vacancy Rates: *Between 7.5% to 9.9%*	16%	16%	27%	28%
US RN Vacancy Rates: *Greater than 10%*	24%	33%	23%	25%
Maryland RN Vacancy Rates	**8%**	**7%**	**9%**	**8%**

Source: U.S. Source: *NSU Nursing Solutions Survey of 42 States (including MD), 2019 National Healthcare Retention and RN Staffing Report, MD Source: HSCRC NSP I Annual Report Data*

In the U.S. Bureau of Labor Statistics (BLS) Employment Projections (2016-2026), RNs are listed among the top occupations for job growth through 2026, with an expected 15 percent increase. In addition, BLS expects the workforce to need over 200,000 new RNs each year to fill newly created positions and replace retiring nurses. The last five years of the NSP II funding has positioned the state well to move with the changes in the profession and maintain the pipeline for new entry-level nurses, as well as, the faculty required to prepare the next generation of nurses.

Use of Agency Nurses

Another indicator that vacancy rates in Maryland are on the rise is the data on agency nurse usage. A recent interview with a Chief Nurse Officer at a Maryland hospital revealed they used a centralized nurse staffing agency for the hospital system that brokers for approximately 100 additional agencies. There are different rates for per diem, local, travel, incentive, and critical needs, which escalate costs respectively. The hourly rate can range from $69 to almost $100. (VP/CNO communication, 8/29/19). To compensate for nurse vacancies, hospitals turned to costly strategies such as overtime, agency staff, and travel nurses. These strategies also had the

potential to negatively affect quality, safety, patient experience, and both physician and hospital employee job satisfaction.

When comparing the cost difference between employed RNs versus travel RNs, the amount is staggering. For every 20 travel RNs eliminated, a hospital can save on average, $1.4 million. For 46 hospitals, the annual cost for agency nurse usage statewide is between $129 and $138 million (Figure 12). Continuing the NSP II investment to prepare more nurses should help maintain a stable workforce and assist hospitals in controlling costs while ensuring quality care.

Figure 12: Maryland Hospital's Agency Nurse Cost, FY 2015 – FY 2018

	FY 2015	FY 2016	FY 2017	FY 2018
Agency RN Costs	$129,011,910	$105,825,500	$137,716,996	$129,988,888
Total Number of Hospitals Reporting	47	46	45	46
Average Cost per Hospital	$2,744,934	$2,300,554	$3,060,378	$2,825,845

Source: HSCRC, NSP I Maryland Hospital Annual Survey

Staff Recommendations for the NSP II Program Going Forward

Considering the variability in nursing workforce projections and the shifts in entry-to-practice programs (from Associate Degree to BSN, Second Degree BSN, and Master's Entry in Nursing), leading researchers recommend the importance of monitoring the actual number of newly licensed nurses who are entering practice each year. As reported previously in this report, applicants are being denied entry to pre-licensure programs, citing insufficient numbers of faculty, clinical sites, classroom space, and clinical preceptors. Schools are hindered by difficulties recruiting experienced faculty. The NSP II program is an important component of the recruitment and retention efforts in Maryland. The nursing pipeline is needed more than ever to more Maryland into the future of healthcare.

The following is the staff recommendations for continuing the NSP II program and implementing improvements to the program.

Recommendation 1: Renew NSP II funding for Five Years, FY 2021 through FY 2025

The NSP I was renewed in 2017 to support ongoing education for staff nurses and nurse residencies across all hospitals with the goal of increasing nursing quality placing further pressure on nursing education programs. The program has succeeded in meeting this goal; however there are areas that can be improved to expand the pipeline further. Therefore, MHEC and HSCRC jointly recommend the renewal of the NSP II funding, up to 0.1% of hospital regulated gross patient revenue for the next five years, FY 2021 through FY 2025, with the following additional recommendations.

Recommendation 2: Establish a Workgroup to Recommend Updates to Statewide Initiatives

MHEC will establish a workgroup to recommend revisions to all faculty-focused programs, which are part of the Statewide Initiatives. The workgroup will review the eligibility

requirements for the GNF to align with the needs of nursing programs. As part of the evaluation, the Maryland Council of Deans and Directors recommended focusing on existing faculty retention measures through new or existing programs, increasing the limits on the NNFF and NEDG programs, as well as, addressing the barriers to course release time and eligible expenditures. In addition, they recommend developing a faculty mentoring program to support the GNF and full-time faculty across all 28 nursing programs to improve faculty retention in education settings.

Recommendation 3: Continue Established Competitive Institutional Grants Initiatives

Leaders for the Maryland Council of Deans and Directors, Maryland Nurses Association, Maryland Action Coalition, Maryland Organization of Nurse Leaders and Maryland Nurse Residency Consortium reviewed and approved the continuation of the following initiatives developed in 2015 by the NSP II Competitive Institutional Grants Workgroup:

- Focus on goals to increase the numbers of pre-licensure nurses,
- Increase the proportion of BSN prepared to 80 percent,
- Double the number of faculty with doctoral degrees,
- Strengthen the data infrastructure for the nursing workforce,
- Ensure lifelong learning,
- Double the number of faculty with certified nurse educator credentials
- Provide resources across state nursing programs to support leadership, clinical simulation, inter-professional education, recruitment and retention of new faculty,
- Preparation of clinical instructors
- Faculty mentoring, and
- Opening more individual nurse-level opportunities to recruit more clinical hospital partners.

The Statewide Academic-Hospital Practice Committee agreed with the approved initiatives and submitted additional priorities for clinical models, preceptors and sites.

Recommendation 4: Form NSP I and NSP II Advisory Board to Address Common Issues Between Academia and Practice

There is broad consensus that nurse leaders at the hospitals and academic nursing programs will need to work closely together on solutions to the shortage of clinical practice sites and restricted access on what nursing students are allowed to practice in the clinical settings (due to size and acuity of the units, patient safety, and hospital requirements). Staff recommend researching the impact of out of state nursing programs on clinical sites to develop a joint statewide agreement between hospitals and nursing programs. Educators will need to create additional clinical opportunities to practice other skills such as, documentation in electronic health records, medication administration, Pyxis access, and other procedures that are no longer

part of the hospital experience for nursing students. In order to streamline the onboarding of students across all hospitals (reducing time and cost to all stakeholders), staff recommend developing universal requirements that can be implemented across all facilities. Staff shall convene a small NSP I and NSP II advisory board to engage leaders, determine strategies, and focus on mutual goals of both programs for possible solutions.

Recommendation 5: Improve Infrastructure for Nursing Workforce Data

Maryland continues to struggle with access to State-level nursing workforce data. Due to insufficient analytic capacity, the Maryland Board of Nursing (MBON) is unable to efficiently provide comprehensive and timely results response to public information act (PIA) requests. Collaboration with the Maryland Board of Nursing, Maryland Nursing Workforce Center, Maryland Nurses Association, Maryland Hospital Association, Maryland Longitudinal Data System, MHEC, and HSCRC to streamline data sharing between state agencies is recommended. Legislation may be considered to ensure that the data required for monitoring the nursing workforce supply and demand is validated, readily accessible, and publicly available. The HSCRC and MHEC staff recommend that NSP II support the MBON in procuring the necessary data processing systems and work with the agencies and organizations listed above to improve the workforce data infrastructure to better inform future recommendations.

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Melanie M. Heuston, DNP, RN, NEA-BC
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October 29, 2019

Mr. Nelson J. Sabatini, Chairman
Health Services Cost Review Chairman
4160 Patterson Avenue
Baltimore, MD 21215

Dr. Mr. Sabatini,

I am writing to offer my support of and to encourage the reauthorization of NSP II funds. The University of Maryland, School of Nursing in partnership with several Maryland hospitals, including Meritus Medical Center have used these funds to work towards the goal of advancing nursing practice.

Here at Meritus we have welcomed representatives from the University of Maryland frequently to talk with our staff about returning to school. They have been able to share important information about the programs that are offered through University of Maryland and assist potential students with reviewing transcripts and discussing financial resources.

We are motivated to ensure that our employees have the information that they need when making the decision to return to school. We have set goals around increasing our BSN rate and greatly appreciate our partnership with the University of Maryland, specifically through the NSP II support.

Sincerely,

Melanie M. Heuston, DNP, RN, NEA-BC
Vice President and Chief Nursing Officer

MARYLAND ACTION COALITION
Creating a Healthier Maryland
FUTURE OF NURSING™ CAMPAIGN FOR ACTION

September 30, 2019

Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Sabatini:

We are writing today to offer our full support for the reauthorization of the funding for the Nurse Support Program II (NSPII). As part of the National Center to Champion Nursing in America, the Maryland Action Coalition was formed in response to the Institute of Medicine's 2011 report on *The Future of Nursing: Leading Change, Advancing Health*. The report laid out a series of recommendations for a well-educated nursing workforce to meet the growing demands for health care.

The availability of the NSPII funding for Maryland's educational programs has been critical for the collective efforts to grow enrollment in entry-level and advanced practice nursing programs. The funding has also removed educational barriers for nurses who enter the profession through an Associate Degree program and then go on to complete their Baccalaureate degree. It has also allowed nursing programs to expand their graduate offerings to provide access to care. Most recently, NSPII funds were secured to establish Maryland's Nursing Workforce Center which will track and provide access to workforce data and better inform an understanding of the supply and demand for nurses in Maryland. We are grateful for the NSPII funds that have been available to date, and we look forward to the continuation of NSPII funding for another five (5) years. Please do not hesitate to contact us at kirschling@umaryland.edu and ptravis2@jhmi.edu if additional information is needed.

Sincerely,

Jane Marie Kirschling

Jane Kirschling, PhD, RN, FAAN
Dean and Professor
University of Maryland School of Nursing
Co-Chair Maryland Action Coalition

Patricia Travis

Patricia Travis, PhD, RN
Co-Chair, Maryland Action Coalition

University of Maryland School of Nursing
655 West Lombard Street, 505 Q, Baltimore, MD 21201

Contact
410-706-7858

Web
campaignforaction.org/state/maryland

October 30, 2019

Nelson J Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Dr. Sabatini,

This letter is to express the Maryland Nurses Association's (MNA) support for the continuation of the Nurse Support Program II (NSP II). Since the program's inception, the Health Services Cost Review Commission's efforts to support nursing and nursing education have resulted in a stronger health care work force for the citizens of Maryland. As MNA President, I have had the opportunity to participate in National forums on nursing education, and Maryland's unique collaboration between education and practice is envied by many. Funding from NSP II has increased not only the capacity of nursing education programs in Maryland, but the quality of the practice of Registered Nursing.

I can testify firsthand to the benefits of NSP II funding for nursing education programs. I have witnessed the increase in nursing simulation, which provides clinical/simulation experience for nursing students in pre-licensure and graduate programs, and Interprofessional Education (IPE) initiatives, which provide much needed collaborative training among health care professionals. As a nursing faculty member, I was personally assisted with funding to complete my doctoral education, which has enhanced my ability as a researcher and educator for students.

Registered Nursing shortages are currently projected in Maryland. Maryland Nursing Association is the voice for nursing advocacy in the State, and our support for the continuation of NSP II funding for nursing education is a priority. It is my hope that the Health Services Cost Review Commission will acknowledge the benefits of this program and continue to support nursing education in Maryland.

Sincerely,

Mary Kay DeMarco, PhD, RN, CNE
President, Maryland Nurses Association

JOHNS HOPKINS
UNIVERSITY

October 23, 2019

Nelson J. Sabatini
Chairman
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, Maryland 21215

Dear Chairman Sabatini:

I write to you regarding the NSP II Program Evaluation that has taken place over the past 5 years. I understand that in November, the HSCRC will receive the draft NSP II Program Evaluation and Outcomes report along with future recommendations. I am writing to provide the strongest possible support for the continuation of funding for nursing educational capacity and nurse faculty focused programs.

The Johns Hopkins University School of Nursing (JHSON) supports the NSP II's goals of reducing the nursing faculty shortage and increasing the number of nurses statewide by increasing nursing school capacity for students. Through the support of NSP II, JHSON has made strides to increase the number of nursing faculty, improve the transition of advanced practice nurses into care, support interprofessional learning events for students at the master's and doctoral level, and establish a Certified Registered Nurse Anesthetist (CRNA) program at Johns Hopkins. These projects led by Johns Hopkins nursing faculty have all contributed to NSP II's goal of increasing the number of nursing faculty and bedside nurses. Additionally, JHSON supports NSP II's adoption of IOM recommendations that promote life-long education for nurses and preparing nurses to be leaders of change in the health care industry.

Supporting Doctoral Education to Increase the Number of Nursing Faculty
Through the Nursing Faculty for the Future project, JHSON has increased the number of PhD-prepared nursing faculty, particularly those from racial or ethnic minority backgrounds, by providing fellows with leadership and teaching skills development and the capacity to build both didactic and online courses through a structured curriculum. To date, eight fellows have completed this program and are eligible to take the Certified Nurse Educator (CNE) exam with five of these fellows currently in the process of registering for the CNE exam.

Increasing the Nursing Workforce by Improved Educational Capacity
The NSP II program has contributed substantially to the establishment of the Certified Registered Nurse Anesthetist (CRNA) program at JHSON through generous financial support which has supported faculty salaries, the hiring of a consultant, and the accreditation fees needed to launch this program. The establishment of a CRNA program at JHSON helps fill an increasing demand for CRNA's and broadens the school's contribution to the education of advanced practice nurses.

Office of the President
Garland Hall 242 3400 North Charles Street Baltimore, MD 21218

Supporting Continued Education and Leadership of Nurses

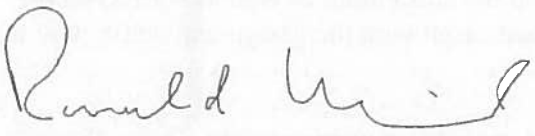
As the number of advanced practice nurses grows, so does the need for educational and residency programs that facilitate their transition into advanced practice care.

- The Supporting Nursing Advanced Practice Transitions program (SNAPT) has used NSP II support to form a partnership with Johns Hopkins Community Physicians to offer a 12-month residency program for new nurse practitioners. SNAPT has been able to develop tools and modules for continuing education and has prepared preceptors who are essential to the nurse residency program. SNAPT seeks to broaden its impact by partnering with more primary care offices in the state of Maryland and presenting their work at the Sigma International Conference in May 2020.
- NSP II has assisted the Post-Master's Pediatric Acute Care Nurse Practitioner program in working with some of our hospital partners to prepare currently employed pediatric primary care NPs to sit for the acute care pediatric certification exam due to the change in certifying agency requirements.
- Finally, NSP II has facilitated the creation of four online interprofessional education (IPE) modules used at JHUSON and by schools across the state of Maryland. In particular, these IPE modules have been adopted by nurse residency programs at twelve hospitals, giving new nurses the skills they need to work on an interdisciplinary health care team.

The NSP II's support of these projects has improved nursing education tremendously through the training of nurse educators, nurse residency programs for new advanced practice nurses, and the creation of a CRNA program that will support the growing demand for doctoral-prepared CRNAs in the healthcare workforce. The NSP II funding improves the quality of nursing education and care in the state of Maryland, benefitting the health systems and patients they serve. The Johns Hopkins University School of Nursing is grateful for the opportunity to further grow the leadership of nurses through the support of NSP II.

Thank you again for your important support of nursing education in Maryland.

Sincerely,



Ronald J. Daniels
President

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October 15, 2019

Mr. Nelson J. Sabatini
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear: Mr. Sabatini

On behalf of Frostburg State University, please accept my highest recommendation for the continuation of the Nurse Support Program II (NSP II).

NSP II grant funding has been critical to the development, expansion, and success of nursing offerings at Frostburg State University. The following is only a brief overview of the positive outcomes made possible by NSP grant awards:

- Development and expansion of an RN-BSN program, including dual enrollment and collaborative articulations with community colleges throughout the state of Maryland. These funds supported the hiring of dedicated staff and faculty to coordinate, advise, and secure community health practicum sites for over 400 students.
- The development and expansion of Master's of Science in Nursing concentrations in Leadership and Management, Nursing Education, Primary Care Family Nurse Practitioner, and Primary Care Psychiatric and Mental Health Nurse Practitioner would not have been possible without NSP II. These funds supported the hiring of faculty to direct and coordinate the program and develop the curriculum as well as staff to secure clinical placements in primary care settings and assist with the design and delivery of the program.

NSP II offers outstanding opportunities for increased capacity in nursing education at all levels and a commitment to serving the state health needs of the state of Maryland's citizens. As such, I strongly recommend NSP II and its continuation.

Sincerely,

Heather A. Gable, DNP, RN, LNHA, CNE, NEA-BC

Chair, Associate Professor

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21133

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October 30, 2019

Nelson J Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Chairman Sabatini,

Today I write to you to request your support for the continuation of funding for the NSP II program for an additional 5 years.

I have served as the Project Director for two NSP II grants benefiting the Community College of Baltimore County's (CCBC's) nursing students. The Associate to Bachelor's (ATB) Nursing Degree Option, made possible by NSP II funding, has allowed over six hundred of CCBC's associate degree students to be dually enrolled with one of our four partner universities (Frostburg State University, Notre Dame of Maryland University, Stevenson University or Towson University) since its inception.

This innovative ATB partnership program, created initially by CCBC and Towson University, is helping to prepare a greater number of Bachelor's prepared nurses in a time and cost efficient manner. The ATB Model has been replicated all over the state of Maryland, giving diverse community college students increased access to a BSN education. Creating a more highly educated and diverse nursing workforce is key to improving healthcare quality and safety in Maryland.

As Project Director, I have attended meetings regularly with others receiving NSP II funds who report on their initiatives. The impact these projects have made on the nursing education community in Maryland has been extraordinary.

I thank you for the NSP II funding that has supported nursing education initiatives in the past and I hope you will support future funding for NSP II.

Sincerely,

Karen Wons, MS, RN, CNE

Karen Wons, MS, RN, CNE
Associate Professor, Nursing
Project Director, Associate to Bachelor's Nursing Degree Option
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UNIVERSITY SYSTEM of MARYLAND

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OFFICE OF THE CHANCELLOR

October 18, 2019

Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Sabatini:

I am writing today to offer the University System of Maryland's (USM) full support for reauthorization of the Nurse Support Program II (NSPII) funding. USM's nursing programs, offered by Bowie State University, Coppin State University, Frostburg State University, Salisbury University, Towson University, and University of Maryland, Baltimore, have all received NSPII funding during the current five-year cycle. This funding has been instrumental in allowing each of these institutions to strengthen their nursing programs, to assure clinical faculty have the necessary knowledge and skills, and to initiate new programmatic offerings in response to Maryland's healthcare workforce needs. Without NSPII funding, the overwhelming majority of these efforts would most likely not have happened.

With NSPII support, an example of an initiative from each of USM's nursing programs is highlighted below:

- Establishment of a Nursing Student Success Center at Bowie State (grant awarded in FY '16) in order to improve retention and graduation rates of BSN students and also their first time NCLEX-RN pass rates.

- Establishment of Leading Educational Academic Retention of Nursing Program (LEARN) at Coppin State University (FY '16) with a focus on pre-admission advisement and intensive academic support services.

- Design and implementation of a Family Nurse Practitioner and Psychiatric/Mental Health Nurse Practitioner program at Frostburg State University (FY '16 and '18) in order to meet the primary health care and behavioral health care needs of Western Maryland.

- Building on the NSPII supported Eastern Shore Faculty Academy and Mentoring Initiatives (ES-FAMI), Salisbury University received funding in FY '20 to develop and pilot advanced *Quality Matters*™ compliant curriculum to expand the number of RNs prepared for clinical teaching roles.
- Design and implementation of an entry-level Master's of Science in nursing degree program (Towson University FY '20) for students who already have a bachelor's degree and want to pursue a career in nursing.

- Design and implementation of the University of Maryland, Baltimore Doctor of Nursing Practice Family Nurse Practitioner program at the Universities at Shady Grove (FY '17) in order to meet the primary health care needs of Western Maryland and Montgomery County.

The USM's nursing programs are deeply committed to preparing well-educated nurses to meet the growing and evolving health care needs in Maryland. Reauthorization of NSPII funding is crucial since it allows the nursing programs to respond to the needs of the residents of Maryland and the health care industry. Thank you for your thoughtful consideration and we look forward to the continuation of NSPII funding for another five years.

Sincerely,

Robert L. Caret

Robert L. Caret, PhD
Chancellor

UNIVERSITY of MARYLAND
BALTIMORE

JAY A. PERMAN, MD
President

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October 18, 2019

Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini,

I am writing today to offer the University of Maryland, Baltimore's full support for reauthorization of funding for the Nurse Support Program II (NSP II). The University of Maryland School of Nursing, the largest nursing school in Maryland, has directly benefited from NSP II funding over the past five years and has been able to address significant nursing workforce needs and issues that otherwise would not have been able to be addressed. This funding resource is invaluable for all of Maryland's nursing programs, including public and private institutions, as well as community colleges, that collectively offer the Associate Degree in Nursing, entry-level baccalaureate degrees in nursing, and graduate-level programs in nursing. All of which are essential to ensuring that Maryland has the diverse nursing workforce needed to care for individuals and communities throughout the State.

Through NSP II support, the University of Maryland School of Nursing has been able to undertake a broad array of initiatives, examples of which are highlighted below:

- In collaboration with Baltimore City Community College, actively engage with the Pathways in Technology Early College High School (P-TECH) at Dunbar High School (FY '19).
- Expand nurse education in substance use and addiction (FY '20).
- Develop curriculum to advance nurses' knowledge of care coordination and case management (FY '17).
- Offer the Doctor of Nursing Practice (DNP) Family Nurse Practitioner (FNP) program at a second location, the Universities at Shady Grove in Rockville, Maryland (FY '17).
- Develop and offer a post-doctoral Psychiatric Mental Health Nurse Practitioner Certificate (FY '17).

— SANDRA R. BERMAN —
SCHOOL OF NURSING and HEALTH PROFESSIONS
STEVENSON
UNIVERSITY

November 6, 2019

Nelson J Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Mr. Sabatini:

This letter is in strong support of the continuation of funding for the Nurse Support II Program for another five year period. The commitment of the Health Services Cost Review Commission (HSCRC) to nursing and nursing education is vital. It is recognized by the nursing education community as an essential component of the continued growth of nursing education in Maryland. Specifically, Nurse Support Program II grants have enabled Stevenson University to increase the enrollment in both the undergraduate and graduate nursing programs. NSP II grants have funded personnel, training, and equipment that have fostered growth and continual improvement in Stevenson's nursing programs.

If you have questions or need additional information, I would be happy to speak with you. I may be reached at 443-394-9818 or by email at jfeustle@stevenson.edu

Sincerely,

Judith A. Feustle

Judith A. Feustle, ScD, RN
Associate Dean, Nursing and
Chief Nurse Administrator

CECIL COLLEGE Cecil College | One Seahawk Drive | North East, MD 21901 | www.cecil.edu

Nelson J Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Chairman Sabatini,

I am writing on behalf of our nursing program to ask for your support of continuation of funding for the nursing educational capacity and nurse faculty focused programs in our state. Through this funding, we have been able to provide additional training and resources for our nursing students. This program has helped to fund projects that have increased enrollment of our graduates into baccalaureate programs, an Institute of Medicine mandate for safety and quality in healthcare.

The funds have also supported faculty by improving their knowledge and expertise through simulation training programs due to the increase shortage in available clinical sites. The funds have supported our student retention plan and helped us to retain qualified faculty, a factor that also improves student retention.

We are projected to have a severe shortage in the nursing workforce in the near future and the NSPII program provides valuable resources that can help minimize the effect of the shortage in our state.

I support the continuation of funding for NSP II for an additional 5 years and I am providing this letter of support for your serious consideration.

Sincerely,

Dr. Nancy Norman-Marzella, MSN, NP, RN
Dean of Health and Human Sciences
Director of Nursing

HARFORD
COMMUNITY COLLEGE

November 7, 2019

Nelson J Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Chairman Sabatini:

Please accept this letter in support of the continuation of funding for NSP II for an additional 5 years. The NSP II funding for nursing education has had a powerful impact on the quality of nursing education in Maryland as well as adding to the number of nursing graduates in Maryland, which directly impacts the quality of health care in Maryland.

Harford Community College has been a recipient of NSP II funding for the last 5 years. Harford Community College has received grant funding specifically to increase nursing pre-licensure enrollments and graduates as well as develop initiatives to advance the education of nursing students from associate to bachelor degrees. The funding has had a significant impact on the quality of the nursing program in multiple ways. It has helped provide simulation equipment equal to what is used in the best health care education program in the nation. The funding has also been used to help provide professional development for nursing faculty to advance in the use of simulation to further develop clinical judgement and problem solving in the clinical setting. It has also provided professional development to help nursing faculty achieve excellence in teaching. These funds have also helped recruit and hire nursing faculty in order to grow and expand the nursing program. The success of the grant initiatives has been shared at national conferences.

In summary, I have shared the specific benefits NSP II funding has had on nursing education at Harford Community College which has positively impacted health care in Harford County. This is being replicated throughout all of the counties of Maryland as well as Baltimore City. The NSP II funds have placed Maryland above many states in supporting quality nursing education to the benefit of improving the quality of health care in the State. I thank you for the support of past years and hope this support will continue.

Sincerely,

Laura Cianelli Preston

Laura Cianelli Preston
Dean of Nursing and Allied Health Professions

401 Thomas Run Road
Bel Air, Maryland 21015
www.harford.edu

Let Curiosity

JOHNS HOPKINS
SCHOOL of NURSING

November 7, 2019

Nelson J Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

RE: Support of continued NSPII funding for nursing education in Maryland

Dear Chairman Sabatini:

I am writing to respectfully request continued funding for the Nurse Support II (NSPII) funding by the Maryland HSCRC. As Dean of Johns Hopkins School of Nursing, the NSPII funds have provided the support for our faculty to develop programs to educate nurses for the state of Maryland. Sixty percent of our new graduates from our pre-licensure program go on to work in Maryland as Registered Nurses (RNs) after graduation. The NSPII funds have also assisted us in preparing nurse practitioner preceptors in practice to mentor nurse practitioner students who will fill the gap between a growing elderly population and the availability of primary and acute care providers who specialize in geriatric care.

Under the exceptional leadership of Dr. Peggy Daw, the leader of NSPII Grants Management, the NSPII grant funding has led to shared educational materials and conferences that have advanced the development of academic programs and faculty at multiple schools of nursing across the state of Maryland.

At Johns Hopkins School of Nursing, our primary mission is to create nursing leaders for the future including future faculty members. We have been pleased and honored to collaborate with our faculty colleagues at the University Of Maryland School of Nursing and other schools on initiatives to increase the number of faculty in Maryland. For the past two years, we have co-sponsored a conference to prepare Master's prepared nurses to select and apply to doctoral education programs in Maryland which upon graduation, will qualify them to be appointed as a nurse faculty member. NSPII funding has supported this effort to address the shortage of nursing faculty members in Maryland. I thank the MD Health Services Cost Review Commission for their consideration of continued NSPII funding.

Sincerely,

Patricia M. Davidson, PhD, MEd, RN, FAAN
Dean and Professor

Office of the Dean

525 North Wolfe Street Room 501 Baltimore, MD 21205 410-955-7544 Fax 410-955-4890 www.nursing.jhu.edu

Salisbury UNIVERSITY

November 8, 2019

To the Health Services Cost Review Commission:

I am writing to in support of the Draft Recommendations for Future Funding for the Nurse Support Program II (NSP II) program. As a nursing professor at Salisbury University and previous grant recipient, I can attest to the impact that the NSP II program has had in our region and across the State.

For example, NSP II grants have supported Salisbury University 's efforts to address the nursing workforce shortage through the Eastern Shore Faculty Academy and Mentorship Initiative. This program recruits expert nurses from hospitals to become part-time clinical faculty to teach for Maryland's nursing programs. With over 150 graduates and offerings on the Eastern Shore, in Central and Western Maryland, this program, nursing programs now have a pool of qualified clinical faculty to support increased student enrollments.

Another NSP II funded initiative, LeadNursingForward.org, is a collaboration between Salisbury University and University of Maryland, Baltimore Schools of Nursing. This web site was developed to be a one-stop web resource for information on becoming a nurse and nurse educator, pursuing advanced education to become a nurse educator, and financial resources. A searchable Career Portal allows Maryland schools of nursing, hospitals and healthcare organizations to post open positions and educational events. Job seekers can search by position title, geographic location, and organization. LeadNursingForward.org

Both projects, LeadNursingForward.org and the Faculty Academy and Mentorship Initiative have received international recognition as high impact programs.

One final example of the far-reaching effects of the NSP II program, is the funding it provided to begin Salisbury University's Doctor of Nursing Practice (DNP) program. With two-entry points, one for those who already hold a master's degree in nursing and one for those with a bachelor's degree in nursing, the DNP program has helped Maryland double the number of individuals holding a doctoral degree. Among the 18 graduates since 2015 are family nurse practitioners, nurse leaders, and nurse faculty. Salisbury's DNP program is one of only two in the State offering a post-bachelor's entry option. This is a vitally important curriculum to encourage entry into advanced education at an earlier age and to provide a seamless transition to a doctoral degree.

These are just a few examples of how the NSP II program has helped address critical nursing and nurse educator workforce shortages to improve the quality of healthcare available to the citizens of Maryland. I highly recommend continued funding so that we can continue to address these healthcare challenges together.

Sincerely,

Lisa A. Seldomridge

Lisa A. Seldomridge, PhD, RN, CNE
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November 7, 2019

Dr. Nelson J.Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Dr. Sabatini,

I am writing to provide a letter of support from the Salisbury University School of Nursing for the MHEC NSP II program continuation of funding for the nursing educational capacity and nurse faculty focused programs.

These programs have provided the means to support our nursing faculty achieve their terminal doctoral degrees, which is critical in the education of our future nurses within the State of Maryland. These funds have also supported the dissemination of research and doctoral projects from the faculties doctoral studies to support the evidence-based structure of the nursing profession. Without these funds, it would have been extremely difficult to assist these vital professionals the means to pursue their advanced degrees.

In addition, the NSP II funds have supported grant activities that have provided fantastic outcomes both for our university and throughout the State of Maryland. We have increased the numbers of qualified adjunct faculties and increased the availability for our students to receive top-notch educational standardized patient and simulation activities through the support of the NSP II funding.

In summary, I could go on and on with the contributions that we, the Salisbury University School of Nursing, have been able to make through the support of the NSP II funds. I sincerely hope that these funds remain available to continue ours and others programs to provide the highest quality faculty and nursing programs for the citizens of Maryland. This program enables us to provide superior nursing educations for our students and provides for faculty to

achieve their highest professional endeavors. These outcomes would not be possible without the support of the NSP II funds.

Again, please accept this letter of support for the NSP II funding. If you have any questions or need further information, please do not hesitate to ask.

Sincerely,

Jeffrey Willey, PhD, RN, CNS, CLNC, CNE
Director and Associate Professor
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Salisbury University
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410-543-6344

HAGERSTOWN COMMUNITY COLLEGE

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November 8, 2019

Mr. Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
November 8, 2019

Dear Mr. Sabatini:

It is my pleasure to write a letter in support of the Nurse Support Grants (NSP). Hagerstown Community College has been very fortunate to have been awarded a number of NSP grants in the last twelve years. These grants have been very beneficial in helping our nursing program grow. Through the NSP II grant, we were able to almost triple the size of our nursing program.

In addition, we have been able to develop a remediation program whereby we have been successful in keeping many students from failing, thus increasing our retention rates. Some of the grants also enabled us to purchase Assessment Technologies Institute (ATI) for each of our students. ATI not only helps students with remediation but has also helped to increase our NCLEX scores which remain some of the highest in the state.

Also through one of the NSP grants, we were able to establish a Simulation network throughout the state through which we helped the other community colleges in Maryland to increase simulation in their nursing programs. In addition, through the NSP grants, we were able to purchase simulators and other simulation equipment which helped to enhance our own simulation program at HCC.

In conclusion, I fully support your efforts to obtain additional money for grants to help our nursing programs.

Sincerely,

Karen Hammond RN, MSN

Karen Hammond
Director of Nursing
Hagerstown Community College

HOOD COLLEGE
FREDERICK, MARYLAND

DEPARTMENT OF NURSING

November 7, 2019

Nelson J Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Mr. Sabatini,

I am writing in support of continued funding for the NSP II Program. The NSP II grant that Hood College received, which is still in progress, has afforded us a substantial opportunity to bring baccalaureate nursing education to this area of Maryland, which helps to ease the nursing shortage. Baccalaureate prepared nurses are essential to the health of our communities, and are prepared to work in multiple settings, with many graduates working in medically underserved areas of Maryland and neighboring states and the District of Columbia.

In the short time the BSN pre-licensure program has been operating at Hood College, we have graduated two classes of students, one with 8 and the last in May 2019 of 20. Our enrollment has continued to grow and we continue to have more applicants than we can accommodate. This fall we admitted 40 students, and still turned away many. Funding from this grant has allowed us to hire doctorally prepared faculty, provide ongoing faculty support and education, and increase our enrollments to meet the needs of the surrounding communities and state. Without these funds, our program would not be able to grow to meet the ongoing need for nurses.

As a Maryland nurse and leader in nursing education, I fully endorse the continued funding of the NSP II grant to meet the health care needs of our state through providing quality nursing education.

Sincerely,

Linda J. Kennedy, PhD, RN, CNE
Chair, Nursing Program
Hood College

Hood College • 401 Rosemont Avenue • Frederick, MD 21701
301-696-3277 • Fax: 301-696-3278 • Email: Nursing@hood.edu • www.hood.edu

Final Staff Recommendation on the

Emory University, Rollins School of Public Health (EU)

Request to Access HSCRC Confidential Patient Level Data

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

November 13, 2019

This is a final recommendation for Commission consideration at the November 13, 2019 Public Commission Meeting.

SUMMARY STATEMENT

The Emory University Rollins School of Public Health (EU) is requesting to use limited Health Services Cost Review Commission (HSCRC) inpatient and outpatient confidential data ("the Data") to investigate the impacts of outdoor air quality and heat on acute severe morbidity in urban and rural locations across the U.S. The Data will be used as part of the federally funded Environmental Exposures and Health Across the Nation (ENVISION) study.

OBJECTIVE

The ENVISION study aims to 1) compare and summarize short-term associations between air pollutants, heat, and other environmental exposures with cause-specific emergency department (ED) visits and hospital admissions (HA), and 2) examine and explain heterogeneity of observed associations across locations considering factors such as air pollution mixtures, climate and seasonality, and population susceptibility and vulnerability (e.g., age, sex, race/ethnicity, and socioeconomic status). Investigators received approval from the EU Institutional Review Board on February 2, 2018. The Data will not be used to identify individual hospitals or patients. The Data will be retained by EU until February 21, 2023; at that time, the Data will be destroyed and a Certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee was comprised of representatives from HSCRC staff, the Maryland Department of Health, and Prince George's County Health Department. The role of the Review Committee is to determine whether the study meets the minimum requirements described below and make recommendations for approval to the Commission at its monthly public meeting.

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

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

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by EU for the limited inpatient and outpatient confidential data files for Calendar Year 2005 through 2016 be approved;

2. This access will be limited to identifiable data for subjects meeting the criteria for the research.

Final Staff Recommendation on the

University of Maryland School of Medicine (UM)
Baltimore's Shock Trauma and Anesthesiology Research Center (STAR),
National Study Center for Trauma and EMS (NSC)

Request to Access HSCRC Confidential Patient Level Data

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

November 13, 2019

This is a final recommendation for Commission consideration at the November 13, 2019 Public Commission Meeting.

SUMMARY STATEMENT

The University of Maryland School of Medicine (UM) Baltimore's Shock Trauma and Anesthesiology Research Center (STAR), National Study Center for Trauma and EMS (NSC) is requesting to use limited Health Services Cost Review Commission (HSCRC) confidential inpatient and outpatient data ("the Data"). The Data will be used in the Crash Outcome Data Evaluation Systems (CODES). The Commission last approved access to the Data for this project on September 2, 2009.

OBJECTIVE

The Data requested will be used in the CODES project that is funded by the Maryland Department of Transportation's Highway Safety Office (MDOT/MHSO) for the purpose of making data related to traffic safety and injury available for analysis. The Data will be used for analysis of injuries to persons treated at Maryland hospitals. Investigators received approval from the University of Maryland Baltimore, Institutional Review Board on July 30, 2019. The Data will not be used to identify individual hospitals or patients. The Data will be retained by UM until November 13, 2024; at that time, the Data will be destroyed and a Certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee was comprised of representatives from HSCRC staff, the Maryland Department of Health, and Prince George's County Health Department. The role of the Review Committee is to determine whether the study meets the minimum requirements described below and make recommendations for approval to the Commission at its monthly public meeting.

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5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

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

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by UM/NSC for the limited inpatient and outpatient confidential data files for Calendar Year 2017 through 2019 be approved;

2. This access will be limited to identifiable data for subjects meeting the criteria for the research.

Monitoring Maryland Performance
Medicare Fee-for-Service (FFS)

Data through July 2019– Claims paid through September 2019

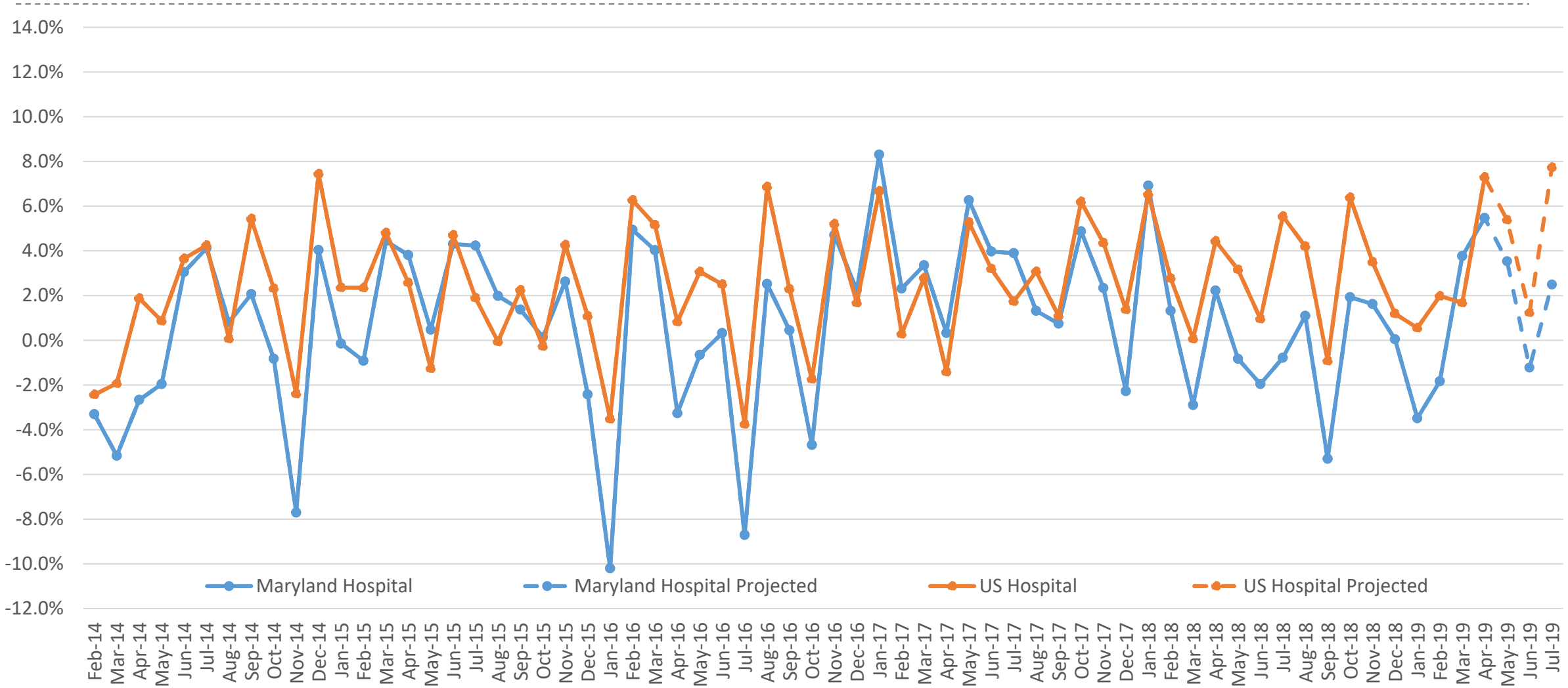
Source: CMMI Monthly Data Set

Disclaimer:

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

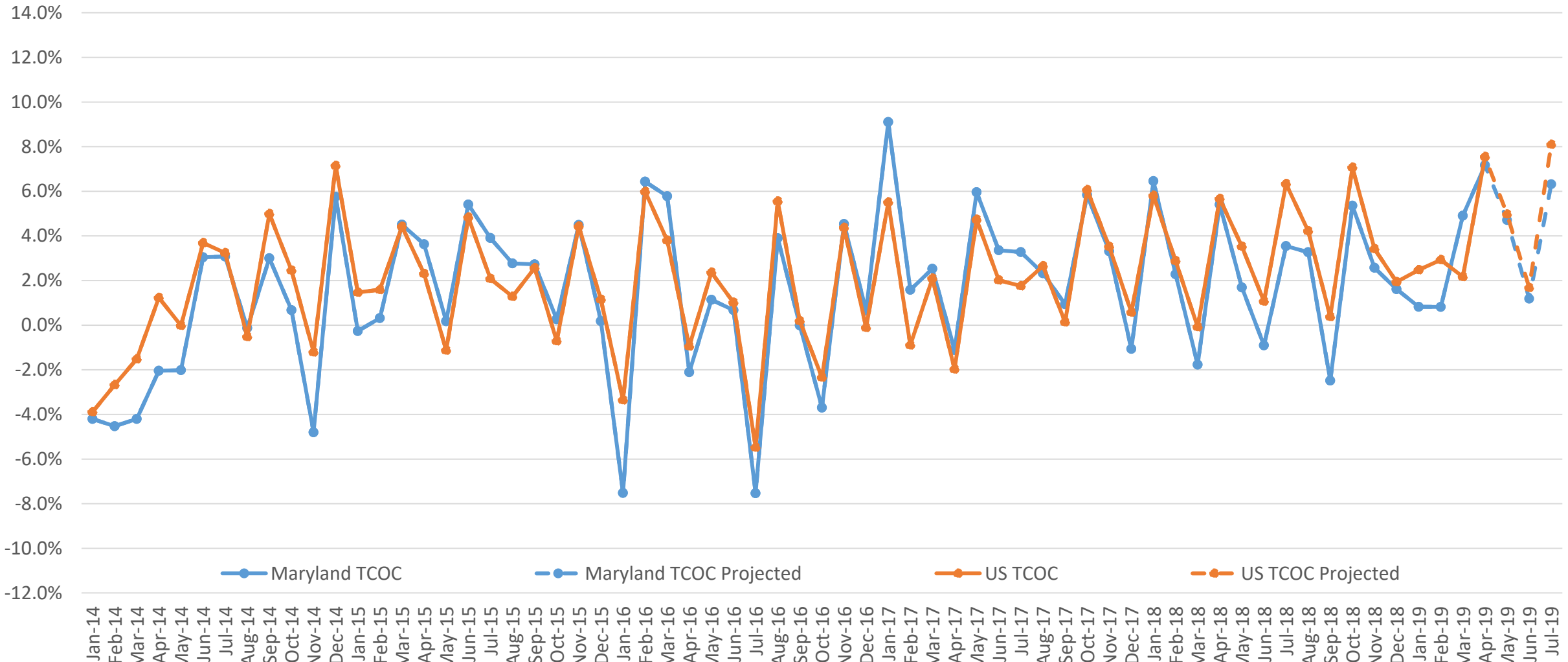
Actual Growth Trend (CY month vs. prior CY month)



HSCRC
Health Services Cost Review Commission

Medicare Total Cost of Care Spending per Capita

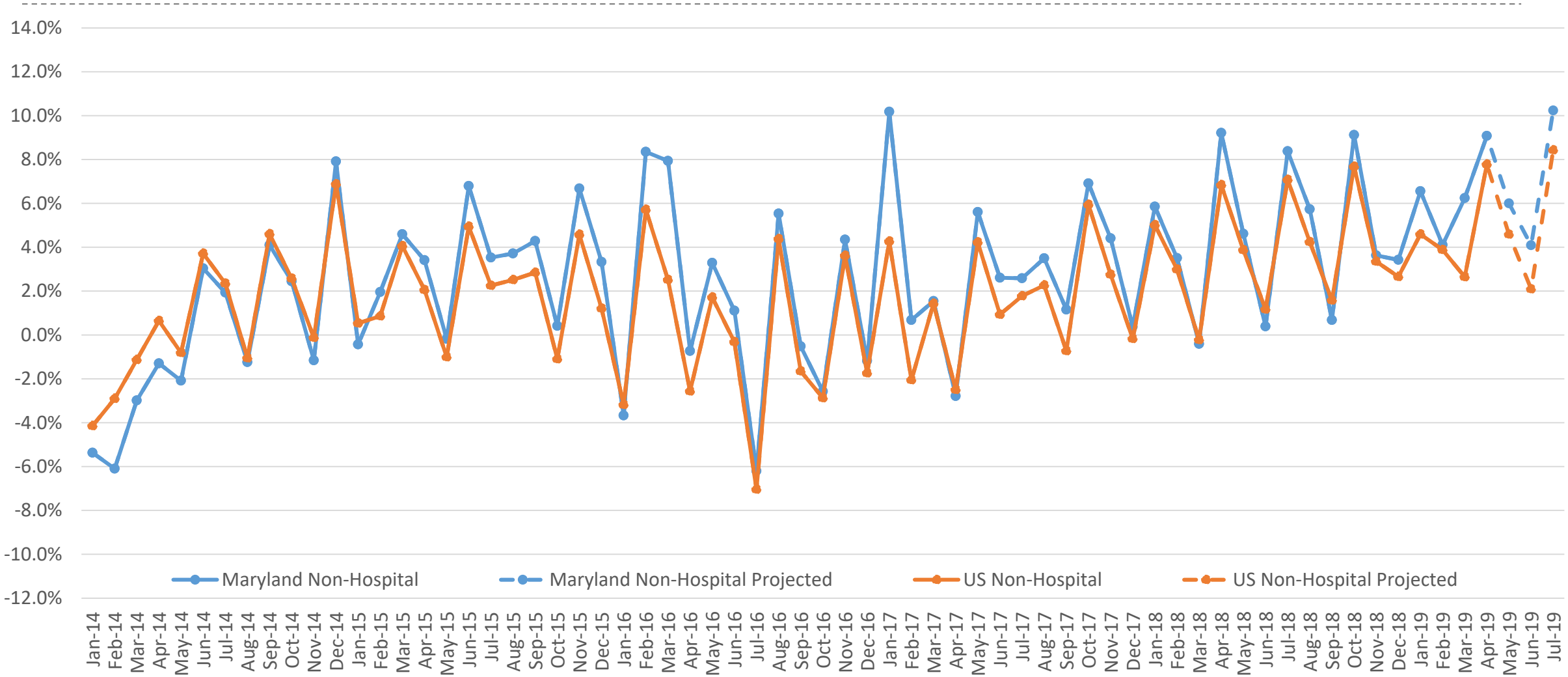
Actual Growth Trend (CY month vs. prior CY month)



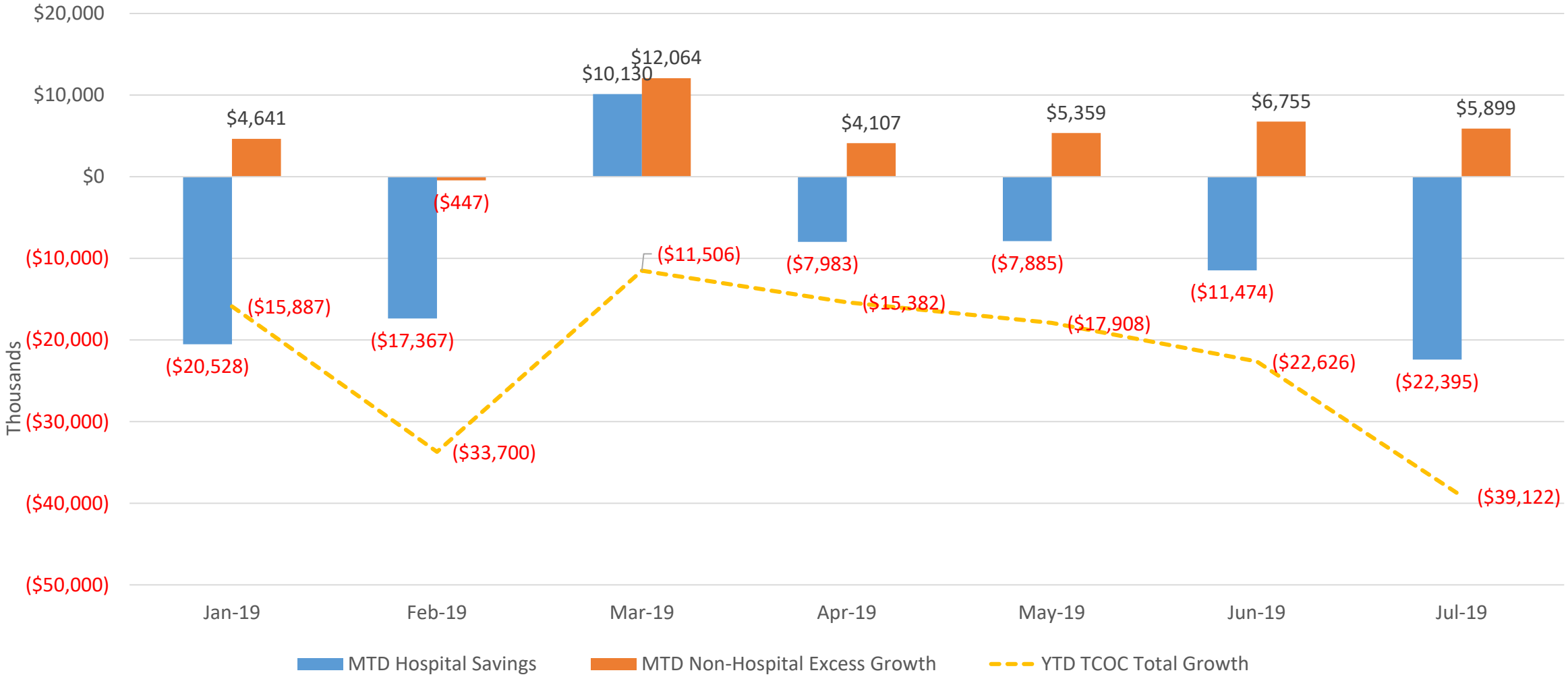
HSCRC
Health Services Cost Review Commission

Medicare Non-Hospital Spending per Capita

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



Maryland Medicare Hospital & Non-Hospital Growth



HSCRC
Health Services Cost Review Commission

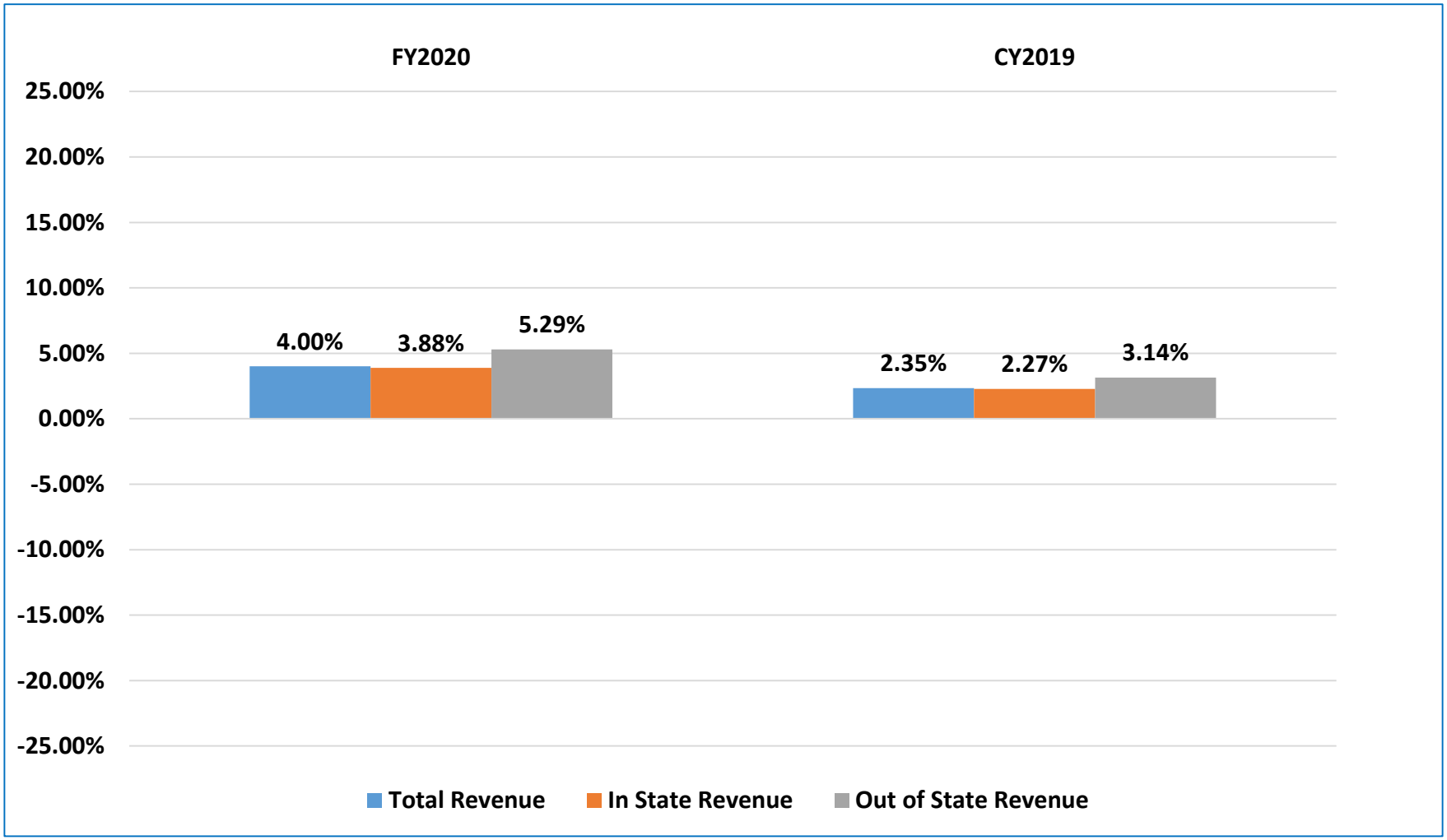
Monitoring Maryland Performance
Financial Data

Fiscal Year and Calendar Year to Date through September 2019

Source: Hospital Monthly Volume and Revenue
Run: November 4, 2019

Gross All Payer Hospital Revenue Growth

FY 2020 (July 2019 – September 2019 over July 2018 – September 2018)
CY 2019 (January 2019 – September 2019 over January 2018 – September 2018)

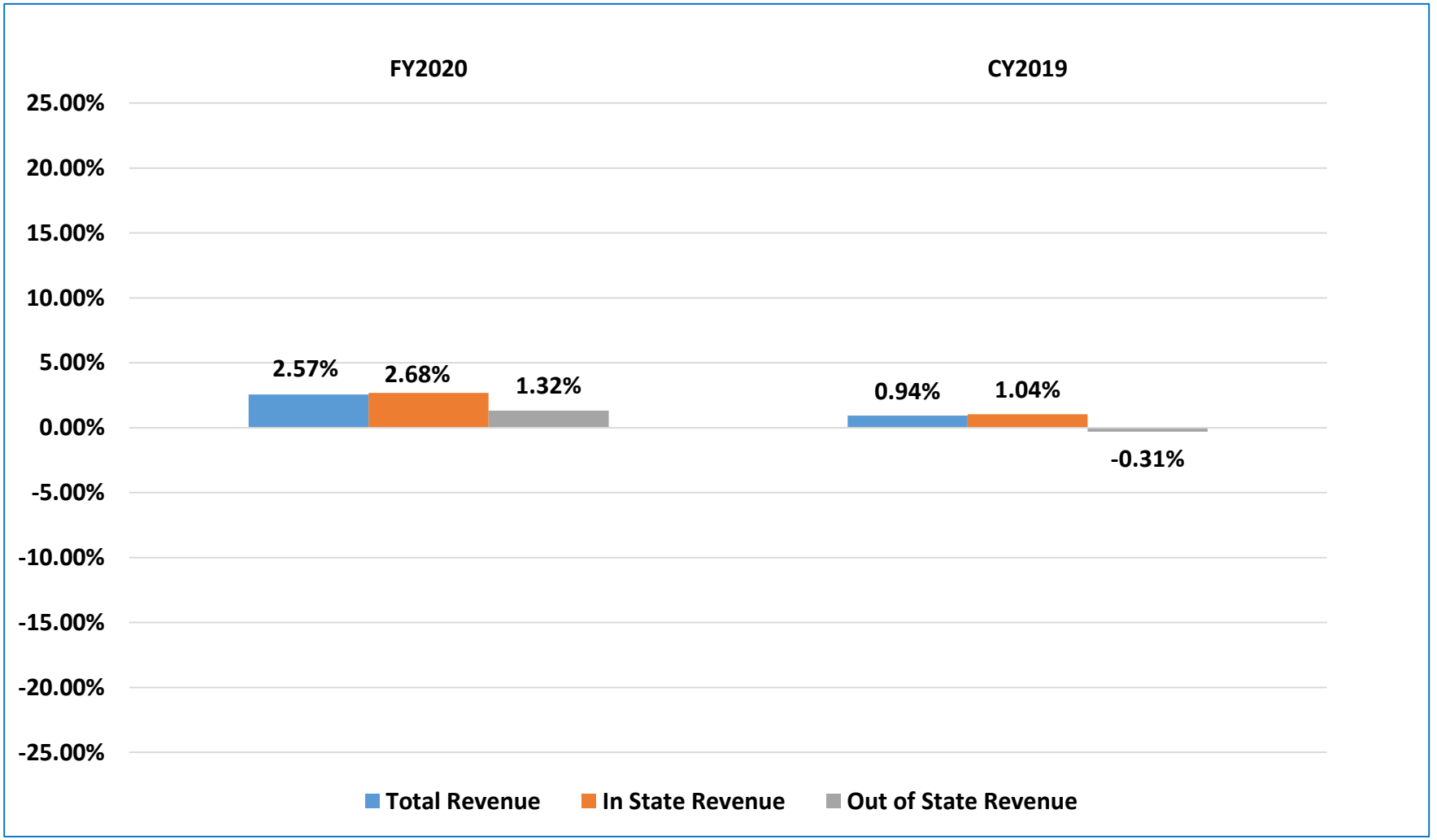


The State's Fiscal Year begins July 1

HSCRC
Health Services Cost Review Commission

Gross Medicare Fee for Service Hospital Revenue Growth

FY 2020 (July 2019 – September 2019 over July 2018 – September 2018)
CY 2019 (January 2019 – September 2019 over January 2018 – September 2018)

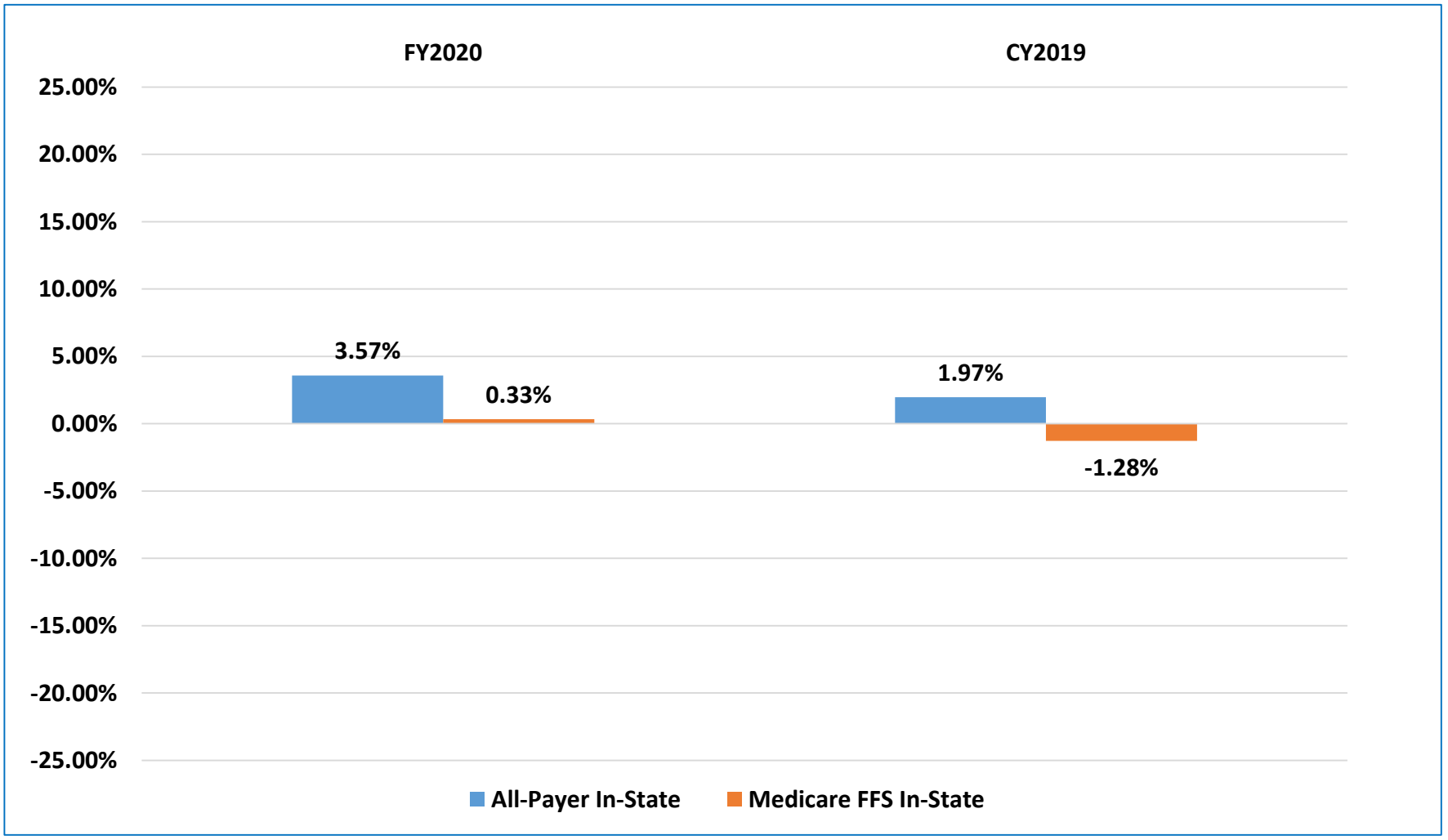


The State's Fiscal Year begins July 1

HSCRC
Health Services Cost Review Commission

Hospital Revenue Per Capita Growth Rates

FY 2020 (July 2019 – September 2019 over July 2018 – September 2018)
CY 2019 (January 2019 – September 2019 over January 2018 – September 2018)

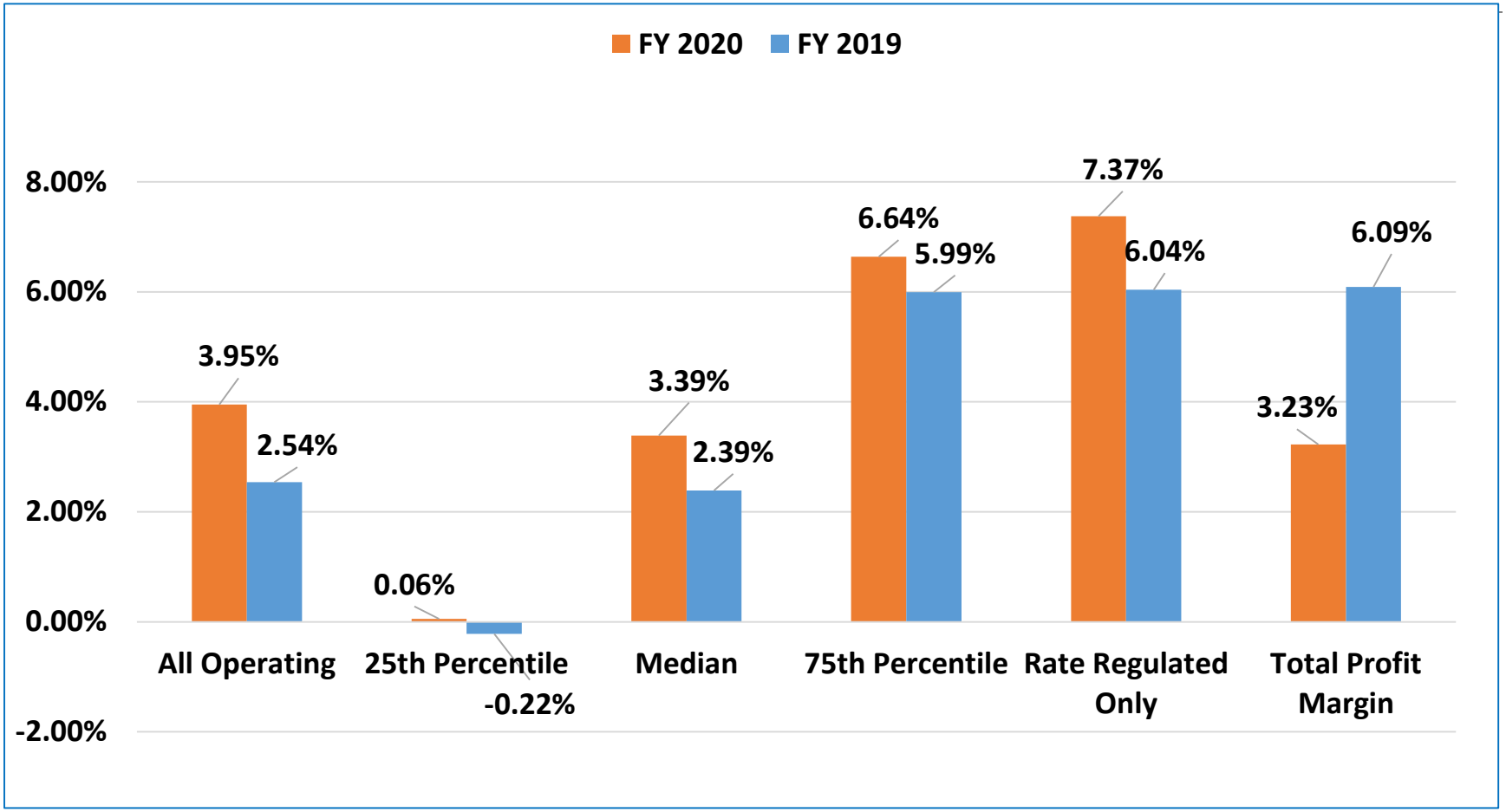


The State's Fiscal Year begins July 1

HSCRC
Health Services Cost Review Commission

Hospital Total Operating, Regulated and Total Profits

Fiscal Year 2020 (July 2019 – September2019) Compared to Fiscal Year 2019 (July 2018 – September 2018)



FY 2020 unaudited hospital operating profits show an increase of 1.41 percentage points in total operating profits compared to FY 2019. Rate regulated profits for FY 2020 have increased by 1.33 percentage points compared to FY 2019. ** Note – Laurel Regional is not included in either fiscal year due to its change in status to freestanding medical facility .

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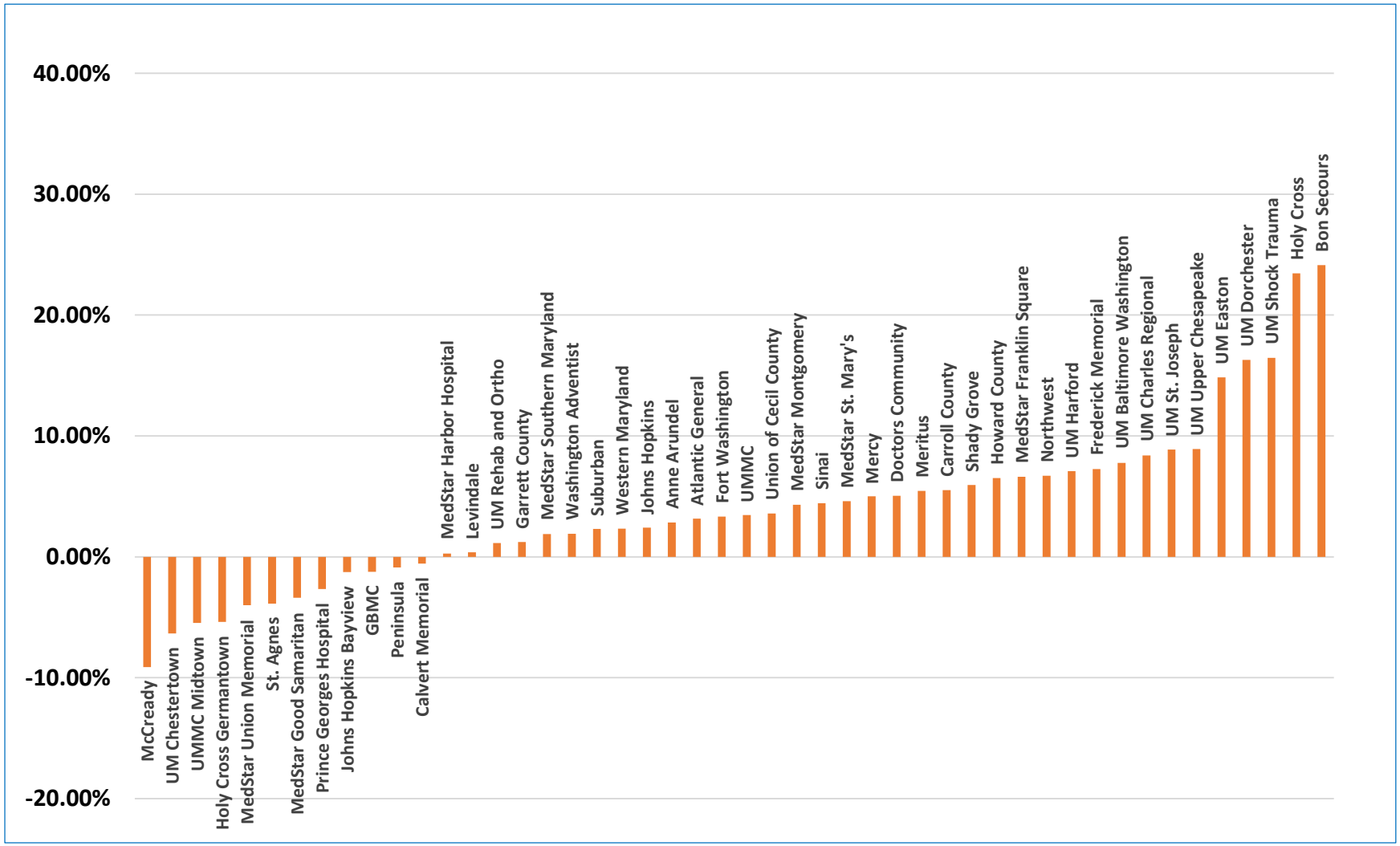
Health Services Cost Review Commission

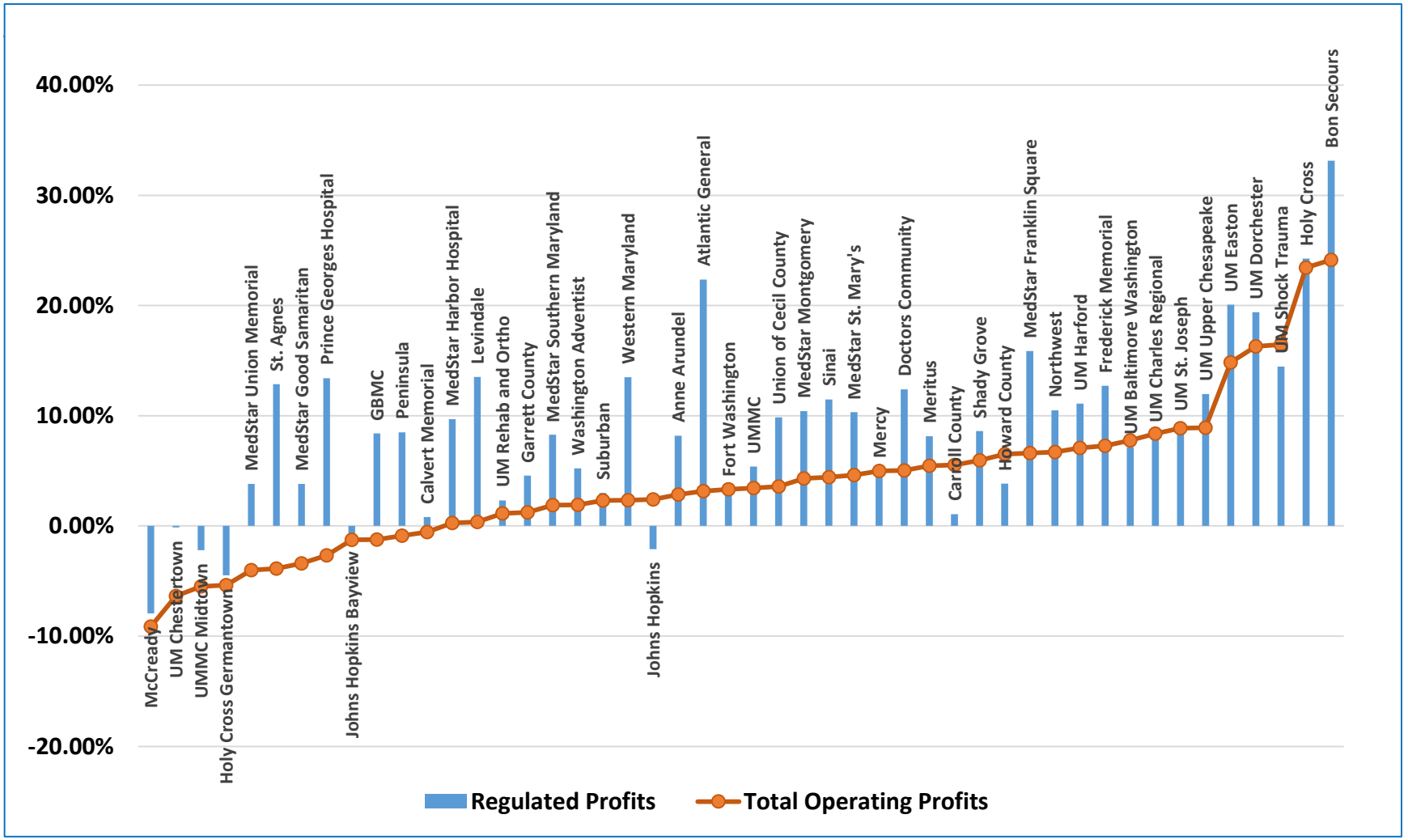
Total Operating Profits by Hospital

Fiscal Year 2020 (July 2019 – September 2019)



Regulated and Total Operating Profits by Hospital

Fiscal Year 2020 (July 2019 – September 2019)



HSCRC
Health Services Cost Review Commission

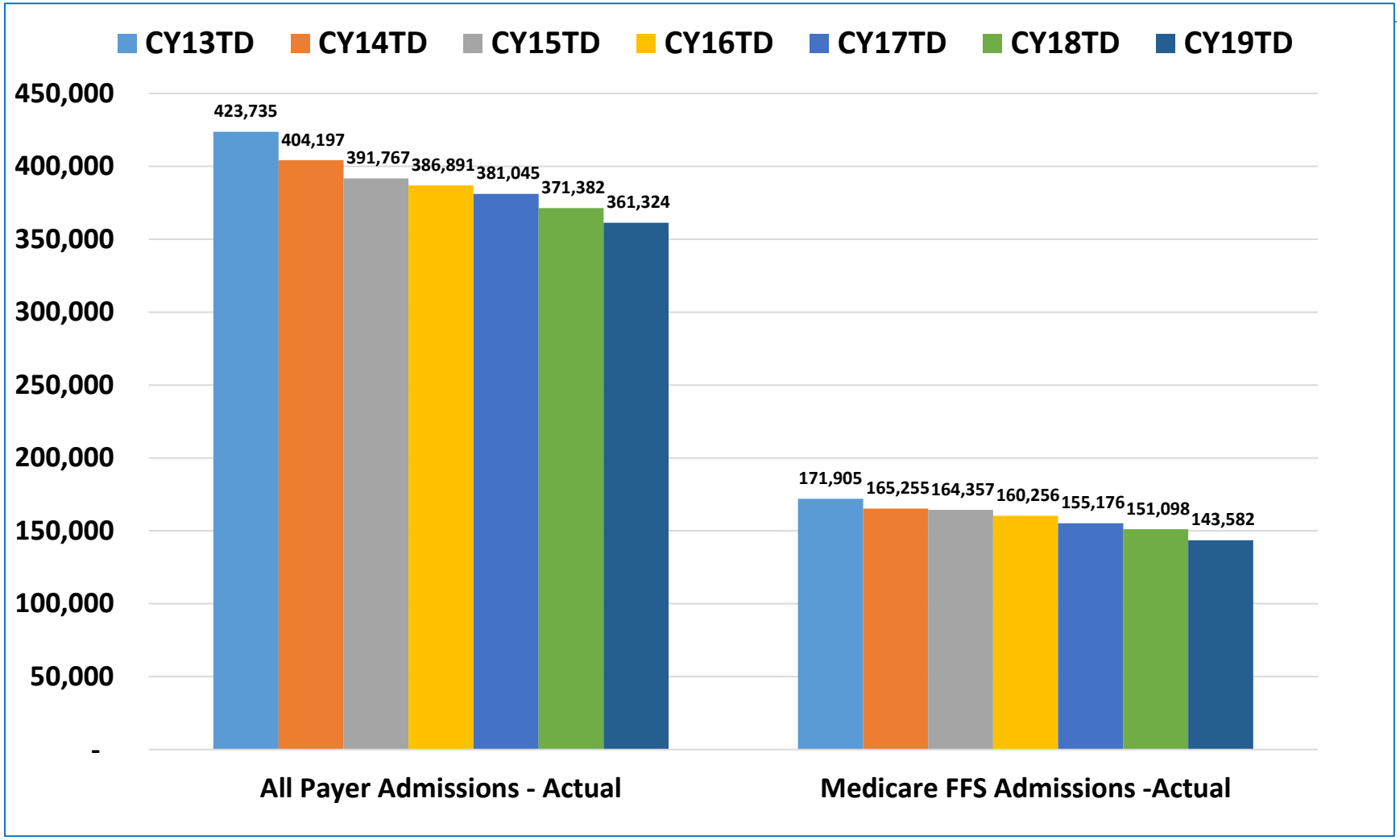
Monitoring Maryland Performance
Financial/Utilization Data

Calendar Year to Date through September 2019

Source: Hospital Monthly Volume and Revenue Data

Actual Admissions by Calendar YTD – September

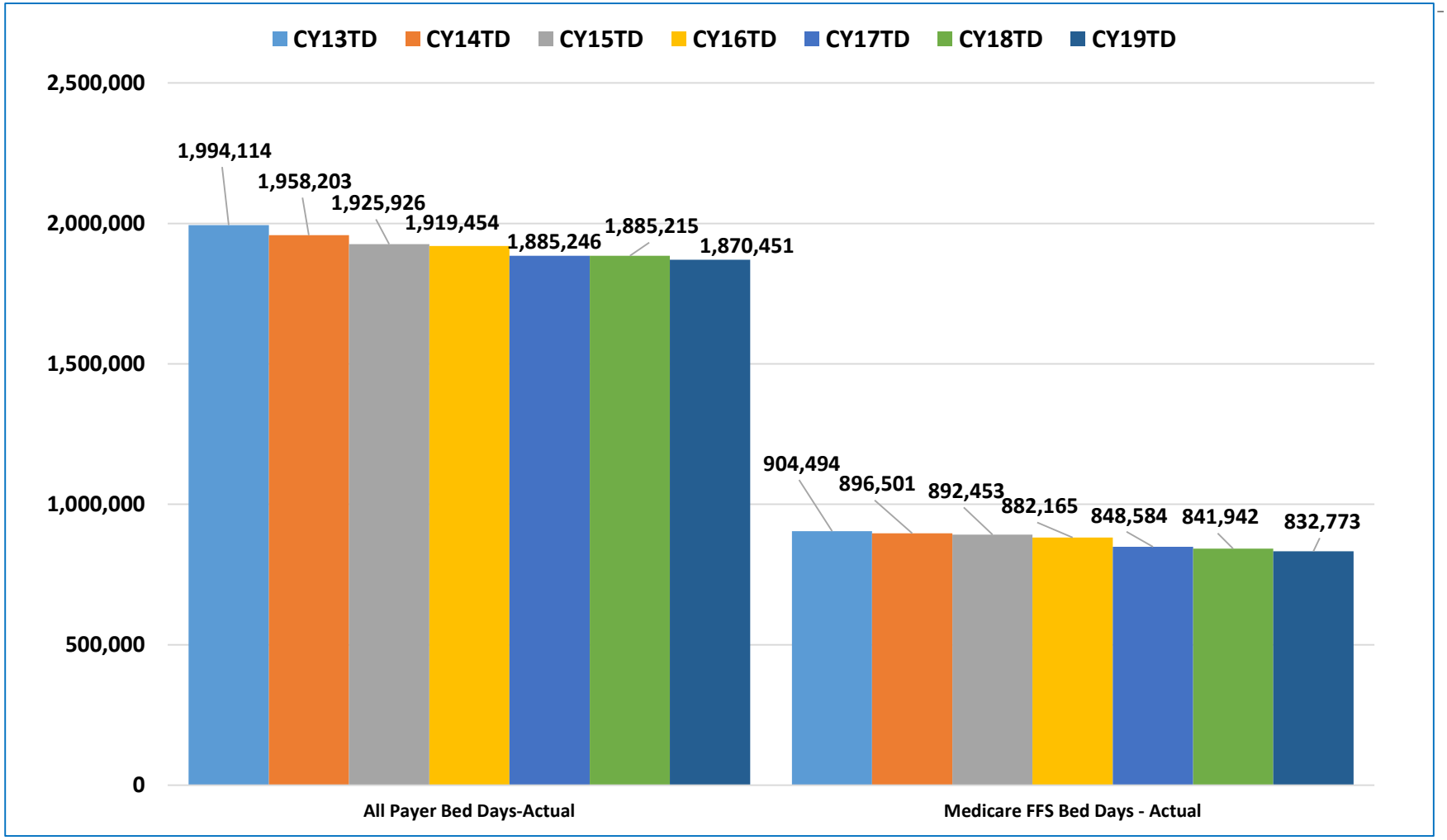
(CY 2013 through CY 2019)



Note - The admissions do not include out of state migration or specialty psych and rehab hospitals.

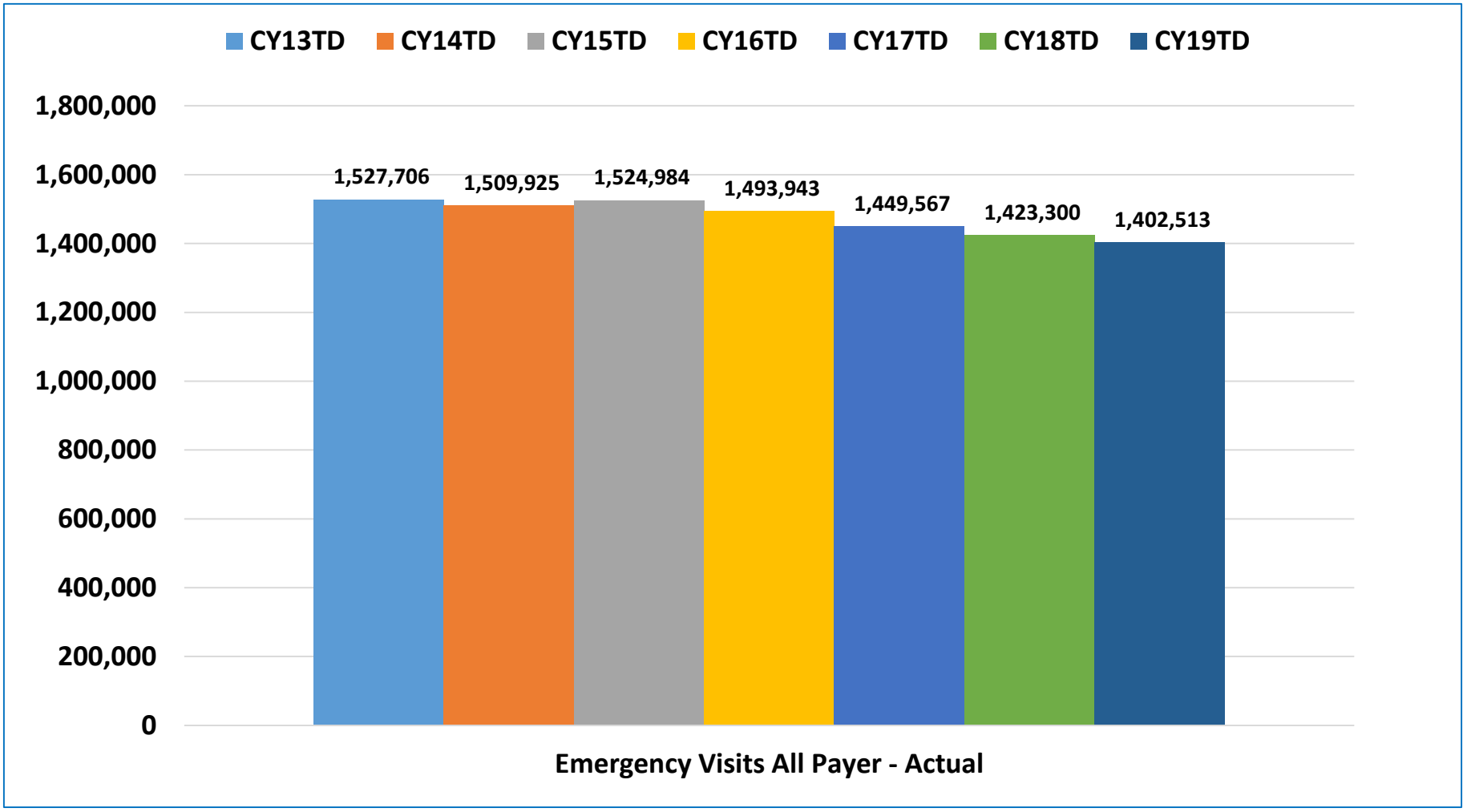
Actual Bed Days by Calendar YTD September

(CY 2013 through CY 2019)



Note - The bed days do not include out of state migration or specialty psych and rehab hospitals.

Actual Emg. Dept. Visits by Calendar YTD – September (CY 2013 through CY 2019)



Note - The ED Visits do not include out of state migration or specialty psych and rehab hospitals.

HSCRC
Health Services Cost Review Commission

Purpose of Monitoring Maryland Performance

Evaluate Maryland's performance against Total Cost of Care Model Requirements:

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP)
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Maryland's Growth in total expenditures for hospital and non-hospital services for Medicare's fee-for-service beneficiaries must reach a savings level of $300 million annually relative to the national growth rate by the end of 2023. The Maryland hospital costs represent approximately half of the Medicare total expenditures for Maryland residents.

Data Caveats

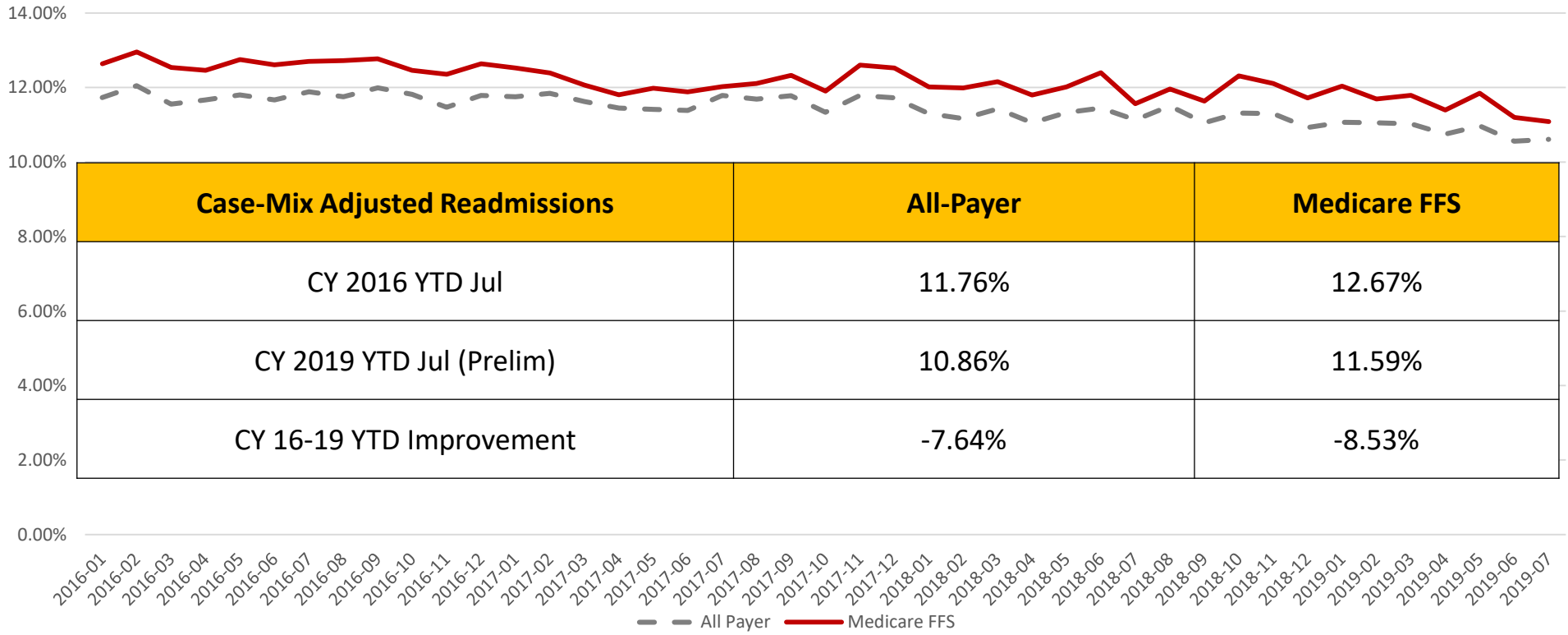
- Data revisions are expected.
- For financial data if residency is unknown, hospitals report these patients as Maryland residents. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.

Monitoring Maryland Performance
Quality Data

October 2019 Commission Meeting Update

Readmission Reduction Analysis

Monthly Case-Mix Adjusted Readmission Rates

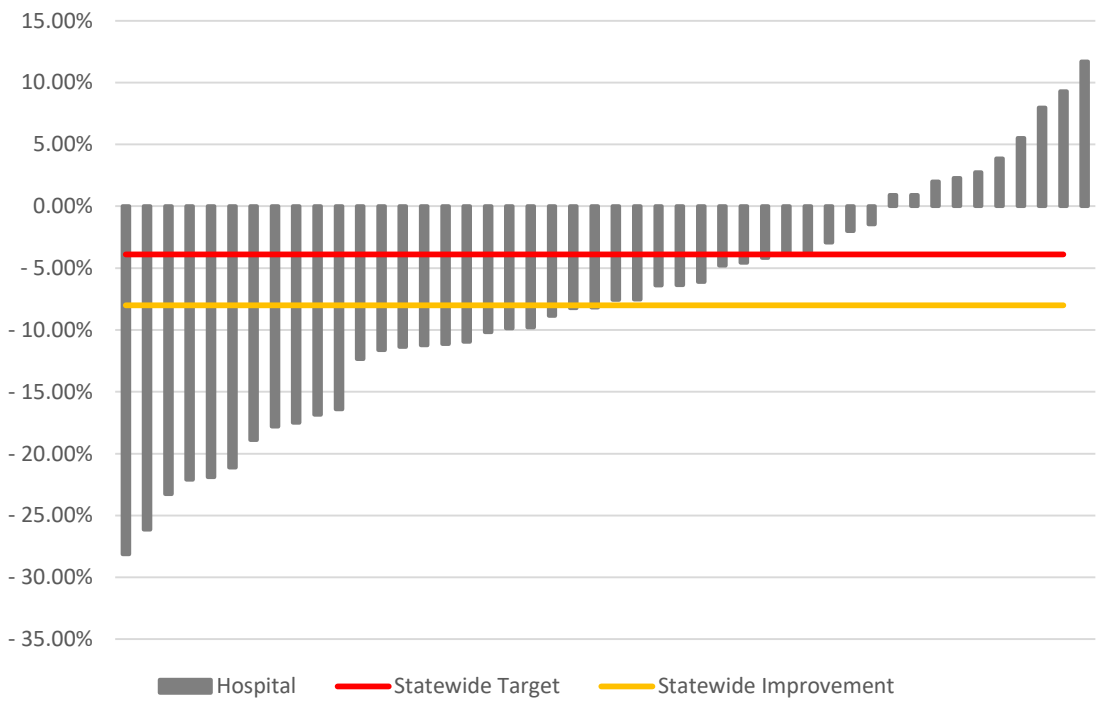


Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
CY 2016 YTD Jul	11.76%	12.67%
CY 2019 YTD Jul (Prelim)	10.86%	11.59%
CY 16-19 YTD Improvement	-7.64%	-8.53%

Note: Based on final data for Jan 2016 – June 2019; Preliminary data through August 2019. Statewide improvement to-date in RY 2021 is CY 2019 YTD compared to the same timeframe in CY 2016.

Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital

Improvement (or Change) CY 2016 YTD compared to CY 2019 YTD through August



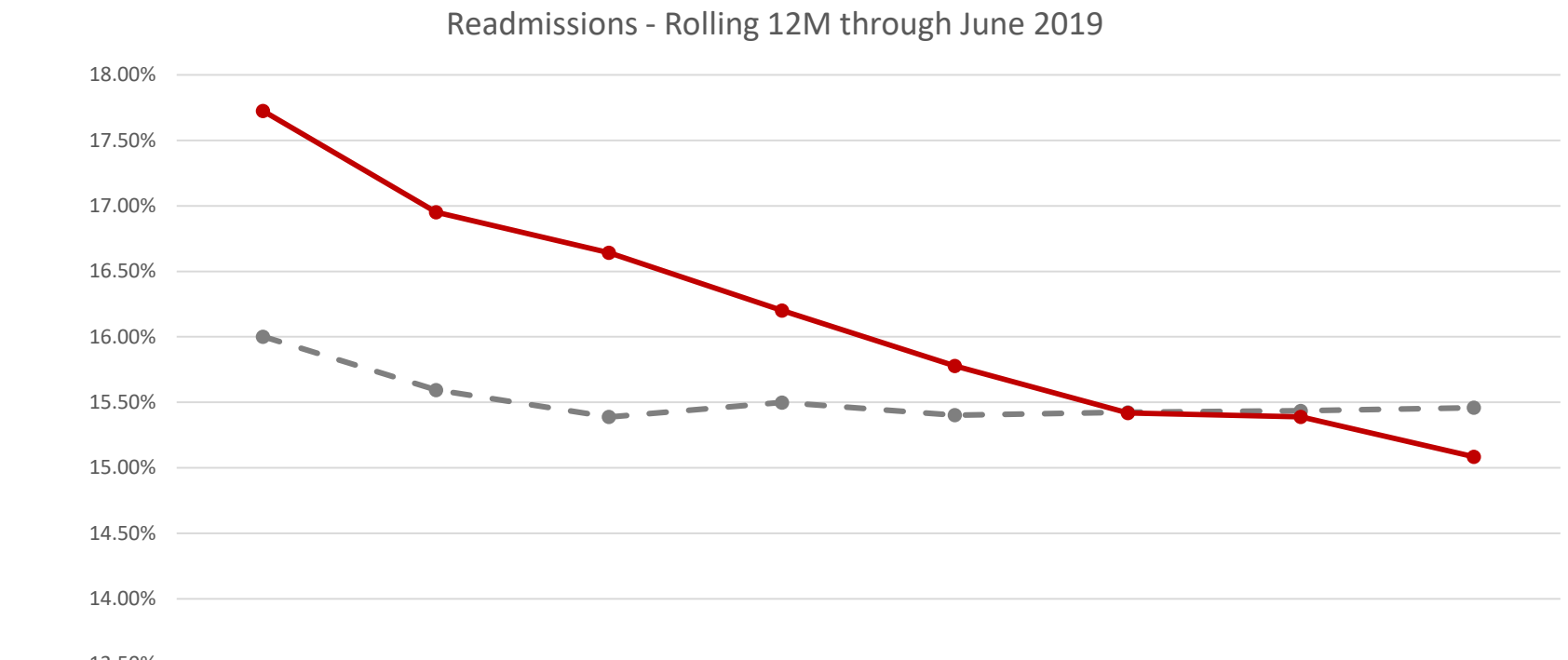
32 Hospitals are on Track for Achieving Improvement Goal

An Additional 3 Hospitals on Track for Achieving Attainment Goal

Note: Based on Final data through June 2019; Preliminary data through September 2019.
*****

Medicare Readmission Model Test

TCOC Model Requirement: Maintain Readmission Rate at or below National Medicare Readmission Rate



	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017	Rolling 12M 2018	Rolling 12M 2019
National	16.00%	15.59%	15.39%	15.50%	15.40%	15.42%	15.44%	15.46%
Maryland	17.72%	16.95%	16.64%	16.20%	15.78%	15.42%	15.39%	15.08%

Data are currently available through June 2019

HSCRC
Health Services Cost Review Commission

Update On University of Maryland Capital Region Health Volume Dissipation

November 13, 2019

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

BACKGROUND

Effective January 1, 2019, the University of Maryland Capital Region Health discontinued inpatient services at the University of Maryland Laurel Regional Hospital (Laurel) and relocated those services to the University of Maryland Prince George's Hospital Center (PGHC). With the relocation of inpatient services, Laurel became a Freestanding Medical Facility (FMF). The conversion of Laurel from an acute care hospital to an FMF began in the fall of 2018 with the relocation of Inpatient Chronic and Inpatient Rehabilitation services. The remaining Inpatient Medical Surgical, Intensive Care and Psychiatric Services were relocated on January 1, 2019. The matter of the conversion of Laurel to an FMF, and the relocation of inpatient services to PGHC, was considered by the Commission in conjunction with the staff recommendation in Proceeding 2450R dated September 12, 2018.

ANALYSIS

As part of its consideration of the rate implications associated with the conversion and relocation of services, the Commission directed Staff to monitor reductions of Laurel volume that does not materialize at another hospital in order to assist the Commission in ensuring that adequate savings are achieved for the State as reductions in capacity occur. Effective January 1, 2019, Staff transferred $58,642,874 from Laurel to PGHC to account for all of the inpatient services that were anticipated to be transferred to PGHC. Of the $58.6 million total, volume associated with $51.9 million of that total transfer actually received care at other hospitals. Applying the standard 50 percent variable cost factor for market shift associated with the movement of that volume results in a reduction of $25,393,431 to the GBR of PGHC (See Exhibit 1 for details).

The retained revenue after adjustments for market shift at PGHC totals $33,249,443, of which $7,440,324 (at 100% variable cost factor) was determined to be dissipation. Staff reviewed the total dissipation and determined that $4,106,428 can be attributed to reductions in PAU, while $3,333,896 can be attributed to dissipation. Consistent with the Commission's directive in Proceeding 2450R, the retained revenue associated with dissipation "should be reduced using no less than a fifty percent variable revenue factor for reductions in volumes of Laurel Regional Hospital that do not materialize at Prince George's Hospital." (Staff Recommendation, Proceeding 2450R, 2018)

PRIOR RECOMMENDATION UPDATE

Therefore, HSCRC staff recommends that the global revenue cap for PGHC be be reduced, at minimum, by a 50 percent variable revenue factor for dissipation that cannot be attributed to any reductions in PAU or market shift. Based on the Staff Recommendation in Proceeding 2450R, the minimum reduction for volume that has not materialized at Prince George's Hospital would total $1,666,948 in FY 2020.

Exhibit 1

UM Capital Region Health
FY2020

Permanent GBR Dollars Moved from Laurel to PGHC		**$ 58,642,874**
Of the $58.6 Million that moved to PGHC, $51.9 million received care at other hospitals		
$7.4 Million dissipated and cannot be attributed to market shift to other hospitals		
PGHC will have retained approximately $27 million for $0 in patient volume		
Market Shift Adjustment to MD Hospitals at 50%	$ (17,682,791)	
Market Shift Adjustment to DC Hospitals at 50%	$ (3,690,000)	
Market Shift Adjustment for PAU to other Hospitals at 50%	$ (4,582,640)	
Chronic Patient Growth at 50%	$ 562,000	
Total Market Shift to be removed at 50%		**$ (25,393,431)**
Subtotal GBR Dollars Retained at PG		**$ 33,249,443**
Dissipation Adjustment at 50%		**$ (1,666,948)**
Total GBR Dollars Retained at PG		**$ 31,582,495**
Total Reductions to PG GBR		**$ (27,060,379)**

Laurel Dissipation Calculation at 100%		
Previous PAU Dissipation	$ (4,106,428)	
Dissipation that cannot be attributed to Market Shift or PAU	$ (3,333,896)	
Total Dissipation at 100%	**$ (7,440,324)**	

State of Maryland
Department of Health

Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

Stacia Cohen

John M. Colmers

James N. Elliott, M.D.

Adam Kane

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Katie Wunderlich
Executive Director

Allan Pack, Director
Population Based
Methodologies

Chris Peterson, Director
Payment Reform &
Provider Alignment

Gerard J. Schmith, Director
Revenue & Regulation
Compliance

William Henderson, Director
Medical Economics &
Data Analytics

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **November 13, 2019**

RE: **Hearing and Meeting Schedule**

December 11, 2019	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
January 8, 2019	To be determined – 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:15 a.m.

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

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