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599th Meeting of the Health Services Cost Review Commission
October 12, 2022

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

EXECUTIVE SESSION
11:30 am

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

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

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on September 14, 2022

2. Docket Status – Cases Closed
   2602T - University of Maryland Midtown Campus

3. Docket Status – Cases Open
   2604A - University of Maryland Medical Center
   2605A - University of Maryland Medical Center
   2606A - John Hopkins Health
   2607A - University of Maryland Medical Center
   2601N - Luminis Health Doctors Community Medical Center

4. Legal Update

5. Regional Partnership - 2021 Report

   a. Staff Report
   b. Baltimore Metropolitan Diabetes Regional Partnership Presentation

6. Draft RY 2025 Quality Based Reimbursement (QBR) Policy

7. Maryland CY 2022 Performance and Next Steps

   a. Model Monitoring
   b. Open Discussion

8. Policy Update and Discussion

   a. RY 2023 Quality Revenue Adjustments Update
   b. Maryland Progression Plan Development

9. Hearing and Meeting Schedule

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MINUTES OF THE
598th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
September 14, 2022

Chairman Adam Kane called the public meeting to order at 11:32 a.m. Commissioners Joseph Antos, PhD, James Elliott, M.D., and Maulik Joshi, DrPH, were also in attendance. Commissioner Stacia Cohen participated virtually. Upon motion made by Commissioner Antos and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:20 p.m.

REPORT OF SEPTEMBER 14, 2022, CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the September 14, 2022, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE JULY 13, 2022, CLOSED SESSION AND PUBLIC MEETING AND AUGUST 1, 2022, PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the July 13, 2022, Public Meeting and Closed Session and August 1, 2022, Public Meeting (Mid-town Rate Considerations).

ITEM II
CLOSED CASES

2599A- University of Maryland Medical Center
2600A- University of Maryland Medical Center

ITEM III
OPEN CASES

2589R - Shady Grove Adventist Medical Center
2601N - Luminis Doctor's Community Medical Center
2603R – Luminis Anne Arundel Medical Center
2604A – University of Maryland Medical Center
2605A – University of Maryland Medical Center

Adam Kane, Esq
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

Stacia Cohen, RN, MBA

James N. Elliott, MD

Maulik Joshi, DrPH

Sam Malhotra

Katie Wunderlich
Executive Director

William Henderson
Director
Medical Economics & Data Analytics

Allan Pack
Director
Population-Based Methodologies

Gerard J. Schmith
Director
Revenue & Regulation Compliance

ITEM IV
LEGAL UPDATE

Regulations

Proposed Action

Rate Application and Approval Procedures – COMAR 10.37.03.2

This proposed amendment would establish a moratorium on regular rate applications to be in effect for no longer than June 30, 2023. Under the proposal, a hospital may not file a full rate application with the Commission until the Commission staff can determine through analysis that the data used to evaluate a full rate application has not been substantially affected by the COVID pandemic. COVID resulted in changes in revenue, expenses, volume, and mix of patients, reflected by, among other things, hospitals changing the services they provide, altering their normal discharge practices, experiencing unusually long lengths of stay, maintaining an unclear revenue picture due to federal funding during the pandemic and adopting telehealth medicine as an increasingly common practice in interacting with their patients.

During the period of the moratorium, hospitals will be able to avail themselves of other avenues for obtaining rate changes such as, the integrated efficiency methodology, supportable GBR adjustments, market shift adjustments and population growth, temporary rate relief, the Update Factor, avenues that have been frequently traveled by hospitals in attempting to have their approved revenue increased.

Application for Temporary Change in Rates- COMAR 10.37.10.05

Hospitals may file temporary rate applications during the moratorium. That is why it is necessary to update the standard for an approved temporary rate, which currently resides in regulation. The current standard of not permitting a temporary rate increase to result in a "hospital's screening position being higher than 2% below the Statewide average on the regression-adjusted inpatient screen" is outdated. The proposed amendment requires the Commission to consider the hospital's financial condition in addition to its relative efficiency and effectiveness in its performance under the TCOC Model and prohibits a temporary rate increase to result in regulated revenue exceeding regulated expenses over the most recently completed fiscal year.

Commission Review of Established Rates - COMAR 10.37.10.04

This proposed amendment would clarify that in conducting a review of a hospital's full rate structure, either through a Commission-initiated proceeding or through a full rate application, the Commission will consider the hospital's performance since the implementation of the All-Payer Model Agreement, which took place in February 2014. We believe the Commission already has this authority; this amendment makes that explicit.

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

Item V

Final Recommendation on UM-Midtown Temporary Rate Application

Ms. Katie Wunderlich, Executive Director, presented an update on the University of Maryland Medical Center – Midtown ("Midtown") request for a permanent rate adjustment.

The University of Maryland Medical System ("UMMS"), on behalf of the University of Maryland Medical Center Midtown Campus ("Midtown," or "the Hospital"), applied to the Health Services Cost Review Commission ("HSCRC," or "the Commission") for a temporary change in rates pursuant to Section 10.37.10.05 of the Code of Maryland Regulations ("COMAR") to be effective July 20, 2022. The Hospital testified at the July Commission meeting and again at the August Commission meeting in response to the Staff's initial recommendation to this request.

Midtown, part of the UMMS, is a non-profit 179-bed urban community hospital, providing care in more than 30 specialties to the community of West Baltimore and surrounding metropolitan area. Located on UMMC Midtown's campus is the University of Maryland Center for Diabetes and Endocrinology, recognized by the National Committee of Quality Assurance; the University of Maryland ALS (amyotrophic lateral sclerosis) Center, the only Treatment Center of Excellence in Maryland certified by the ALS Association, and the University of Maryland Center for Pulmonary Health offering comprehensive care for a range of disorders including asthma, interstitial lung diseases, COPD, bronchitis, and lung cancer. Through its free health screenings, Midtown helps more than 15,000 people a year manage health issues like diabetes and high blood pressure. Midtown also partners with community groups such as churches, health fairs, and schools to bring health education and other services to the residents of Baltimore City.

The Hospital's request through this temporary rate application is for funding of $30.3 million in FY 2023 to be reconciled in a full rate application or full rate review, and an additional cost strip in the Inter-Hospital Cost Comparison ("ICC"). Specifically, the application requested the following adjustments:

- Permanent adjustment of $20.3 million to its Global Budget Revenue ("GBR") to account for a reversal of the 2018 Commission-approved spenddown of the Hospital ($15.2 million as inflated to FY 2023 dollars) and $5.1 million to its GBR to fund above average insurance company denials at the Hospital's Emergency Department.
- One-time adjustment of $15 million over two fiscal years (FY 2023 and FY 2024) to fund cost reduction initiatives that are intended to lead to long-term financial sustainability; and
- Additional cost strip in the ICC for the Hospital's Disproportionate Share ("DSH") percentage, on top of the adjustments already made in the ICC that account for the Hospital's concentration of DSH patients.

Ms. Wunderlich noted that Maryland COMAR 10.37.10.05 specifies that a hospital may apply at any time for a temporary change in rates provided that one of the following conditions is met:

1. A decline in the hospital's experienced or projected net revenues, due to factors beyond the

hospital's control, requiring funds beyond those normally available.
2. An increase in the hospital's experienced or projected expenses, due to factors beyond the hospital's control, requiring funds beyond those normally available; or
3. A hospital's expenses from regulated services exceed its revenues from regulated services, or the hospital's financial integrity is otherwise jeopardized (for example, for breaching its bond covenants).

Based on the analyses conducted, Staff does not find that the Hospital has met any of the three conditions in COMAR 10.37.10.05:

1. Revenue decreases beyond the hospital's control
   The Spenddown was negotiated with the Hospital and approved by the Commission in public session; the revenue reduction was only half of the potential amount; finally, revenue transfers from UMMC to Midtown have been identified and implemented.

2. Expense growth beyond the hospital's control
   Since 2019, the Hospital did not reduce expenditures, but rather increased both regulated and unregulated spending.

3. Expenses from regulated services exceeds revenues
   Except for RY2022, the hospital had sufficient regulated revenue to cover regulated expenses. In RY 22, the Hospital projected a $3.3 million loss. Market shift adjustments and GBR revenue transfers were evaluated by staff and will be added to the Hospital's rates totaling $5.4 million, thereby addressing the shortfall experienced in RY 22.

In response to the Temporary Rate Change request filed by the Hospital on July 20, 2022, and based on Staff analysis, Staff recommends as follows:

1. Based on the thresholds outlined in COMAR 10.37.10.05, Staff does not find that the Hospital has met the requirements for a temporary change in rates. Staff recommends that the Commission deny the temporary rate change.

Commissioners voted unanimously in favor of Staff's recommendation.

Item VI

Review and Recommendation on UM-Midtown Negotiated Spenddown

During the public Commission meeting on August 1, 2022, Commissioners expressed a desire to better understand the differences between the negotiated spenddown agreement with Midtown approved by the Commission in November 2018 (implemented in July 2019) and the evolved Integrated Efficiency Policy (formally adopted for implementation July 2021).

Beginning in 2017, the Commission asked Staff to develop an updated Inter-hospital Cost Comparison (ICC) tool based on the GBR construct and requested that Staff evaluate high-cost outlier hospitals that have retained an excessive amount of revenue causing high charges for patients and payers. Additionally, the advent of the Total Cost of Care Model Agreement with CMS, signed in July 2018, required the State to contain the growth of costs for both hospital and non-hospital services on a per capita basis. With these considerations, Staff used a combination of factors to identify high-cost outlier hospitals, considering cost per case efficiency under the ICC, performance on Medicare total cost of care (TCOC) per capita growth, potentially avoidable use (PAU) levels and reductions achieved, and quality indicators such as the Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement (QBR) performance.

During this evaluation, Midtown was identified by Staff as an outlier hospital. Using the ICC for RY 2018 revenue, Staff determined that the Hospital had the most unfavorable adjusted cost per case compared to other Maryland hospitals, with an inefficiency of -32.65% compared to the peer group standard. The Hospital was also in the least favorable quintile of hospitals for Medicare TCOC growth rate per capita, with a growth rate of 8.02% from 2013 to 2017, compared to the State average TCOC growth rate of 3.9%. The Hospital was able to reduce the growth of PAU admissions more rapidly than the State, but still had high levels of PAU (30.8% of eligible revenue as compared to the statewide average of 18.3%), partially as a result of the health disparities of the population it serves. Finally, the Hospital had mixed quality outcomes. While it ranked in the most favorable quintile for reductions in potentially preventable complications, as measured through the Maryland Hospital Acquired Conditions Program, it was in the second least favorable quintile for patient satisfaction surveys, as measured through HCAHPS surveys in the Quality Based Reimbursement Program, and the least favorable quintile for case-mix adjusted readmissions rates, as measured through the Readmissions Reductions Incentive Program.

As the HSCRC efficiency policy has evolved, Staff believes it is appropriate for the Commission to consider reversing the spenddown decision and applying the Integrated Efficiency calculation instead. While the Integrated Efficiency calculation was broad-based and evaluated all hospitals for relative efficiency, the negotiated spenddown only affected one hospital. Calculating inflation (inclusive of PAU) and the Demographic Adjustment, the value of the spenddown totals $15,194,347 in RY 22. If the spenddown had not been in place, and the Hospital retained the full amount of their rates in RY 19 and RY 20, the Hospital would have been subject to a RY 22 Integrated Efficiency reduction of $1,614,895. On balance, replacing the negotiated spenddown with the Integrated Efficiency calculation would result in a rate increase of $13,579,452 added on a permanent basis. The Hospital should also be subject to future adjustments associated with the Integrated Efficiency Policy.

In response to the Commission's directive to review the negotiated spenddown of Midtown and a comparison of the Integrated Efficiency policy, Staff recommends the following:

- Provide a permanent rate adjustment of $13,579,452 to reverse out the permanent rate reductions associated with the negotiated spenddown and implement the rate reduction associated with the RY 2022 Integrated Efficiency Policy.

Commissioners voted unanimously in favor of Staff's recommendation.

ITEM VII
POPULATION HEALTH COST REPORT PRESENTATION

Mr. William Henderson, Director, Medical Economics & Data Analytics, stated that in FY 2021, Staff developed a supplemental annual report that focused on population health spending. The new report was needed because the current Annual Report of Revenues, Expenses and Volumes (Annual Report) did not disclose population health spending.

The goals for the supplemental report were as follows.

- Foster greater understanding of the level and nature of physician and non-physician population health expenditures by the hospital (regulated and unregulated) and outside the hospital (by the health system)
- Capture the amount of retained revenue from the GBR Maryland hospital systems are investing in population health both inside and outside the regulated space
- To get a sense of the size and nature of investments as defined by hospitals.
    a) Include all physicians and categorize rather than trying to differentiate non-population health and population health physicians.
    b) Complexities in broad definition of population health

Hospitals were asked to categorize regulated population health costs by the Annual Report cost centers. The total population health expenses totaled $177 million in FY2021. Mr. Henderson noted that in FY21, when indirect allocations, including investments outside regulated space were added, the total population health costs increased to $302.9 million.

Mr. Henderson noted that the population report will not be required to be submitted in FY22; however, it may be reinstated in FY23.

ITEM VII
POLICY UPDATE AND DISCUSSION

Model Monitoring

Ms. Caitlin Cooksey, Deputy Director of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 5 months ending May 2022. Maryland's Medicare Hospital spending per capita growth was unfavorable when compared to the nation. Ms. Cooksey noted that Medicare Nonhospital spending per-capita was trending unfavorably when compared to the nation. Ms. Cooksey noted that Medicare Total Cost of Care (TCOC) spending per-capita was unfavorable when compared to the nation. Ms. Cooksey noted that the Medicare TCOC guardrail position is 3.23% above the nation through December. Ms. Cooksey noted that Maryland Medicare hospital and non-hospital growth through December shows a run rate erosion of $145,144,442.

Workgroup Update

Ms. Wunderlich provided the following workgroup update:

Health Disparities workgroup led by Princess Collins, Chief, Quality Initiative, supported by Quality Methodologies has met three times. The goals of the group were to adopt a definition of health equity, stratify qualify measures by social demographics, discuss, explore and identify methodologies to measure health equity in the Maryland hospitals through quality programs.

Population Health workgroup led by Anwesha Majumder, Chief, Population Health, supported by Quality Methodologies has met three times. The focus of the group was to measure diabetes metrics.

The Total Cost of Care workgroup led by Willem Daniel, Deputy Director, Payment Reform, has been meeting to discuss the MPA policy for the upcoming year.

The Diversity Equity and Inclusion workgroup has been established. The goal of the workgroup is to establish and improve office culture and health policy development.

ITEM VII
HEARING AND MEETING SCHEDULE

October 12, 2022	Times to be determined- 4160 Patterson Ave HSCRC Conference Room
November 9, 2022	Times to be determined- 4160 Patterson Ave. HSCRC Conference Room

There being no further business, the meeting was adjourned at 2:50 pm.

Closed Session Minutes
of the
Health Services Cost Review Commission

September 14, 2022

Upon motion made in public session, Chairman Kane called for adjournment into closed session to discuss the following items:

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

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

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

The Closed Session was called to order at 11:32 a.m.

In attendance in addition to Chairman Kane were Commissioners Antos, Elliott, and Joshi. Commissioner Cohen participated via conference call.

In attendance representing Staff were Katie Wunderlich, Allan Pack, William Henderson, Geoff Dougherty, Will Daniel, Alyson Schuster, Cait Cooksey, Bob Gallion, Erin Schurmann, and Dennis Phelps. Jerry Schmith and Claudine Williams participated via conference call.

Also attending were Eric Lindemann, Commission Consultant and Stan Lustman and Ari Elbaum Commission Counsel.

Item One

Ms. Wunderlich updated the Commission on the Total Cost of Care (TCOC) Model Progression and the Commission's role in providing guidance and advice to staff. In addition, Alyson Schuster, Deputy Director-Quality Methodologies, updated the Commission on the most recent Maryland Quality performance.

Item Two

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

Item Three

Ms. Wunderlich summarized the Correction Action Plan Triggers under the federal contract, and staff and the Commission discussed potential Corrective Action principles.

The Closed Session was adjourned at 1:05 p.m.

Cases Closed

The closed cases from last month are listed in the agenda

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2022**
MEDICAL CENTER	*	**FOLIO:**	**2394**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2604A**

Staff Recommendation

October 12, 2022

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on August 30, 2022, 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 October 1, 2022.

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 continue to manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating 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.

V. STAFF EVALUATION

The staff found that the experience under this arrangement for the prior year has been unfavorable. According to the Hospital, the losses under this arrangement can attributed to several extraordinary outlier cases. Staff believes that absent these cases that the Hospital can again achieve favorable experience under this arrangement

VI. STAFF RECOMMENDATION

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 October 1, 2022. 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. 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:**	**2022**
MEDICAL CENTER	*	**FOLIO:**	**2395**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2605A**

Staff Recommendation

October 12, 2022

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on August 30, 2022, 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 heart, liver, kidney, lung, and pancreas transplants, SPK services, blood and bone marrow transplants and VAD services for a period of one year with Cigna Health Corporation beginning October 1, 2022.

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 services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating 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 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.

V. STAFF EVALUATION

The staff found that the Hospital's experience under this arrangement for the previous year was favorable. Staff believes that the Hospital can continue to achieve a favorable performance.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for heart, liver, kidney, lung, and pancreas transplants, SPK services, blood and bone marrow transplants and VAD services, for a one year period commencing October 1, 2022. The Hospital will need to file a renewal application 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. 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:	2022
SYSTEM	*	FOLIO:	2416
BALTIMORE, MARYLAND	*	PROCEEDING:	2606A

Staff Recommendation

October 14, 2022

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on September 28, 2022, on behalf of its member Hospitals (the "Hospitals") for a new alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a global rate arrangement for Cardiovascular services, Bariatric Surgery, Orthopedic Services (shoulder, hip, knee, and spine), Gallbladder, Thyroid/Parathyroid, Oncology Diagnosis, and Prostate services with Employer Direct Healthcare. The System requests that the approval be for a period of one year beginning November 1, 2022.

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 experience under this arrangement for the last tear has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Cardiovascular services, Bariatric Surgery, Orthopedic Services (shoulder, hip, knee, and spine), Gallbladder, Thyroid/Parathyroid, Oncology Diagnosis, and Prostate services with Employer Direct for a one-year period commencing November 1, 2022. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2022**
MEDICAL CENTER	*	**FOLIO:**	**2417**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2607A**

Staff Recommendation

October 14, 2022

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed a renewal application with the HSCRC on September 1, 2022, 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 Humana for a period of one year beginning November 1, 2022.

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 one year beginning November 1, 2022.

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.

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Proceeding 2601N – Partial Rate Application

Luminis Doctors Community Medical Center

Proceeding 2601N - Luminis Doctors Community Medical Center

- On July 18, 2022, Doctors Community Medical Center (“DCMC” or “the Hospital”), submitted a partial-rate application to obtain a new Psychiatric Acute (PSY) rate. The Hospital would like to establish a unit rate for PSY services effective November 1, 2022.
- The Hospitals has an approved Certificate of Need to establish a 16-bed inpatient adult psychiatric unit.
- HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital’s projections. The Hospital requested a PSY rate of $1,612.80 per patient days, which represents the statewide median rate for PSY services.

Recommendation

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

1. That the PSY rate of $1,612.80 per patient days be approved effective November 1, 2022;

2. That the PSY rate center not be rate realigned until a full year of cost data has been reported to the Commission; and

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

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
LUMINIS HEALTH DOCTORS	*	**DOCKET: 2022**
COMMUNITY MEDICAL CENTER	*	**FOLIO: 2411**
LANHAM, MARYLAND	*	**PROCEEDING: 2601N**

Staff Recommendation
October 12, 2022

Introduction

On July 18, 2022, Luminis Health Doctors Community Medical Center ("the Hospital"), submitted a partial-rate application to obtain a new Psychiatric Acute (PSY) rate. The Hospital has an approved Certificate of Need to establish a 16-bed inpatient adult psychiatric unit. They requested to establish a unit rate for PSY services effective November 1, 2022.

Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on the Hospital's projections. The Hospital requested a PSY rate of $1,612.80 per patient days, which represents the statewide median rate for PSY services.

Service	Service Unit	Unit Rate	Projected Volumes	Approved Revenue
Psychiatric Acute	Patient Days	$1,612.80	1,688	$2,722,406

Recommendation

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

1. That the PSY rate of $1,612.80 per patient days be approved effective November 1, 2022;

2. That the PSY rate center not be rate realigned until a full year of cost data has been reported to the Commission; and

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

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, Sections §§19-207and 19-215, Annotated Code of Maryland

Notice of Proposed Action

[20-168-P-I]

The Health Services Cost Review Commission proposes to amend Regulation **.02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions.** This action was considered and approved for promulgation by the Commission at an open meeting held on October 12, 2022, notice of which was given through the Commission's website.

If adopted, the proposed amendments will become effective on or about January 15, 2023.

Statement of Purpose

The purpose of this action is to update the Commission's manual entitled "Accounting and Budget manual for Fiscal and Operation Management (August 1987)," which has been incorporated by reference.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to William Hoff, Chief, Audit and Compliance, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore , MD 21215, or call 410-764-3488, or email to William.hoff@maryland.gov , or fax to 410-358-6217. Comments will be accepted for thirty (30) days following the publication of this proposal. A public hearing has not been scheduled.

Open Meeting

It is anticipated that final action on the proposal will be considered by the Health Services Cost Review Commission during a public meeting to be held on December 14, 2022, at 1 p.m., at 4160 Patterson Avenue, Baltimore, MD 21215.

.02 Accounting System; Hospitals.

A. The Accounting System.

(1) (text unchanged)

(2) (text unchanged)

(a)—(x) (text unchanged)

(y) Supplement 25 (February 10, 2020); **[**and**]**

(z) Supplement 26 (January 14, 2021)**[**.**]**;

(aa) Supplement 27 (October 12, 2022).

(3)—(5) (text unchanged)

B.—D. (text unchanged)

ADAM KANE
Chair
Health Services Cost Review Commission

REPORTING REQUIREMENTS

OVERVIEW

Commission regulation 10.37.01.03 has been amended to authorize the Commission to prescribe the format for the submission of required reports. Effective immediately, reports MUST be filed in the format prescribed below or hospitals will be subject to fines as provided for by COMAR 10.37.01.03 N. Format references can be found at the end of this document.

1. ANNUAL REPORTS

A. Reports due 120 days after the end of the hospital's fiscal year (By regulation (COMAR 10.37.01.03(A)(2) reports listed in Sections A & B of Annual Reports and Sections A, B, & C of Alternative Method of Rate Determination Reports are due 90 days after the end of hospitals' fiscal year. The Commission granted a blanket 30-day extension.)

1) Annual Report of Revenue, Expenses, and Volumes - Format #1

2) Audited Financial Statements - Format #6

3) Trustee Disclosure Information – Format #12

   1. List of Trustees with business addresses. Designate individual trustees who have engaged in business in the amount of $10,000 or more with the hospital.
   2. Individual disclosure form of each trustee doing business in the amount of $10,000 or more of business with the hospital.
   3. If no trustees have engaged in business in the amount of $10,000 or more with the hospital, a letter submitted to the assigned email address should so indicate.

4) Credit and Collection Policy – Format #6

5) Financial Assistance Policy – Format #6

6) Annual Debt Collection/Financial Assistance Report – Format #7

7) Hospital Outpatient Services Survey – Format #1 & Format #2

B. Report due 140 days after end of fiscal year.

Special Audit Report - Should include audit procedures for alternative method of rate determination if hospital related entity's fiscal year is the same as hospital - Format #1 & Format #6

C. Report due 6 months and 15 days after end of fiscal year

Federal IRS Form 990 – Format # 6

REPORTING REQUIREMENTS

D. Report due June 1 each year

Wage & Salary Survey - Format #2

E. Report due December 15th each year

Community Benefit Report – Format #2 or Format #9

F. Report due January 15th or 30 days after the due date of Hospital's Medicare Cost Report

Schedule IRS – Intern, Residents Survey – Format #2

II. ALTERNATIVE METHOD OF RATE DETERMINATION REPORTS

A. Reports due 90 days after the end of the related entity's fiscal year:

Audited Financial Statements of Hospital Related Entities; contracting entities related to the hospital participating in HSCRC approved Alternative Methods of Rate Determination arrangements - Format #6

B. Reports due 110 days after the end of the related entity's fiscal year:

Special Audit Report - if fiscal year of related entity is different from the hospital (see I B above) - Format #6

C. Reports due 90 days after the end of the related entity's fiscal year:

Annual AR1, AR2, AR3 Reports - Format #6

D. Reports due 30 days after the end of the quarter:

Quarterly AR1, AR2, AR3 Reports - Global Pricing/Capitation - Format #6

REPORTING REQUIREMENTS

III. CASE MIX DATA

A. Reports are due according to the Production Schedule posted on the HSCRC website:

www.hscrc.maryland.gov/hsp_info1.cfm

1. Outpatient Abstracts – Format #3

B. Reports are due according to the Production Schedule posted on the HSCRC website:

www.hscrc.maryland.gov/hsp_info1.cfm

1. Inpatient Discharge Abstracts - Format #3
2. Psychiatric Discharge Abstracts - Format #3

IV. QUARTERLY REPORTS

A. Reports due 30 days after the end of the calendar quarter:

1. Outpatient Plastic / Cosmetic Surgery Operating Room Give-Up Policy Report – Format #10
2. Denials Report – Format #10
3. Shared Savings Report – Format #11

B. Reports due 45 days after the end of the calendar quarter:

1. General Inpatient Hospice Care Project Report – Format #10

C. Reports due 60 days after the end of the calendar quarter:

1. Uncompensated Care Write-Offs Report – Format #10

D. Reports due 67 days after the end of the calendar quarter:

1. Reconciliation Reports – Format #10

IV. MONTHLY REPORTS

A. Reports due 30 days after the end of the month: **

1. Hospital volumes and revenues (formerly known as MS, NS, PS, RS, CSS, and OVS) - Format #4 and #5

2. Hospital financial information and unaudited financial statements (formerly known as FSA, FSB) - Format #4 and #5

REPORTING REQUIREMENTS

Extensions:

Hospitals may file written requests for reasonable extensions of time to file any or all the requested reports. Requests shall be supported by justification for approval of the extension request. Requests for extensions shall be made at a reasonable time **before the due date** of the required report. Such requests should be directed to the Executive Director

Acceptable Formats

1) a) Download approved spreadsheet from www.hscrc.maryland.gov/hsp_info2.cfm,
   b) e-mail completed Excel spreadsheet to hscrc.annual@maryland.gov

2) Download approved spreadsheet from www.hscrc.maryland.gov:

	Email completed Excel spreadsheet and any PDF documents to:
Intern, Residents Survey (Repository Data Submission)	https://rds.thestpaulgroup.com
Wage and Salary	hscrc.wagesalary@maryland.gov
Community Benefit Report	hscrc.cbr@maryland.gov
Hospital Outpatient Services Survey	hscrc.opsurvey@maryland.gov

3) A dedicated secure private connection (point-to point circuits) to connect your hospital to our State Vendor for the data submission.

4) Internet based reporting at https.//rates.hscrc.maryland.gov/project1

5) PDF of the hospital internal unaudited financial statements, price variance letter. Excel file of supplemental births schedule and CSS schedule (MSS/CDS) e-mail:

hscrc.monthly@maryland.gov

6)

PDF File Only	Emailed to:
Audited Financial Statements	hscrc.audited@maryland.gov
Special Audit Report	hscrc.specialaudits@maryland.gov
Credit and Collection Policy	hscrc.creditcollection@maryland.gov
Financial Assistance Policy	hscrc.financialassistance@maryland.gov
IRS Form 990 & Approved Applications	

REPORTING REQUIREMENTS

For Extension on Time to File	hscrc.form990@maryland.gov
Alternative Method of Rate Determination (ARM)	hscrc.audit-compliance@maryland.gov

7) Excel File & PDF — Emailed to:

Annual Debt Collection/Financial Assistance Report (DCFA) & Documentation	hscrc.dcfa@maryland.gov

8) Download approved spreadsheet from the HSCRC website: www.hscrc.maryland.gov/hsp_Rates4.cfm under **Case Mix**

9) Internet Based Reporting — cb.hscrc.maryland.gov

10) Assigned Template — Repository Data Submissions (RDS)

General Inpatient Hospice Care Project Report	hscrc.hospice@maryland.gov
Outpatient Plastic / Cosmetic Surgery Operating Room Give-Up Policy Report	hscrc.Opcosmetics@maryland.gov
Uncompensated Care Write-Offs Report	hscrc.ucc@marland.gov
Denials Report	hscrc.acctswrittendenials@maryland.gov
Reconciliation Reports	hscrc.reconciliation@maryland.gov

11) Excel Only — Emailed to:

Shared Savings Report	hscrc.shared-savings@maryland.gov

12) Internet Based Reporting at https://hscrc.maryland.gov/Pages/Trustee-Disclosure-Information.aspx

Trustee Disclosure Letters and Extension Requests	Emailed to: hscrc.trustees@maryland.gov

GENERAL ACUTE HOSPITALS

NAME OF HOSPITAL	HOSPITAL NUMBER
Anne Arundel Medical Center	0023
Atlantic General Hospital	0061
Baltimore Washington Medical Center	0043
Bowie Emergency Center	0333
Calvert Memorial Hospital	0039
Capital Region Medical Center	0003
Carroll County Hospital Center	0033
Charles Regional Medical Center	0035
ChristianaCare, Union Hospital	0032
Doctors Community Hospital	0051
Fort Washington Medical Center	0060
Franklin Square Hospital	0015
Frederick Memorial Hospital	0005
Garrett County Memorial Hospital	0017
Germantown Emergency Center	0087
Good Samaritan Hospital	0056
Grace Medical	0013
Greater Baltimore Medical Center	0044
Harbor Hospital Center	0034
Harford Memorial Hospital	0006
Holy Cross Hospital	0004
Holy Cross Germantown Hospital	0065
Howard County General Hospital	0048

GENERAL ACUTE HOSPITALS (cont.)

NAME OF HOSPITAL	HOSPITAL NUMBER
Johns Hopkins Hospital	0009
Johns Hopkins Bayview	0029
Laurel Regional Hospital	0055
McCready Memorial Hospital	0045
Mercy Medical Center	0008
Meritus Medical Center	0001
Montgomery General Hospital	0018
Northwest Hospital Center	0040
Peninsula Regional Medical Center	0019
Rehabilitation & Orthopedic Institute	0058
St. Agnes Healthcare, Inc.	0011
St. Joseph’s Medical Center	0063
St. Mary's Hospital	0028
Shady Grove Medical Center	5050
Shore Medical at Chestertown	0030
Shore Medical at Dorchester	0010
Shore Medical at Easton	0037
Shore Medical at Queenstown	0088
Sinai Hospital of Baltimore	0012
Southern Maryland Hospital Center	0062
Suburban Hospital	0022

GENERAL ACUTE HOSPITALS (cont.,)

NAME OF HOSPITAL	HOSPITAL NUMBER
Union Memorial Hospital	0024
University of Maryland Medical Center	0002
University of Maryland Midtown	0038
University of Maryland Shock Trauma	8992
Upper Chesapeake Medical Center	0049
UPMC Western Maryland	0027
White Oak Medical Center	0016

PSYCHIATRIC HOSPITALS

NAME OF HOSPITAL	HOSPITAL NUMBER
Brook Lane Health Services	4003
The Sheppard Pratt Health System	4000
J. Kent McNew Family Medical Center	4020

CHRONIC HOSPITALS

NAME OF HOSPITAL	HOSPITAL NUMBER
Levindale Hebrew Geriatric Center & Hospital	0064
Mount Washington Pediatric Hospital	3300

maryland health services cost review commission

Regional Partnership Catalyst Program

Calendar Year 2021 Activities

October 2022

Erin Schurmann

Chief, Provider Alignment & Special Projects

HSCRC Regional Partnership "Catalyst Program"

Purpose

Invests in hospital partnerships with community organizations to build **sustainable programs that support the population health goals** of the Total Cost of Care (TCOC) Model.

How it Works

- Hospitals must develop and maintain meaningful community partnerships related to program funding, resource sharing, and/or in-kind support.
- Funding streams are based on the Statewide Integrated Health Improvement Strategy (SIHIS) population health priority areas.

Funding Stream I: Diabetes Prevention & Management Programs	Funding Stream II: Behavioral Health Crisis Services
• Support implementation of CDC approved diabetes prevention programs and diabetes management programs	• Support behavioral health models that improve access to crisis services

- **Program timeline:** January 1, 2021 to December 31, 2025

HSCRC Regional Partnership “Catalyst Program” (cont.)

Funding and Collaboration

- The HSCRC issued $165.4 million in five-year cumulative funding to nine proposals.
  - $86.3 million to six diabetes proposals
  - $79.1 Million to three behavioral health proposals
- Over 30 hospitals participating in at least one Regional Partnership funding stream.
- Robust statewide community collaboration with 250+ community-partners, including local health departments, non-profits, local businesses, faith-based organizations, community healthcare providers, academic institutions, and others.

Diabetes Prevention & Management Programs Regional Partnerships
• Saint Agnes and Lifebridge Diabetes Health Collaborative • Baltimore Metropolitan Diabetes Regional Partnership • Nexus Montgomery • Totally Linking Care • Western Regional Partnership • Full Circle Wellness for Diabetes in Charles County

Behavioral Health Crisis Services Regional Partnerships
• Greater Baltimore Integrated Crisis System • Totally Linking Care • Tri-County Behavioral Health Engagement

Diabetes Prevention and Management

Total CY 2021 Funding: $14.2 Million

DPP Infrastructure & Planning Activities

- CY 2021 was an initial period of planning, relationship building, and infrastructure development for the five-year program cycle.
  - Hiring new staff, including DPP lifestyle coaches, to expand DPP capacity
  - Enhancing referral platforms through HIT, engaging with providers, and coordinating with community partners
  - Developing education and marketing materials
- Regional Partnerships had different starting points and strategies to expand DPP.
  - Expanding existing programs that the hospital is already offering.
  - Partnering with current community-based DPP providers and establishing referral relationships with those providers.
  - Establishing new programs their service area.
- All six Regional Partnerships met the CY 2021 scale target to have at least one preliminary, pending, or full CDC-recognized program in its service area with qualification in a payment program.
- Regional Partnerships focused on expanding both physical capacity for in-person DPP and/or offering virtual options for DPP due to the pandemic.

DPP Referral & Enrollment Activities

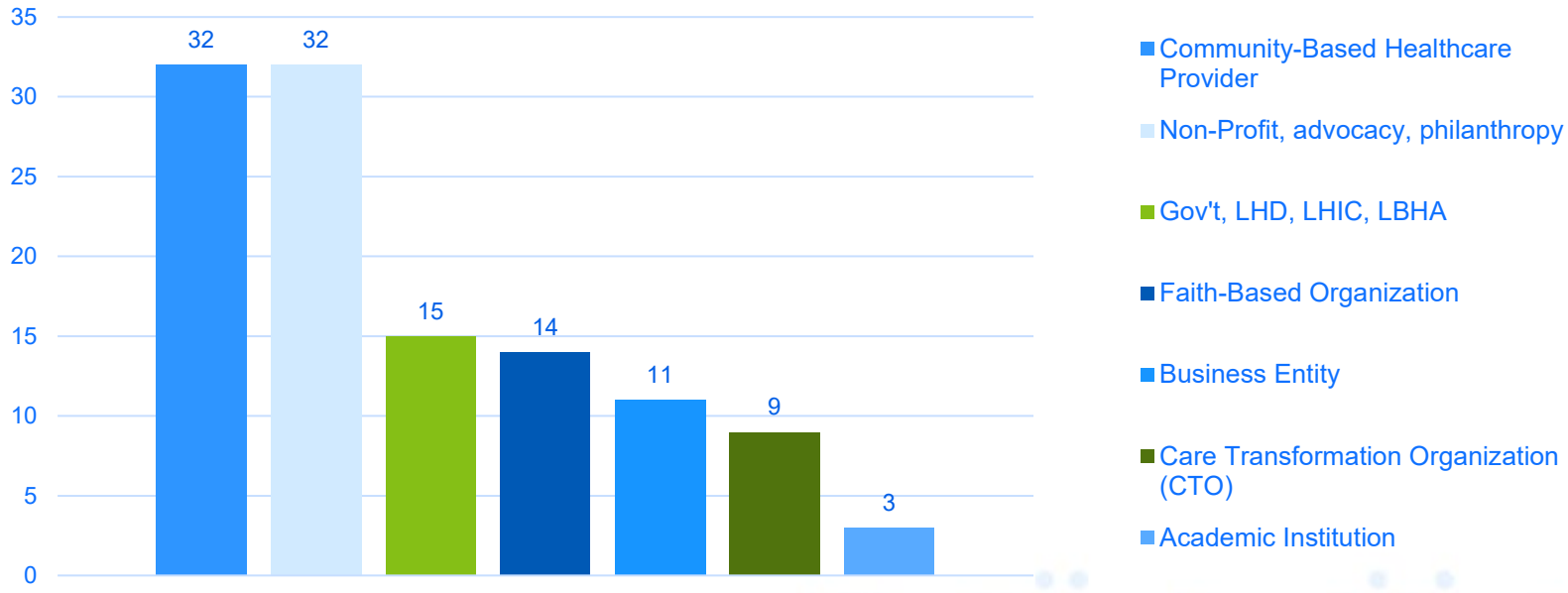
- Regional Partnerships are establishing and scaling a variety of referral strategies.
  - Leveraging health information technology
  - Working closely with primary care providers
  - Engaging with managed care organizations (MCOs) and community-based organizations
- Regional Partnerships reported launching 32 new DPP cohorts in 2021.
  - HSCRC will formally measure DPP enrollment through Medicare and Medicaid claims in 2023, but RPs with existing DPPs continued to enroll patients while scaling their programs.
- Regional Partnerships offer wrap-around services through community partnerships to maximize patient success in DPP.
  - Food access programs
  - Exercise programs
  - Transportation

Diabetes Self-Management Activities

- Most Regional Partnership hospitals have been implementing DSMT/ES for several years in group cohorts and individual sessions.
- All six Regional Partnerships met the CY 2021 scale target to have ADA or AADE accreditation.
- Main strategies to increase DSMT/ES uptake include:
  - Increasing the number of certified diabetes care and education specialists (CDCES) and practice sites to expand capacity.
  - Enhancing referral platforms through HIT and hiring staffing to promote enrollment.
  - Engaging physician practices, FQHCs, and community partners to generate referrals and support DSMT retention and completion.
- Regional Partnerships are also offering wrap-around services to patients to promote success.
  - Medical Nutrition Therapy (MNT)
  - Food Access Programs
  - Exercise Programs
  - Transportation

Diabetes Community Partner Engagement

- There is a total of 116 community partner organizations across the six diabetes Regional Partnerships.
- The two most common types of organizations are community-based healthcare providers and non-profit advocacy or philanthropy organizations.



DPP & DSMT/ES Sustainability & Billing

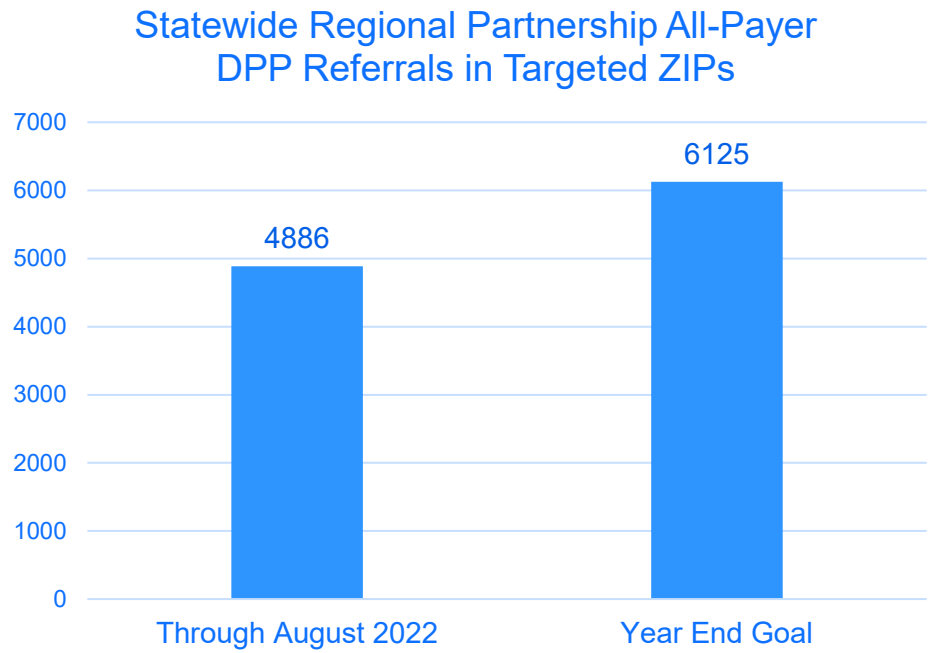
- Regional Partnerships are expected to establish self-sustaining programs by the end of 2025 when RP funding expires.
  - After RP funding expires in 2025, Regional Partnerships may employ a variety of strategies to support DPP and DSMT/ES (e.g. other grants, community benefit dollars), but HSCRC staff has clearly communicated that billing is crucial to the long-term financial sustainability of these programs.
- Regional Partnerships must have billing operations stood up by January 2023 when HSCRC begins measuring performance using claims data.
  - Some Regional Partnership DPP providers are already billing Medicare and/or Medicaid.
  - Some Regional Partnerships are establishing umbrella hub arrangements with partner DPP providers to support billing operations.
- Regional Partnerships are also working to contract with commercial payers to build sustainable programs.

Preliminary CY 2022 Scale Target Performance – DPP Referrals

- HSCRC is measuring all-payer DPP referrals in 2022 and 2023 as an accountability metric. HSCRC will begin measuring Medicare and Medicaid DPP enrollment through claims data beginning in 2023.
- Regional Partnership scale targets are intended to be aspirational, but achievable.
- HSCRC set a goal for Regional Partnerships to refer 5% of its prediabetic patient population (using 10.5% BRFSS prevalence) to DPP in 2022.
- Referrals are measured in targeted ZIP codes that were self-selected by Regional Partnerships in their 2020 proposals.
- There is a significant number of referrals being generated outside of targeted ZIP codes that HSCRC does not give “credit” for in reporting since measurement is ZIP-based.

Performance Summary as of 8/31/2022

- In aggregate, RPs generated 4,886 all-payer referrals to DPP within targeted ZIPs, reaching 80% of the 2022 5% referral goal of 6,125 referrals.
- Actual referral performance may exceed this, but HSCRC measures referrals in targeted ZIPs only.



These numbers reflect performance of five of the six diabetes Regional Partnerships. HSCRC staff is working with one Regional Partnership to address challenges impacting their referral workflows.

Behavioral Health Crisis Services

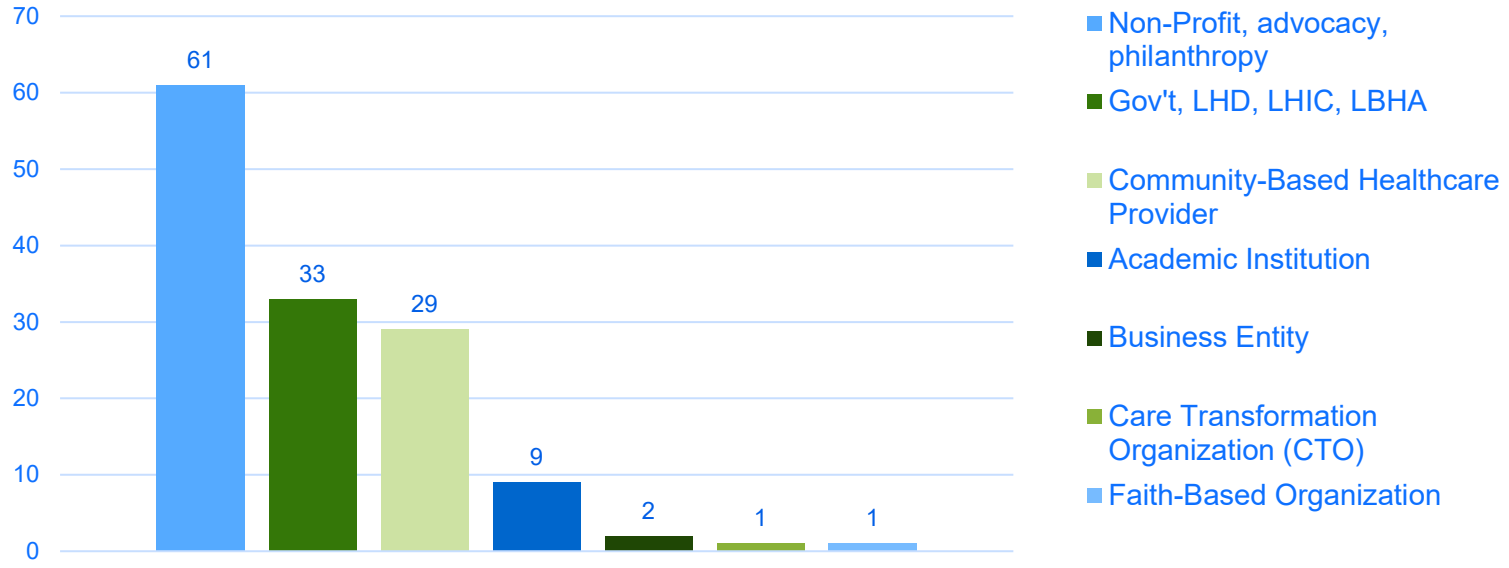
Total CY 2021 Funding: $8.5 Million

Regional Partnership Behavioral Health Activities

- Infrastructure Development
  - Establishing governance structures and engaging stakeholders
  - Building administrative capacity
  - Working with consultants to conduct needs assessments
  - Identifying workflows and protocols to support patients
- Care Traffic Control (CTC)
  - GBRICS and TLC procured Behavioral Health Link to provide software to support the comprehensive call center as well as deployment and coordination of crisis services in real time.
  - Decisions related to CTC have also been dependent on the launch of the national 988 system.
- Community-Based Mobile Crisis Teams
  - Developed mobile crisis team standards in collaboration with stakeholders to incorporate into the procurement and expansion of MCT providers in CY 2022.
  - Wide-scale MCT expansion will coincide with CTC launch in Fall 2022.
- Stabilization Centers
  - Two behavioral health crisis centers opened on the Lower Eastern Shore in Berlin (January 2022) and Salisbury (August 2022).
  - TLC contracted a national leader in crisis services and has secured a facility for a stabilization center to open in Prince George's County 2023.

Behavioral Health Community Partner Engagement

- There is a total 136 community partners across the three behavioral health Regional Partnerships.
- The largest category was non-profit, advocacy, or philanthropy organizations, followed by local public entities, and community-based healthcare providers.



Behavioral Health Sustainability

- Regional Partnerships coordinated with the “Fund Maryland 988 Campaign” to establish a Maryland 988 Trust Fund to support crisis call centers across the State.
- Regional Partnerships worked with the Behavioral Health Administration (BHA) to identify potential funding sources through grants and insurer reimbursement to enhance program funding.
- Of note, Medicaid now reimburses for mobile crisis care and stabilization services, a significant milestone in sustainably funding behavioral healthcare in Maryland.

Expenditures Summary

- CY 2021 Awards - $22.8 Million
  - Diabetes - $14.3M
  - BH - $8.5M
- Total program expenditures were $9.3 million
  - Workforce - $5.6M
  - Other implementation activities - $2.1M
  - IT Services - $990K
  - Wraparound Services - $590K
- HSCRC staff allowed one-time rollover of $11M in unspent funds due to COVID-19 impacts.

	Regional Partnership	Total Expenditures
Diabetes Prevention and Management	Baltimore Metropolitan Diabetes Regional Partnership	$2,065,599
	Western Regional Partnership	$1,729,290
	Nexus Montgomery	$942,942
	Totally Linking Care	$580,525
	Saint Agnes and Lifebridge	$520,121
	Full Circle Wellness	$254,053
Behavioral Health Crisis Services	Greater Baltimore Region Integrated Crisis System	$810,880
	Total Linking Care	$948,232
	Tri-County Behavioral Health Engagement (TRIBE)	$1,478,155
	Total Program Expenditures	**$9,329,797**

Regional Partnership Health Equity Efforts

- Adopting guiding principles to advance health equity through policy and systems change
- Prioritizing engaging historically excluded and marginalized communities for outreach in the stakeholder engagement process
- Incorporating equity into staffing and procurement practices
- Screening for social determinants of health and connecting clients to resources
- Customizing service delivery modes for DPP and DSMT/ES
- Other targeted outreach efforts to specific populations

Moving Forward - Late 2022 and CY 2023

- Diabetes Prevention & Management
  - Increase referrals and enrollment into DPP and provision of DSMT/ES services
  - Finish standing up billing operations and plan for long-term program sustainability
  - Continue to promote provider awareness of DPP and DSMT/ES
  - Build payer relationships
  - Implement wraparound services
- Behavioral Health Crisis Services
  - Launch CTC in the Greater Baltimore Region and Prince George's County
  - Expand MCT in the Greater Baltimore Region and Prince George's County
  - Open stabilization center in Prince George's County
  - Continue to operate primary and satellite crisis centers on the Lower Eastern Shore with long-term goal to expand service hours

Questions?

Baltimore Metropolitan Diabetes Regional Partnership

Presenters:

Angela Ginn Meadow, RN, RDN, CDCES (University of Maryland Medical Center)

Alice Siawlin Chan, MS, MBA (Johns Hopkins Health System)

Nisa Maruthur, MD, MHS (Johns Hopkins Health System)

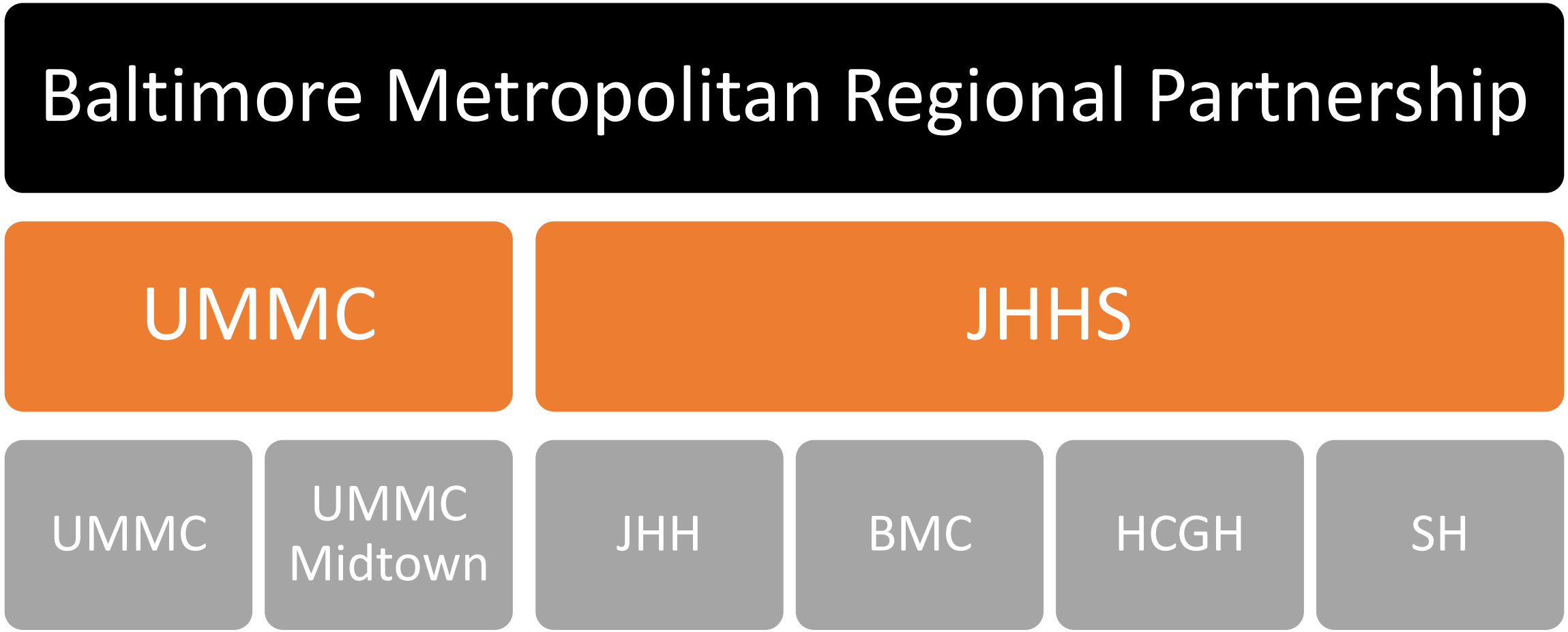
Nestoras Mathioudakis, MD, MHS (Johns Hopkins Health System)

October 12th, 2022

Outline

- **Opening Remarks**
- Overview of Regional Partnership
- Implementation Strategies to expand DPP & DSMT
- Successes & Challenges
- Planning for Year 3 Implementation
- Questions/Feedback

Overview of the BMDRP



HSCRC Diabetes Regional Partnership – Awarded $43Mil (2021-2025)

Infrastructure-Building Grant for Two Evidence-Based Programs

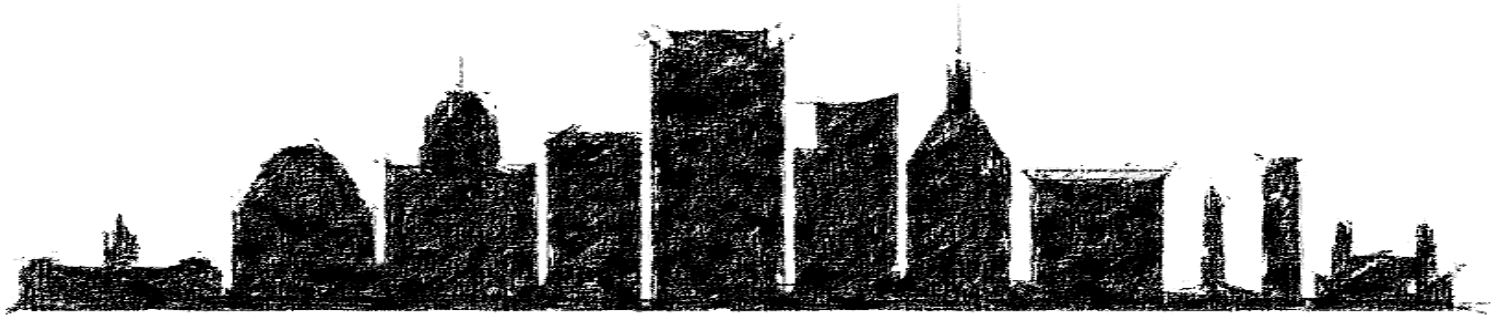
- CDC's National Diabetes Prevention Program (DPP)
- ADA's Diabetes-Self-Management Training (DSMT) program

And related **wrap-around services** to ensure success of programs

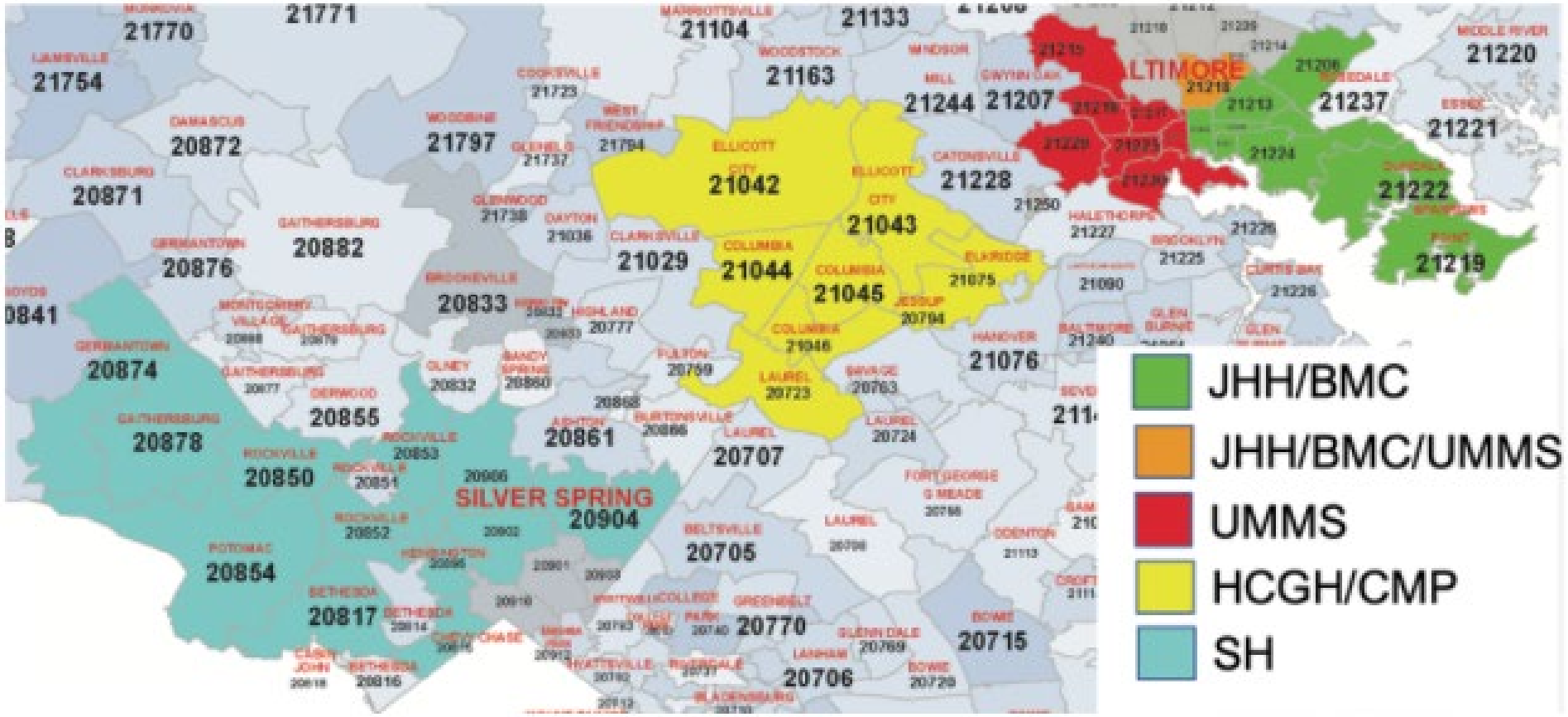
JOHNS HOPKINS MEDICINE

UNIVERSITY of MARYLAND MEDICAL CENTER

Target Population



BMDRP Target Population



Targeted Provider and Patient Outreach

Provider Outreach 

- Lectures/presentations (emphasis on standard of care, evidence-based interventions)
- Internal marketing (emails, social media posts, website)
- Provider champions
- Patient Engagement Program modules
- EMR tools
  - Best practice advisories for both DPP and DSMT
  - Development of systems lists/reports for eligible patients

Patient Outreach 

- Targeted EMR-based notifications/campaign
- Outreach through community partners
- Patient and Family Advisory Council input

Community Engagement - DPP

Shiloh Baptist Church

Memorial Baptist Church

Israel Baptist Church

Garden of Prayer Christian Church

The Y in Druid Hill

Mt. Pleasant Church and Ministries

Mt. Moriah Baptist Church

Koinonia Baptist Church

Zion Baptist Church

United Baptist Church

Allen AME Church

Galilee Baptist Church

UMB Community Engagement Center

Community Network - DSMT

Baltimore City Department of Health

Bethesda NEWtrition & Wellness Solutions

University of Maryland St. Joseph Medical Center

Maryland Endocrine

LifeBridge Health

Baltimore Medical System
THE HEART OF COMMUNITY HEALTH

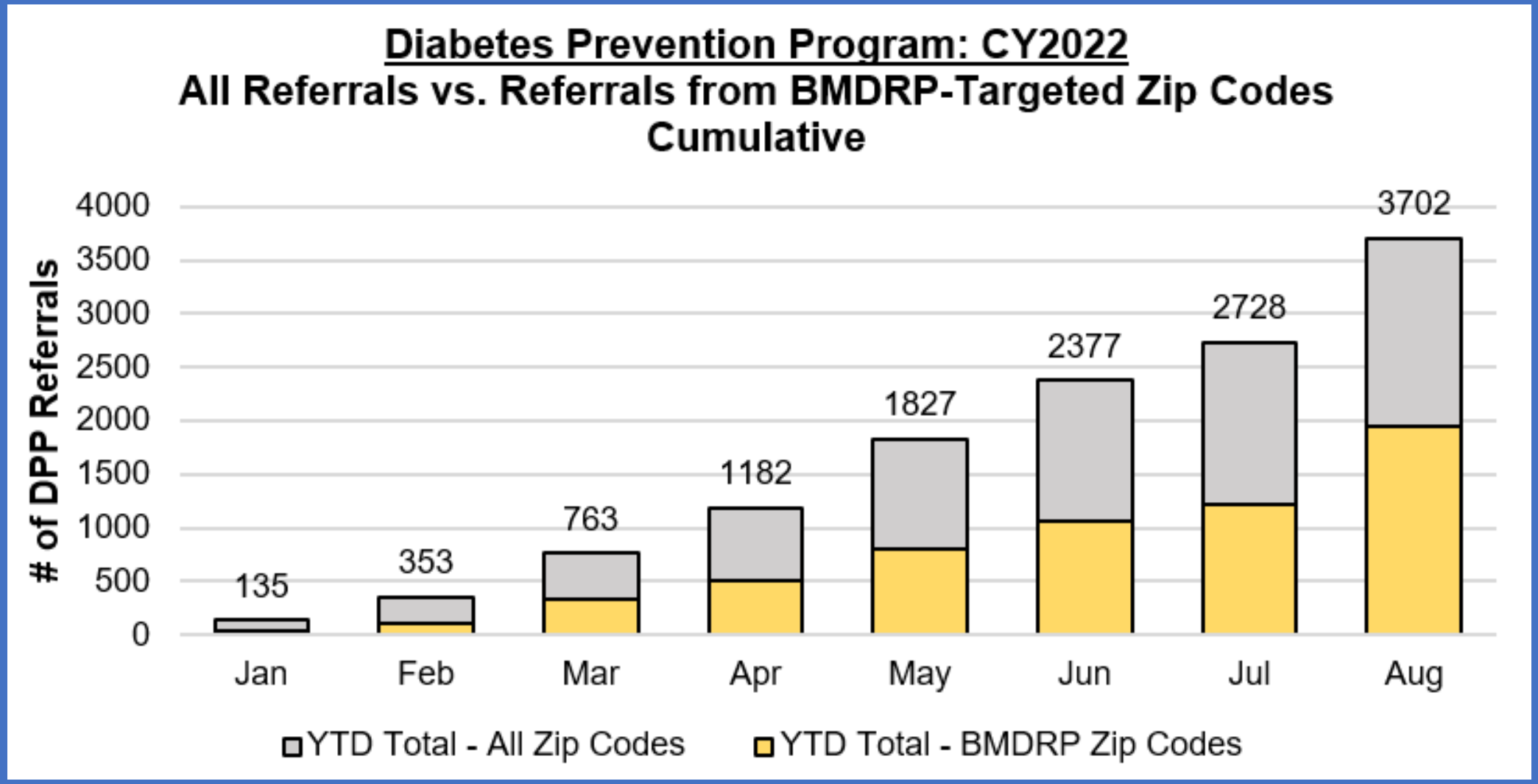
University of Maryland Baltimore Washington Medical Center

University of Maryland Upper Chesapeake Health

Chase Brexton Health Care

Johns Hopkins Medicine
Johns Hopkins Community Physicians

American Diabetes Association.
Connected for Life


Diabetes Prevention Program: CY2022
All Referrals vs. Referrals from BMDRP-Targeted Zip Codes
Cumulative
# of DPP Referrals
4000
3500
3000
2500
2000
1500
1000
500
0
135
353
763
1182
1827
2377
2728
3702
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
YTD Total - All Zip Codes
YTD Total - BMDRP Zip Codes

DPP Successes and Challenges

Successes 

- ↑in referrals and enrollment
- Internal marketing campaign
- Expansion of services across Maryland
- UMMC approved as Medicare and Health Choice DPP
- Full recognition of JHHS distance learning program
- Significant EMR/IT infrastructure build

Challenges 

- Awareness: Provider & community
- Operational needs and staffing for sustainability
- EMR build
- ↑ in referrals from non-BMDRP zip codes
- Delays in recruiting/contracting external marketing
- Low reimbursement rates for long-term program sustainability

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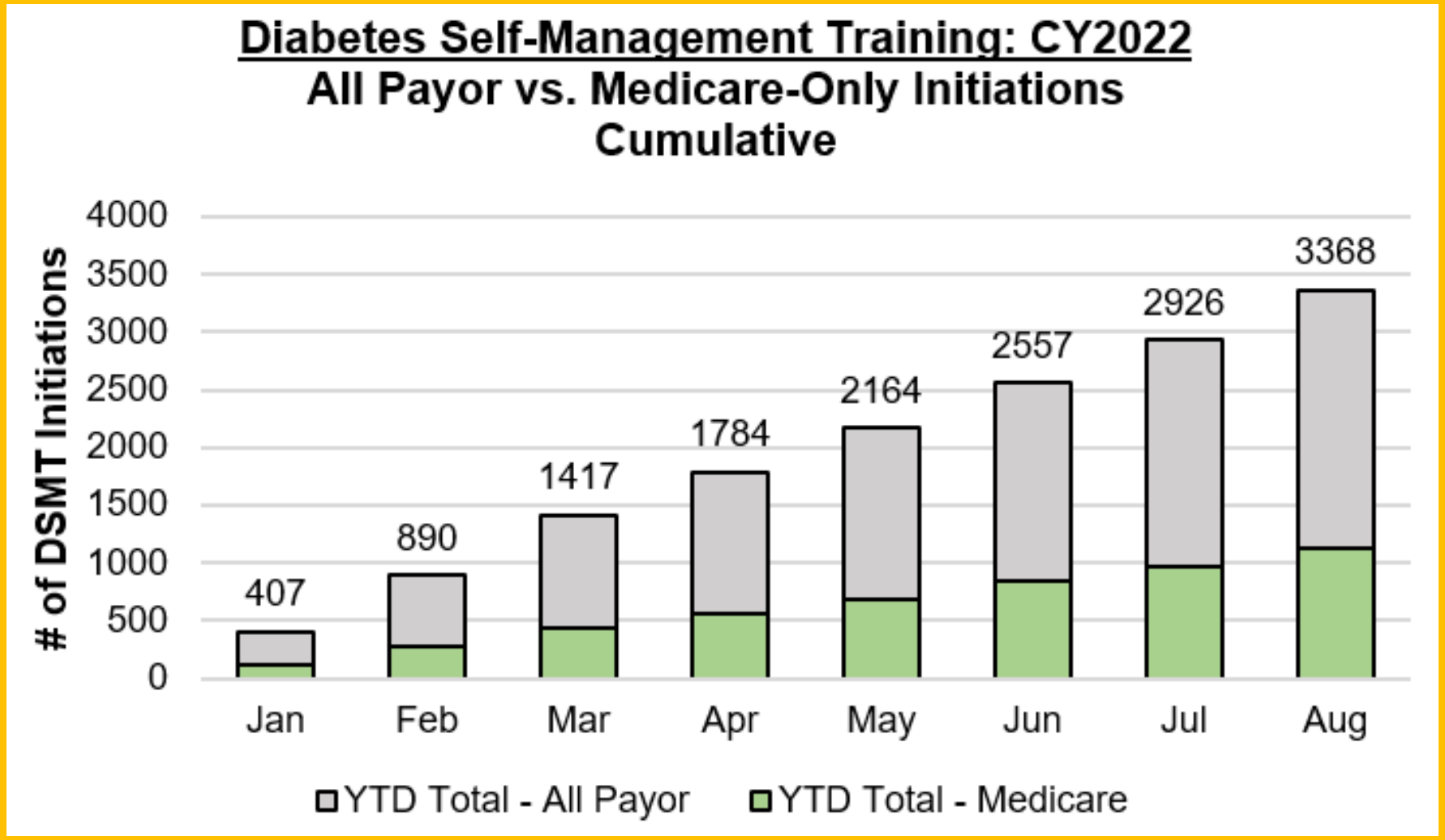


DSMT Success and Challenges

Successes 

- Tremendous increase in referrals and enrollment from baseline
- Expansion of DSMT in non-hospital ambulatory settings
- Increased provider awareness
- Health system leadership engagement and support
- Significant EMR/IT infrastructure build
- Implementation of diabetes e-consult
- Continuous Glucose Monitoring (CGM) integration

Challenges 

- Reaching Medicare beneficiaries
- Complexity of billing compliance (regulated/unregulated space)
- Operational needs and staffing for sustainability
- Patient referrals from inpatient setting at some hospitals
- Recruiting/contracting external marketing (delays)
- Staffing shortages in EMR/IT
- Operation sustainability

Payer Engagement & Sustainability Planning

Year 3 Planning

DPP

- Expansion of DPP recruitment and classes with focus on community recruitment
- Community partnership expansion
- Challenged with budget vs. operational expansion

DSMT

- Expansion of CDCES recruitment and DSMT program
- Challenged with budget
  - Lagging ROI information
- Community partner expansion: retail pharmacy partnership, Total Health Care, the YMCA, McCulloh Homes
- Operationalized CGM integration

- Telemedicine / virtual visit advocacy for both DPP and DSMT

Payer Engagement & Sustainability Planning

JHHS

- Direct referrals from Priority Partners and Jai (+Billing)
- Expansion of EHP coverage (Feb 2022)
- Continued billing of Medicare/Medicare Advantage
- Direct referrals from EHP and Hopkins Advantage
- DSMT ambulatory accreditation and billing build

UMMC

- DPP Medicare approval (5/2/22)
- DPP Medicaid approval (6/3/22)
- Preparing Epic EMR for DPP billing
- Will begin MCO outreach when billing infrastructure complete
- Will work with University of Maryland Health Advantage for DPP

Questions/Feedback-

Thank you

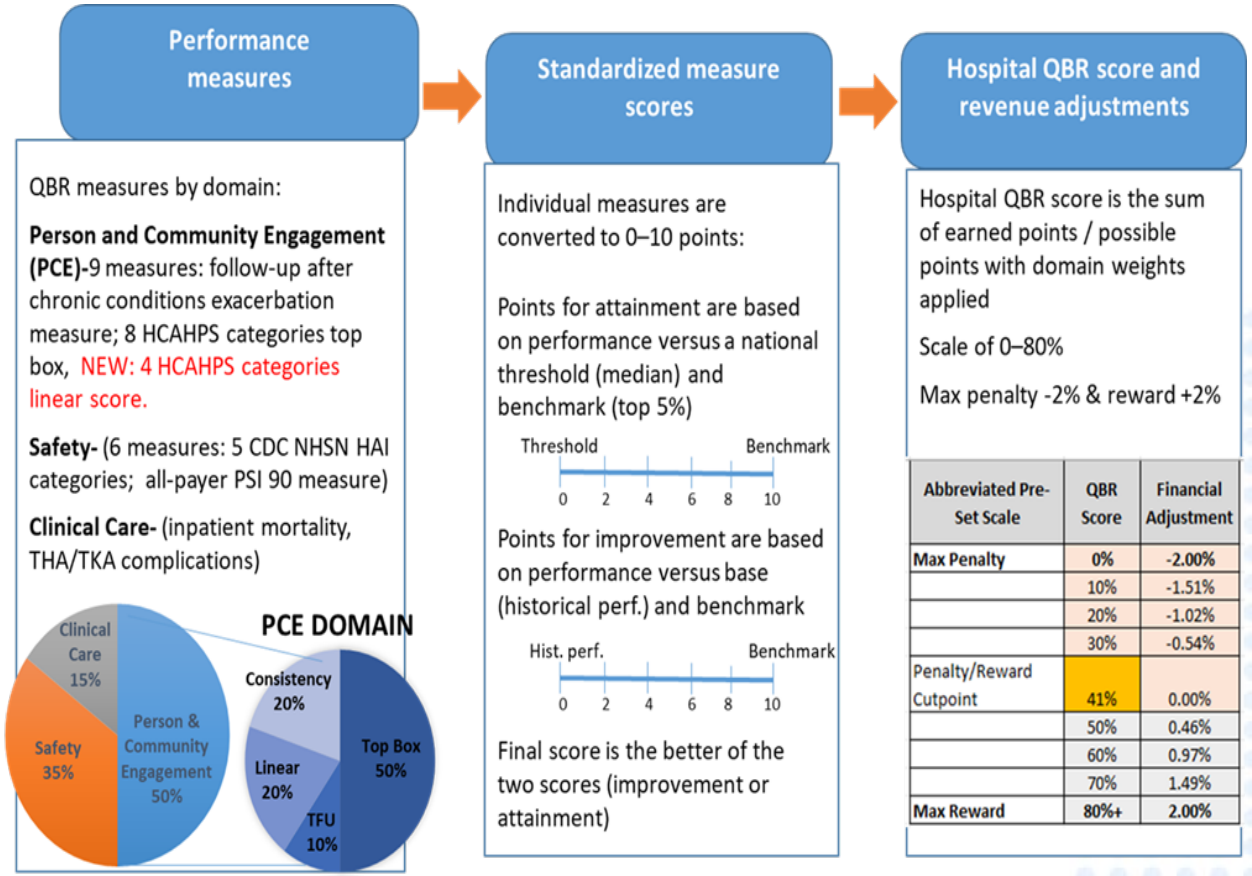
QBR RY 2025 Draft Recommendation

RY 2025 QBR

Following the major revision to the RY 2024 QBR policy, the program largely remains the same in RY 2025 with the exception of:

- Adding the Timely Follow-Up measure for Medicaid within the Person and Community Engagement Domain
- Outlining areas for future policy expansion and review:
  - HCAHPS
  - ED Wait Times
  - Digital Quality Measures
  - Mortality

RY 2024 QBR Policy Methodology Overview



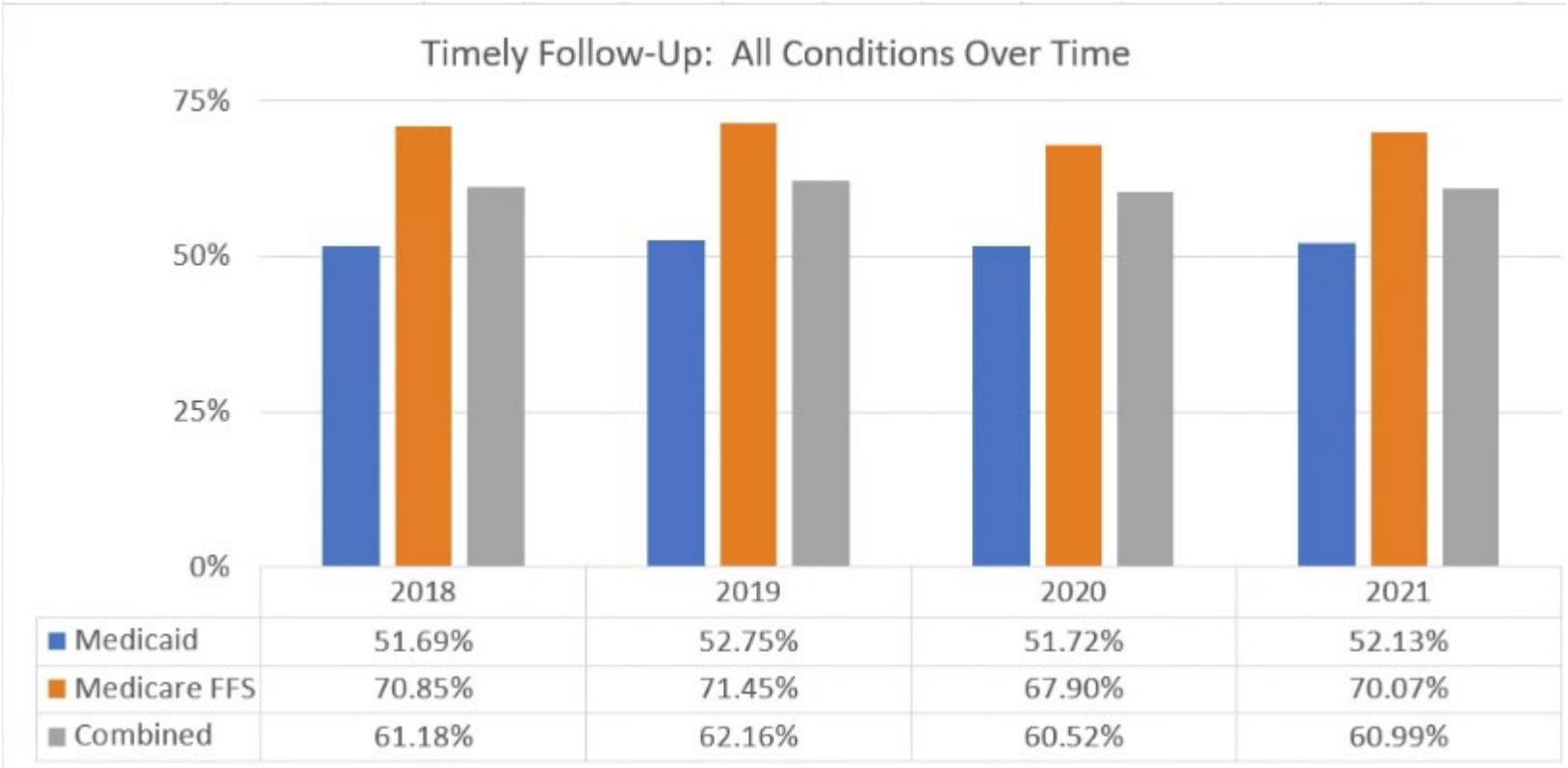
Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	0%	-2.00%
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	80%+	2.00%

Timely Follow-Up After Discharge Measure

1. What is it?
    a. Measure of timely follow-up after an acute exacerbation of 6 specified chronic conditions
2. What we discussed with PMWG for RY 2024 policy based on redesign input?
    a. Measure expansion
        i. Expanding to include Medicaid beneficiaries
        ii. Expanding to include behavioral health-related hospitalizations
3. What we reported to CMMI/decided?
    a. Work with PMWG to develop a **monitoring report** for Medicaid and/or Behavioral Health
    b. Potential inclusion of Medicaid and/or Behavioral Health in future payment policy

Timely Follow-up for Medicaid

- Hospitals are currently receiving monitoring reports for TFU for medicaid



	2018	2019	2020	2021
Medicaid	51.69%	52.75%	51.72%	52.13%
Medicare FFS	70.85%	71.45%	67.90%	70.07%
Combined	61.18%	62.16%	60.52%	60.99%

Strategies/Framework to Improve HCAHPS

Administrative Leadership Accountability:

- HSCRC to work with MHA to identify hospital the key hospital staff accountable for HCAHPS performance.
  - ***Anticipated Timeline:*** *by December 2022.*

Data Analysis and Data Sharing:

- HSCRC will conduct or facilitate data analysis of HCAHPS data to stratify hospital-specific reporting on performance on top box scores, linear scores, and patient-specific demographic factors that may be contributing to hospital-specific trends or that may indicate disparities in performance.
  - ***Anticipated Timeline:*** *We anticipate beginning analyses as of January 2023.*

Hospital Sharing and Adoption of Best Practices:

- Hospitals will be surveyed on approaches they have implemented to improve their performance. Hospitals will be convened to share their experiences in designing and implementing best practices
  - ***Anticipated Timeline:*** *Beginning in CY 2023 and continuing into CY 2024.*

ED Wait Times

1. What is it?
   a. One measure of ED Throughput - ED-2b: Decision to Admit until IP Admission - designed to reduce “ED Boarding”
2. What we discussed with PMWG for RY 2024 policy based on redesign input?
   a. Maryland’s continued poor performance on ED wait times
   b. Belief that poor performance on HCAHPS could be improved if ED wait times improved
   c. Discontinuation of ED wait time measures, including most recently the eCQM
3. What we reported to CMMI/decided?
   a. Per Commission directive to include ED wait times, HSCRC will pursue eCQM data reporting capability

Digital Measures Infrastructure

In 2020, the Cures Act established a goal of “complete access, exchange, and use of all electronically accessible health information,”

- A defined set of patient information available to authorized users (patients, other providers, other health plans) with no special effort using Fast Healthcare Interoperability Resources (FHIR®) application programming interfaces (APIs).

Maryland’s early adoption of eCQMs/digital measures will allow the state to leverage the established infrastructure to:

- Monitor and improve quality
- Progress to a less burdensome FHIR-enabled environment, and
- Allow for earlier adoption of such measures as patient reported outcomes.

Digital Measures Reporting Timeline/Status

1. Calendar Year 2021 "Test Run" Submission of Data- Hospitals to optionally submit to CRISP/Medisolv the same QRDA 1 files they submitted to CMS in Spring 2022
   - 4 eCQM's with 2 quarters of CY 2021 performance period data
   - > 50% Hospitals submitted 2021 pilot data

2. Calendar Year 2022 Required Data Submission- Starting with Q 1, 2022 performance period, all hospitals submit to CRISP/Medisolv quarterly data: 2 required eCQM's and 2 optional eCQM's

Performance Period Submission Windows

Q1 2022 data	Open: 7/15/2022	Close: 09/30/2022*
Q2 2022 data	Open: 7/15/2022	Close: 09/30/2022*
Q3 2022 data	Open: 10/15/2022	Close: 12/30/2022
Q4 2022 data	Open: 1/15/2023	Close: 3/31/2023

*ECE Requests due by September 16, 2022.

3. Calendar Year 2023 Maryland will will require submission of ED-2 and Safe Opioid measures, and 4 additional measures aligned with SIHIS goals; beginning in July 2023 Maryland will require clinical data elements for hybrid 30-day mortality and readmission measures consistent with CMS.

Mortality - options for RY 2025 and moving forward

RY 2025:

- Use IP mortality in QBR
- Adopt 30-day claims-based mortality measure for monitoring for CY 2023

RY 2026-2027

- Transition to 30-day digital hybrid mortality measure for attainment and improvement

Previous QBR comment letters from Medstar, Hopkins, and UMMS supported moving to a 30-day measure but requested time for monitoring

RY 2025 QBR Draft Recommendations (slide 1 of 2)

1. Continue Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 50 percent, Safety (NHSN measures) - 35 percent, Clinical Care - 15 percent.
   a. Within the PCE domain, continue to include four linear HCAHPS measures weighted at 10% of QBR score; remove associated revenue at risk from top box.
   b. Within the PCE domain, add the Timely Follow-Up measure for Medicaid.
2. Develop the following monitoring reports for measures that will be considered for adoption after RY 2025:
   a. 30-day all-payer, all-cause mortality (claims based)
   b. Timely Follow-Up for Behavioral Health
   c. Disparity gaps for Timely Follow-Up
3. Implement the HCAHPS improvement framework with key stakeholders.

RY 2025 QBR Draft Recommendations (slide 2 of 2)

4. Continue collaboration with CRISP on infrastructure to collect hospital electronic clinical quality measures and core clinical data elements; For CY 2023 require submission of:
   a. ED-2 eCQM for monitoring; consider for re-adoption after RY 2025 (in CY 2024)
   b. Safe Opioid Use eCQM for monitoring
   c. Four additional eCQM measures aligned with the SIHIS goals and hospital improvement priorities
   d. Clinical data elements for 30-day mortality and readmission hybrid measures beginning July 2023
5. 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.
   a. Retrospectively evaluate 41 percent cutpoint using more recent data to calculate national average score

maryland
health services
cost review commission

Draft Quality-Based Reimbursement Program for Rate Year 2025

October 12, 2022

This document contains the staff draft recommendations for updating the Quality-Based Reimbursement Program for RY 2025. Comments on this draft are due by COB October 19, 2022 and may be submitted to HSCRC.quality@maryland.gov.

P: 410.764.2605 4160 Patterson Avenue | Baltimore, MD 21215 hscrc.maryland.gov

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 Bloodstream Infection
CMS	Centers for Medicare & 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
TFU	Timely Follow Up after Acute Exacerbation of a Chronic Condition
THA/TKA	Total Hip and Knee Arthroplasty Risk Standardized Complication Rate
VBP	Value-Based Purchasing

POLICY OVERVIEW

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Quality-Based Reimbursement (QBR) program, are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.	The QBR program is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value within a global budget framework.	The QBR policy currently holds 2 percent of hospital inpatient revenue at-risk for Person and Community Engagement , Safety, and Clinical Care outcomes.	This policy ensures that the quality of care provided to consumers is reflected in the rate structure of a hospital's overall global budget. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	Quality programs that reward hospitals for the better of attainment or improvement (QBR and RRIP) better allow the policies to target improvements in hospitals that serve a high proportion of under-resourced patients. The Health Equity Workgroup (HEW) analyzed the Medicare Timely Follow-Up measure and found disparities by race, dual-status, and Area Deprivation. Over the coming year, HSCRC staff will explore methods to assess disparities in Timely Follow-Up across social factors and develop hospital incentives for reducing these disparities, similar to the approved readmission disparity gap improvement policy.

RECOMMENDATIONS

This document puts forth the RY 2025 Quality-Based Reimbursement (QBR) draft policy recommendations. This recommendation proposes maintaining updates from RY 2024 with minimal changes to the program measures as outlined below. It also makes several recommendations for the development of monitoring reports and building of infrastructure that will support expansion of the QBR program in future rate years. Staff greatly benefits from Commissioner support on these longer-term initiatives.

Draft Recommendations for RY 2025 QBR Program:

1. Continue Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 50 percent, Safety (NHSN measures) - 35 percent, Clinical Care - 15 percent.
    a. Within the PCE domain, continue to include four linear HCAHPS measures weighted at 10% of QBR score; remove associated revenue at risk from top box.
    b. Within the PCE domain, add the Timely Follow-Up measure for Medicaid.
2. Develop the following monitoring reports for measures that will be considered for adoption after

RY 2025:

   a. 30-day all-payer, all-cause mortality (claims based)
   b. Timely Follow-Up for Behavioral Health
   c. Disparity gaps for Timely Follow-Up

3. Implement the HCAHPS improvement framework with key stakeholders.
4. Continue collaboration with CRISP and other partners on infrastructure to collect hospital electronic clinical quality measures and core clinical data elements; For CY 2023 require submission of:
   a. ED-2 eCQM for monitoring; consider for re-adoption after RY 2025 (in CY 2024)
   b. Safe Opioid Use eCQM for monitoring
   c. Four additional eCQM measures aligned with the SIHIS goals and hospital improvement priorities
   d. Clinical data elements for 30-day mortality and readmission hybrid measures beginning July 2023
5. 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.
   a. Retrospectively evaluate 41 percent cutpoint using more recent data to calculate national average score

INTRODUCTION

Maryland hospitals have been funded under a population-based revenue system with a fixed annual revenue cap under the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and continuing under the current Total Cost of Care (TCOC) Model agreement, which took effect in 2019. Under the global budget system, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk in Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. The revisions include annual updates to each program policy, which must be approved by the Health Services Cost Review Commission (HSCRC), and have also included more recent large-scale overhauls of the Maryland Hospital Acquired Condition Program and Readmissions Reduction Incentive Program to better align program policies with the expanded and evolving goals of the TCOC Model agreement.

Under the TCOC Model, Maryland must request exemptions each year from CMS pay-for-performance programs, e.g., the Value Based Purchasing (VBP) program for which the Quality Based Reimbursement (QBR) is the state analog. CMS assesses and grants these exemptions based on a report for each program showing that Maryland's results continue to meet or surpass those of the nation. CMS notified the HSCRC on October 29, 2021, that Maryland's exemptions were granted for federal fiscal year 2022. However, CMS raised concerns about Maryland's subpar performance on measures in two QBR Program domains: (1) the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures in the Person and Community Engagement domain and (2) the Centers for Disease Control and Prevention's (CDC's) National Health Safety Network infection measures in the Safety domain. CMS also noted its support for re-adoption of ED wait time measurement due to Maryland's historical poor performance. Finally, as part of exemption approval, CMS stipulated that Maryland develop a high-level work plan to redesign the QBR program and then a report summarizing the potential changes that would be recommended to the Commission. Further, CMS noted they expect the State to advance hospital quality improvement, total population health, and health equity. State improvements in each of these three areas are fundamental to the overall success of the Maryland TCOC Model. As such, they should be comprehensively integrated and aligned across the spectrum of healthcare delivery. CMS noted their evaluation of future CMS Quality Program Waiver requests will consider Maryland's performance improvement and advancement in these three high-priority areas. HSCRC has submitted our exemption request for FY 2023 and responded to the issues raised by CMS in last year's exemption approval; staff is awaiting CMS' response.

This RY 2025 policy recommendation summarizes the state's efforts to implement updates identified during last year's redesign of the QBR Program, which was the first hospital pay-for-performance program implemented by the HSCRC. Specifically, it describes the work done by the HSCRC staff and QBR Redesign Subgroup convened in 2021, and by the standing PMWG which moved the subgroup findings forward. This policy includes recommended changes to the program for RY 2025 (see Figure 1 for status and progress of work by domain and measure). See the RY 2024 QBR policy for additional information on the findings from the QBR Redesign.

Figure 1. Status and Progress on QBR Redesign Tasks

Domain/ Measure	RY 2025	Future program years
Person and Community Engagement domain		
HCAHPS	• Monitor HCAHPS linear and overall scores after allocating 10% of points for the linear scores to the Person and Community Engagement (PCE) domain • Use HCAHPS patient level data from the Maryland Health Care Commission (MHCC) for additional analytics, including on disparities, and hospital improvement • Work with stakeholders to facilitate more sharing of best practices	• Continue to use HCAHPS patient-level data from the MHCC for additional analytics, including on disparities, and hospital improvement. • Continue working with stakeholders to facilitate more sharing of best practices
Emergency department (ED) wait times	• Conduct more research and analyses, such as an analysis of ED median times during the COVID-19 pandemic if the data are publicly released by CMS • Use infrastructure for electronic clinical quality measures (eCQMs) to enable the collection of data for an ED wait time measure; begin collection in CY 2022	• Continue to collect the ED wait time measure eCQMs; consider adopting the ED measure in the QBR Program in future years • Determine components to allow inclusion of measure in program (such as performance standards)
Follow-up measure	• Identify strategies for all hospitals in Maryland to achieve the SIHIS goal for Timely Follow-up • Develop monitoring reports for behavioral health for the Timely Follow-Up measures	• Evaluate the results in the monitoring reports for the Medicaid and behavioral health follow-up measures; consider adding a measure that includes Medicaid and/or behavioral health to the QBR Program in RY 2025
Safety domain		
CDC National Health Safety Network	• In light of the work group's findings that demonstrate that Maryland is on par with national performance, maintain alignment with the national VBP Program; focus on improvement on current measures. • Analyze impact of COVID on MD vs national trends	• Continue to analyze Maryland trends compared to national performance. • Explore working with CDC to add more innovative and less burdensome "digital" measures.

Domain/ Measure	RY 2025	Future program years
Clinical Care domain		
30-day mortality	• Review additional analyses related to 30-day measure • Continue to develop the 30-day measure for monitoring in RY 2025	• Continue to evaluate 30-day measure • Consider developing a hybrid measure using eCQM infrastructure • Consider adoption for RY 2026
Total hip arthroplasty/total knee arthroplasty	• Consider expansion of the current inpatient total hip arthroplasty/total knee arthroplasty measure to all-payers and to outpatient cases.	• When eCQM infrastructure is developed, explore adaptation of provider measures to assess all-payer inpatient and outpatient complications • Explore opportunities for Patient Reported Outcome Measures (PROMs)

Implications of COVID-19

Like the rest of the United States, Maryland has spent the past two and a half years battling the COVID-19 pandemic. First responders, nurses, doctors, hospitals, and health care providers have worked heroically to combat this dangerous virus. Emergency measures have transformed our health care landscape, in some cases temporarily and in others permanently.

CMS has paused revenue adjustments for both the VBP (QBR-analogous) and HAC Reduction programs for FY 2023 due to COVID impact concerns; Maryland shares the same concerns and is considering suspension of the revenue adjustments for RY 2023 for the QBR and MHAC programs. Given the expected persistence of COVID-19, Maryland might decide that more adjustments are needed to further account for the effects of the pandemic in the RY 2024 QBR policy. Thus, staff recommended to the Commission that we retrospectively assess the need for changes for the RY 2024 policy and report those changes to the Commission. For RY 2025, staff is only recommending retrospectively evaluating the revenue adjustment scale cutpoint to allow for national comparison and to take into account any COVID issues (i.e., rather than adjusting measurement, focus on how measures are converted to revenue adjustments).

BACKGROUND

Overview of the QBR Program

The QBR Program, implemented in 2010, includes potential scaled penalties or rewards of up to 2 percent of inpatient revenue. The program assesses hospital performance against national standards for its Person and Community Engagement and Safety domains. For the Clinical Care domain, the program uses Maryland-specific standards for the inpatient mortality measure and national standards for the Medicare only measure of total hip arthroplasty/total knee arthroplasty (THA/TKA) complications. Figure 2 compares RY 2024 QBR measures and domain weights to those used in the VBP Program.

Figure 2. RY 2024 QBR measures and domain weights compared with those used in the VBP Program

Domain	Maryland QBR domain weights and measures	CMS VBP domain weights and measures
Clinical Care	**15 percent** Two measures: All-cause inpatient mortality; THA/TKA complications	**25 percent** Five measures: Four condition-specific mortality measures; THA/TKA complications
Person and Community Engagement	**50 percent** Nine measures: Eight HCAHPS categories top box score and four categories linear score; Medicare follow-up after chronic conditions exacerbation	**25 percent** Eight HCAHPS measures top box score.
Safety	**35 percent** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**25 percent** Five measures: CDC NHSN HAI measures
Efficiency	n.a.	**25 percent** One measure: Medicare spending per beneficiary

With the selected measures from above, the QBR Program assesses hospital performance based on the national threshold (50th percentile) and benchmark (mean of the top decile) values for all measures, except the HSCRC calculated in-hospital mortality rate and Medicare Timely Follow-Up (which uses state data to calculate performance standards). Each measure is assigned a score of zero to ten points, then the points are summed and divided by the total number of available points, and weighted by the domain weight. Thus, a total score of 0 percent means that performance on all measures is below the national threshold and has not improved, whereas a total score of 100 percent means performance on all measures is at or better than the mean of the top decile (about the 95th percentile). This scoring method is the same as that used for the national VBP Program. But unlike the VBP Program, which ranks all hospitals relative to one another and assesses rewards and penalties to hospitals in a revenue neutral manner retrospectively based on the distribution of final scores, the QBR Program uses a preset scale to determine each hospital's revenue adjustment. This gives Maryland hospitals predictability and an incentive to work together to achieve high quality of care, instead of competing with one another for better rank.

The preset scale for revenue adjustments is 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 or receives a penalty is 41 percent. This reward and penalty cut-point is based on an analysis of the national VBP Program

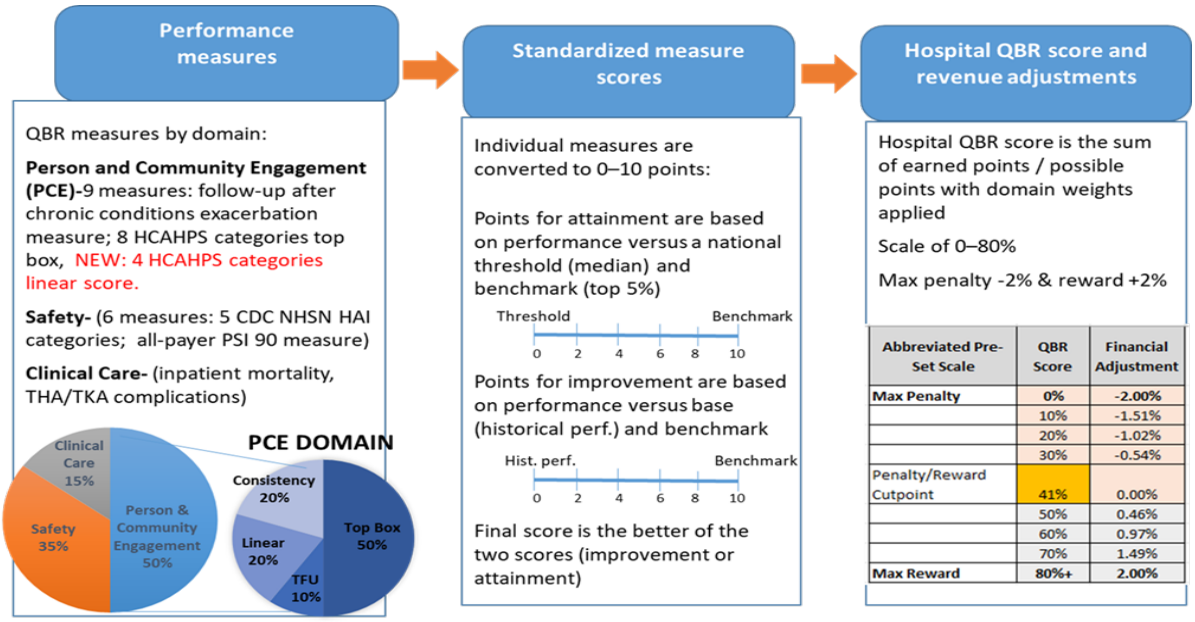
scores for federal fiscal years 2016–2021, which indicated the average national score using Maryland domain weights (without the Efficiency domain) was around 41 percent (ranging from 38.5 to 42.7).

As a recap, the method for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019. It 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 to 100 percent) by weighting the domains, based on the overall percentage or importance the HSCRC placed on each domain
5. Converting the total hospital QBR scores into revenue adjustments using the preset scale (range of 0 to 80 percent)

This method is shown in Figure 3.

Figure 3. RY 2024 QBR Policy Methodology Overview



Appendix A contains more 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 the QBR program, compared to the nation when national data is available. In addition, staff has proposed a preliminary revenue adjustment scale and a method

for assessing the scale retrospectively, but does not present new modeling of potential revenue adjustments.

Person and Community Engagement Domain

The Person and Community Engagement domain currently measures performance using the HCAHPS patient survey and a measure of timely follow-up (TFU) after discharge for an acute exacerbation of a chronic condition for Medicare FFS beneficiaries. This domain accounts for 50 percent of the overall QBR score. In addition this domain previously included the emergency department (ED) wait time measures for admitted patients, which were retired in CY 2019 and CY 2020 due to federal discontinuance of these measures. This section also discusses the HSCRC staff's work with CRISP to collect the eCQM version of the ED wait time measure.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The HCAHPS survey is a standardized, publicly reported survey that measures patient's perceptions of their hospital experience. In keeping with the national VBP Program, the QBR Program scores hospitals on either improvement or attainment, whichever is highest, across the following HCAHPS domains: (1) communication with nurses, (2) communication with doctors, (3) responsiveness of hospital staff, (4) communication about medicine, (5) hospital cleanliness and quietness, (6) discharge information, (7) a composite care transition measure, and (8) overall hospital rating. The QBR Program also scores hospitals separately on consistency[1]; a range of 0-21 consistency points are awarded by comparing a hospital's HCAHPS survey lowest performing measure rates during the performance period to all hospitals' HCAHPS survey measure rates from a baseline period.

The VBP and QBR program have historically measured HCAHPS based on the top-box score (e.g., the percent of respondents who indicate they strongly agree). As part of the RY 2024 QBR Redesign, the state decided to also score hospitals on the HCAHPS linear scores, which are the average response across all response categories. Specifically, HCAHPS linear scores were added as 20% of the PCE domain (i.e., 10 percent of overall QBR score) for the following domains: the nurse communication, doctor communication, responsiveness of staff and care transition. The addition of the linear measures is designed to further incent focus on HCAHPS by providing credit for improvements along the continuum and not just improvements in top box scores. Also by focusing on just 4 of the 8 measures, staff believes additional emphasis will be put on these important measures that have been shown to be correlated with other patient safety outcomes. The HSCRC staff recommends including the linear measures for RY 2025; however, staff will assess if adding the linear measures helps improve top-box scores over the

[1] For more information on the national VBP Program's performance standards, please see https://qualitynet.cms.gov/inpatient/hvbp/performance.

coming 2-3 years. If top box scores do not improve, the staff will recommend removing the linear measures in future rate years.

Figures 4 and 5 below provide graphic and numeric representations respectively of the HCAHPS measure results for Maryland compared to the Nation, revealing that:

- Maryland continues to lag behind the Nation.
- Both the Nation and Maryland declined slightly from the base to the performance periods for most of the HCAHPS categories.
- For the "Overall Rating 9 or 10" category, Maryland performs worse than the Nation but both Maryland and the Nation maintained their performance from the base.
- For " Discharge Information Provided", Maryland and the Nation performed on par with one another and maintained their performance levels from the base.

Subsequent to the state vs. national analysis through 3/31/21, updated data through 6/30/21 was released on CMS Care Compare showing similar trends of Maryland lagging behind the nation and poorer performance for both Maryland and the nation in the performance period compared with the pre-COVID base period.

Figure 4. HCAHPS Top Box Results: Maryland Compared to the Nation, CY 2019 vs 10/1/20-9/30/21

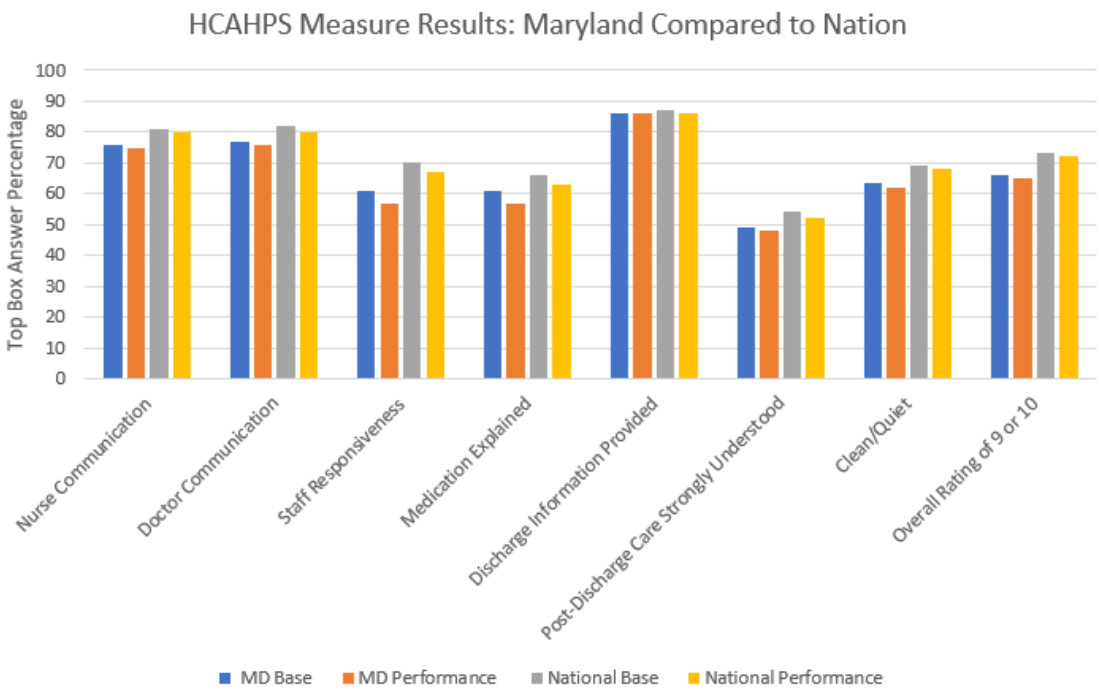


Figure. 5 HCAHPS Numeric Results: Maryland Compared to the Nation

	MD Base	MD Performance	National Base	National Performance
Nurse Communication	76	75	81	80
Doctor Communication	77	76	82	80
Staff Responsiveness	61	57	70	67
Medication Explained	61	57	66	63
Discharge Information Provided	86	86	87	86
Post-Discharge Care Strongly Understood	49	48	54	52
Clean/Quiet	63.5	62	69	68
Overall Rating of 9 or 10	66	65	73	72

Maryland HCAHPS Improvement Framework

Background

One important area CMMI has identified in feedback to the Commission is the need for targeting improvement in HCAHPS in the Person and Community Engagement domain, worth 50% of the QBR program score. Specifically, CMMI's correspondence noted the following:

> "CMS encourages the State to prioritize strategies to investigate the root cause of poor HCAHPS performance, create a formalized platform for hospitals to share HCAHPS best practices, and invest in infrastructure to capture patient-level-data; CMS believes that these strategies have the greatest potential to maximize sustained performance improvement in HCAHPS, long-term. CMS suggests the State consider implementing a State-wide HCAHPS performance improvement initiative that leverages input from providers, industry experts, and other stakeholders to develop future improvement goals. CMS is looking for the State to further develop these strategies and commit to creating a framework for setting HCAHPS performance improvement goals for future performance years. CMS expects the FFY 2023 CMS Quality Program Waiver request to include a framework development timeline and proposal outlining the State's approach for developing HCAHPS performance improvement goals. This proposal and timeline will be heavily considered in evaluating the State's CMS Quality Program Waiver request for FFY 2023. "

Historic Efforts to Improve HCAHPS

The State and hospitals have worked to target HCAHPS improvement over the past several years. In addition to increasing the incentives to double that of the nation under the QBR program, the Maryland Hospital Association (MHA) has worked with hospitals and health systems to assess HCAHPS performance and develop improvement initiatives stemming from best practices and leveraging efforts correlated with improvements in patient satisfaction. MHA planned additional collaboratives for CY 2020,

but these plans were halted because, like many hospitals around the country, all staff were fully engaged in responding to the COVID crisis.

Past Learning Collaboratives and Programs

In 2018, MHA initiated a Patient Experience Mentoring Program. The program identified hospitals whose patient satisfaction scores were a top box, exceeded the Nation average, and improved over time. MHA reached out to them to know their success strategies and possibly replicate them state-wide. MHA paired the hospitals to create an inter-hospital sharing platform to guide/support each other and identify opportunities to improve HCAHPS scores. The pilot began with patient experience leads visiting their partner hospital for a discrete on-site visit. The leads toured the ED/patient rooms, attended morning bed huddles, observed nurse leader rounding, etc. They filled out a site visit guide with observations and shared it with the partner hospital. Hospitals have expressed that the peer program was beneficial and enhanced staff engagement.

In 2019, MHA conducted a **Patient Experience learning Conference**. The participants of the MHA mentoring program were in attendance to share their lessons learned/experiences. MHA began the event by sharing state-wide HCAHPS scores to help hospitals identify and close the gaps. National HCAHPS expert Carrie Brady facilitated the rest of the conference. Ms. Brady conducted a panel discussion on technology to support rounding, organizational structures to support patient experience, Nurse leader rounding, and staff engagement. Ms. Brady also made participants take the HCAHPS survey and reviewed the Always Events Toolkit. The takeaway of the conference was for the participants to receive a guide to creating their peer-to-peer learning program within the hospital or health system.

To address the ongoing concerns going forward, HSCRC will work in collaboration with Maryland hospitals, MHA, and other important stakeholders committed to developing and implementing a framework that supports improving Maryland performance on HCAHPS. An initial critical component of the framework includes collaboration with all key stakeholders, including Maryland Hospital Association (MHA), hospital staff/entities accountable for HCAHPS survey administration and for data analysis, patient representatives, and the Maryland Healthcare Commission (MHCC). Critical components of the framework are outlined below.

Administrative Leadership Accountability:

HSCRC will first identify for each hospital the key hospital staff accountable for HCAHPS survey administration, data analysis, and improvement. These hospital contacts will be engaged in all activities established under the HCAHPS improvement framework.

Anticipated Timeline: *HSCRC will work with MHA and hospitals to identify HCAHPS-accountable hospital contacts by December 2022.*

Data Analysis and Data Sharing:

HSCRC will conduct or facilitate data analysis of HCAHPS data to stratify hospital-specific reporting on levels and rankings of performance on both top box scores, and on linear scores newly added to the QBR program as of rate year 2024. The analysis will also include hospital performance on specific HCAHPS categories. Further, HSCRC will work with MHCC to understand patient-specific demographic factors that may be contributing to hospital-specific trends or that may indicate disparities in performance.

Anticipated Timeline: *HSCRC will work with MHCC to analyze patient-level HCAHPS data once hospitals have submitted data for a full year. HCAHPS data submission began with MHCC receiving CY 2021 Q3 data in January 2022. We anticipate beginning an analysis of the HCAHPS data as of January 2023.*

Hospital Adoption and Sharing of Best Practices:

Drawing from a review of the literature on improving HCAHPS, hospitals will be surveyed on approaches they have implemented to improve their performance. Subsequently, hospitals will be convened so that they can share their experiences in designing and implementing best practices, which will include but are not limited to those outlined below.

Anticipated Timeline: *HSCRC will work with MHA, MHEI and hospitals to plan and implement sharing of best practices to improve HCAHPS beginning in CY 2023 and continuing into CY 2024.*

Organizational Factors

In a study of organizational factors that may improve patient experience, interviews of staff and patient representatives were conducted at eight geographically spread out organizations that included three inpatient hospitals known for such improvements. The study identified the following processes for improving patient-centered care:

1. strong, committed senior leadership,
2. clear communication of strategic vision,
3. active engagement of patient and families throughout the institution,
4. sustained focus on staff satisfaction,
5. active measurement and feedback reporting of patient experiences,
6. adequate resourcing of care delivery redesign,

7. staff capacity building,
8. accountability and incentives and
9. a culture strongly supportive of change and learning.[2]

Patient-Physician Communication

One publication provided a summary of current literature that lays out best practices that hospitals can employ to improve physician-patient communication, specifically targeting the HCAHPS survey. [3] The article outlined Best Practices summarized in the Figure 6 below.

Figure 6. Hospital Provider Communication Best Practices

Demonstrating Courtesy and Respect	Best Practices for Improving Listening	Best Practices for Explaining
● Knock before entering a patient's room. ● Greet the patient by name. ● Introduce yourself and your role. Review the chart prior to entering the room. ● Treat every concern brought up as important and ex-plain why you prioritize certain concerns over others in the hospital. ● Ask the patient for permission to conduct a physical examination. ● At the end of an encounter, ask for questions in an open-ended fashion ● End the hospital stay on a positive note.	● Avoid interrupting the patient. ● Take notes so they know you take their concerns seri-ously ● Summarize key points of a discussion. ● Pay attention to nonverbal cues, and acknowledge emotions ● Sit at the bedside. ● Use social touch to convey empathy. ● Be comfortable with silence: allow 5 seconds to re-sume conversation when there is a pause. ● Watch your body language; don't appear hurried, bored or fidgety; don't cross your arms.	● Avoid medical jargon ● Explain physical examination findings as you are conducting the examination. ● Use the teach-back method to ensure understanding; utilize open-ended questions. ● Explain procedures/testing before they are ordered/ performed. ● Write out important information, if needed (use white-boards in rooms). ● Give patients a way to contact you with any questions after the hospital stay.

[2] Luxford, Karen, Dana Gelb Safran, and Tom Delbanco. "Promoting Patient-Centered Care: A Qualitative Study of Facilitators and Barriers in Healthcare Organizations with a Reputation for Improving the Patient Experience." *International Journal for Quality in Health Care*, vol. 23, no. 5, 2011, pp. 510–515.

[3] Dutta, Suparna, and Syeda Uzma Abbas. "HCAHPS And The Metrics Of Patient Experience: A Guide For Hospitals And Hospitalists." *Hospital Medicine Practice*, vol. 3, no. 6, June 2015. Available at http://medicine.med.miami.edu/documents/Patient_Satisfaction_6-15.pdf.

Discharge Planning/Care Transition

A study surveyed 1,600 acute care hospitals on whether the following strategies were used:

1. use of a dedicated discharge planner or discharge coordinator, create discharge summary prior to discharge and share with outpatient provider,
2. schedule follow-up appoints for all patients prior to discharge,
3. use electronic tools to reconcile discharge medications, and
4. use formal discharge checklist to document components of the discharge process.[4]

After categorizing responders into low-strategy, mid-strategy, and high-strategy groups based on quartiles of the number of strategies that used, the study found that compared with low-strategy hospitals, high-strategy hospitals had a higher overall rating (+2.23 percentage points (pp), P<0.001), higher recommendation score (+2.5 pp, P<0.001), and higher satisfaction with discharge process (+1.35 pp, P=0.01) and medication communication (+1.44 pp, P=0.002).

Next Steps

Building off of the past efforts, MHA is working with Maryland Healthcare Education Institute (MHEI) and the Maryland Patient Safety Center (MPSC) on two current initiatives to support HCAHPS improvements through education and training efforts:

- What Do Our Patients Want From Us Now?
- BIRTH Equity: Breaking Inequality Reimagining Transformative Healthcare

HSCRC, again working with identified key stakeholders, will collaborate to finalize and implement the framework. Throughout the remainder of CY 2022 and going forward, the Commission will provide periodic updates on the framework and its implementation, including HCAHPS data trends.

Emergency Department Wait Time Measure

Long ED wait times are an enduring issue in Maryland, which has had longer wait times than the national average pre-dating the start of global budgets in 2014. Concerns about unfavorable ED throughput data have been shared by many Maryland stakeholders, including the HSCRC, the Maryland Health Care Commission, payers, consumers, emergency room physicians, the Maryland Institute of Emergency

[4] Figueroa, J.F., Y. Feyman, X. Zhou, and K.J. Maddox. "Hospital-Level Care Coordination Strategies Associated with Better Patient Experience." *BMJ Quality & Safety,* vol. 27, 2018, pp. 844–851. Available at https://qualitysafety.bmj.com/content/qhc/27/10/844.full.pdf.

Medical Services Systems, and the Maryland General Assembly.[5] Under alternative payment models, such as hospital global budgets or other hospital capitated models, there may be an incentive to reduce staffing that leads to ED throughput issues. Measuring ED wait times is one way to monitor for unintended consequences of the Model on hospital throughput. In general, ED staff supported including the inpatient wait time measures to address the issue of ED boarding and hospital throughput.

In RY 2020 (CY 2018 measurement period), the QBR Program introduced the use of the two inpatient ED wait time measures (ED-1b and ED-2). The HSCRC included the measures as part of the QBR Person and Community Engagement domain because of the correlation between ED wait times and HCAHPS performance. To ensure fairness in performance assessment Maryland hospitals are compared to national peer groups based on ED volume. Stakeholders have also voiced concern about whether the measures should be risk adjusted for occupancy. Staff analysis of 2019 data do indicate that ED visit volume and occupancy are both statistically significantly associated with ED-2b in univariate regression analyses ($p < .05$). However, after controlling for ED volume, occupancy is no longer statistically significant. Based on this analysis, hospitals with greater volumes should be given a higher time threshold, and staff also suggested considering continuous volume adjustment in the future. In CYs 2019 and 2020, CMS's Hospital Inpatient Quality Reporting (IQR) program stopped requiring submission of the ED-1b and ED-2b measures, respectively, which meant that the HSCRC had to remove the measures from the QBR Program. However, the Commissioners requested that staff pursue other options to obtain ED wait time data. Staff recommended the CMS electronic clinical quality measure (eCQM) version of the ED-2 measure, which is optional for hospitals to submit. However, in the FY 2022 IPPS Final Rule, CMS finalized plans to remove this measure beginning with CY 2024 reporting. Despite its removal from the IQR program, HSCRC staff believes it will be possible for hospitals to continue to report the measure electronically since the measure is already nationally specified and continues to be used voluntarily by hospitals for submission to CMS for CYs 2022 and 2023, and is part of the Joint Commission measure set.

Collection of ED Wait Time Data

Currently staff is collaborating with CRISP and its contractor, Medisolv, to collect electronic clinical quality measures (eCQMs), including the ED-2 eCQM, and clinical core data elements for hybrid measures since CMS is signaling this direction for quality measurement. Half of hospitals began submitting the measure using CY 2021 data, and all hospitals have been required to submit the measure for all four quarters in

[5] For the "Emergency Department Overcrowding Update" November 2019 Joint Chairman Report, please see http://www.miemss.org/home/Portals/0/Docs/LegislativeReports/miemss-ed-overcrowding-update-10-31-19.pdf?ver=2019-11-19-174743-763.

CY 2022. Please see more information regarding Maryland's hospital eCQM Infrastructure in the section below. The eCQM ED-2 measure has several advantages:

- Nationally specified measure
- National historical data will be available for establishing performance standards
- Aligns with CMS requirements for submitting eCQMs through CY 2023, and is still used voluntarily by the Joint Commission

Stakeholders are supportive of monitoring the eCQM ED-2 measure, appreciating that it correlates with patient experience and serves as a broad measure of hospital efficiencies: many departments have to be working properly for a decrease to take place in the time between the decision to admit and actual admission. Broadly, subgroup members noted that eCQM measures are simple, perform better than other collected measures (for example, abstraction measures), and give hospitals the ability to look at data in real time.

Concerns raised about implementing eCQM ED-2 into payment include the lack of comparable historical or national data on all hospitals for creating a benchmark since reporting is voluntary. Because it is a voluntary metric nationally, poor performing hospitals may choose not to report. Noting the concerns around implementing ED-2 into payment, staff believes that there are ways to develop performance standards. For example, staff note that we could continue with the same performance standards as we had with the chart abstracted measure or develop a scoring methodology that only looks at improvement. Thus, for this policy we are asking Commissioners to approve the recommendation to require hospitals to submit the ED-2 eCQM for CY 2023 performance and then in future policies consider readopting the measure for payment.

Timely Follow-Up After Discharge

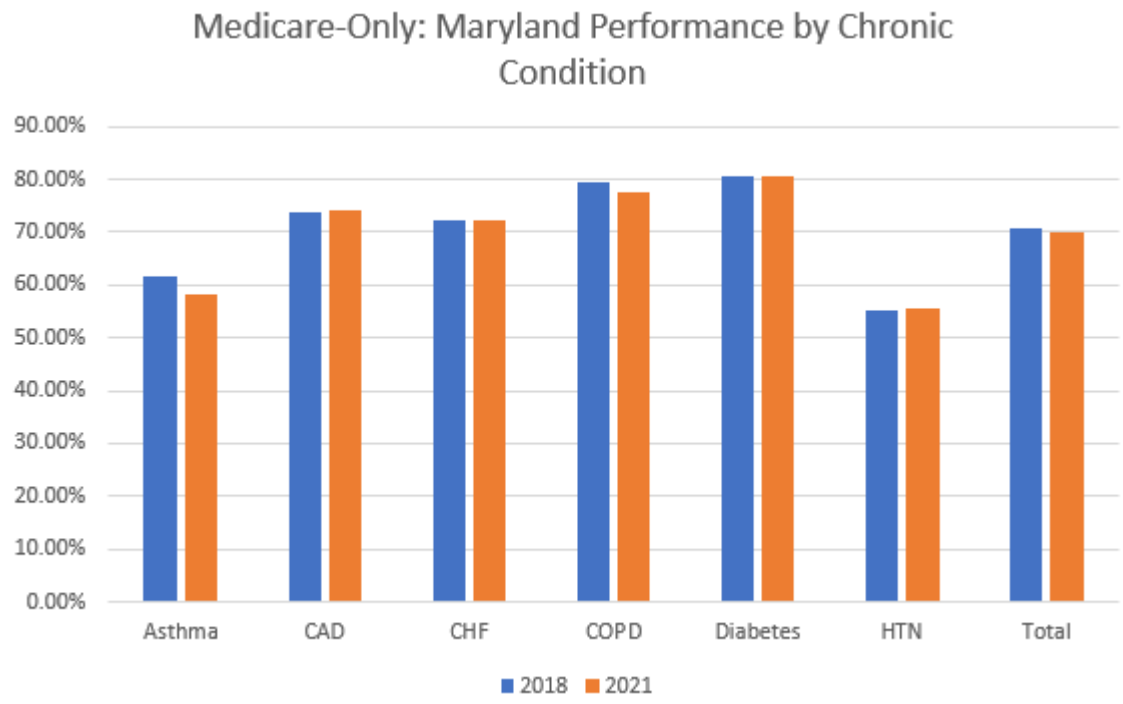
On March 17, 2021, CMS approved Maryland's proposed SIHIS, which included a National Quality Forum-endorsed health plan measure of timely follow-up (TFU) after an acute exacerbation of a chronic condition in the Care Transition domain. The SIHIS goal is to achieve a 75 percent TFU rate for Medicare FFS beneficiaries across the six specified conditions and respective time frames. To hold hospitals accountable for meeting this goal, the HSCRC introduced this measure for Medicare beneficiaries into the RY 2023 QBR Program within the Person and Community Engagement domain and recommend continuing it in the RY 2025 QBR program weighted at 10 percent of the PCE domain (20 percent of the overall QBR score).

The measure assesses the percentage of ED visits, observation stays, and inpatient admissions for one of six conditions in which a follow-up was received within the time frame recommended by clinical practice:

- Hypertension (follow-up within seven days)
- Asthma (follow-up within 14 days)
- Heart failure (follow-up within 14 days)
- Coronary artery disease (follow-up within 14 days)
- Chronic obstructive pulmonary disease (follow-up within 30 days)
- Diabetes (follow-up within 30 days)

Figure 7 shows Maryland's performance over time for each chronic condition and all conditions combined. For all conditions, there was a slight drop from 2018 to 2021 (70.85% to 70.07%) and thus Maryland did not meet the Year 3 SIHIS goal of 72.38 percent. The largest drop in follow-up was for asthma (-3.5%) and COPD (-1.7%), which also had increases in the number of discharges requiring follow-up in CY 2021 and thus higher weighting in the total composite. For CAD, CHF, diabetes, and hypertension there were slight increases in follow-up but also decreases in the number of discharges in 2021. Thus the weighting or number of discharges in the composite also impacts the total rate and may need to be considered as we assess progress on increasing follow-up.

Figure 7. Medicare-only: Maryland Timely Follow-Up by Condition



Note: Maryland numbers are claims-based and built on the Claim and Claim Line Feed with a four-month runout. CAD = coronary artery disease, CCW = Chronic Conditions Data Warehouse; CHF = coronary heart failure; COPD = chronic obstructive pulmonary disease; HTN = hypertension.

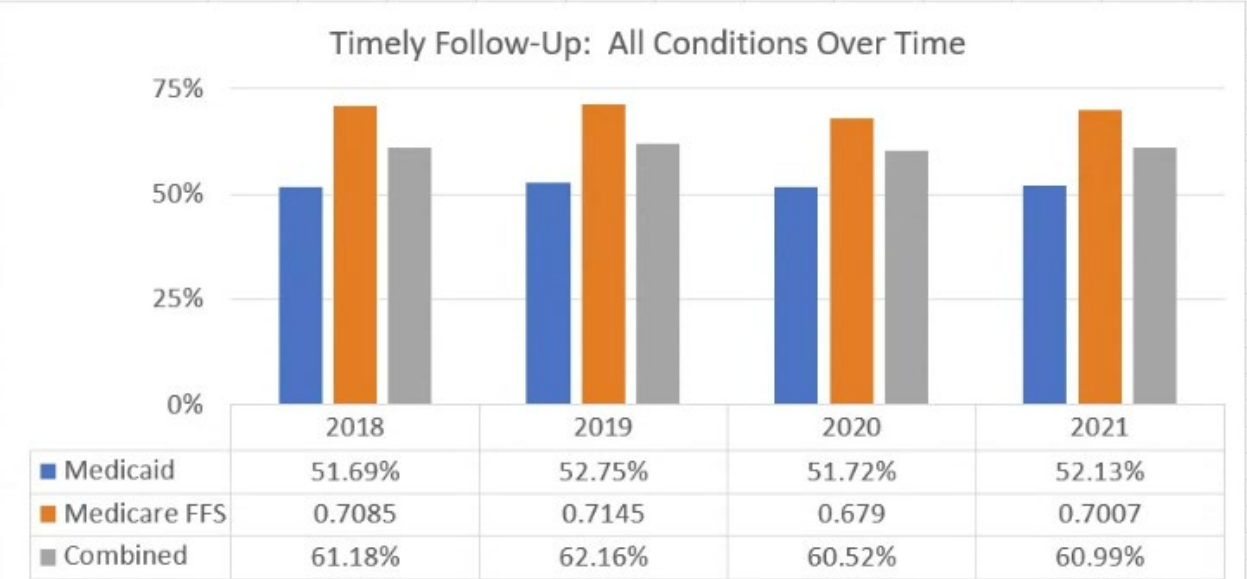
Figure 8 shows the annual performance on the total TFU measure for Maryland and the Nation (national data is based on the Chronic Condition Warehouse 5 percent sample). Overall there was a drop in TFU for both the State and the nation during the COVID-19 PHE. Based on the data from CY 2021, the state was at 70.07 percent TFU across all conditions and as mentioned above did not meet the Year 3 SIHIS goal of a TFU rate of 72.38 percent. However, Maryland did have some recovery in 2021 from 2020 and performed about 2.5 percent better than the Nation despite missing the SIHIS goal.

Figure 8. Medicare-only: Timely Follow-Up across All Conditions

	CY2018	CY2019	CY2020	CY2021
Maryland	70.85%	71.45%	67.90%	70.07%
US	66.82%	69.00%	64.75%	67.68%

As part of the SIHIS proposal, it was noted that staff would explore expanding the timely follow-up rates for chronic conditions to other payers and adding follow-up after a hospitalization for behavioral health. In Calendar Year 2022, staff worked with CRISP and Maryland Medicaid to provide hospitals monthly Medicaid Timely Follow-Up reports on the CRS portal. Figure 9 shows the TFU rate for both Medicare FFS and Medicaid individually and combined. Currently staff is vetting with the PMWG how to incorporate Medicaid in the payment program. Issues to discuss include the concerns of the SIHIS goal being missed for Medicare FFS, the significant differences between Medicare and Medicaid rates that make it less suitable as a combined measure, and the weight that would be put on a Medicaid measure (i.e., how would the current 5 percent of the PCE domain be split and is that weight significant enough of an incentive). The HSCRC staff will further review these issues with PMWG in October and request that comment letters provide feedback on how to incorporate Medicaid. Based on this discussion the staff will provide a final recommendation for consideration in November.

Figure 9 Medicaid and Medicare FFS: Timely Follow-Up across All Conditions



	2018	2019	2020	2021
Medicaid	51.69%	52.75%	51.72%	52.13%
Medicare FFS	0.7085	0.7145	0.679	0.7007
Combined	61.18%	62.16%	60.52%	60.99%

Staff is continuing to work to understand the Medicare and Medicaid behavioral health data and creating a Timely Follow-Up monitoring report for Behavioral Health.

Health Equity Workgroup Findings

In the Summer of CY 2022, staff convened a Health Equity Workgroup which stratified Maryland's quality measures by social demographic factors to glean disparities. For the QBR program, staff stratified the Timely Follow-Up measure by race, dual-eligibility status, and Area Deprivation Index (ADI). Results of this stratification analysis are below in Figures 10, 11, and 12, but overall the analysis found disparities on all three factors. For example, Figure 10 indicates that Blacks have a 58 percent higher odds of not receiving follow-up compared to Whites. Similar trends were seen where duals and those with higher area deprivation had a higher odds of not receiving follow-up. Given that the state did not meet the 2021 Year 3 Milestone Target and the overwhelming evidence of disparities in this measure, HSCRC staff will develop hospital incentives for reducing these disparities, similar to the approved readmission disparity gap improvement policy, over the next year. The methodology will address how to measure disparities in the three exposure factors above using a composite exposure variable that is not associated with the outcome. This differs from the current readmission methodology and will require time to develop the measure before reports can be provided to hospitals. However, this is a priority of the staff and will hopefully aid the state in achieving the final SIHIS goal of a 75 percent (or 0.5% better than the nation) timely follow-up rate in CY 2026.

Figure 10. Odds Ratio of No Follow-Up by Race

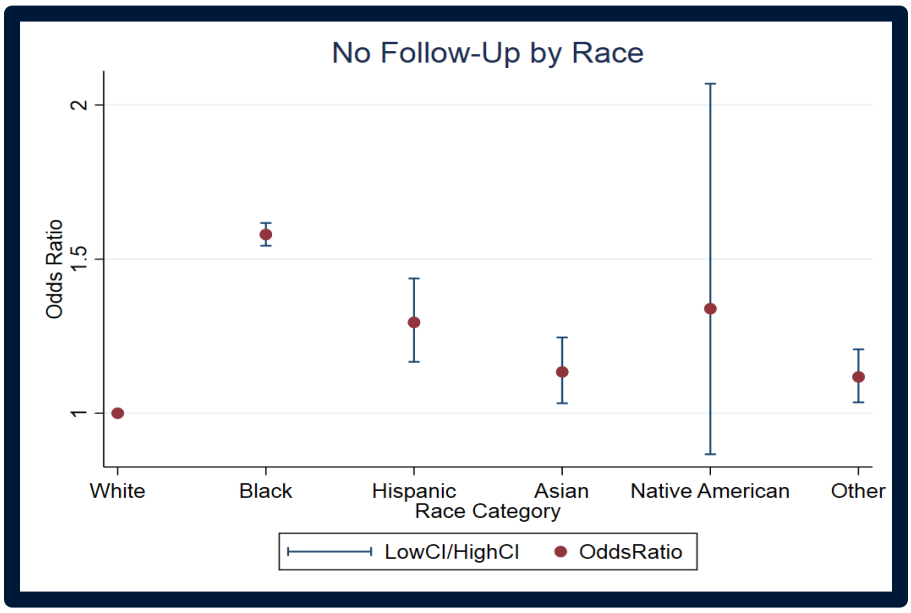


Figure 11. Odds Ratio of No Follow-Up by ADI Decile

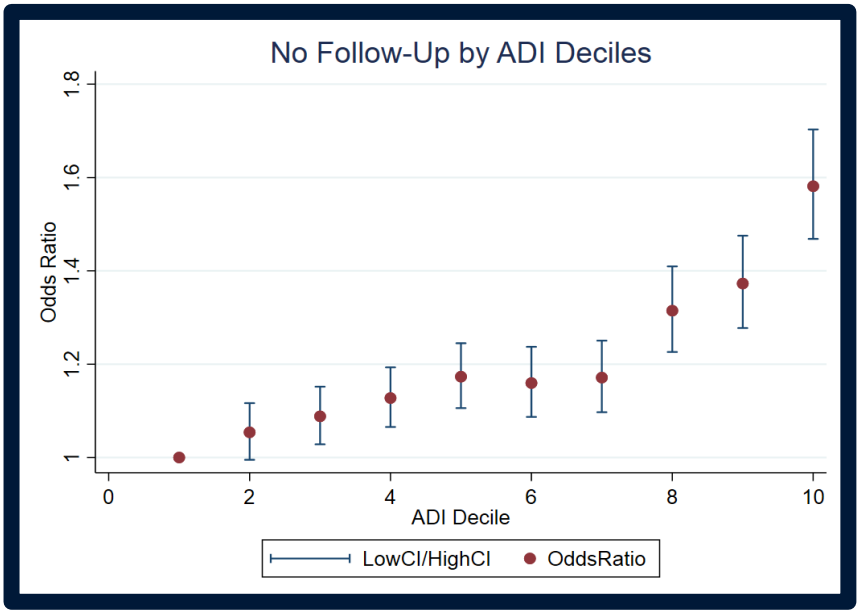
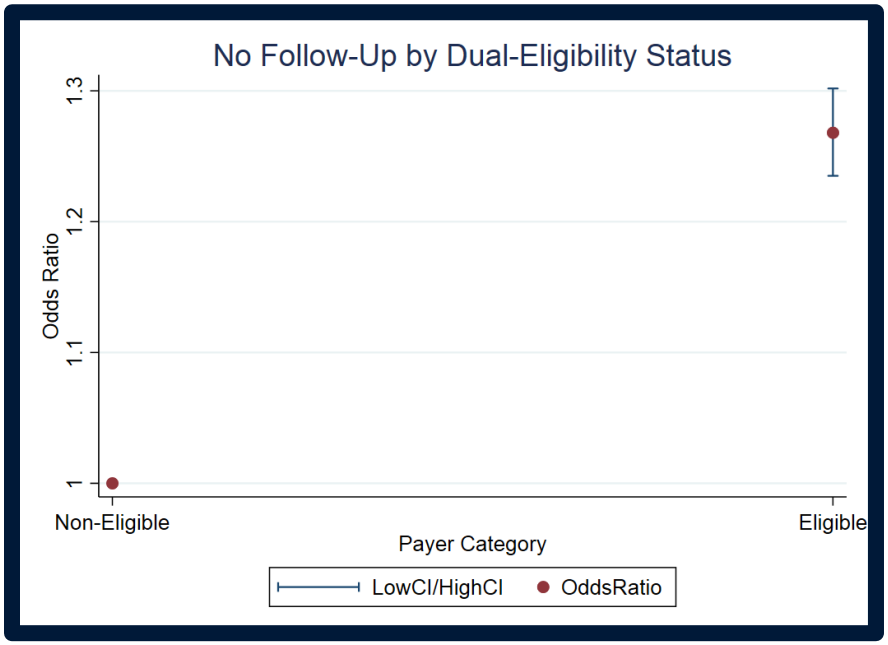


Figure 12. Odds Ratio of No Follow-Up by Dual-Eligibility Status



Safety Domain

The QBR Safety domain contains five measures from six CDC NHSN HAI categories and the AHRQ Patient Safety Index Composite (PSI-90).[6] It is weighted at 35 percent of the QBR score.

CDC NHSN HAI measures

The CDCs National Healthcare Safety Network (NHSN) tracks healthcare-associated infections such as central-line associated bloodstream infections and catheter-associated urinary tract infections. Both Maryland and the nation have seen increases in HAIs during CY 2020 and CY 2021. Specifically, CDC has reported that there were significant increases in the national SIRs for CLABSI, CAUTI, VAE, and MRSA bacteremia in 2020 compared to 2019, but that the increases varied by quarter and State. In Maryland, there were statistically significant increases in CLABSI in 2020, while all other NHSN measures for Maryland did not show a statistically significant change despite increases. Furthermore a recent study has shown that the increase in HAI SIRs continued into CY 2021.[7] For example, nationally CLABSI increased by 45 percent from Q1 2019 to Q1 2021. Based on these trends, the FY 2023 CMS final rule suppressed the NHSN HAI measures in the national VBP program based on the significant changes in the national results during COVID, as well as significant shortages in health personnel that would impact

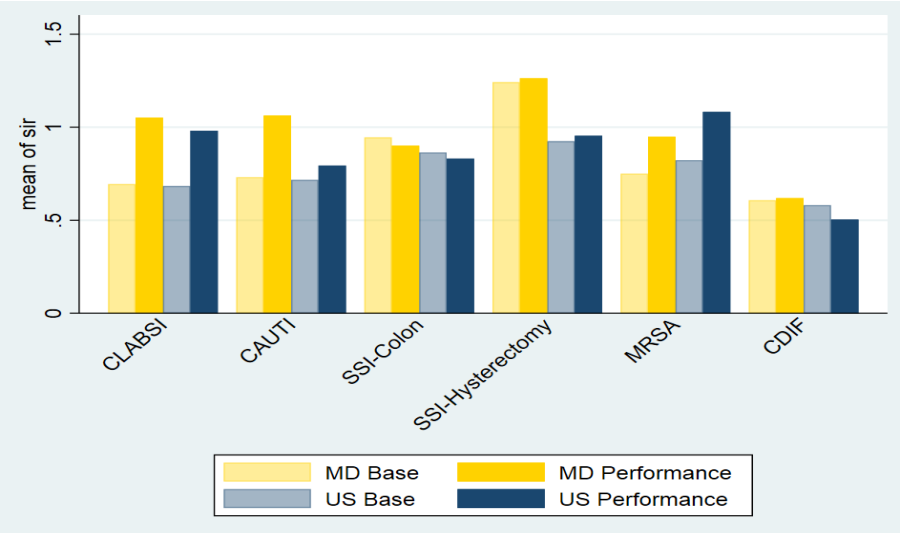
[6] For use in the QBR Program, as well as the VBP program, the SSI Hysterectomy and SSI Colon measures are combined.

[7] Lastinger, L., Alvarez, C., Kofman, A., Konnor, R., Kuhar, D., Nkwata, A., . . . Dudeck, M. (2022). Continued increases in the incidence of healthcare-associated infection (HAI) during the second year of the coronavirus disease 2019 (COVID-19) pandemic. *Infection Control & Hospital Epidemiology,* 1-5. doi:10.1017/ice.2022.116

care delivery. Thus, the Maryland and national results below should be interpreted cautiously and the HSCRC staff will need to monitor whether CMS makes any additional recommendations for suppressing measures during the RY 2025 performance period.

CMS Care Compare has updated the HAI SIR data tables for the nation and by state through October 2021. As Figure 13 below indicates, Maryland's performance is worse (higher SIRs) on all measures with the exception of MRSA. Furthermore, Maryland performed worse on all measures except SSI-Colon from 2019; nationally the measures also got worse except for MRSA and c.Diff.

Figure 13. NHSN SIR Values for CY19 compared to Q4 CY20-Q3 CY21, Maryland versus the nation.



Patient Safety Index (PSI-90)

To align with the VBP program and expand the QBR program's measurement of preventable complications that cause patient harm and increase the cost of hospital care, the Commission approved the adoption of the all-payer version of the PSI-90 measure in the RY 2023 QBR program at the recommendation of staff and PMWG stakeholders. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators were developed[8] and released in 2003 to help assess the quality and safety of care for adults in the hospital. PSI-90 focuses on a subset of ten AHRQ-specified PSIs of in-hospital complications and adverse events following surgeries, procedures, and childbirth. The PMWG noted that CMS removed the PSI-90 measure from the VBP program in FY 2024, but retained the measure in the Hospital Acquired Conditions Reduction Program. Since Maryland does not have PSI-90 in the MHAC program, staff is recommending to retain it in the RY 2025 QBR program.

As illustrated in Figure 14 below, for CY 2021 (with COVID cases removed as recommended by AHRQ) compared with CY 2019, Maryland's statewide performance is as follows:

- The state has **improved** with lower rates in 2021 on PSIs 09 Perioperative Hemorrhage or Hematoma Rate and 14 Postoperative Wound Dehiscence Rate.
- The state has **neither improved or declined** on PSIs 03 Pressure Ulcer Rate, 08 In-Hospital Fall With Hip Fracture Rate, and 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate.

[8] AHRQ contracted with the University of California, San Francisco, Stanford University Evidence-based Practice Center, and the University of California Davis for development. For additional Information: https://www.qualityindicators.ahrq.gov/Modules/psi_resources.aspx

- The state has **worsened** with higher rates in 2021 on PSIs 06 Iatrogenic Pneumothorax Rate, 11 Postoperative Respiratory Failure Rate, 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate, 13 Postoperative Sepsis Rate, and 15 Abdominopelvic Accidental Puncture or Laceration Rate.
- On the overall PSI 90 composite measure, the state has worsened slightly.

Figure 14. Maryland Statewide All-Payer Performance on PSI-90 and Component Indicators, COVID Removed, CY 2021 Compared to CY 2019

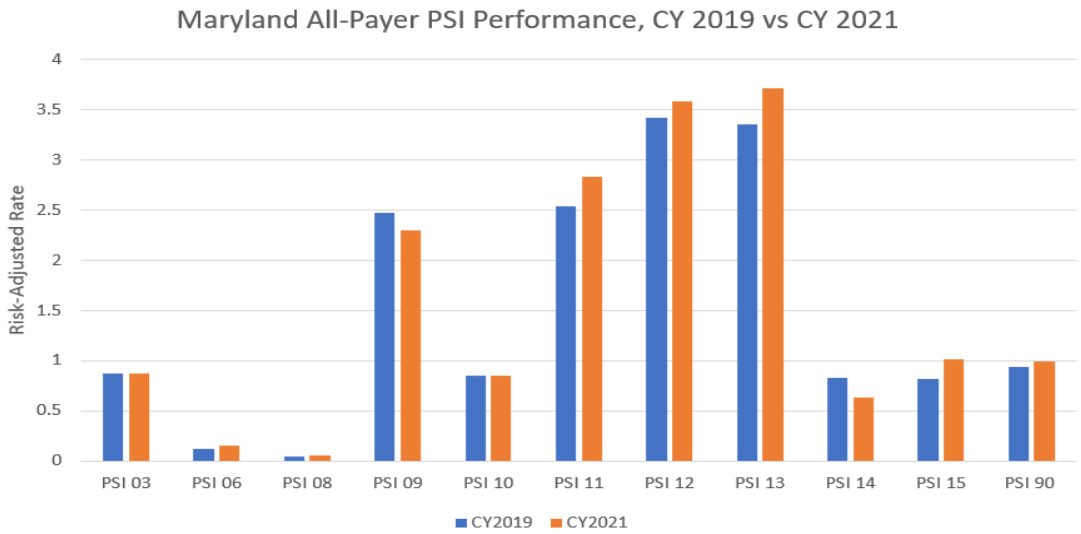
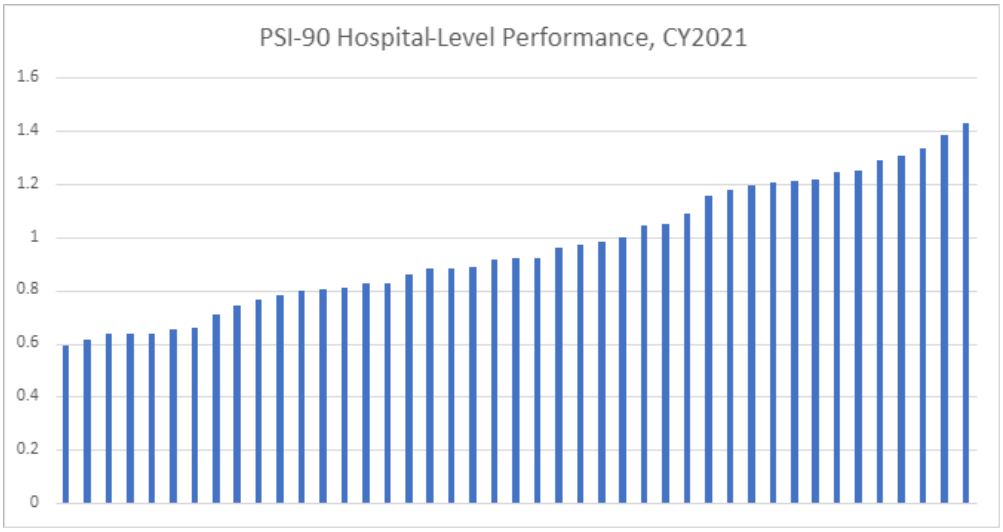


Figure 15 below illustrates the hospital-level performance on the all-payer PSI-90 composite measure for CY 2021; the variation in performance by hospital suggests there may be opportunity for improvement on this measure. However, it should be noted that this data may be impacted by the COVID PHE even though COVID cases were removed.

Figure 15. PSI-90 Hospital-Level Performance, CY 2021



Clinical Care Domain

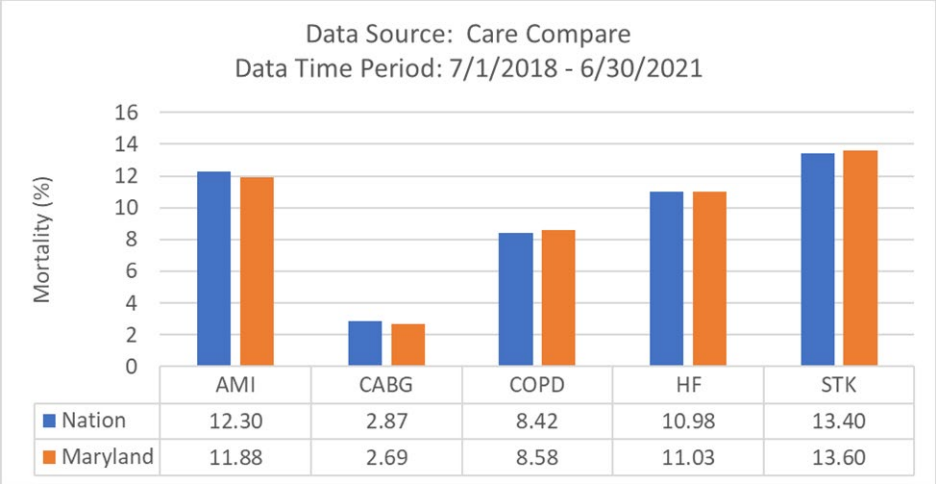
This domain, weighted at 15 percent of the QBR score, currently includes:

- A broader inpatient, all-payer, all-condition mortality measure that is weighted at 10 percent. This differs from the CMS VBP Program that uses four condition-specific, 30-day mortality measures for Medicare beneficiaries. Medicare also monitors two additional 30-day mortality measures for Coronary Artery Bypass Graft (CABG) and Stroke (STK). The HSCRC is in the process of developing an all-payer, all-cause 30 day mortality measure and recommends developing monitoring reports for RY 2025.
- The inpatient Medicare Total Hip Arthroplasty-Total Knee Arthroplasty (THA/TKA) Complications measure is weighted at 5 percent. This is also used by the CMS VBP program.

Mortality

Based on the most recently available data through June of 2021, Maryland performs on par with the nation on all five of the condition specific mortality measures (data on pneumonia was removed in the latest Care Compare release due to COVID). Specifically Maryland performs slightly better than the nation on AMI and CABG, and slightly worse on COPD, HF, and STK (Figure 16). It should be noted that this data was impacted by the COVID PHE and that the first 6 months of CY 2020 was excluded from the three year measure (i.e., the measurement period was shorter than normal).

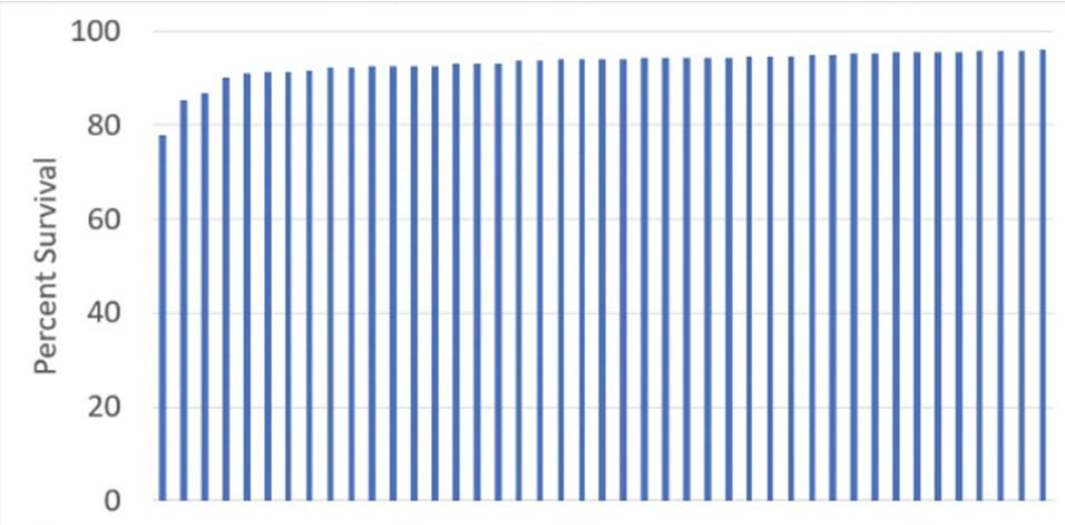
Figure 16. Maryland vs. National Hospital Performance on CMS Condition-Specific Mortality Measures



	AMI	CABG	COPD	HF	STK
Nation	12.30	2.87	8.42	10.98	13.40
Maryland	11.88	2.69	8.58	11.03	13.60

For the QBR all-payer inpatient mortality measure, which assesses hospital services where 80% of the mortalities occur (80% DRG exclusion), statewide survival rate decreased during the COVID PHE from 94.86% in the CY 2019 base period to 93.63% in the CY 2021 performance period. These mortality results modified our risk-adjustment model to add patient COVID status during admission and percent of patients at the hospital with COVID to the CY 2021 regression to better account for COVIDs impact on mortality. As illustrated in Figure 17 below, there are less than a handful of hospitals that appear to have lower survival rates, whereas most perform above 90 percent.

Figure 17. Maryland Hospital Performance, CY 2021 QBR Inpatient All Condition, All Payer Mortality Measure

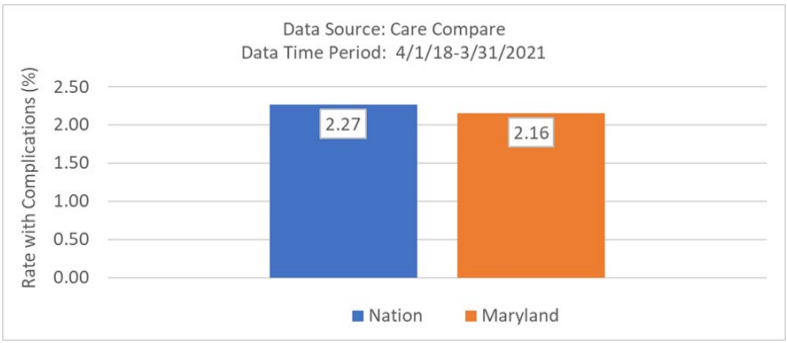


For RY 2024, staff is not proposing any significant methodology changes to the inpatient mortality measure. However, staff continue to assess impacts of COVID on the mortality measure. Furthermore, work continues to develop a 30-day, all-payer,all-cause mortality measure that can be monitored during CY 2023. Staff believe that expansion to a 30-day measure will better capture the quality of care delivered by hospitals. Last, as part of the digital measures initiative, staff plan to move the 30-day mortality measure from fully claims-based to a hybrid measure.

Hip and Knee Arthroplasty Complications

For the hip and knee complication rate measure based on the most recent data available on Care Compare, Figure 18 illustrates that, based on analysis of the weighted average rates for Maryland and the nation, Maryland performed around 5 percent better than the nation.

Figure 18. Maryland THA/TKA Measure Performance Compared to the Nation, 4/1/18-3/31/2021



Since this measure is calculated by Hospital Compare using Medicare claims data using 3-year base and performance periods 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. Although CMS reversed its action, with the previous removal of elective 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 Program should consider both payer and care setting applicability options for measure expansion.[9]

Going forward, Commission staff will work with the PMWG and other stakeholders to continue building a multiyear, multipronged, broad strategy for inclusion of outpatient measures in the HSCRC's quality programs. Specifically, for a THA/TKA measure, staff and stakeholders should explore approaches to adapting CMS's current claims-based inpatient THA/TKA measure to the all-payer population, and the feasibility, validity and reliability of specifying the eCQM version of the measure at the hospital level. Further in the future, staff and stakeholders should explore the feasibility of developing an infrastructure to collect and use a hospital-level PRO-PM for elective primary THA/TKA procedures. For additional specific details on the options for THA/TKA outpatient and all-payer measure adaption or adoption, please see the Quality Based Reimbursement RY 2024 Policy.

Electronic Clinical Quality Measures (eCQM)/ Digital Quality Measures Infrastructure

CMS Digital Quality Measures Roadmap

Like the national programs, the quality programs in Maryland provide incentives for and/or penalties for performance on quality measures, contribute to improvements in health care, enhance patient outcomes, inform consumer choice, and promote transformation to a digital health ecosystem. Over the past decade, CMS has led efforts to advance the use of data from electronic health records (EHRs) to enhance and expand quality measurement. However, accessing clinical patient data from EHRs for the purpose of quality reporting remains relatively burdensome. Additionally, CMS's current approach to quality

[9] In the CY 2022 Hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system final rule, CMS finalized the year's Medicare payment rates for hospital outpatient and ASCs. CMS paused the elimination of the inpatient only list due in part to receiving overwhelming stakeholder feedback arguing that patients' safety would be at far greater risk with a total elimination. The final rule added back to the IPO list all the services removed in 2021 except for three distinct procedures and their associated anesthesia codes. The services described by the following CPT codes will remain off the IPO list:

- 22630 (lumbar spine fusion)
- 23472 (reconstruct shoulder joint)
- 27702 (reconstruct ankle joint)
- The anesthesia codes corresponding to these procedures

measurement does not easily incorporate emerging digital data sources such as patient-reported outcomes (PROs) and patient-generated health data (PGHD). There is a need to streamline the approach to data standardization, collection, exchange, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, quality improvement, and learning.

Advancements in the interoperability of healthcare data from EHRs create an opportunity to dramatically improve quality measurement systems and realize creation of a learning health system. In 2020, the Department of Health and Human Services (HHS) finalized interoperability requirements in CMS's Interoperability and Patient Access final rule and in the Office of the National Coordinator for Health Information and Technology's (ONC's) 21st Century Cures Act final rule. Driven by the Cures Act's goal of "complete access, exchange, and use of all electronically accessible health information," these changes will greatly expand the availability of standardized, readily accessible data for measurement. Most important, CMS's and ONC's interoperability rules and policies require specified healthcare providers and health plans to make a defined set of patient information available to authorized users (patients, other providers, other plans) with no special effort using Fast Healthcare Interoperability Resources (FHIR®) application programming interfaces (APIs). The scope of required patient data and standards that support them will evolve over time, starting with data specified in the United States Core Data for Interoperability (USCDI) Version 1, structured according to the Health Level Seven International (HL7®) FHIR US Core Implementation Guide (US Core IG).

This increasing availability of structured, FHIR-formatted EHR data can be leveraged to greatly reduce long-standing challenges to quality measurement. Currently, implementing individual EHR-based measures requires providers to install and adapt measure calculation software in their respective EHR systems, which often use variable or proprietary data models and structures. This process is burdensome and costly, and it is difficult to reliably obtain high-quality data across EHR instances. Once providers map their EHR data (structured using a uniform FHIR standard) to a FHIR API to meet the Cures Act requirements, it will be possible to exchange much of the foundational data needed for measures without significant additional provider investment or effort. Learnings from these activities can be leveraged and applied to other digital data that live outside the clinical EHR, enhancing and expanding the use of data such as PRO and PGHD for quality measurement in the future. The advances in interoperability will enable development of measure calculation tools (MCTs) for digital quality measures (dQMs) that solely use EHR data, so providers will no longer need to install measures one-by-one and update them annually in their unique EHR systems. Measures can be self-contained tools executed by the provider on-site, and by multiple other key actors in measurement — including states, CMS, other payers, clinical registries, and data aggregators. This approach to measurement tools could reduce provider measurement burden, facilitate the cross-provider aggregation of data needed for high priority measures such as outcome measures, and support the alignment of measures and data across multiple agencies and payers.

Maryland, like CMS, believes that In the future, interoperability of EHR and other digital health data can fuel a revolution in healthcare delivery and advance MCTs to leverage data beyond just EHRs and across settings and providers. A learning health system powered by advanced analytics applied to all digital health data can optimize patient safety, outcomes, and experience.[10]

Near-Term Reporting Requirements

As noted earlier Maryland has implemented a statewide infrastructure and required all acute hospitals to report eCQM measures to the state. The reporting requirements are more aggressive than the national CMS requirements as Maryland believes early adoption and migration to the FHIR-formatted data and measures will constitute less burden for hospitals and provide greater opportunity for the state and hospitals to measure and improve quality. Figure 19 below illustrates Maryland and CMS reporting requirements for eCQMs.

Figure 19. CMS-Maryland CY 2022-CY 2024 Anticipated eCQM Reporting Requirements

Reporting Period/ payment determination	CMS Measures	Maryland Measures
CY 2022/ FY 2024	Three self-selected eCQMs plus Safe Use Opioids Concurrent Prescribing	Four eCQMs: Two self-selected eCQMs Two required measures: -Safe Opioids -ED-2
CY 2023/ FY 2025	Three self-selected eCQMs plus Safe Use Opioids Concurrent Prescribing Clinical data elements for two hybrid measures (beginning July 2023) -30-day mortality -30-day readmissions	Six proposed required eCQMs: -Safe Opioids -ED-2 -hyperglycemia -hypoglycemia -Cesarean Birth -Severe Obstetric complications Clinical data elements for two hybrid measures (beginning July 2023) -30-day mortality -30-day readmissions

[10] Please see CMS Digital Quality Measurement Strategic Roadmap: https://ecqi.healthit.gov/sites/default/files/CMSdQMStrategicRoadmap_032822.pdf, last accessed 8/9/2022.

Reporting Period/ payment determination	CMS Measures	Maryland Measures
CY 2024/ FY 2026	Three self-selected eCQMs; Three required eCMQs -Safe Use of Opioids -Cesarean Birth -Severe Obstetric Complications Clinical data elements for two hybrid measures -30-day mortality -30-day readmissions	Number of eCQMs TBD Required eCQMs- -Safe Opioids -ED-2 -hypoglycemia -hyperglycemia -Cesarean Birth -Severe Obstetric complications Clinical data elements for two hybrid measures -30-day mortality -30-day readmissions

The state notes that earlier adoption of a full four quarters of data on eCQMs that are consistent across all hospitals in the state will allow Maryland to publicly report these measures through collaboration with the MHCC and its quality reporting website.

In addition to the eCQM reporting requirements, Maryland will also utilize the established infrastructure to collect 30-day Hospital Wide Readmission (HWR) and Hospital Wide Mortality (HWM) hybrid measures adapted to our all-payer environment required as of July 1, 2023. The state notes that adoption of an all-payer hybrid HWM measure will allow Maryland to transition to the 30-day mortality measure from its current inpatient mortality measure under the QBR program. In addition, beginning with January 2023, hospitals may submit HWR and/or HWM hybrid measures voluntarily to the state. The required submission timeline is consistent with the CMS timeline requirements as well.In summary, Maryland's early adoption of eCQMs/digital measures will again allow the state to leverage the established infrastructure to monitor and improve quality and to progress to a less burdensome FIHR-enabled environment, and allow for earlier adoption of such measures as patient reported outcomes.

Revenue Adjustment Methodology

For this policy, staff believe it is important to have a preset method for taking scores and converting those scores to revenue adjustments on a prospective basis. However, over the course of the COVID-19 PHE this has become more and more difficult to do prospectively. Thus for RY 2025, staff propose to maintain the 0-80 percent scale where rewards start for those who score greater than 41 percent. The 41 percent cutpoint is the most difficult part to estimate as we want to set it high enough to not reward hospitals in Maryland that are performing below the national average. Normally staff would use Care Compare data

to approximate QBR scores for all hospitals nationally and set the cutpoint at the average national score over the last several years. However, staff have not repeated this analysis on more recent data due to concerns about its validity and reliability, as well as some data being wholly suppressed due to the COVID PHE. Thus staff proposes to maintain the current scale, but determine if the cutpoint needs to be amended once we have more recent complete data. If staff determine the cutpoint needs to be amended, we will report this to the Commission.

DRAFT RECOMMENDATIONS FOR RY 2025 QBR PROGRAM

1. Continue Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 50 percent, Safety (NHSN measures) - 35 percent, Clinical Care - 15 percent.
    a. Within the PCE domain, continue to include four linear HCAHPS measures weighted at 10% of QBR score; remove associated revenue at risk from top box.
    b. Within the PCE domain, add the Timely Follow-Up measure for Medicaid.
2. Develop the following monitoring reports for measures that will be considered for adoption after RY 2025:
    a. 30-day all-payer, all-cause mortality (claims based)
    b. Timely Follow-Up for Behavioral Health
    c. Disparity gaps for Timely Follow-Up
3. Implement the HCAHPS improvement framework with key stakeholders.
4. Continue collaboration with CRISP and other partners on infrastructure to collect hospital electronic clinical quality measures and core clinical data elements; For CY 2023 require submission of:
    a. ED-2 eCQM for monitoring; consider for re-adoption after RY 2025 (in CY 2024)
    b. Safe Opioid Use eCQM for monitoring
    c. Four additional eCQM measures aligned with the SIHIS goals and hospital improvement priorities
    d. Clinical data elements for 30-day mortality and readmission hybrid measures beginning July 2023
5. 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.
    a. Retrospectively evaluate 41 percent cutpoint using more recent data to calculate national average score

APPENDIX A
QBR PROGRAM BACKGROUND

Detailed Overview of HSCRC QBR Program

Maryland's QBR Program, in place since July 2009, uses 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 HSCRC 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 using 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 HCAHPS survey instrument to 50 percent. The weighting was increased to raise incentives for HCAHPS improvement, as Maryland has consistently lagged behind the nation 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. For RY 2022, ED-2b was removed from QBR because CMS no longer required submission of the measure for the Inpatient Quality Reporting Program.

Although 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 A.1 compares the RY 2023 and 2024 QBR measures and domain weights to those used in the CMS VBP Program.

Figure A.1. RY 2024-2125 QBR measures and domain weights compared with those used in the VBP Program

	Maryland QBR domain weights and measures	CMS VBP domain weights and measures
Clinical Care	**15 percent** Two measures: All-cause inpatient mortality; THA/TKA complications	**25 percent** Five measures: Four condition-specific mortality measures; THA/TKA complications
Person and Community Engagement	**50 percent** Nine measures: Eight HCAHPS categories; follow-up after chronic conditions exacerbation for Medicare PROPOSED NEW:follow-up after chronic conditions exacerbation for Medicaid	**25 percent** Eight HCAHPS measures
Safety	**35 percent** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**25 percent** Five measures: CDC NHSN HAI measures
Efficiency	n.a.	**25 percent** One measure: Medicare spending per beneficiary

Note: Details of CMS VBP measures can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019. It 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 HSCRC has placed on each domain; and (5) converting the total hospital QBR scores into revenue adjustments, using a preset scale ranging from 0 to 80 percent.

1. Domain weights and revenue at risk

As already noted, the policy weights theClinical 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 called scaling.[11] 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

[11] Scaling refers to the differential allocation of a predetermined portion of base-regulated hospital inpatient revenue based on an assessment of hospital performance.

applied on a one-time basis and are not considered permanent revenue. The HSCRC previously approved scaling a maximum reward of 2 percent and a penalty of 2 percent of the total approved base revenue for inpatients 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,[12] enabling the HSCRC to use data submitted directly to CMS. Maryland implemented an efficiency measure outside of the QBR Program, based on potentially avoidable utilization (PAU). The PAU savings adjustment to hospital rates is based on the costs of potentially avoidable admissions, as measured by the Agency for Healthcare Research and Quality's Prevention Quality Indicators and avoidable readmissions. HSCRC staff will continue to work with key stakeholders to finish developing an efficiency measure that incorporates population-based cost outcomes.

2. QBR score calculation

QBR scores are evaluated by comparing a hospital's performance rate to its base period rate, as well as to 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 roughly the 95th percentile, during the baseline period).

Attainment points: During the performance period, attainment points are awarded by comparing a hospital's rates with the threshold and the benchmark. With the exception of the Maryland mortality measure and ED wait time measures, the benchmarks and thresholds are the same as those used by CMS for the VBP Program measures.[13] For each measure, a hospital that has a rate at or above the 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: 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 the 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.

[12] VBP measure specifications can be found at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

[13] One exception is the ED wait time measures. For these measures, attainment points are not calculated; instead, the 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.

Consistency points: Consistency points are awarded only in the Experience of Care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in all 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 the national 0 percentile (floor) and the 50th percentile (threshold) and is awarded points proportionately.

Domain denominator adjustments: In certain instances, QBR measures will be excluded from the QBR Program for individual hospitals. Hospitals are exempt from measurement for any of the NHSN Safety measures for which there is less than one predicted case in the performance period. If a hospital is exempt from an NHSN measure, its Safety domain score denominator is reduced from 50 to 40 possible points. If it is exempt from two measures, the Safety domain score denominator would be 30 possible points. Hospitals must have at least two of five Safety measures to be included in the Safety domain.

Domain scores: The better of the attainment score and improvement score for each measure is used to determine the measure points for each measure. The measure points are then summed and divided by the total possible points in each domain and multiplied by 100.

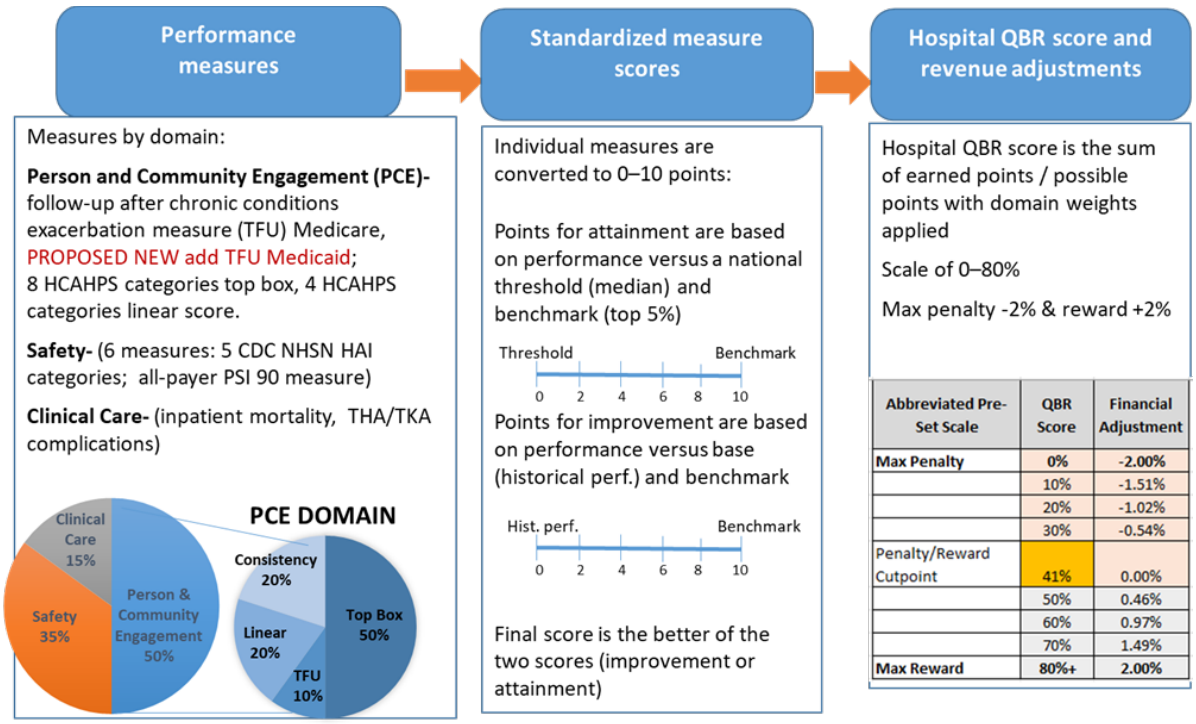
Total performance score*:* The total performance score is computed by multiplying the domain scores by their specified weights and then adding those totals together. The total performance score is then translated into a reward or penalty that is applied to hospital revenue.

3. RY 2023 and 2024 QBR Program

For RY 2023, the HSCRC did not make fundamental changes to the QBR Program's methodology but implemented the addition of the Follow-Up After Acute Exacerbation of Chronic Conditions measure and PSI-90 composite measures.

Figure A.2 shows the steps for converting measure scores to standardized scores for each measure, and then to rewards and penalties based on total scores earned, reflecting the updates for RY 2023 and proposed for RY 2024.

Figure A.2. Process for calculating RY 2024 QBR scores, and Proposed updates for RY 2025



There were no fundamental changes for the measures and domain weighting for RYs 2024 and 2025, as shown in Figure A.3.

Figure A.3. RY 2024-2125 QBR domains, measures, and data sources

	Clinical Care	Person and Community Engagement	Safety
QBR RY 24 Program	**15 percent** **2 measures** • **Inpatient mortality (HSCRC case-mix data)** • **THA TKA (CMS Hospital Compare, Medicare claims data)**	**50 percent** **9 measures** • **8 HCAHPS domains (CMS Hospital Compare patient survey)** • **Follow-Up After Acute Exacerbation of Chronic Conditions (Medicare claims, proposed add Medicaid for RY 2025)**	**35 percent** **7 measures** • **6 CDC NHSN HAI measures (CMS Hospital Compare chart abstracted)** • **PSI 90 all-payer (HSCRC case-mix data)**

a. PSI 90 measure (adopted beginning RY 2023)

Newly adopted in RY 2023, the Patient Safety Indicator composite measure was developed by the Agency for Healthcare Research and Quality in 2003.[14] CMS first adopted the composite measure in the VBP program in FFY 2015 and removed the measure in FY 2019-FY 2022 due to operational constraints from the International Classification of Diseases, Tenth Revision (ICD-10) transition. The HSCRC had used the ICD-9 version of this measure in the QBR program but applied it to Maryland's all-payer population. CMS adopted the updated NQF endorsed ICD-10 version of the measure (Medicare only) that is used beginning with the FY 2023 Hospital VBP program[15] **,** and also adopted by the QBR program (all-payer version) in RY 2023.

AHRQ's specified PSI uses include:

- Assess, monitor, track, and improve the safety of inpatient care
- Comparative public reporting, trending, and pay-for-performance initiatives
- Identify potentially avoidable complications that result from a patient's exposure to the health care system
- Detect potential safety problems that occur during a patient's hospital stay

The discharge weighted average of the observed-to-expected ratios for the following subset of AHRQ's PSIs comprise the PSI-90 composite measure:

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall With Hip Fracture Rate
- PSII 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

[14] Source: https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2020/TechSpecs/PSI%2090%20Patient%20Safety%20and%20Adverse%20Events%20Composite.pdf.

[15] For more information on the measure removal and adoption, reference the FY 2018 IPPS/LTCH PPS final rule (82 FR 38242-38244) and (82 FR 38251-38256).

PSI 90 combines the smoothed (empirical Bayes shrinkage) indirectly standardized morbidity ratios (observed/expected ratios) from selected Patient Safety Indicators. The weights of the individual component indicators are based on two concepts: the volume of the adverse event and the harm associated with the adverse event. The volume weights were calculated based on the number of safety-related events for the component indicators in the all-payer reference population. The harm weights were calculated by multiplying empirical estimates of the probability of excess harms associated with each patient safety event by the corresponding utility weights (1–disutility). Disutility is the measure of the severity of the adverse events associated with each harm (for example, the outcome severity or the least-preferred states from the patient perspective).

The PSI 90 measure scores are converted to program scores, as described in the QBR Score Calculation section of this appendix.

b. Follow-Up After Acute Exacerbation for Chronic Conditions (adopted for RY 2023)

Newly proposed for RY 2023, this measure was developed by IMPAQ on behalf of CMS.[16] Technical details for calculating measure scores are provided below.

Measure full title: Timely Follow-Up After Acute Exacerbations of Chronic Conditions

Measure steward: IMPAQ International

Description of measure: The percentage of issuer-product-level acute events requiring an ED visit or hospitalization for one of the following six chronic conditions: hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes mellitus (Type I or Type II), where follow-up was received within the time frame recommended by clinical practice guidelines in a non-emergency outpatient setting.

Unit of analysis: Issuer-by-product

Numerator statement: The numerator is the sum of the issuer-product-level denominator events (ED visits, observation hospital stays, or inpatient hospital stays) for acute exacerbation of the following six conditions in which follow-up was received within the time frame recommended by clinical practice guidelines:

1. Hypertension: Within 7 days of the date of discharge
2. Asthma: Within 14 days of the date of discharge

[16] Source: https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions

3. HF: Within 14 days of the date of discharge
4. Coronary artery disease: Within 14 days of the date of discharge
5. Chronic obstructive pulmonary disease: Within 30 days of the date of discharge
6. Diabetes: Within 30 days of the date of discharge

Numerator details: This measure is defined at the issuer-by-product level, meaning that results are aggregated for each qualified insurance issuer and for each product. A product is defined as a discrete package of health insurance coverage benefits that issuers offer in the context of a particular network type, such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity. Issuers are broadly defined as health insurance providers who participate in the Federally Facilitated Marketplaces and health insurance contracts offered in the Medicare Advantage market.

Timely follow-up is defined as a claim for the same patient after the discharge date for the acute event that (1) is a non-emergency outpatient visit and (2) has a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code indicating a visit that constitutes appropriate follow-up, as defined by clinical guidelines and clinical coding experts. The follow-up visit may be an office or telehealth visit and takes place in certain chronic care or transitional care management settings. The visit must occur within the condition-specific time frame to be considered timely and for the conditions specified in the numerator. For a list of individual codes, please see the data dictionary.[17]

The time frames for a follow-up visit for each of the six chronic conditions are based on evidence-based clinical practice guidelines, as laid out in the evidence form.

Denominator statement: The denominator is the sum of the acute events—that is, the issuer-product-level acute exacerbations that require an ED visit, observation stay, or inpatient stay—for any of the six conditions listed above (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes).

Denominator details: Acute events are defined as either an ED visit, observation stay, or inpatient stay. If a patient is discharged and another claim begins for the same condition on the same day or the following day, the claims are considered to be part of one continuous acute event. In this case, the discharge date of the last claim is the beginning of the follow-up interval. The final claim of the acute event must be a discharge to community.

An acute event is assigned to [condition] if:

[17] Please see https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions.

1. The primary diagnosis is a sufficient code for [condition].

OR

2. The primary diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].
    - If the event has two or more conditions with a related code as the primary diagnosis and a sufficient code in additional diagnosis positions, **assign the event to the condition with a sufficient code appearing in the "highest" (closest to the primary) diagnosis position**.

If the visits that make up an acute event are assigned different conditions, the event is assigned the condition that occurs last in the sequence. Following this methodology, only one condition is recorded in the denominator per acute event.

Denominator exclusions: The measure excludes events with:

1. Subsequent acute events that occur two days after the prior discharge but still during the follow-up interval of the prior event for the same reason; to prevent double-counting, the denominator will include only the first acute event
2. Acute events after which the patient does not have continuous enrollment for 30 days in the same product
3. Acute events in which the discharge status of the last claim is not "to community" ("left against medical advice" is not a discharge to community)
4. Acute events for which the calendar year ends before the follow-up window ends (for example, acute asthma events ending less than 14 days before December 31)
5. Acute events in which the patient enters a skilled nursing facility, non-acute care, or hospice care during the follow-up interval

Measure scoring:

1. Denominator events are identified by hospitalization, observation, and ED events with appropriate codes (that is, codes identifying an acute exacerbation of one of the six included chronic conditions).
2. Exclusions are applied to the population from Step 1 to produce the eligible patient population (that is, the count of all qualifying events) for the measure.
3. For each qualifying event, the claims are examined to determine whether they include a subsequent code that satisfies the follow-up requirement for that event (for example, whether a diabetes event received follow-up within the appropriate time frame for diabetes, from an

appropriate provider). Each event for which the follow-up requirement was satisfied is counted as one in the numerator. Each event for which the follow-up requirement was not satisfied is counted as zero in the numerator.

4. The percentage score is calculated as the numerator divided by the denominator.

Measure-scoring logic: Following the National Quality Forum's guideline, we use **opportunity-based weighting** to calculate the follow-up measure. This means each condition is weighted by the sum of acute exacerbations that require either an ED visit or an observation or inpatient stay for all of the six conditions that occur, as reflected in the logic below.

[NUM(ASM) + NUM(CAD) + NUM(HF) + NUM (COPD) + NUM(DIAB) + NUM(HTN)] / [DENOM(ASM) + DENOM(CAD) + DENOM(HF) + DENOM (COPD) + DENOM(DIAB) + DENOM(HTN)]

Although the development team designed the measure to aggregate each condition score in the manner described above into a single overall score, programs may choose to also calculate individual scores for each chronic condition when implementing the measure. Individual measure scores would be calculated by dividing the condition-specific numerator by the condition-specific denominator, as in the example for heart failure: NUM(HF) / DENOM(HF).

The follow-up measure scores are converted to QBR scores, as described in the QBR Score Calculation section above.

5. QBR RY 2025 base and performance periods by measure

Figure A.4 shows the proposed base and performance period timeline for the RY 2025 QBR Program.

Figure A.4. RY 2025 timeline (base and performance periods; financial impact)

Rate year (Maryland fiscal year)	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	Q1-23	Q2-23	Q3-23	Q4-23	Q1-24	Q2-24	Q3-24	Q4-24
Calendar year	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	Q1-23	Q2-23	Q3-23	Q4-23	Q1-24	Q2-24
QBR base and perfor-mance periods	BASE- CMS Hospital Compare base period (HCAHPS measures, all CDC NHSN measures)*																					
																PERFORMANCE: CMS Hospital Compare performance period (HCAHPS measures, all CDC NHSN measures)						
							BASE- inpatient mortality, PSI-90, follow-up chronic conditions															
																	PERFORMANCE: inpatient mortality, PSI-90, follow-up chronic conditions)					
							PERFORMANCE: THA/TKA Complications**															

*As described more fully in section V.I.4.b. of the preamble of this final rule, we are finalizing our proposals to update the baseline periods for the measures included in the Person and Community Engagement and Safety domains for FY 2025.

**In accordance with the CMS ECE granted in response to the COVID-19 PHE and the policies finalized in the September 2, 2020 interim final rule with comment titled "Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments(CLIA), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency," (85 FR 54820), we will not use Q1 and Q2 2020 data that was voluntarily submitted for scoring purposes under the Hospital VBP Program.

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Maryland CY 2022 Performance and Next Steps

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Update on Medicare FFS Data & Analysis

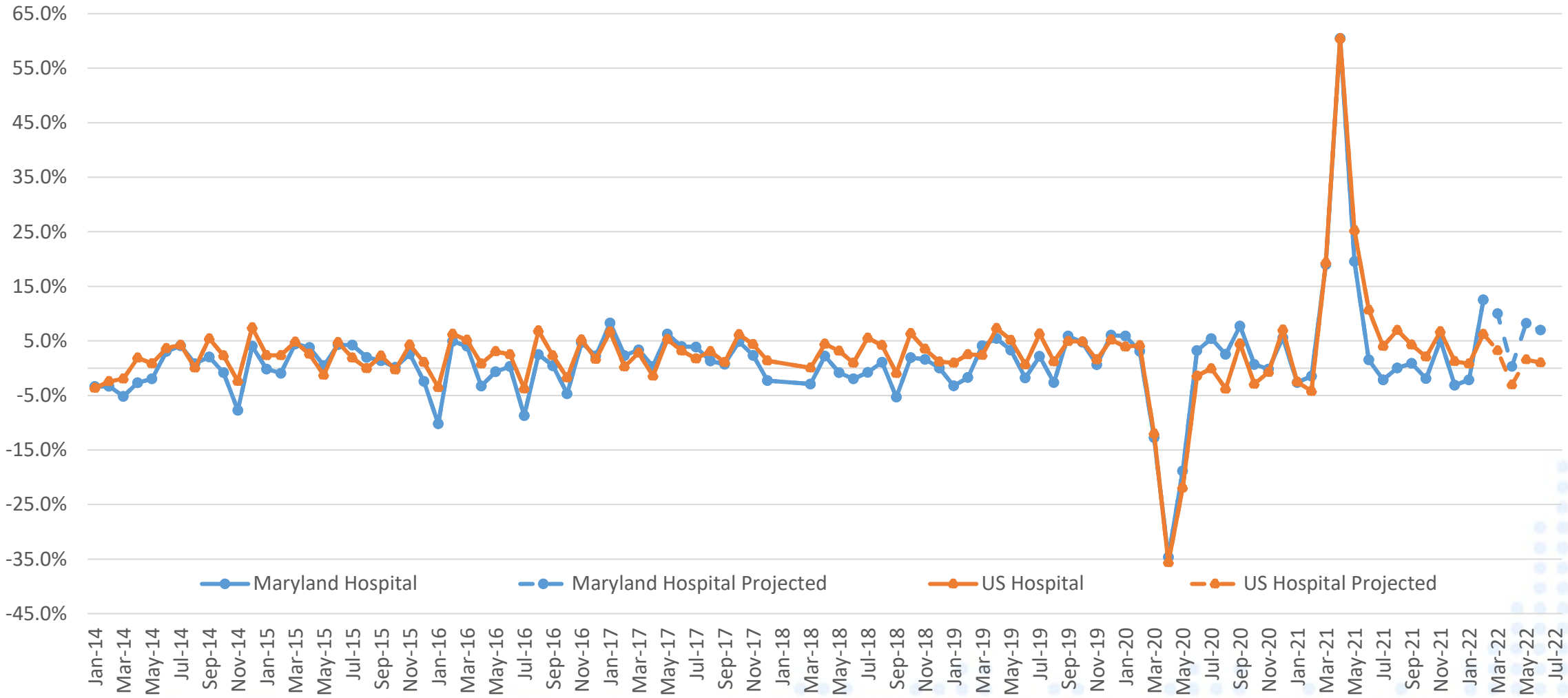
October 2022 Update

Data through June 2022, Claims paid through August 2022

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital Spending per Capita

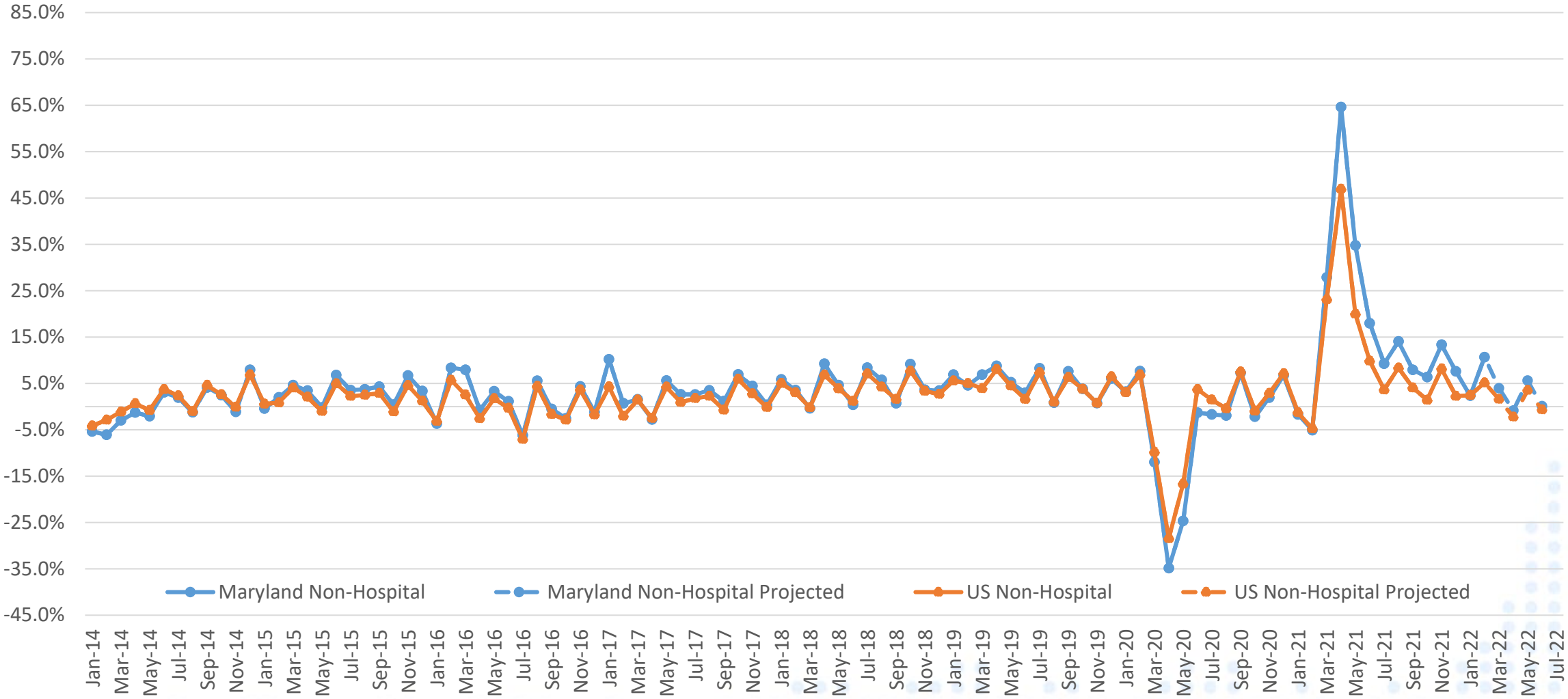
Actual Growth Trend (CY month vs. Prior CY month)



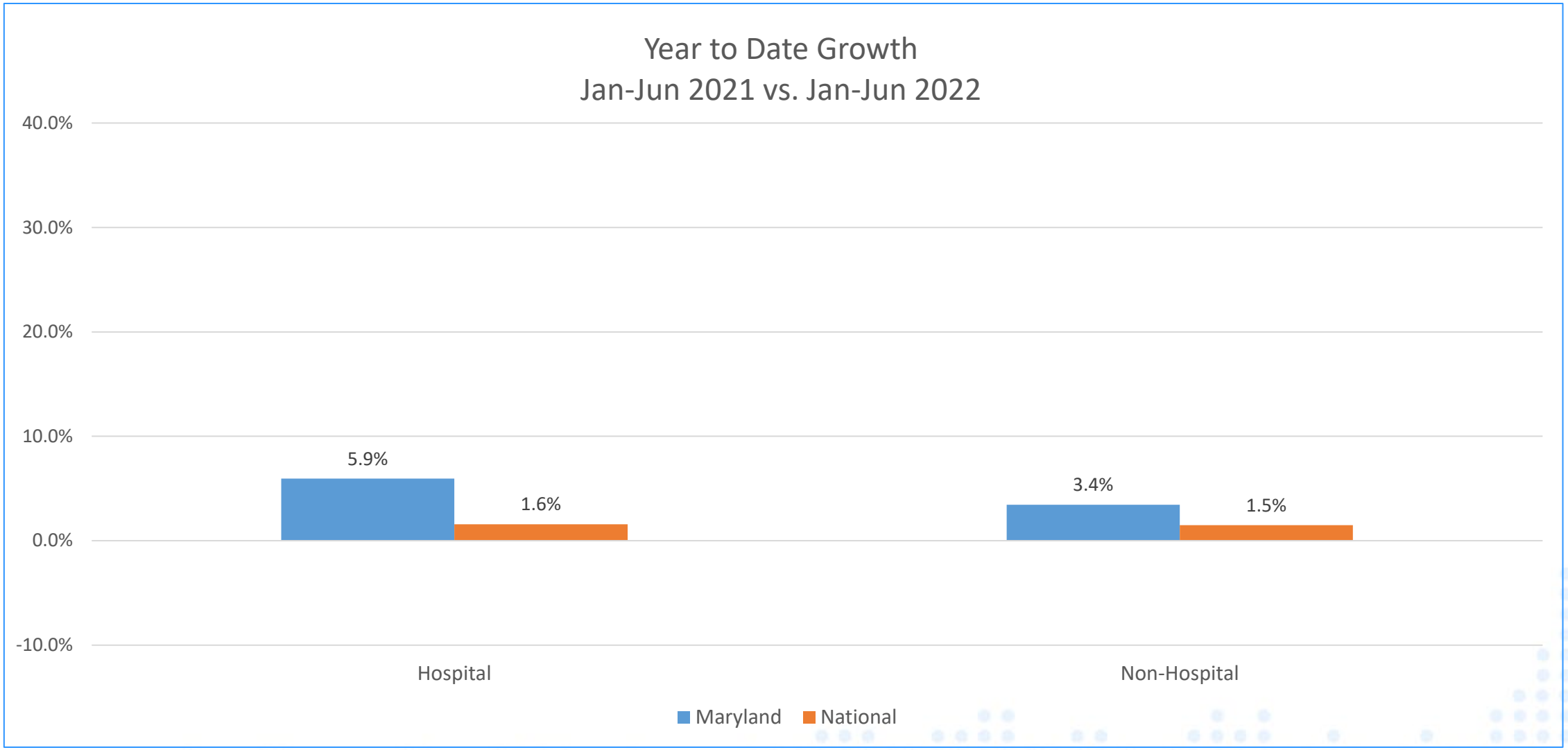
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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

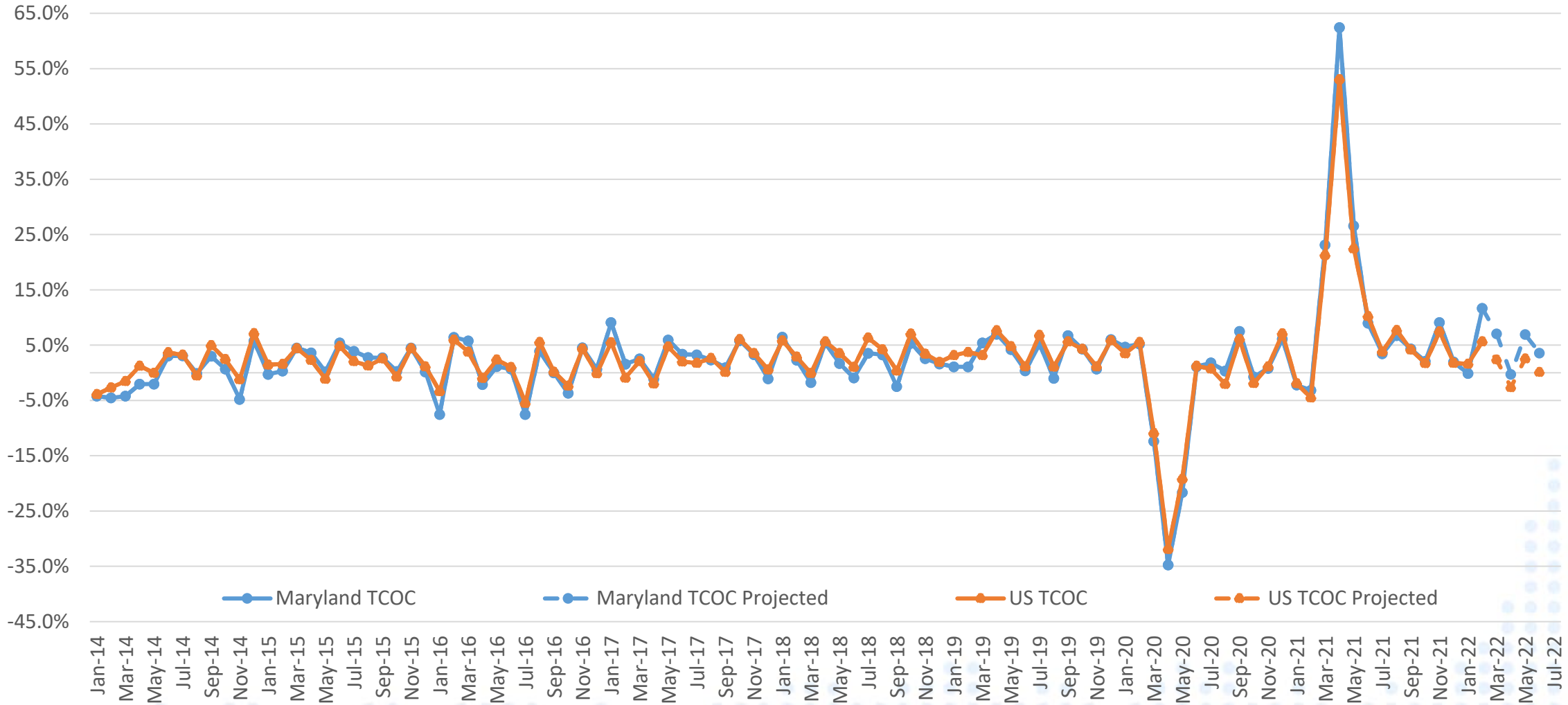


Medicare Hospital and Non-Hospital Payments per Capita



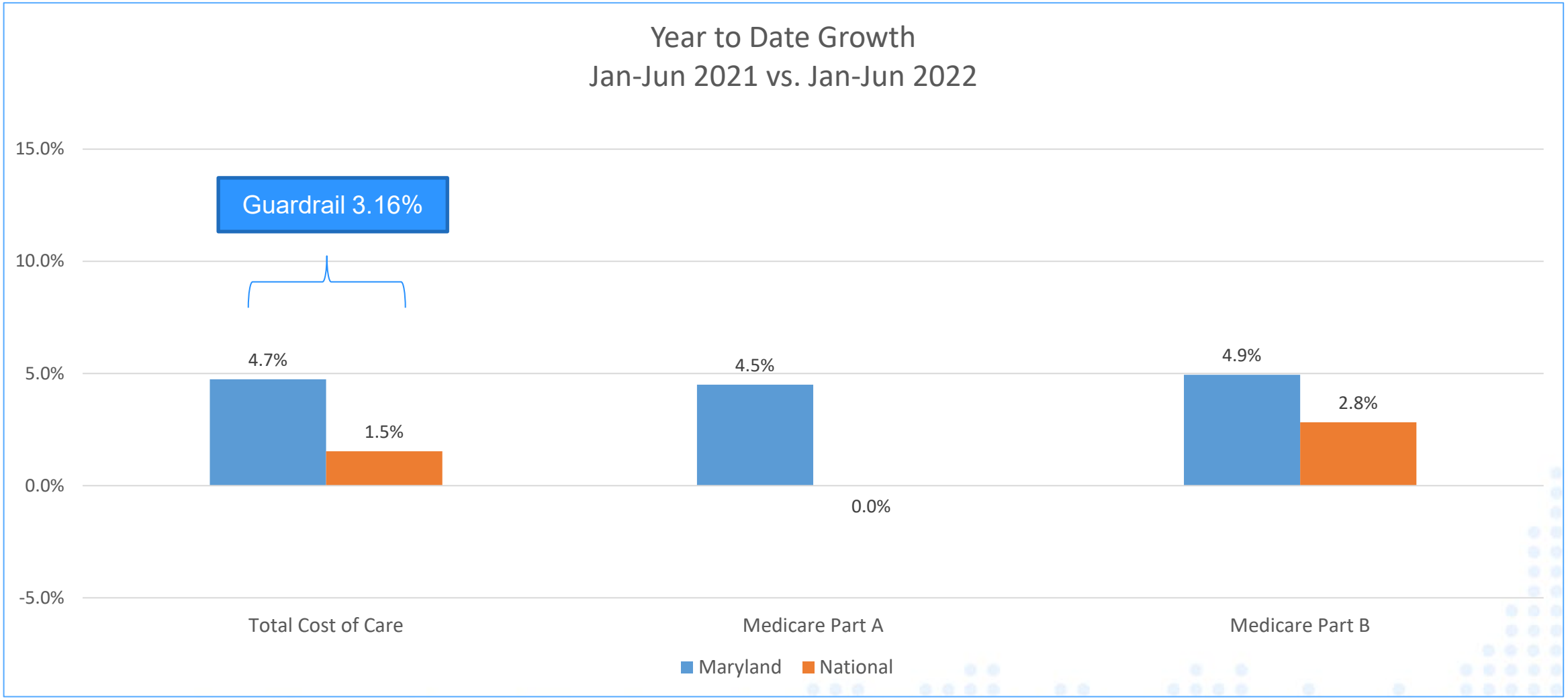
Medicare Total Cost of Care Spending per Capita

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



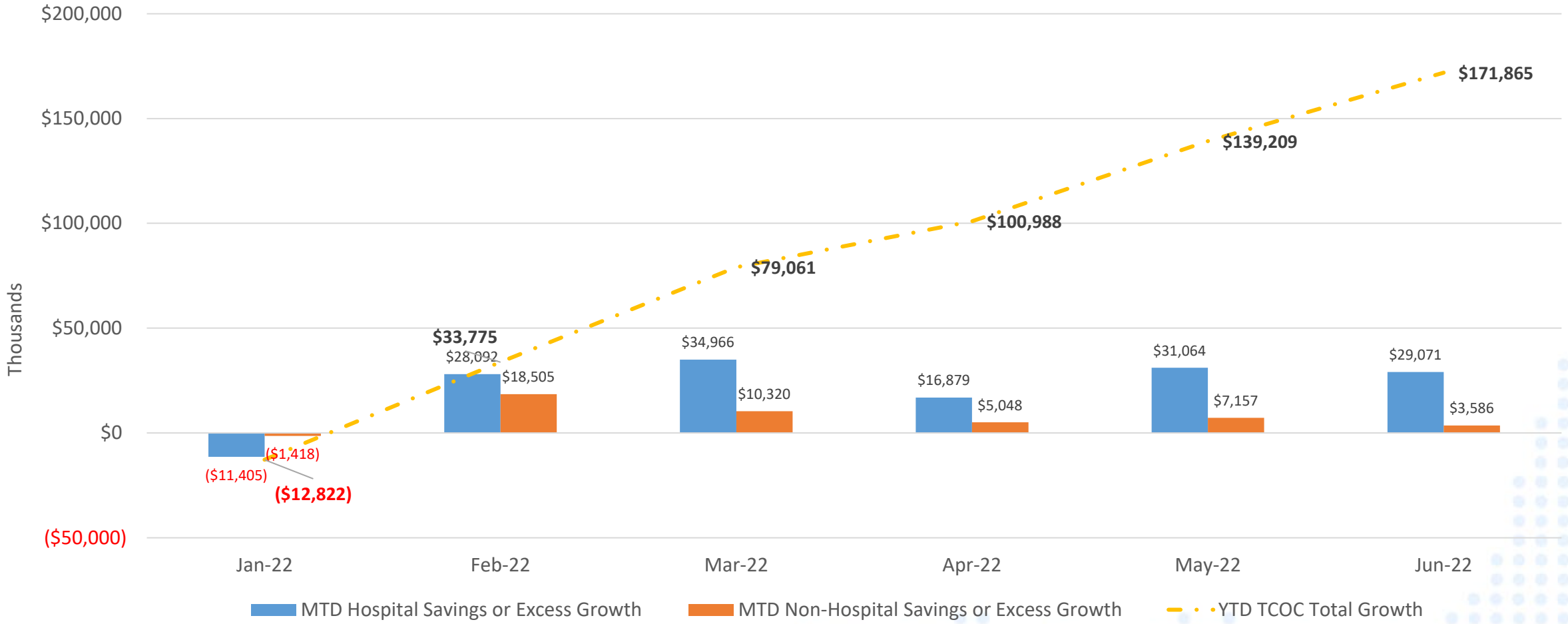
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through June 2022



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CY 22 Performance Considerations

Public Session

October 12, 2022

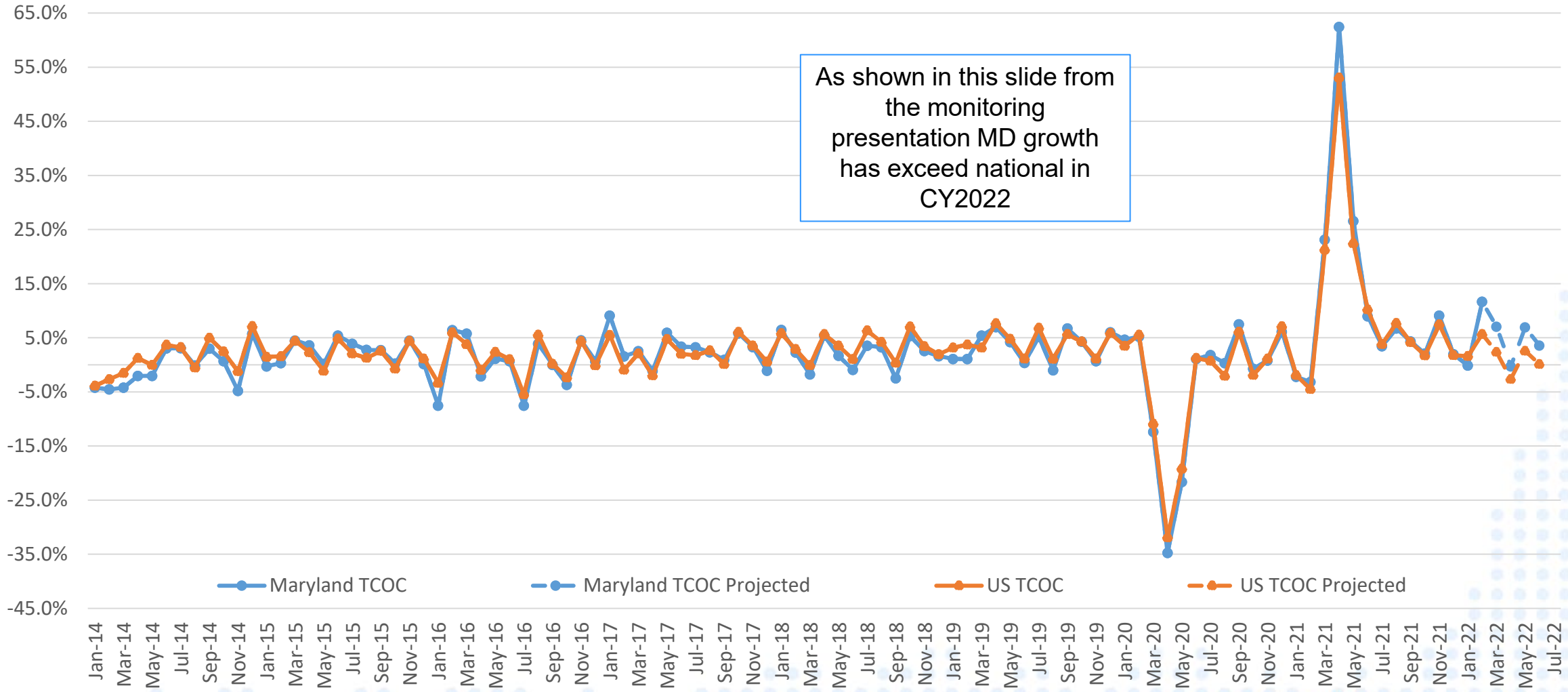
Discussion

- Analysis of Current and Projected Variance
- Model Goals and Principles
- Options for Adjusting Excess Cost Growth
- Public Testimony and Commission Discussion

Analysis of Current and Projected Variance

Medicare Total Cost of Care Spending per Capita

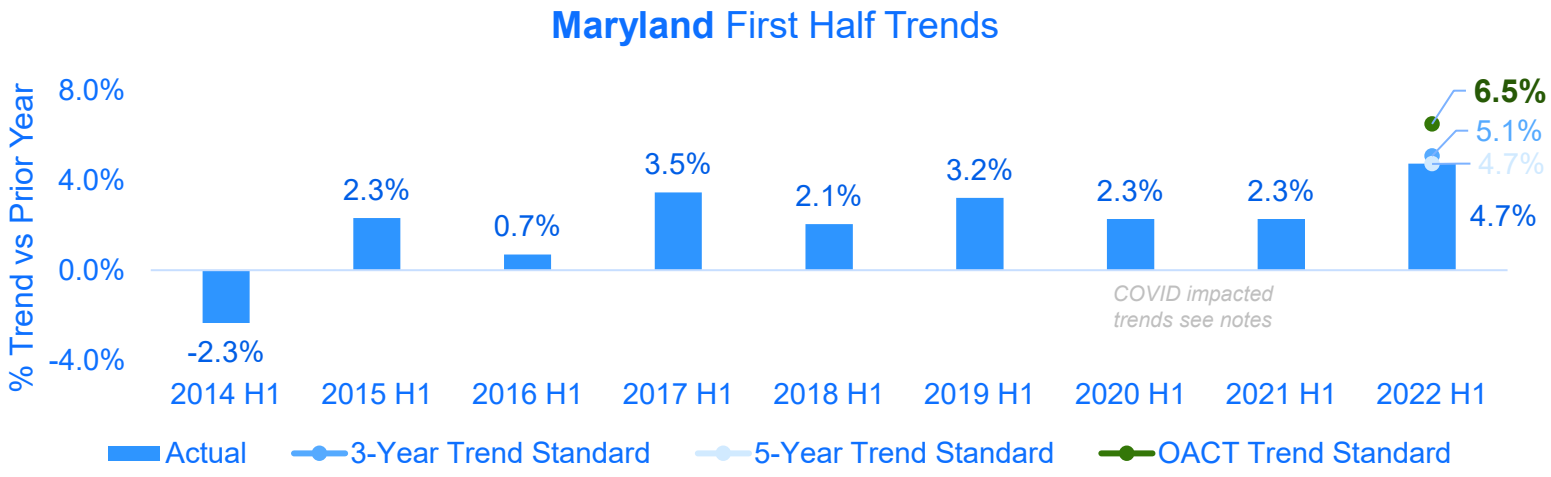
Actual Growth Trend (CY month vs. Prior CY month)

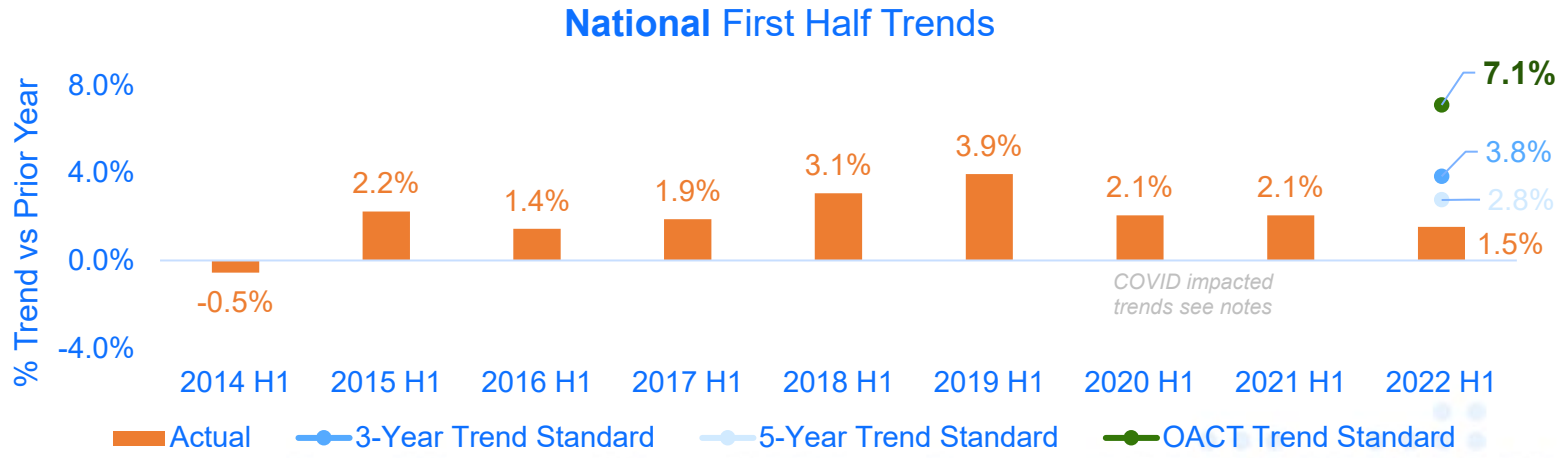


As shown in this slide from the monitoring presentation MD growth has exceed national in CY2022

CY16 has been adjusted for the undercharge

Comparison of YTD Results to Update Factor Projections



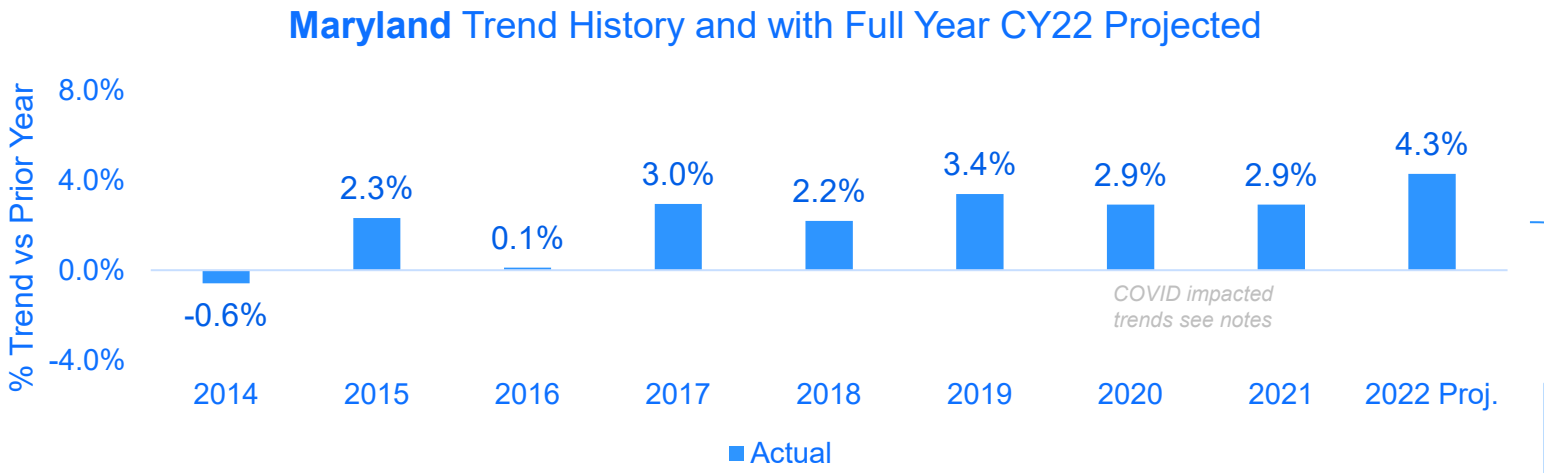


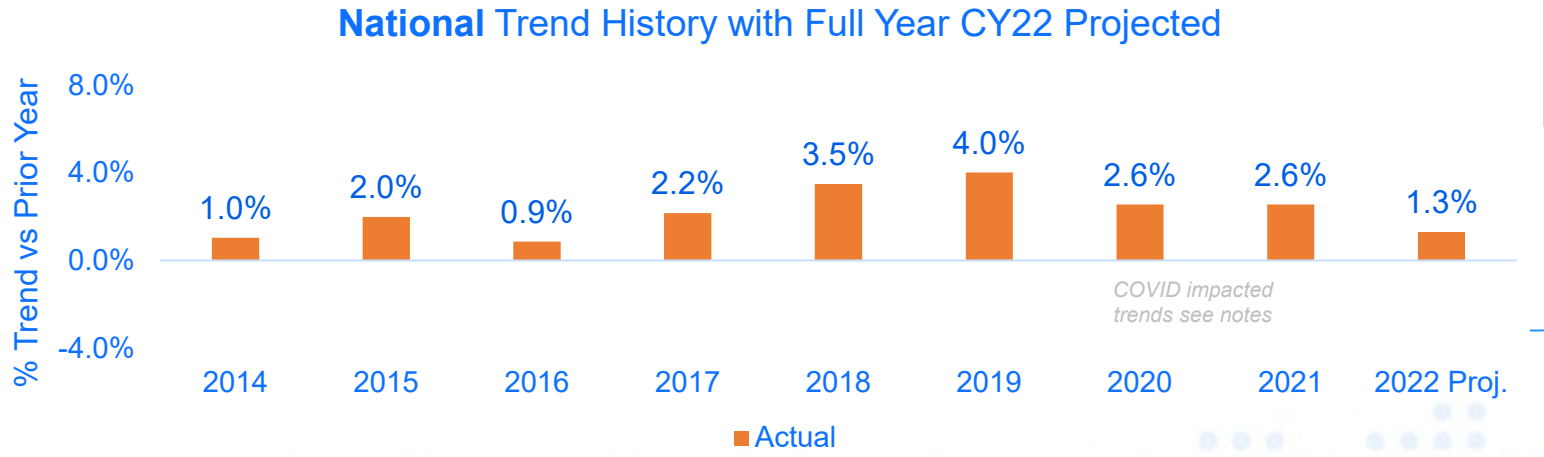
YTD 3.2% Shortfall = ~$300 M Medicare savings loss, eliminating nearly all savings

- Shortfall results national trends running lower than anticipated.
- The recommendation used a 3.25% UF. This was then combined with one-time hospital and non-hospital assumptions to yield the Maryland growth projections shown which were then compared to 3 projections of national growth.
- The final UF was approved based on the more generous OACT standard.
- OACT assumed a bounce back to offset lower 2020 and 2021 utilization by 2024 resulting in higher assumed trends. The other standards were based on trends prior to COVID but with no bounce back assumption.
- Had the Commission enforced the 3-Year Standard the UF would have been 1.3% lower (~ $130 M Medicare, ~$400 M all payer)

Notes:
1. Trends for the first half of 2020 and 2021 were distorted by significant 2020 drop in utilization therefore the values shown for both years is the average growth rate from the first half of 2019 to the first half of 2021. Annual values were as follows: MD- CY20 = -10.2%, CY21 = 16.5%, Nat'l- CY20- CY20= -9.1%, CY21= 14.6%.
2. The 3 and 5-Year trend standards were developed by Staff based on trend history and were Scenarios 1 and 2 in the final UF Recommendation (June 2021). The OACT standard comes from OACT projections and was Scenario 3 in that recommendation. Amounts may not tie exactly as the CY21 base year amounts have been slightly revised.

Projected Full Year Results





Projected 3.0% deficit similar CY22 impact to mid-year

- Projection assumes a slight recovery based on lower MD hospital spending in the 2nd half of the year.
- Projection assumes national trends continue at approximately the same rate. However, there is considerable uncertainty around national trends and CY2023 performance could vary considerably (>1% or $100 M).

* Trends for the first half of 2020 and 2021 were distorted by significant 2020 drop in utilization therefore the 2020 and 2021 values shown are the average growth rate from 2019 to 2021. Actual annual values were as follows: MD- CY20 = -3.8%, CY21 = 10.2%, Nat'l- CY20- CY20= -3.7%, CY21= 9.2%.

Projected Savings Target Outcomes

	CY 2022	CY2023
Projected Cumulative Savings		
Prior Year Savings	$380 M	$80 M
Current Year Results	($300 M)	?
Yearend Position	$80 M	$80 M
Comparison to Target		
Yearend Savings Position	$80 M	$80 M
Target	$267 M	$300 M
Excess (Shortfall)	($197 M)	($220 M)

- Assuming $300 M of deterioration in savings in CY2022 the State will be just under $200 M below target on a cumulative basis at the end of this year.
- If there is no improvement or deterioration in CY2023 the State would be $220 M below target in the CY2023, the last year of the model evaluation.

Model Goals and Principles

Model Goals and Principles

The Maryland Model, stabilized and embracing a population health approach for all providers, will serve as the nation's leader in health equity, quality, access, total cost, and consumer experience by leveraging value-based payment methodologies across all payers.

Strengths of the TCOC Model

Broad Mandate

- Fosters Accountability and Aligns Incentives Across Delivery System
- Transforms Care
- Drives Affordable Healthcare
- Improves Population Health

Flexibility

- Leverages best practices from national value-based approaches and customizes for Maryland
- Creates new programs to foster transformation
- Provider-led innovation
- Regulatory responsiveness to stakeholder feedback

All-Payer System

- Avoids cost shifting
- Provides equitable rates
- Funds uncompensated care

Global Budgets

- Incentivizes value-based care
- Provides hospitals with financial stability
- Enables diverse hospital approaches to healthcare improvement

Infrastructure Support

- Funds the Health Information Exchange
- Supports Graduate Medical Education
- Supports training for other advanced practice professionals

Cost & Quality Improvements

- Contains Growth of Hospital Costs
- APM: exceeded cost and quality expectations
- TCOC: showing a strong start

Considerations to Guide Action Steps

1. **Broad Mandate** – Commission should consider actions that support the broad mandate of the Model to drive savings and cost growth reductions, appropriately fund hospital delivery to incentivize care transformation, and identify funding of population health efforts.
2. **Recognition by State and Federal Partners** – Commission should advocate for State and Federal consideration to support Model success and appropriate corrective actions
3. **Balance All-Payer and Medicare-only savings tools** - Prioritize All-Payer tools to preserve the character of the Maryland Model, to the extent practicable
4. **Balance Temporary vs. Permanent Adjustments** – While the 'miss' in 2022 appears to be attributable to slower than expected national rebound, permanent policy adjustments should be considered if they contribute to long-term Model success.
5. **Timing of Adjustments** – The corrective action should be implemented on January 1st to spread the disruption over the entire calendar year, understanding that additional steps can be taken during the July 2023 update factor discussion to ensure compliance.
6. **Adhere to Implementation of Existing Policies** – Continue to implement existing policies, despite corrective action steps, to plan for long-term Model success.

Options for Adjusting for Excessive Growth in CY 22

Options for Addressing Excess Cost Growth

State and Federal Support

- Advocate for adjustments within the control of Governor and CMS

All-Payer Rate Reductions

- Targeted Reductions for relatively inefficient hospitals (Integrated Efficiency), with revenue for reform option in out years
- Across the board inflation reduction

Medicare-Only Adjustments

- MPA Savings Component

Public Testimony and Commission Discussion

Maryland
Hospital Association

October 7, 2022

Adam Kane, Chairman
Katie Wunderlich, Executive Director
Health Services Cost Review Commission

Dear Mr. Kane and Ms. Wunderlich,

On behalf of our member hospitals and health systems, we write in response to your request for input on Maryland's Total Cost of Care Model performance. It appears Maryland will miss the 2022 (calendar year) annual savings target and the year-over year guardrail. The main cause, volatility driven by the COVID-19 pandemic, will likely continue into 2023.

MHA and our members, the Commission, the State of Maryland, commercial payers, physician groups and other stakeholders all share the same goal: improve performance because our Model benefits everyone. Our proposal, unanimously endorsed by MHA's governing body after extensive deliberation, allocates responsibility among all stakeholders.

Please find attached the hospital field's unified proposition. It has four components:

1) The State will secure relief from the CMS Innovation Center when it measures Maryland's Model performance for calendar years 2022 and 2023.
2) Reverse HSCRC-approved one-time adjustments, suspend the Medicaid deficit assessment for one year, and raise the public payer differential 1%.
3) Collaborate to establish clear mutually agreed policy aims and then set a plan to revise payment policies accordingly.
4) Reduce hospitals' Medicare payments by $25 million effective January 1, 2023, using a formula tied to HSCRC's efficiency policy.

Hospitals take very seriously our role in securing the Model's future. All parties in the state must come together to help overcome the immediate challenge and to make the Model sustainable for the long term.

Hospitals truly value our longstanding partnership with HSCRC and we appreciate your support during this difficult time. If you have any questions, please contact me.

Sincerely,

Bob Atlas
President & CEO

6820 Deerpath Road, Elkridge, MD 21075 ▪ 410-379-6200 ▪ www.mhaonline.org

Maryland Hospital Association
Position on 2022 Total Cost of Care Model Performance
October 7, 2022

Maryland will miss our calendar year 2022 Medicare total cost of care savings target. In response to HSCRC's September 27 request for public comments to improve performance, the hospital field proposes the actions below to close this gap. The actions are presented as a hierarchy, beginning with seeking protection under the exogenous factors clause and ending with hospital payment reductions.

1) **Maryland should formally ask CMMI to adjust Maryland's Total Cost of Care Model CY2022 and CY2023 targets—or savings performance—for COVID-19 and its aftershocks, as an exogenous factor.** The poor CY2022 performance isn't because Maryland hospitals have done something wrong. Rather, national Medicare growth is far lower than CMS forecasted (1.7% versus 7.1%) and HSCRC temporarily boosted rates but will reverse those measures. We ask the following:

    a. CMS would accept Maryland's actual end-of-CY2022 savings performance as fulfilling the contractual requirement. Thus, no corrective action for CY2022 performance would be called for.

    b. CMS would also adjust CY2023 performance if national Medicare growth does not rebound.

    c. There will be no changes to the CY2024-CY2026 savings targets specified in the August MOU. Maryland expects on-goal performance to return by the end of 2023, provided that HSCRC and the hospital field can agree upon some basic adjustments to payment policies (see part 3).

    d. During 2023, if it appears the Model savings measures need permanent restructuring because of the ongoing effects of the pandemic, Maryland and CMMI will collaborate to amend the contract.

    HSCRC is already asking CMMI for an exogenous factors exemption because Maryland failed our 2021 statewide readmissions target. Moreover, there are precedents for CMMI and CMS to adjust performance for extenuating circumstances. Notably, CMMI adjusted performance targets in the Vermont demonstration and offered to suspend targets in the Pennsylvania rural hospital model due to the COVID pandemic.[1]

[1] MHA is preparing a document for HSCRC that itemizes specific contract provisions that should be modified, cites relevant precedents, and justifies our ask.

2) **Apply a combination of adjustments to reduce the savings gap.** Notwithstanding the above, Maryland hospitals do not shy away from appropriate individual and collective accountability in accordance with the Model's terms. Hospitals recognize that Maryland's savings performance must improve. Our proposal responds to HSCRC's call for immediate action, combining temporary and permanent adjustments, and acknowledging that long-term policy solutions are needed. The adjustments are summarized in the table below, followed by an explanation of each.

Excluding the reversal of one-time adjustments, $40 million is a conservative estimate of savings by the end of 2022. Medicare is raising inpatient payments in all other states on October 1 and Maryland has consistently outperformed the nation in the latter half of each calendar year. If Maryland's 2022 target is $267 million, then it seems a $227 million performance improvement plan is needed to get back on track by the end of 2023.

Combined Adjustments to Restore Savings

	Estimated Medicare Savings Improvement ($ millions)		
Action	**Temporary**	**Permanent**	**Total**
Reverse $100m advance and undercharge support		101	101
Suspend Medicaid deficit assessment in 2023	100		100
Raise the public payer differential by 1%		26	26
Total			**$227**

a. **Reverse one-time rate actions as planned.** HSCRC has added nearly $300 million to rates in CY2022, creating the *appearance* that our costs are high. All temporary support will be reversed by year's end, improving our Medicare results by $101 million. This includes:

   i. Removing $100 million of CY2022 advance. $200 million July 1 reduction to reverse *and* pay back the amount.

   ii. Removing CY2022 support for previous undercharges. $118 million in first half of CY2022, reversed and replaced with $96 million in second half. Average support of $107 million for the year.

   iii. Assuming Medicare is one-third of the total, the net Medicare savings improvement is $101 million. ($200 x 33% + $107 x 33%) = $101.

b. **Temporarily suspend the Medicaid deficit assessment.** Maryland can afford to pause the assessment for one year. This gives time for national trends to stabilize and for Maryland to devise long-term policy adjustments to meet agreed-upon 2024-2026 targets.

The enhanced federal Medicaid match continues along with the public health emergency. The State budgeted expecting the match to return to 50% in FY2023, so this adds to Maryland's large budget surplus. The State should use some of this surplus to zero out the deficit assessment in CY2023. The assessment is almost $300 million, so Medicare savings would improve by $100 million.

c. **Raise the public payer differential by 1%.** With CMMI's approval, HSCRC can raise the differential by 1%. An increase in the differential of 1% yields approximately $25-30 million of Medicare savings.

   Maryland is more than 15% favorable compared to our *all-payer, per capita hospital* growth limit, yet we are going over our Medicare total cost of care cap. Some rebalancing is needed. Private payers in Maryland get a very good bargain on hospital prices. Outside of Maryland, hospitals are pushing aggressively for higher commercial insurance payments.

   This will not materially alter the all-payer nature of our system. After the increase, commercial payers in Maryland would pay 8.7% more than public payers. Outside of Maryland, commercial payers, on average, pay 60% more than public payers.

3) **Collaborate with HSCRC to propose payment policy revisions**. Hospitals and HSCRC agree that policy changes are needed, and hospitals applaud HSCRC for opening a two-way dialogue with commissioners at a public meeting. *Public policy must not be changed without full deliberation, transparency, and full advance approval by the cognizant authority.* There is HSCRC precedent for this approach.[2]

   Beginning with the October public meeting, we ask two things of HSCRC. First, Commissioners should set a policy strategy with clear aims linked to Model incentives before revising policies. Second, Commissioners, aided by HSCRC staff, should engage with the hospital field to process policy options to achieve the key aims.

   Hospitals would like to engage with the Commission on five key policy areas, listed below.

   a. **A stable way to address efficiency and retained savings, both removal and redistribution.** Hospitals and HSCRC should collaborate to accomplish shared goals – to appropriately remove revenue from the system to improve Model performance and to redistribute resources so hospitals all have adequate revenues to serve their populations.

[2] In the late 1990's, HSCRC's system correction factor spurred a two-year dialogue to agree on new HSCRC vision and supporting policies. HSCRC adopted its charge-per-case system, the new inter-hospital cost comparison (ICC) and other important foundational policies during this period.

Specific examples include revising the market shift policy and creating a stable measure to use for annual, scaled efficiency adjustments and specific adjustments if a hospital files a full rate application.

We also need fair and simple ways to remove revenues from GBRs when services are deregulated and when hospital volumes fall past a certain point. HSCRC never implemented these mechanisms, so one-off negotiations are required for every transaction.

b. **A single total cost of care growth incentive.** Maryland is accountable for total Medicare spending in our contract. The current version of the Model calls for hospital-specific accountability. HSCRC has three separate policy tools to hold hospitals accountable for total cost of care: Medicare Performance Adjustment, Care Transformation Initiatives, and the benchmarking component. There should be a simple way, that all stakeholders can trust, to incentivize performance. Modifying the population attribution algorithm must be a part of this change.

c. **Accountability for population health investments and outputs.** Hospitals agree that we must be accountable for some level of population health investments. Our first step is defining population health – what is it, what do we want to accomplish, how do we measure it and why? Measures and incentives must be negotiated, not dictated by HSCRC staff. For example, HSCRC must acknowledge that a broad range of physician subsidies are legitimate population health investments.

d. **Stronger incentives to align service capacity.** When HSCRC began system redesign in the late 1990's, it focused on ways to remove excess capacity. As the regulatory body, HSCRC should reinforce existing incentives and potentially add short-term dollars to gain long-term savings. Using HSCRC's Bond Indemnification Program to retire the debt in a hospital closure is an example of a power existing incentive to assist in this goal.

e. **Assess potential changes to incentives to reverse Maryland's length-of-stay (LOS) growth.** Hospitals everywhere are seeing longer LOS. Case mix (patient acuity) is rising, and hospitals very often cannot discharge patients to post-acute or behavioral care settings because of capacity problems there. In 2021 and into 2022, Maryland's LOS rose faster than the nation's. Under MS-DRG payment, hospitals have powerful incentives to minimize every inpatient's LOS. Those incentives have grown as variable costs (labor and supplies) have risen.

   We will work with HSCRC to develop a suitable policy response, including appropriate risk adjustments to account for a change in service mix.

4) **Medicare Payment Cut.** To demonstrate our commitment to the Model's success, going beyond the proposition stated above, the hospital field will accept a reduction in

Medicare payments of $25 million in aggregate on January 1, 2023. This amount is equal to one-half the aid the General Assembly provided in 2022 to address hospitals' critical workforce issues. This reduction will improve Maryland's performance, and there will remain the opportunity to revisit as more data become available. Coupled with other actions, Maryland's performance would improve by more than $300 million in 2023.

Against the backdrop of continuing financial challenges, hospital leaders agree that we must all share the burden of performance improvement. More than half of Maryland's hospitals reported negative operating margins in 2022. This incremental measure—a *permanent reduction* in the face of what appears to be a short-term performance concern—demonstrates the Model's value to hospitals and our patients.

We justify reducing Medicare payments only using the same reason for raising the public payer differential: Maryland is well ahead on its all-payer hospital performance.

We ask HSCRC to refrain from even considering any further cuts until full CY2022 data are final. Moreover, hospitals will work with commissioners and staff on a plan to better align all payment policies to put incentives and regulatory demands into proper order. MHA and HSCRC jointly should examine this adjustment in conjunction with the rate year 2024 annual payment update.

We propose the following, effective January 1, 2023:

a. $25 million permanent Medicare payment reduction, calculated as follows:
    i. Apply 25% of reduction to all hospitals, proportioned on all-payer charges.
    ii. Apply 75% of the reduction using the latest published efficiency policy. The scaled amount applies progressively to hospitals from most efficient to least efficient.
b. The reduction is to Medicare payments only, applied using the HSCRC Medicare Payment Adjustment – Savings Component (MPA-SC). MHA and HSCRC will address MPA-SC mechanics to make the reduction permanent.

Charlene MacDonald
Senior Vice President,
Chief Government Affairs Officer

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
Tel. 202-680-5207

October 7, 2022

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

Dear Chairman Kane:

CareFirst BlueCross Blue Shield (CareFirst) appreciates this opportunity to provide commentary on potential corrective action the State might take to comply with financial targets under the Total Cost of Care (TCOC) Model contract and ensure its success into the future. CareFirst is proud to be an active participant and stakeholder in the TCOC Model. We continue to prioritize doing what is right and best for Marylanders while looking for opportunities to collaborate across the healthcare ecosystem to achieve the improvements the patients and communities we collectively serve deserve. We are committed to working through current performance challenges with HSCRC, our hospital industry partners, and the Center for Medicare and Medicaid Innovation (CMMI).

This period of uncertainty we have been living through has made innumerable changes to the healthcare system and makes projections about the future much more challenging, while also presenting opportunities to refresh our approach. While Maryland's total cost of care growth in 2021 and 2022 outpaced that of the nation, we need to understand both the drivers and the outlook as we look toward the future. It is clear the general population is utilizing the delivery system differently today than before the COVID-19 pandemic, rendering some previous assumptions obsolete. We need to remain nimble and continue to respond to and anticipate our patients' and members' demands, but we need to incorporate new ways of thinking and respond to our new reality. For example, we recognize the financial challenges caused by the national labor crisis as the pandemic exacerbated the nursing shortage. The regulatory system in Maryland enabled HSCRC to make some adjustments in 2020, 2021, and 2022 that provided stability and flexibility to hospitals, which helped to preserve access. Simultaneously, households continue to face inflationary pressures not seen in years. The net effect of these and several other dynamics though must be addressed to preserve our Model.

CareFirst believes HSCRC should act to acknowledge the State's commitment to its contract with CMMI. The TCOC Model is a key enabler of our healthcare system, and we need to get back on track with prior years' performance. Because all-payer rate-setting and equity among purchasers are fundamental tenets of the Model, it is appropriate that any adjustment to global budgets apply across payers. We request that HSCRC evaluate the ability of Maryland hospitals to withstand the full adjustment required to deliver the necessary estimated rate correction for Medicare. If HSCRC's evaluation calls into question access and stability, we should explore alternatives at that point.

As we think about the current state of the TCOC Model, we would like to offer our thoughts on future policymaking, guiding principles, and Model objectives.

- **The State should develop a health outcomes dashboard, improvement targets, and track progress on those goals.** To date, dollars have been provided to invest in population health, either through infrastructure funding or retained revenue. Staff advanced the Revenue for Reform policy, but it has yet to be approved. There is a lot of conversation about how dollars are being spent and whether those investments are appropriate, or creditable. Further, there is little detail available about the nature of these investments, their effectiveness, nor their appropriateness when evaluated against community needs. The Model seems to be using total cost of care as a proxy for population health, and otherwise tracking hospital-based quality metrics. If the industry collectively agreed upon statewide population health goals or commitments, the investments and spending would be less important because the outcomes would become the focus. Performance could be measured and incentivized by region to facilitate greater collaboration.

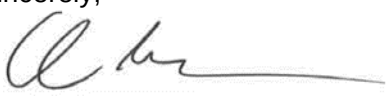
- **Cost efficiency should be examined and required.** With capped revenue budgets beginning in 2014, hospitals theoretically increased their focus on costs years ago. However, none of the HSCRC's current policies seeks to determine whether cost structures are efficient. It seems the industry could benefit from collaboration and streamlining. We have several different hospitals treating overlapping populations but developing separate population health strategies and employing duplicative teams. Population health in particular is a function that should be coordinated to best benefit the patient. Introducing a tool to hold hospitals accountable would facilitate collaboration and provide evidence of funds being spent for the benefit of patients. One such tool used in health insurance regulation is the medical loss ratio, which enforces that at least 85% of premium dollars are spent on care costs.

- **The delivery system should be updated to meet community needs.** As avoidable hospital utilization has declined, retained revenue has accumulated along with empty hospital beds. We should evaluate both whether retained revenues should continue to be inflated and how retained revenues can be used to repurpose existing space and deliver enhanced value for the same total cost of care. Communities still want and need to access healthcare; they are just changing how they consume care, and the delivery system should reflect that.

- **To narrow disparity gaps, the State should study the appropriateness of resource allocation.** Outcome and quality metrics look drastically different in various parts of the State. Similarly, performance is often evaluated at the aggregate level, which ignores gaps between subpopulations. To close gaps, we need to unearth them and consider them in funding mechanisms. Public health has taught us a lot, especially of late, about the impact of social determinants of health on outcomes. We need to be measuring and redistributing funds in acknowledgement of and based on these factors.

CareFirst appreciates the opportunity to provide commentary on the potential corrective action ahead. We are committed to working through this challenge alongside our industry partners.

Sincerely,



Charlene MacDonald

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WVU Medicine

GARRETT REGIONAL MEDICAL CENTER

October 7, 2022

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

Dear Chairman Kane and Executive Director Wunderlich:

Garrett Regional Medical Center (GRMC) submits the following comments in response to the request from the Health Services Cost Review Commission (HSCRC or the Commission) for input from stakeholders regarding (1) potential corrective action steps that the State should take to ensure compliance with the Total Cost of Care Model contract (the Model); and (2) potential policy corrections that will set the State up for long-term success.

GRMC is uniquely situated to provide these comments as the longest standing Maryland hospital to operate under a global budget model, which has been in place at GRMC since 1987, as well as its standing as the most price-efficient hospital in the State and its superb track record on quality.

GRMC supports the proposition offered to the HSCRC by the Maryland Hospital Association (MHA), particularly in light of the MHA's proposal that 75% of the Medicare payment reduction would be scaled based on the most recently published efficiency policy. Notwithstanding, GRMC respectfully requests that the Commission strongly consider policy corrections or other solutions to adequately address the challenges faced by Maryland's rural hospitals in order to ensure the sustainability of these hospitals and of the Model. Maryland created the global payment system in an effort to create an alternative to our country's traditional and untenable approach to healthcare. The Maryland model should continue to evolve as the HSCRC strives to help hospitals provide the best care possible to Maryland's citizens. While the system has worked well for many hospitals, particularly larger systems in the state's more populated regions, it has become clear that the global payment system needs to be adjusted in order to better serve the state's rural communities.

GRMC believes that the Model's long-term success depends entirely upon the Model being sustainable for ALL Maryland hospitals and ALL Maryland patients. GRMC is concerned that certain Commission policies are not aligned with its goals of ensuring access to high quality, low cost care for all Marylanders, and changes must be made to ensure that all hospitals—including GRMC—have the resources they need to serve their populations in accordance with Maryland law and the Model.

GRMC faces unique challenges as a rural sole-community hospital.

GRMC is an award-winning Joint Commission accredited acute care facility with 55 inpatient beds in Oakland, Maryland, which is in Maryland's westernmost county. GRMC serves a population of 46,000 within Garrett County and surrounding communities in Maryland, Pennsylvania, and West Virginia and is

the sole community provider of nearly all outpatient diagnostic, inpatient, rehab, and emergency medical services. Originally established in 1950, the hospital has continuously evolved to advance the health and wellness needs of the region. As a member of the WVU Health System, GRMC offers comprehensive health care services unique to a rural location that has no other option for healthcare services within an hour travel distance.

GRMC serves a disadvantaged patient population. For example (and according to published HRSA data), 34.7% of people in Garrett County live below 200% of the federal poverty level, and, of those, 36.4% have incomes below 50% of the federal poverty level. The individual income for that 36.4% is $6,070 annually. In contrast, in the state of Maryland overall, 22.3% of the population lives below 200% of the federal poverty level. In addition, 23.6% of Garrett County's population is enrolled in Medicaid, while 19.9% of the state's population participates in Medicaid. The poverty and Medicaid numbers are worse when considering the hospital's total service area (including West Virginia and Pennsylvania). 70% of all births at the hospital each year are Medicaid recipients, and the hospital's service area also has relatively large Amish and Mennonite communities who do not carry health insurance.

Garrett County is also a designated Medically Underserved Area (MUA) and is a designated Health Provider Shortage Area. The community needs the leadership of the hospital to make necessary investments in the healthcare network and population health initiatives, which it has done to ensure access to care and to address the health disparities and the social determinants of health for this disadvantaged population.

GRMC has a demonstrated track record on efficiency and quality.

By the most recently published HSCRC efficiency model, GRMC is the most price efficient hospital in the state and ranks in the top quartile of Maryland hospitals overall. The hospital has embraced the Maryland Total Cost of Care model and has a demonstrated history of low cost and high quality. For example, the hospital's FY 2021 quality data is superlative:

- In state, case mix adjusted readmission rate 5.77% #1 position in state
- Out of state case mix adj readmission rate 8.79 #1 position in state
- Maryland Hospital Acquire Conditions Score 97% #1 position in state
- Zero catheter associated Urinary tract infections in over five years
- Zero central line associated blood stream infections in over seven years
- Zero NHSN reportable surgical site infections in 2022
- Zero C-section infections in over five years
- Top-20 NRHA Rural and Community Hospital in 2021 and 2022
- Top 100 NRHA Rural and Community Hospital for last 5 years in a row
- Leapfrog Patient Safety Grade rating of "A" for last three consecutive years in a row
- Skilled Nursing Unit designated as 5-star from US News and World Report for last eight consecutive years.

Despite (and perhaps due to) its success under the Model, GRMC faces extreme financial pressures.

Due to the low price structure of the hospital, GRMC does not have the ability to absorb the current financial challenges of the economic environment and is unable to break even. To retain staff and avoid a mass exodus during the pandemic, GRMC had to increase the minimum wage to $15 per hour and

implement market adjustments to address compression issues for the rest of the staff to bring the hospital up from the 20th percentile toward the median in the latest MHA salary survey data.

Despite achieving success under the Model, our efficient and high-performing hospital is beginning to close services in order to avoid a rapid spend down of its cash reserves. Because GRMC is no longer able to maintain its services, nor invest in improving access to care, the overall health of this already underserved population will begin to deteriorate.

As hospital services begin to shrink and close, the result will predictably be a higher incidence of unmanaged chronic disease conditions, especially for a rural population like ours where alternative care options are often up to an hour away. Patients do not have the resources to travel for preventive services but will be forced to seek care as a result of health complications. This will result in poorer health outcomes as well as patients seeking care in a higher-cost hospital emergency department and with increased severity of illness.

Long-term solutions are needed for Maryland's rural hospitals, including GRMC.

While I understand and appreciate the far-reaching negative financial consequences that the pandemic has had to Maryland hospitals state-wide, as well as the negative impact to the state's performance under the Model, I find it confounding that a hospital as high performing and efficient as ours will need to close and limit necessary services relied upon by our disadvantaged community under the current Model. I believe that certain Commission policies—by not fully considering issues unique to rural hospitals in particular—have had the unintended and unfortunate consequence of exacerbating GRMC's financial difficulties as it tries to weather this current storm. It is my hope that the HSCRC will work quickly to develop some sensible and much-needed long-term solutions for rural hospitals in Maryland, and I look forward to working with the Commission on these issues in a meaningful and collaborative way.

Sincerely,

Mark Boucot
President & CEO
Garrett Regional Medical Center

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Frederick Health Hospital

400 West 7th Street
Frederick, MD 21701

240-566-3300

October 7, 2022

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

Dear Mr. Kane and Ms. Wunderlich,

On behalf of Frederick Health Hospital, the purpose of this letter is to provide commentary in response to the request at the September Public Session for input on Maryland's Total Cost of Care Model performance.

Regarding the request for commentary on corrective action, Frederick Health Hospital supports the Maryland Hospital Association (MHA) recommendation to implement a $25 million Medicare adjustment with 25% being distributed across all GBR hospitals and 75% of the adjustment being scaled based on the most recent published integrated efficiency results. In addition, we are supportive of the MHA's broader thoughts regarding approach to the savings target, including adjusting CY2022 and CY2023 savings targets due to exogenous factors, temporarily suspending the Medicaid deficit assessment, and increasing the public payer differential. We believe this to be a reasonable approach in a period of significant financial challenge.

Regarding the request for commentary on broader, long-term policy improvements to ensure the ongoing success of the model, we would note several points of emphasis regarding the HSCRC's Integrated Efficiency and Revenue for Reform policy proposals:

1. **HSCRC should evaluate its policies around relative hospital efficiency.** Frederick Health Hospital believes that the Integrated Efficiency Metric implements only limited accountability for relative hospital efficiency, removing very little from inefficient hospitals and providing only limited pathways to incremental resources for efficient hospitals. There remains a need to more substantially redistribute resources based on hospital efficiency in our capped revenue model to ensure that hospitals are appropriately equipped to achieve the goals of the Medical Total Cost of Care Model.

2. **There continue to be growing distortions in the distribution of resources that have developed during the nearly eight years under fixed revenue caps, creating an inequity in access to funds for investment in achieving the goals of the Maryland Total Cost of Care Model.** Frederick Health Hospital believes that, for hospitals that are price and cost efficient with low amounts of avoidable utilization, the pathways to funding the non-hospital investments in community health required to achieve model goals are limited. As we inevitably layer on new expectations for investments in care transformation in an increasingly constrained system, we must consider the levers that we have to create available funds that can be thoughtfully distributed to address both system savings requirements and needed investments in care transformation.

Thank you for the opportunity to provide commentary this important issue. We appreciate both the Commission's and MHA's continued efforts on TCOC performance and are committed to working with HSCRC staff to evaluate long-term policy improvements to ensure the ongoing success of the Maryland TCOC Model. If you have any questions, please do not hesitate to contact me.

Sincerely,

Hannah Jacobs
Hannah R. Jacobs
Sr. VP and CFO

JOHNS HOPKINS
MEDICINE

October 7, 2022

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

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the potential corrective actions that may be required if the State does not meet the savings targets required by the Waiver.

JHHS supports the Maryland Hospital Association (MHA) position regarding the potential corrective action steps, specifically the approach of consideration of exogenous factors, increasing the public payer differential, Medicaid deficit assessment relief and a reduction in hospital Medicare rates with the majority of the reduction achieved using the latest efficiency policy. This is a balanced approach that requires contributions from all stakeholders that benefit from the Maryland Model, including hospitals, commercial payers and the state of Maryland. This approach also reflects a thoughtful compromise across the hospital industry.

While JHHS is supportive of the MHA position, it is important to highlight that this approach towards corrective action does not solve the systemic problems within the Maryland Model and the Global Budget Revenue (GBR). Failing to meet the Medicare savings target presents Maryland with the opportunity to pursue a thoughtful evaluation of the policies within the Total Cost of Care Model that are improving patient care and those that are not.

JHHS has repeatedly raised the issue of retained revenue and the need for a rational population-based and clinical needs approach to bed capacity. There is a need for clear and updated policies and guidance on the impact of retained revenue on volume reduction. Data indicate that since the implementation of GBR, hospitals with retained revenue have seen an overall decrease in volume, not just potentially avoidable utilization (PAU). There is no data at this time to indicate that hospitals with decreased volume and retained revenue have achieved that decrease through population health investments – instead, this may have been achieved simply through the elimination or reduction of services. In order to achieve the goals of the model and deliver ongoing savings, the HSCRC must develop policies that –

instead of recognizing all volume reduction – only recognize volume reductions associated with PAU or due to population health related programs. Some HSCRC staff have publicly indicated that the Maryland Model and the GBR are designed to reward any volume reduction. This is a reckless policy perspective that offers to incent rationing of health care services. Additionally, given that Maryland is benchmarked against the national Medicare spend, with a requirement to ensure Medicare fee-for-service total cost of care grows less than the nation, the current approach to retained revenue is counter-productive. While in other states, hospitals with declining overall volumes may otherwise close, in Maryland they remain open, adding to the state's total cost of care and hindering progress on the benchmark.

JHHS, like many other hospital partners and policy makers, believes that the Maryland Model is intended to incentivize thoughtful investments in community and population health strategies that will produce the long-term outcome of reduced hospital utilization through lower rates of chronic conditions and improved health. There is a critical need to rebalance the system with longer-term policy corrections in order to achieve savings targets along with population health goals. JHHS remains firm in its belief that the goals of the model cannot be achieved over a 10-year period without directly reinvesting retained revenues in population health, creating quantifiable savings and investments. Population health investments should be strategic and regional with the initial focus on jurisdictions with higher rates of poverty and health disparities. As JHHS has noted in previous comment letters, industry-wide savings targets will be increasingly hard to reach if all retained revenue is allowed to stay within the system – however some portion of retained revenue should be redirected to targeted investments in population health that focus on social determinants of health in Maryland's most disadvantaged communities.

While JHHS believes that the exogenous factor of the pandemic is a reason for the miss of the savings target, we also believe there are fundamental issues with the Maryland Model's policies and methodologies that hinder the State and industry from achieving our goals and financial targets. In order to achieve these goals, it is necessary to implement longer-term policy corrections that address retained revenues and inappropriate volume reductions. JHHS appreciates the opportunity to comment on the potential corrective actions and longer-term policy corrections that may be required of the State and the industry.

Sincerely,

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

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

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

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www.umms.org

CORPORATE OFFICE

October 7, 2022

RE: UMMS Comments Regarding TCOC Performance Potential Corrective Action Steps

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

Dear Mr. Kane and Ms. Wunderlich,

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, I am providing commentary in response to the request at the September Public Session for input on potential corrective action steps that may be required if the State does not meet the financial targets required by the Maryland Total Cost of Care Model.

The Maryland Total Cost of Care (TCOC) Model is enormously beneficial to providers, commercial payers, and, most importantly, the citizens of Maryland. Given the serious nature of this issue, it is critical that hospitals come together in the effort to tackle the shared task of improving Model performance and respond collectively. With that in mind, we strongly support the industry's position regarding the potential immediate corrective action steps, specifically the consideration of exogenous factors in determining the magnitude and timing, increasing the payer differential, Medicaid deficit relief, the application of a January 1 corrective action directly to Medicare fee-for-service via the Medicare Performance Adjustment Savings Component, and the proposed approach to distributing a small portion of the correction across-the-board, while distributing the majority of the correction according to the existing efficiency policy.

Since the inception of the Maryland Demonstration Model in CY2014, Maryland has consistently met its targeted growth rates. This remains true this year in Maryland, as our TCOC growth rate per beneficiary remains consistent with the projected growth rates contemplated in the FY2023 update factor discussions. Our State has continued to achieve what is expected under the Model, however, what is unexpected is the national trend. It is clear that CY2022 national trends are significantly out of line with expected performance and driven by factors such as the ongoing volume disruption due to the COVID-19 pandemic, extreme inflation, and uncertainty around the timing of nationwide recovery. Based on our track record of success and the continuing expectation that the nation will eventually recover from volume disruptions, UMMS believes it is prudent to make an incremental correction on January 1 and allow more time to re-evaluate the issue in July with a more robust, data-driven understanding of the issue. As this issue is unique to Medicare, and Commercial payers continue to benefit from the Model, we believe that Medicare-only action is warranted in this situation. While longer-term policy corrections would certainly include all-payer considerations, applying immediate actions that are meant to directly address CY2022 Medicare performance on an all-payer basis would be a significant, unanticipated burden on hospitals in a time of unprecedented financial challenges.

In addition to the industry's proposal for immediate action, UMMS continues to believe that we must initiate a comprehensive review of the methodologies that drive distribution of resources within our capped system and the growing distortions that have resulted if we are to ensure the long-term sustainability of the Maryland Total Cost of Care Model. Because hospitals in most cases operate on narrow total margins, the appropriate distribution of resources is critical to the long-term viability within a constrained revenue model. This reality is in particular focus during this difficult period. UMMS believes that the Commission and Hospitals must engage in a thoughtful evaluation of the existing methodologies and policies that currently drive the distribution of resources under the Global Budget Revenue model:

1. UMMS has in prior comments expressed concern that relative hospital efficiency, driven by price, is the prevailing policy tool for addressing hospitals with significant volume declines under the fixed revenue model.
    a. Beyond Potentially Avoidable Utilization (PAU), reductions in the amount of care provided at hospitals must be addressed to ensure long-term viability of the model.
    b. The market shift is a net neutral calculation which does not address overall reductions in care provided. The Integrated Efficiency Method cannot be the only mechanism to adjust for large declines in volume over time.
    c. UMMS believes a conversation about rebasing is needed after eight-plus years of GBR.
    d. This would require a establishing a valid understanding of retained revenue and clear accountability around its use.
2. UMMS has been progressive in our approach to removing excess capacity as volume reductions are achieved, as we have transitioned inpatient facilities to Freestanding Medical Facilities and generated savings. We believe that clear policies that reduce excess capacity as volumes decline are needed Statewide.
3. We must continue our policy discussion of how to increase accountability for investments in care transformation and ensure that they are distributed through a lens of health equity (including how to best target investment in health equity directly into the areas of highest need)
4. We should evaluate the existing Integrated Efficiency Method to ensure that we are not inadvertently penalizing communities with significant disparities while directing rewards toward well-resourced communities.

5. Finally, UMMS serves a broad, diverse set of communities in Maryland. Our policies must be able to account for the differential resources required to serve the unique circumstances such as academic medical centers, sole community rural providers, and providers with safety net functions.

As a State, we have made significant progress under the fixed revenue GBR model in terms of establishing broad incentives to reduce utilization, bending the cost curve, and generating resources to invest in ongoing opportunities for care transformation. UMMS believes it is necessary to evaluate these policy issues as part of a broader process to address the appropriate distribution of resources within our capped system. Working together to develop policies that create clear, direct incentives around these issues will be key to the long-term sustainability of our Model. We look forward to continuing discussions with the Commission on these topics.

Sincerely,

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

Cc: Joseph Antos, Vice Chairman, HSCRC
Tori Bayless
Stacia Cohen
James Elliot
Maulik Joshi
Sam Maholtrac
Michelle Lee, CPA, CFO
Alicia Cunningham

LIFEBRIDGE HEALTH

October 6, 2022

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

Dear Katie –

Thank you for affording the industry the opportunity to offer comments and recommendations as part of the Commission's decision-making process of the possible need for an adjustment to hospitals global budget revenues in response to the State's performance on overall total-cost-of-care.

LifeBridge Health supports the Maryland Hospital Association (MHA) recommendation of an immediate (January 1st, 2023) $25 million Medicare adjustment using a 25% proportioned reduction to all hospitals and 75% reduction based on the most recent efficiency policy results. In addition, we are also supportive of the broader measures beginning with fiscal year 2024 identified by MHA as mechanisms to reduce the savings gap, notably through payment policy revisions, application of an increase in the public payer differential, suspension of the Medicaid deficit assessment and use of the Waiver contract's exogenous factor clause.

However, if the HSCRC decides to make an adjustment greater than the $25 million proposed we would not be supportive of utilizing the aforementioned 25%/75% split logic. LifeBridge Health continues to have significant concerns about methodology distortions within the Integrated Efficiency methodology which need to be addressed if the methodology will be used for a larger or additional GBR adjustments. Those distortions include the following:

- The current Interhospital Cost Comparison ("ICC") utilizes outdated volumes (FY2019) and more current volumes remained distorted due to the impact of COVID.
- The HSCRC has placed a moratorium on Full Rate Applications due to concerns with the validity of the Integrated Efficiency Methodology
- The Total Cost of Care attainment methodology does not adequately address health disparities and needs further refinement.
- LifeBridge continues to question whether the disproportionate share methodology adequately accounts for the costs in urban settings after the elimination of long-standing peer groups.

- The medical education resident adjustment needs to be evaluated to ensure that credit for non-academic hospitals is appropriate

In addition, we want to emphasize our support of the MHA position paper regarding collaboration on policy revisions. While arguably imperfect, the conversion of the inpatient charge-per-case in transitioning to the global budget revenue system created easily understood and statewide endorsed incentives as hospitals shifted from a volume-based model to a value-based model. We believe the current economic instability being experienced by hospitals through volume-related challenges, labor/staffing shortages, core expense inflation and escalating physician coverage concerns underscore the importance of creating policies that remain stable of a period of time.

Sincerely,

David Krajewski
Executive Vice President and Chief Financial Officer – LifeBridge Health
& President – LifeBridge Health Partners

CC: Adam Kane, Esq.
HSCRC Chairman

MedStar Health

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October 6, 2022

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

Dear Mr. Kane and Ms. Wunderlich:

On behalf of the MedStar Maryland hospitals, we are responding to your request for input on Maryland's Total Cost of Care Model performance. Our understanding is Maryland will likely miss the calendar year 2022 annual savings target and the year-over year guardrail. The main cause for this result is the volatility driven by the COVID-19 pandemic and its aftermath.

We support the goal of overcoming the Maryland Model's immediate challenges created by the volatility, and we support the field's compromise-based approach outlined in MHA's comment letter. We offer the following as further context:

We lend this support even though the significant financial challenges continue. Our Maryland hospitals and many others continue to experience real financial stresses in the aftermath of the pandemic from the significant cost increases driven by workforce shortages and the impact of high inflation rates. We expect the financial challenges/difficulties will continue into 2023, and likely into 2024.

The MHA's proposed methodology for allocating 75% of the $25M Medicare payment reduction to hospitals is based on the Inter-hospital Cost Comparison (ICC). We recognize the HSCRC has determined the ICC is not a stable methodology in today's volatile environment. **Nevertheless, we agreed to support this allocation method despite the current limitations in the ICC efficiency policy only in this limited and unique situation.** We hope the ICC efficiency metrics will be refined over time to make them more valid for performing inter-hospital comparisons.

We believe it is vital that all parties (hospitals, the State of Maryland, and commercial payers) come together to contribute to support the Model at this critical time. We believe the MHA's proposed approach can accomplish this goal.

There have been very large fluctuations in hospital volumes and healthcare needs over the last couple of years since the pandemic started. Historic information most likely will look much different than current and future state. As we move forward, policy changes undoubtedly will be necessary, however, decisions made on historic data may not reflect current realities and could jeopardize delivery of healthcare services. As a result, HSCRC's historical disciplined process will be more important than ever in making future policy changes.

Thank you for the opportunity to comment.

Sincerely,

Susan K. Nelson
Executive Vice President and Chief Financial Officer
MedStar Health, Inc.

cc: Joseph Antos, PhD
Victoria W. Bayless
Stacia Cohen, RN, MBA
James Elliott, M.D.
Maulik Joshi, DrPH
Adam Kane, Esq. Chairman
Sam Malhotra
Kenneth A. Samet, President & CEO, MedStar Health Inc.

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

October 7, 2022

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

Dear Chairman Kane:

On behalf of the Medicaid Administration at the Maryland Department of Health (MDH), I appreciate the opportunity to comment on the ongoing discussions surrounding Maryland's Total Cost of Care Model (TCOC Model).

All-Payer vs. Medicare-Only Actions

MDH maintains strongly that the Commission should not make any concessions or allowances for Medicare-only rate corrections. Specifically, stakeholders have suggested that the Medicare Performance Adjustment should be used to adjust Medicare rates on the back end to bring the State into compliance. As discussed in prior Commission meetings, adjusting for Medicare-only rate corrections would violate the principles of the all-payer, hospital-rate-setting system, which is the central tenet of the TCOC Model. Such adjustments would be in direct violation of the Medicaid Upper Payment Limit Test. Federal rules do not permit Medicaid to pay more than Medicare. This test is applied whether the adjustment to rates occurs upfront or on the back end—the same adjustment to Medicare must be made to Medicaid.

Additionally, stakeholders have suggested that a reduction in the Medicaid Deficit Assessment should be used to assist in achieving any savings targets. It is important to note that:

1. The Medicaid Deficit Assessment is included in the 2014 base global budget and has significantly decreased since 2014;
2. 42 other state Medicaid programs have an assessment on hospital revenues—a reduction in the Medicaid Deficit Assessment would not guarantee that Maryland will meet the growth guardrail test (*i.e.*, not growing faster than the national Medicare rate); rather, a reduction in the Medicaid Deficit Assessment would assist in meeting the growth guardrail only if the Commission were to implement a conservative hospital-rate increase next year; and

3. For every dollar saved by Medicare due to a decrease in the Assessment, the State would lose more than two dollars. The State receives approximately 60 percent in a federal match when such funds are used to support the Medicaid program.

The Department of Budget Management has tracked the cumulative savings of the elimination of the Assessment, decreases in the Medicaid Deficit Assessment and decreases in uncompensated care due largely to Medicaid eligibility expansions and enrollment growth. The cumulative savings from 2014 through 2021 is in excess of $1.3 billion.

Year	Medicaid Deficit Assessment	MHIP Assessment	Uncompensated Care	TOTAL	Difference from FY 2014	Total savings since FY 2014
FY 2014	$412,455,978	$103,829,280	$139,500,681	$655,785,939		
FY 2015	$389,825,000	$62,213,806	$130,811,255	$582,850,061	-$72,935,878	
FY 2016	$389,825,000	$0	$112,558,880	$502,383,880	-$153,402,059	
FY 2017	$364,825,000	$0	$98,234,002	$463,059,002	-$192,726,937	
FY 2018	$364,825,000	$0	$94,770,554	$459,595,554	-$196,190,385	
FY 2019	$334,825,000		$80,692,469	$415,517,469	-$240,268,470	
FY 2020	$309,825,000		$87,401,148	$397,226,148	-$258,559,791	
FY 2021	$294,825,000		$97,348,845	$392,173,845	-$263,612,094	-$1,377,695,614
FY 2022	$294,825,000		$115,000,000	$409,825,000	-$245,960,939	
FY 2023	$294,825,000		$112,005,372	$406,830,372	-$248,955,567	-$1,872,612,120

Longer-Term Policy Corrections to Deliver Ongoing Savings, Ensure Funding for Population Health and Appropriately Fund Hospitals

As the Commission examines longer-term policies to capitalize on the savings for the TCOC Model, MDH affirms its longstanding position that continued investments in population health will improve the livelihood of Marylanders and will be cost effective to the broader system.

- *Reimbursement for Innovative Benefits*: Recent initiatives include residential treatment for serious mental illness and substance use disorder, certified peer-recovery specialists, community-violence prevention, mobile crisis and crisis stabilization, Maternal Opioid Misuse model, doulas/birth workers, CenteringPregnancy, HealthySteps, home visiting services, childhood asthma home visiting, lead abatement, supplemental payments, new treatment modalities for EMS providers, comprehensive adult dental, tenancy support services and others; and
- *Coverage Expansions*: Recent expansions include 12-month postpartum coverage, coverage for undocumented pregnant women, and additional sites for the All-Inclusive Care of the Elderly program.

These types of investments will contribute to long-term savings. It is critical that hospitals and other payers make similar investments, in the interests of improving the health of Marylanders and of achieving the financial tests under the TCOC Model.

Sincerely,

Tricia Roddy
Deputy Medicaid Director

CC: Katie Wunderlich
Marc Nicole
Steven Schuh
Tricia Roddy
Laura Goodman

Advanta Government Services, LLC

October 7, 2022

Willem Daniel
Deputy Director
Center for Provider Alignment and Payment Reform
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
Email: willem.daniel@maryland.gov

Dear Mr. Daniel,

Thank you for the opportunity to provide testimony with respect to potential corrective action steps the State may want to take to be in compliance with the financial targets under the Total Cost of Care (TCOC) Model contract. Current projections indicate that the State will miss the CY 2022 annual savings test by more than $100 million.

I encourage the Health Services Cost Review Commission (HSCRC) to be conservative in potential corrective action steps as I believe that a portion of the dissavings will self correct. As a result of the outbreak of the novel coronavirus disease (COVID-19) a tremendous amount of nonurgent medical and surgical care was deferred beginning in March 2020.[1] Healthcare utilization decrease in 2020, both in the State and nationally, for hospital, physician, and clinical services. Between February and April 2020, inpatient revenues in Maryland declined 17.0 percent and hospital outpatient revenues declined 45.5 percent.[2] At the same time, hospitals experienced longer lengths of inpatient stays due to changes in utilization patterns with an increase in intensive care unit (ICU) stays and inter-hospital transfers. The August 2022 TCOC Workgroup reported that Maryland admits per capita in 2019 were 80 percent of 2013 levels while national admits per capita were 90 percent of 2013 levels (10 percent advantage). The 2022 year-to-date Maryland was almost 60 percent while national was below 70 percent of 2013 levels. While the advantage in admits per capita shrunk, a portion of the decrease was due to COVID-19 pandemic utilization decreases, suggesting that the Maryland admits per capita advantage will increase as hospital utilization normalizes post pandemic. In addition, as nonurgent medical and surgical care increases in the inpatient and outpatient settings, the average length of hospital stays is likely to decrease.

The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary projected spending growth of 10.4 percent in 2021 due to increasing utilization of hospital services that moderate slightly in 2022, related more to decreases in supplemental payments to hospitals rather than easing of utilization. Increasing utilization was projected in physician and clinical services with pandemic-related effects continuing through 2024. The impact of the increasing utilization in Medicare is likely to increases in admits per capita and per beneficiary costs increase at a faster rate nationally than Maryland over the next several years.

[1] Levy, J. F., Ippolito, B. N., & Jain, A. (2021). Hospital revenue under Maryland's total cost of care model during the COVID-19 pandemic, March-July 2020. *JAMA*, *325*(4), 398-400.
[2] Ippolito, B. N., Jain, A., & Levy, J. (2021). Hospital Revenue Under Maryland's Total Cost of Care Model During the COVID-19 Pandemic, March-July 2020. JAMA.

Should the corrective action steps taken ensure recovery of the entire miss from CY 2022? Or should we target an incremental recovery in January 2023 and wait until July 2023 to ensure a full correction?

I propose waiting until July 2023. Gross operating revenue has been tight over the pandemic with restricted outpatient revenue along with increasing supply, drug, and labor costs. Waiting until July 2023 will give providers an opportunity to recover and give the State the opportunity to realize the extent of the correction needed.

Should actions be considered that affect Medicare rates only or should the actions be all-payer in nature? Should there be an allowance for Medicare-only rate corrections?

The TCOC Model is assessed through the savings to Medicare. The consideration as the whether the corrective action be all-payer or Medicare-only is difficult. If Medicare-only rate corrections are necessary, it should only be for limited time. The annual savings test is assessed on Medicare payments but instituting a deviation in the all-payer model would create an uncomfortable precedent. The all-payer rate system works because it aligns the incentives for hospital inpatient and outpatient care across the system.

How should the corrective action steps be distributed across the industry? As an across the board reduction or based on existing policies?

I would encourage that any corrective action steps be distributed based on existing policies. Further analysis would need to be performed to identify which policies could be identified to provide the most immediate correction.

What longer-term policy corrections should be considered in place of across the board cuts?

To ensure ongoing savings, Maryland needs to better incorporate professional and non-hospital outpatient providers into shared savings and population health initiatives. Non-hospital Part A and Part B are a growing area of Medicare costs per capita that are not subject to HSCRC rate regulation. Maryland has the most ambulatory surgical centers (ASC) per capita[3], in part, due to incentive structures created by the Global Budgets. The Episode Quality Improvement Program (EQIP) has the potential to generate savings for the State through improved alignment between providers subject the HSCRC rate regulation and providers who are not. Currently, the EQIP is a voluntary program. Expansion of programs to non-hospital providers along with increased inducement of hospital participation in quality improvement programs may be a cost-effective and incentive compatible strategy to deliver ongoing savings.

Sincerely,

Maurice (Mark) Moffett, PhD
Senior Health Economist
Advanta Government Services, LLC
MarkMoffett@AdvantaGovernmentServices.com
(240) 554-1200

[3] https://www.beckersasc.com/benchmarking/10-states-with-the-highest-number-of-ascs-per-capita.html?oly_enc_id=0417B8500489I0E

1. **HSCRC Question: Should the corrective action steps taken ensure recovery of the entire miss from CY 2022? Or should we target an incremental recovery in January 2023 and wait until July 2023 to ensure a full correction? The intention of HSCRC is to not implement any corrective actions in CY 2022, but rather wait until CY 2023 to take corrective actions.**

   - **Response:** Agree. HSCRC should target incremental recovery and build bandwidth. To build CY2023 bandwidth, identify potential Commission member(s) with CMMI project and or rate setting experience and without Maryland conflicts.
   - **Commentary**

     Regulatory Commissions evolve and require varying expertise and information to meet changing challenges.[1] In 1971 the HSCRC Commissioners were primarily hospital trustees. Their decision making revolved around hospital accounting. In the 90s and in the early 2000s, DRG based case mix adjustments and volume adjustments[2] became key measures Provider representation increased evolving to the current Commissioner composition. There have been few if any non-Maryland Commissioners. The TCOC era requires understanding of and implementation of an array of benchmarks, statistical models, and vetting the steady flow of CRISP calculated applications.

     In the early years, Maryland's Commissioner's responsibilities were unique as no other states had sophisticated volume adjustments and global budgeting. Since 2012 CMMI has supported and evaluated 21 models and demonstrations.[3] See Appendix for list of 21. This Synthesis of Evaluation results across these 21 Medicare models will have cultured diverse health care leaders familiar with acute targeted populations and primary care and population management. 2023 is an opportunity to add a non-Maryland leader to the Commission to support corrective action implementation in 2023.

[1] Michael Howlett & Joshua Newman (2013) After "the Regulatory Moment" in Comparative Regulatory Studies: Modeling the Early Stages of Regulatory Life Cycles, Journal of Comparative Policy Analysis: Research and Practice, 15:2, 107-121, DOI: 10.1080/13876988.2013.765618

[2] Kalman NS, Hammill BG, Murray RB, Schulman KA. Removing a constraint on hospital utilization: a natural experiment in Maryland. Am J Manag Care. 2014 Jun 1;20(6):e191-9. PMID: 25180502.

[3] Synthesis of Evaluation Results across 21 Medicare Models, 2012-2020. CMS https://innovation.cms.gov/data-and-reports/2022/wp-eval-synthesis-21models

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2. **Should actions be considered that affect Medicare rates only or should the actions be all-payer in nature? A cornerstone of the Model is the all-payer rate setting system. Should there be an allowance for Medicare-only rate corrections?**

- **Response:** Yes, but not to the exclusion of all-payer rate setting**.** HSCRC can **a**ccess and use national and regional Medicare Spending Per Beneficiary (MSPB) data. A Workgroup can be identified to track and target Medicare performance gaps.
- **Commentary**

  For care transformation, Maryland has deep experience benchmarking.[4] PPS hospitals have received Medicare Spending Per Beneficiary (MSPB) feedback since 2013. Because of Maryland's unique waiver, Maryland providers have not had access to these standardized performance monitoring data. CMS has now standardized both Maryland waiver hospitals and Critical Access Hospitals for services provided.[5] MSPB for Maryland hospitals can be available.

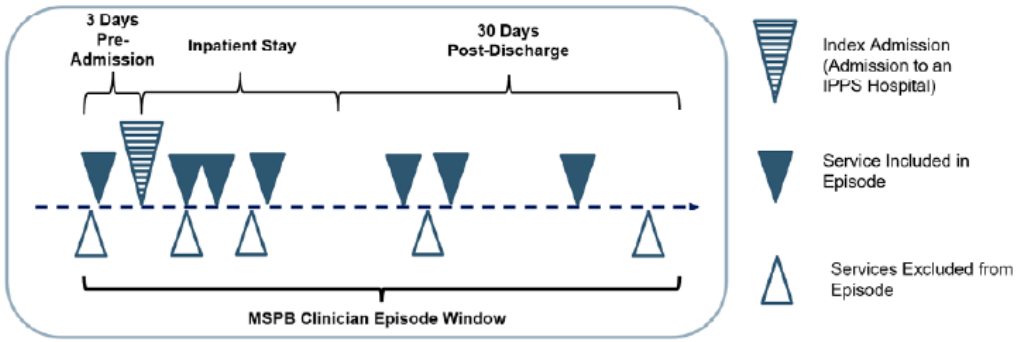
  The MSPB episode framework is provided in Figure 1.[6] Three days pre-admission, inpatient stay and 30 days post discharge are bundled. The management of post acute care is essential for efficient MSPB performance. Example MSPB tables are found at the link.
  https://qualitynet.cms.gov/inpatient/measures/mspb/reports

[4] August 2020 Total Cost of Care Benchmarking materials – Benchmarking Overview Presentation 8-24

[5] CMS Standardization Methodology For Allowed Amount– v.2 (sic) For Services Provided During - 2006 – 2012 – (updated 5/16/2013) "In general – the standardization method for acute hospital claims follows the inpatient prospective payment system (IPPS) payment rules. All IPPS hospitals, as well as **Maryland** (emphasis added) waiver hospitals, critical access hospitals, cancer hospitals, and children's hospitals are included in this section. Although **Maryland** (emphasis added) hospitals, CAHs, cancer hospitals and children's hospitals are paid under special systems, they provide a similar set of acute hospital services as IPPS hospitals. Since the goal of standardization is to allow for resource use comparisons across the country on an equal basis, all acute hospitals are standardized under the same methodology." V.10, Page 7

[6] Quality Payment Program. Merit-based Incentive Payment System (MIPS): Medicare Spending Per Beneficiary (MSPB) Clinician Measure. Measure Information Form. 2021 Performance Period. https://mdinteractive.com/files/uploaded/file/mips_cost_measures_2021/2020-12-14-mif-mspb-clinician.pdf

Figure 1: MSPB Clinician Episode Framework



3. **How should the corrective action steps be distributed across the industry? As an across-the-board reduction or based on existing policies?**

- **Response:** Corrective action steps should be distributed across the industry and based on existing policies and strengthening the incentives. The Readmission Reduction Incentive Program (RRIP) can be enhanced by creating an across industry state-wide readmission risk pool. State-wide achievement would be necessary for full recovery of the risk pool. This is an across-the-board initiative modifying existing policies.
- **Commentary**

Readmissions and corrective action incentive steps are one of six requirements of notable concern by CMMI.[7] Currently the RRIP Revenue Adjustment Methodology causes hospitals to be the unit of analysis. That is, an individual hospital's performance determines whether the scaled results are a reward up to 1% of revenue or a penalty up to 2% of revenue.

However, CMMI and the Maryland agreement targets the state rate as the unit of analysis. To encourage attention to the state rate it is suggested that a state level reward/penalty pool be established. For example, take 0.1% of the 1% reward revenue and create an earn-back risk pool. If the desired state readmission level is not achieved this portion (0.1%) of the reward pool is retained by the state. This approach incentivizes hospitals to work together and directly respond to CMMI.[8] The current incentive structure follows.

Revenue Adjustment Methodology

The RRIP assesses improvement in readmission rates from base period, and attainment rates for the performance period with an adjustment for out-of-state readmissions. The policy then determines a hospital's revenue adjustment for improvement and attainment and takes the better of the two revenue adjustments, with scaled rewards of up to 1 percent of inpatient revenue and scaled penalties of up to 2 percent of inpatient revenue. The figure below provides a high-level overview of the RY 2021 RRIP methodology for reference and will be updated for RY 2022 once the policy is approved.

If a state-wide pool is an insufficient incentive, the Commission should consider reinstating the Value Adjustment System (VAS) used by HSCRC beginning 1976 and ending 2001. THE VAS discourages the initial admission by allowing only 80% for volume growth beyond the baseline.[9]

[7] Letter to Katie Wunderlich from Janelle Gingold CMMI dated July 15, 2022

[8] Atkinson JG, Masiulis KE, Felgner L, Schumacher DN. Provider-initiated pay-for-performance in a clinically integrated hospital network. J Healthc Qual. 2010 Jan-Feb;32(1):42-50; quiz 50. doi: 10.1111/j.1945-1474.2009.00063.x. PMID: 20151591.

[9] Berenson RA, Murray RB. How Price Regulation Is Needed To Advance Market Competition. Health Aff (Millwood). 2022 Jan;41(1):26-34. doi: 10.1377/hlthaff.2021.01235. PMID: 34982623.

4. **What longer-term policy corrections should be considered in place of across-the-board cuts? For example, should the State consider policy improvements that set the State up for success to deliver ongoing savings, ensure funding for population health, and appropriately fund hospitals? Please provide examples.**

- **Response:** Longer term enhancement and strengthening the Consumer Standing Advisory Committee (CSAC) membership is key. Including access and use of CRISP performance data, CMS Compare data and Maryland Health Care Commission (MHCC) results will leverage CSAC views on population health funding.
- **Commentary**

The HSCRC Consumer Standing Advisory Committee (CSAC) did not meet in 2021 and 2022. The current membership is a mix of health department, provider, and public representatives. Particularly germane to 2023 are two of 2020 CSAC goals: "Promoting a broad understanding about the TCOC Model and its impact on improving health and health care for consumers/patients; and Gather input from patients and consumers and represent their voices to ensure that the perspectives of patients / consumers are used to inform the design and management of state policies related to the TCOC Model."[10] Maryland's performance data are increasingly valid, reliable, robust and accessible. CSAC goal achievements can be evaluated and monitored using CRISP, CMS Compare and MHCC report detail. (See the table extract below.[11] The icons for this hospital are directional and suggest accountability. This is excellent iconography and an example of supporting a CSAC goal.)

[10] https://hscrc.maryland.gov/Pages/hscrc-csac.aspx

[11] https://healthcarequality.mhcc.maryland.gov/Hospital/Detail/15

See confidence intervals

Better than Maryland
Same as Maryland
Worse than Maryland
No data for comparison

Better than National
Same as National
Worse than National
No data for comparison

No data = not enough data to calculate, not enough data to report, or no data available

Subtopic	Measure	Hospital Score	Maryland Score	National Score	Performance Comparison	95% (LCI, UCI)
Communication	How often did doctors communicate well with patients?	76.0%	75.5%	80.0%	= / Worse than National	(73.8%, 78.2%)
Communication	How often did nurses communicate well with patients?	75.0%	75.0%	80.0%	= / Worse than National	(72.7%, 77.3%)
Communication	How often did staff explain about medicines before giving them to patients?	56.0%	57.2%	63.0%	= / Worse than National	(53.4%, 58.6%)
Communication	How well do patients understand their care when they leave the hospital?	52.0%	47.4%	52.0%	Better than Maryland / =	(49.4%, 54.6%)

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Table 1. 21 Medicare Models & Demonstrations, Evaluation Data Sources

CMS Innovation Center Model or CMS Demonstration	Data Source	Performance/ Periods Years covered
Accountable Care Organization (ACO) Investment Model (AIM)	Final Evaluation Report	1-3
Advance Payment (AP) ACO Model	Final Evaluation Report	1-3
Bundled Payments for Care Improvement (BPCI) Initiative	Final Evaluation Report	1-5
Bundled Payments for Care Improvement Advanced (BPCI-A) Model	Third Evaluation Report	1-2
Comprehensive ESRD Care (CEC) Model	Fifth Annual Evaluation Report	1-5
Comprehensive Joint Replacement (CJR) Model	Fourth Annual Report	1-4
Comprehensive Primary Care (CPC) Initiative	Final Evaluation Report	1-4
Comprehensive Primary Care+ (CPC+)	Fourth Annual Report	1-4
Financial Alignment Initiative for Medicare-Medicaid Enrollees (FAI) Demonstration, Washington[6]	Fifth Annual Report	1-6
Home Health Value-Based Purchasing (HHVBP) Model	Fifth Evaluation Report	1-5
Independence at Home (IAH) Demonstration	Year Five Evaluation Report [7]	1-5
Maryland (MD) All-Payer Model	Final Evaluation Report	1-4
Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model	Report First Three Years	1-3
Medicare Care Choices Model (MCCM)	Fourth Annual Report	1-4
Million Hearts® (MH): Cardiovascular Disease Risk Reduction Model	Fourth Annual Report	1-4
Next Generation ACO (NGACO) Model	Fourth Evaluation Report	1-4
Oncology Care Model (OCM)	Performance Periods 1-5 [8]	1-5
Part D Enhanced Medication Therapy Management (Part D Enhanced MTM) Model	Third Evaluation Report	1-3[9]
Pioneer ACO Model	Final Evaluation Report	Final
Prior Authorization of Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT)	Final Evaluation Report	1-5
Vermont (VT) All-Payer ACO Model	First Evaluation Report	1-2

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October 7, 2022

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

Dear Mr. Kane and Ms. Wunderlich,

On behalf of Luminis Health, the purpose of this letter is to provide commentary in response to the request at the September Public Session for input on Maryland's Total Cost of Care Model performance.

Regarding the request for commentary on corrective action, Luminis Health supports the Maryland Hospital Association (MHA) recommendation to implement a $25 million Medicare adjustment. In addition, we are supportive of the MHA's broader thoughts regarding the approach to the savings target, including adjusting CY2022 and CY2023 savings targets due to exogenous factors, temporarily suspending the Medicaid deficit assessment, and increasing the public payer differential. We believe this to be a reasonable approach during a significant financial challenge.

Regarding the request for commentary on broader, long-term policy improvements to ensure the ongoing success of the model, we would reiterate several of our points of emphasis in the previous commentary on the HSCRC's Integrated Efficiency and Revenue for Reform policy proposals:

1. **HSCRC should evaluate its policies around relative hospital efficiency.** Luminis Health has consistently commented that the Integrated Efficiency Metric implements limited accountability for relative hospital efficiency, removing very little from inefficient hospitals and providing limited pathways to incremental resources for efficient hospitals. There remains a need to substantially redistribute resources based on hospital efficiency in our capped revenue model to ensure that hospitals are appropriately equipped to achieve the goals of the Medical Total Cost of Care Model.

2. **There continue to be growing distortions in the distribution of resources that have developed during the nearly eight years under fixed revenue caps, creating an inequity in access to funds for investment in achieving the goals of the Maryland Total Cost of Care Model.** Luminis Health remains concerned that, for hospitals that are price and cost-efficient with low amounts of avoidable utilization, the pathways to funding the non-hospital investments in community health required to achieve model goals are limited. As we layer on new expectations for investments in care transformation in an increasingly constrained system, we must consider the levers to create available funds that can be thoughtfully distributed to address system savings requirements and needed investments in care transformation.

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Thank you for the opportunity to provide commentary on this critical issue. We appreciate both the Commission's and MHA's continued efforts on TCOC performance and are committed to working with HSCRC staff to evaluate long-term policy improvements to ensure the ongoing success of the Maryland TCOC Model. If you have any questions, please do not hesitate to contact me.

Sincerely,

Kevin Smith
Chief Financial Officer
Luminis Health

Ascension
Saint Agnes

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

October 7, 2022

Dear Ms. Wunderlich,

I am writing on behalf of Ascension Saint Agnes to provide feedback to the Health Services Cost Review Commission (HSCRC) as it considers potential actions that may need to be taken to address the State's performance on the Total Cost of Care (TCOC) Agreement with the Centers for Medicare and Medicaid Services (CMS). We appreciate the HSCRC's commitment to soliciting feedback from the hospital industry as it weighs potential options. Ascension Saint Agnes supports the hospital industry's unified proposition as submitted by the Maryland Hospital Association in its comment letter. We would like to highlight the following points as the HSCRC discerns this matter.

Should the corrective action steps taken ensure recovery of the entire miss from CY 2022? Or should we target an incremental recovery in January 2023 and wait until July 2023 to ensure a full correction? The intention of HSCRC is to not implement any corrective actions in CY 2022, but rather wait until CY 2023 to take corrective actions.

Ascension Saint Agnes supports a limited adjustment in January 2023 to demonstrate to CMS that the State, and by extension Maryland's hospitals, is taking its obligations seriously under the TCOC Agreement. Since the final performance for CY 2022 will not be known until mid CY 2023, however, any recovery should be limited and not an attempt to fully course correct based on current data.

Ascension Saint Agnes
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Baltimore, MD 21229
667-234-3114

Should actions be considered that affect Medicare rates only or should the actions be all-payer in nature? A cornerstone of the Model is the all-payer rate setting system. Should there be an allowance for Medicare-only rate corrections?

Although Ascension Saint Agnes supports the all-payer system, we believe that a temporary, Medicare-only action is warranted in this situation. The State's TCOC Agreement with CMS is a Medicare-only test. Applying the rate reduction across all payers unreasonably penalizes hospitals that are already struggling with unprecedented financial challenges. It also potentially provides a windfall to commercial insurers that already benefit from the all-payer model in the form of lower provider reimbursements.

How should the corrective action steps be distributed across the industry? As an across-the-board reduction or based on existing policies?

Ascension Saint Agnes supports a targeted approach to any rate adjustments rather than an across the board reduction. The basic premise of the Integrated Efficiency Policy is to provide additional funds for low cost and price efficient hospitals while taking money away from higher cost and inefficient hospitals. The HSCRC should apply this same premise to any rate adjustments, rather than implementing an across the board reduction that doesn't distinguish between inefficient and efficient hospitals and is inconsistent with HSCRC's stated policy goals.

What longer-term policy corrections should be considered in place of across the board cuts? For example, should the State consider policy improvements that set the State up for success to deliver ongoing savings, ensure funding for population health, and appropriately fund hospitals? Please provide examples.

Ascension Saint Agnes continues to believe that Maryland's hospitals, both due to our missions and the global budgets, have a responsibility to the health of the communities that we serve. We continue to invest extensively in population health programs, including but not limited to:

- **Food Rx** provides a food prescription of fresh fruits and vegetables to patients based on their chronic disease, acuity and social needs. The pilot project has shown decreased hospital and Emergency Department (ED) utilization.
- **Care in the Gap** provides personal care services 8 hours per week to patients at high risk of readmission due to lack of support while convalescing. Preliminary data shows a decrease in hospitalizations and ED visits. Additional savings include decreases in Skilled Nursing Facility (SNF) utilization.

- **Chronic Disease Home Monitoring Kit** program provides home monitoring devices and education materials for heart failure, Chronic Obstructive Pulmonary Disease (COPD) and diabetes management.
- **Chaperone Program** links trained volunteers with vulnerable patients for support and ride shares. Initial data demonstrates decreases in missed appointments for patients utilizing services at the Heart Failure Center, Cancer Center, and primary care.

As part of its consideration of next steps to address Maryland's shortfall for the TCOC Agreement savings targets, Ascension Saint Agnes would encourage the HSCRC to be mindful of the ongoing investments that are being made and not to overcorrect to the point that these needed community investments would no longer be tenable.

In addition, the HSCRC has many assessments in rates for things like the Medicaid deficit assessment, Catalyst Regional Partnerships, etc., that collectively add cost to the system and negatively impact Maryland's performance under the TCOC Agreement. These assessments should be examined to determine if they are still appropriate, both in their policy goals and magnitude.

Thank you again for the opportunity to provide feedback to the HSCRC on this important issue.

Regards,

Ed Lovern

CC: Mitch Lomax
Dawn O'Neill

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Rate Year 2023 Quality Revenue Adjustments

RY 2023 Quality Program Revenue Adjustments

- Quality adjustments for RY 2023 were delayed from July 2022 to January 2023, pending CMS policy decisions for quality adjustments in the FY 2023 Final Rule
  - Staff and PMWG established that Maryland would follow CMS guidance

	VBP/QBR	HACRP/MHAC	HRRP/RRIP
CMS	Suspend based on Final Rule	Suspend based on Final Rule	Remove COVID patients and pneumonia measure, plus risk-adjust history of COVID; **Implement scaled penalties up to 3 percent.**
HSCRC	Suspend based on Final Rule	Suspend based on Final Rule	Implement approved policy (+/-2%) with use of concurrent norms (i.e., determine expected using CY 2021 data to account for COVID); Provide disparity gap improvement reward.

Note: Maryland must continue to meet aggregate at-risk requirements

RY 2023 Estimated Revenue Adjustment Estimates

RY23 with COVID Adjustments	MHAC*	RRIP* + Disparity Gap	QBR^	Total Adjustments
State Total	**-$8,175,070**	**$65,081,927**	**-$56,797,674**	**$109,183**
Penalty	**-$32,559,478**	**-$9,308,344**	**-$60,812,273**	**-$42,684,679**
% Inpatient	**-0.30%**	**-0.09%**	**-0.56%**	**-0.39%**
Reward	**$24,384,408**	**$74,390,271**	**$4,014,599**	**$42,793,862**
% Inpatient	**0.22%**	**0.68%**	**0.04%**	**0.39%**

*Uses concurrent norms which increases penalties and reduces rewards

^Uses updated cutpoint for revenue adjustment scale to take into account poorer performance during COVID; lowers penalties and increases rewards.

RY 2023 Estimated Revenue Adjustment Estimates

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*Uses concurrent norms which increases penalties and reduces rewards

^Uses updated cutpoint for revenue adjustment scale to take into account poorer performance during COVID; lowers penalties and increases rewards.

Decision for commissioners is whether full 2 percent readmission rewards should be released:

- Staff and PMWG believe that concurrent norms largely addresses COVID PHE concerns (net statewide revenue adjustments go from $96M to $65M with concurrent norms)
- Implementing full rewards follows approved policy
- Need RRIP revenue adjustments to meet potential aggregate at-risk requirement

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Katie Wunderlich
Executive Director

William Henderson
Director
Medical Economics & Data Analytics

Allan Pack
Director
Population-Based Methodologies

Gerard J. Schmith
Director
Revenue & Regulation Compliance

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: October 12, 2022

RE: Hearing and Meeting Schedule

November 9, 2022 To be determined – In-person/Hybrid or GoTo Webinar

December 14, 2022 To be determined – In-person/Hybrid or GoTo Webinar

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

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