maryland
health services
cost review commission

598th Meeting of the Health Services Cost Review Commission
September 14, 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 July 13, 2022 and August 1, 2022

2. Docket Status – Cases Closed
   2599A – University of Maryland Medical Center
   2600A – University of Maryland Medical Center

3. Docket Status – Cases Open
   2589R – Shady Grove Adventist Medical Center
   2601N – Luminis Doctor's Community Medical Center
   2602T – University of Maryland Midtown Campus

4. Legal Update - proposed regulations, regular and emergency basis

5. UM – Midtown Rate Considerations
   a. Final Recommendation on UM- Midtown Temporary Rate Application
   b. Review and Recommendation on UM- Midtown Negotiated Spenddown

6. Population Health Cost Report Presentation

7. Policy Update and Discussion

   a. Model Monitoring
   b. Workgroup Update

8. Hearing and Meeting Schedule

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MINUTES OF THE 597th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION July 13, 2022

Chairman Adam Kane called the public meeting to order at 11:36 a.m. Commissioners Joseph Antos, PhD, Victoria Bayless, James Elliott, M.D., and Maulik Joshi, DrPH, were also in attendance. Commissioners Stacia Cohen and Sam Malhotra 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 1:34 p.m.

MODEL MONITORING

Katie Wunderlich, Executive Director, reported for the four months ending April 2022, the Maryland Total Cost of Care is 3.38% higher than the nation when compared to the same time in 2021.

REPORT OF JULY 13, 2022, CLOSED SESSION

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

ITEM I
REVIEW OF THE MINUTES FROM THE JUNE 8, 2022, CLOSED SESSION AND PUBLIC MEETING AND JUNE 21, 2022, PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the June 8, 2022, Public Meeting and Closed Session and June 21, 2022, Public Meeting (Revenue for Reform) .

ITEM II
CASES CLOSED

2587R- TidalHealth Peninsula Regional
2588R- Carroll Hospital
2596N- UM Shore Emergency Center at Queenstown
2597A- Johns Hopkins Health System
2598A- Johns Hopkins Health System

ITEM III
OPEN CASES

2589R – Shady Grove Adventist Medical Center
2599A – University of Maryland Medical Center
2600A – University of Maryland Medical Center

ITEM IV
PRESENTATION SUPPORTING UNIVERSITY of MARYLAND MEDICAL CENTER- MIDTOWN REQUEST FOR A PERMANENT RATE ADJUSTMENT

Dr. Mohan Suntha, President and Chief Executive Officer, University of Maryland Medical System, presented information in support of the University of Maryland Medical Center – Midtown ("Midtown") request for a permanent rate adjustment.

Dr. Suntha delineated Midtown's role as a vital safety net hospital and the need for a permanent increase in its GBR. Dr. Suntha pointed out that in November 2018, the Commission placed Midtown on a $14.1M spend-down agreement. At that time, Midtown had the highest rate of cost per case of any Maryland hospital, was in the top quintile for TCOC growth rate per capita, significant PAU, and mixed quality outcomes.

Dr. Suntha observed that since that time Midtown has made dramatic improvements in access and quality of care. In addition, Midtown has made significant investments in meeting community health needs. However, partially due to the spend-down, Midtown expects to report a $35M operating loss (- 18% total operating margin) in FY 2022 and is budgeting for a similar loss in FY 2023. Since the implementation of the spend-down, Midtown has posted cumulative losses of more than $67M.

To sustainably continue operations, Midtown requests that the Commission authorize the Staff to review its approved revenue and to:

1. Restore on a permanent basis the $14.1M from the spend-down as an investment in addressing health outcomes in a historically disadvantaged community.
2. Provide one-time bridge funding of $15M over FY 2023 and FY 2024 as part of an improvement initiative to be executed over FY 2023-FY 2025.
3. Evaluate and address the disproportionate impact of denials on a safety net provider. In FY 2021, Midtown experienced $5M in denials beyond the statewide average denial rate.
4. Evaluate how safety net hospitals are considered in the Integrated Efficiency Policy.

Allan Pack, Principal Deputy Director, Population-Based Methodologies, stated that while Midtown is among the highest in statewide Disproportionate Share Hospital (DSH) percentage, this is directly risk-adjusted in the ICC. Mr. Pack added that according to Mathematica, there is no statistical relationship between DSH percentage and the ICC score.

Commissioner Bayless asked what would happen to Midtown without the requested revenue enhancement.

Dr. Suntha explained that Midtown would have to assess the defunding of programs and services that are known to positively impact the community, mentioning the mobile integrated health program as a specific example.

Commissioner Bayless asked whether Midtown has pursued other revenue sources outside the regulated GBR.

Dr. Suntha responded that Midtown has not been able to identify any profitable unregulated revenue strategies given the community they serve in West Baltimore.

Commissioner Malhotra inquired why Midtown, despite the spend-down, has continued to invest in regulated staff faster than other Maryland hospitals.

Dr. Suntha provided examples of strategic decisions to invest in behavioral health and open a neurological intermediate care unit at Midtown to free up capacity at the downtown facility. Dr. Suntha explained that freeing up capacity at the UMMC Downtown Campus benefits not only the region but the entire state.

Commissioner Malhotra then asked whether Midtown is considered separately from UMMC Downtown in Campus in University of Maryland Medical System's (UMMS) consolidated audited financials, given their close relationship.

Dr. Suntha responded that the two facilities are considered independently, and that any University of UMMS's corporate expense allocations are done based on total patient revenue.

Chairman Kane thanked Dr. Suntha for his presentation.

ITEM V
LONG-TERM CARE PARTNERSHIP PROGRAM- FINAL REPORT

Ms. Erin Schurmann, Chief, Provider Alignment and Special Projects, provided a final report on the Long-Term Care Partnership Program.

The HSCRC provided funding to hospitals through the Long -Term Care Partnership Funding Program (LTC Funding Program) to foster collaboration between hospitals and long-term care facilities and other congregate living facilities that serve vulnerable populations during the COVID-19 crisis. The LTC Funding Program was intended to provide critical short-term funding to hospitals to reduce the spread of COVID-19. Under the LTC Funding Program, hospitals and their long-term care/congregate living partners collaborated on data sharing, infection prevention and control, resource sharing, and patient management strategies to reduce the spread of COVID-19 in these settings. The program initially ran from July 1, 2020, through June 30, 2021. However, in recognition of the unprecedented nature of the pandemic, the HSCRC permitted hospitals to extend their program activities through December 31, 2021, with existing grant dollars.

Hospital and health system awardees must partner with at least one licensed long-term care or congregate living facility serving vulnerable populations in Maryland. Only one hospital could receive funding for work with a particular long-term care or congregate living facility partner.

The LTC Funding Program was designed to achieve the following:

- Foster partnerships between hospitals and long-term care and/or congregate living facilities
- Support statewide efforts to combat COVID-19 in long-term care and/or congregate living facilities
- Prevent the introduction of COVID-19 into a facility through entry screening and entry restrictions
- Rapidly identify persons with respiratory illness that may be COVID-19 positive
- Prevent the spread of COVID-19 within and among facilities
- Strengthen environmental cleaning and disinfection procedures
- Manage, isolate, and accommodate persons with suspected or confirmed COVID-19

Commissioner Bayless asked whether there were concerns about the program's sustainability if funding is to be discontinued. Ms. Schurmann replied that although funding has expired, she expects that regular communication between many of the hospitals and facilities, as well as training and education on data analytics, will continue as well.

ITEM VI
POLICY UPDATE AND DISCUSSION

Workgroup Update

Population Health Measurement and Evaluation Workgroup

Ms. Anwesha Majumder, Chief Population Health, presented an update on the Population Health Measurement and Evaluation Workgroup

Ms. Majumder stated that the goal of the group was to discuss, explore, and identify a methodological approach to measure hospital-level improvements in population health, particularly the three population health areas identified for SIHIS (diabetes, opioids, maternal and child health).

Ms. Majumder noted that the structured meetings were to focus first on diabetes metric(s) and begin diabetes measurement for 1/1/2023.

The meetings for the Workgroup were scheduled as follows:

June 9th
July 7th (Diabetes)
August 4th (Diabetes)

September/October/November (Performance Measurement subgroup, Payment Models subgroup, HSCRC Commission)
For FY 2023- Review measurement for initial population health metric(s) and continue development of additional metrics.

Health Equity Workgroup

Ms. Princess Collins, Chief, Quality Initiative, presented an update on the Health Equity Workgroup

Ms. Collins stated that the goals of the workgroup were to:

- Adopt a definition of health equity
- Discuss, explore, and identify methodological approaches to measuring health equity in the Maryland hospital quality programs

Ms. Collins noted that each meeting will focus on at least one measure, and will involve discussion through the process of constructing a methodology for assessing disparities; members are encouraged to interject at any time.

Meetings are scheduled for the 2nd Thursday of every month starting at 9am.

ITEM VII
HEARING AND MEETING SCHEDULE

August 10, 2022	Canceled
September 14, 2022	Times to be determined- 4160 Patterson Ave HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:36 pm.

Closed Session Minutes
of the
Health Services Cost Review Commission

July 13, 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 11:36 a.m.

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

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

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

Item One

Mr. Lustman outlined how Robert's Rules of Order applied to the vote on the Inflation Factor recommendation at last month's Public Meeting, as well as the options open to the Commission going forward.

Item Two

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

Item Three

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

Item Four

M's Wunderlich reviewed and the Commission discussed the 5-year structured Spenddown implemented for Midtown Medical Center.

The Closed Session was adjourned at 1:27 p.m.

MINUTES OF THE
598th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
August 1, 2022

Chairman Adam Kane called the public meeting to order at 11:10 a.m. Commissioners Joseph Antos, PhD, Victoria Bayless, James Elliott, M.D., and Maulik Joshi, DrPH, Stacia Cohen and Sam Malhotra also participated virtually.

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

The Commission voted unanimously to approve the minutes of the July 13, 2022, Public Meeting and Closed Session.

ITEM 2

UNIVERSITY OF MARYLAND MIDTOWN CAMPUS TEMPORARY RATE APPLICATION

Katie Wunderlich, Executive Director, presented a summary of Staff's recommendation. Staff recommends were that:

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.

2. Considering the questions that were raised in this temporary rate change analysis, Staff recommends that the Commission initiate a full rate review as soon as practicable.

3. Staff re-examine the Spenddown versus the Efficiency Policy for Midtown.

Dr. Mohan Suntha, President of the University of Maryland Medical System, presented a rebuttal and comments to Staff's recommendations.

After discussion, the parties agreed to delay the decision on the Temporary Rates Application until the September 14, 2022, Public Meeting.

The Public Meeting was adjourned at 12.02, p.m.

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF Septmber 6, 2022

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

Docket Number	Hospital Name	Date Docketed	Purpose	Analyst's Initials	File Status
2589R	Shady Grove Adventist Medical Center	3/16/2022	CAPITAL	JS/AP	OPEN
2601N	Luminis Doctor's Community Medical Center	7/18/2022	I/P PSYCH	WN	OPEN
2602T	University of Maryland Midtown Campus	7/20/2022	TEMPORARY	KW	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

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Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-207, 19-219, 19-220, and 19-222, Annotated Code of Maryland

.03 Regular Rate Applications.

A. **[**A hospital may file a regular (i.e., full) rate application with the Commission at any time if:

(1) The rates being requested are not the subject of a hospital-instituted case pending before the Commission; or

(2) The subject hospital has not obtained rates through the issuance of a Commission rate order following a regular rate application within the previous 365 days.**]** *A hospital may not file a full rate application with the Commission until the Commission staff is able to determine through analysis that the data used to evaluate a full rate application has not been substantially affected by the COVID pandemic. During this interim period, a hospital may seek a rate adjustment under any other administrative remedy available to it under existing Commission law, regulation, or policy. In no event shall this moratorium continue in effect beyond June 30, 2023. Once the moratorium is lifted, a hospital may file a regular rate application at any time if:*

(1) The rates being requested are not the subject of a hospital-instituted case pending before the Commission; or

(2) The subject hospital has not obtained permanent rates through the issuance of a Commission rate order within the previous 365 days.

B.—C. (text unchanged)

.04 Commission Review of Established Rates.

A—B. (text unchanged)

C. In reviewing a hospital's established rates during a Commission-initiated rate proceeding or while reviewing a hospital's full rate application, the Commission shall consider the hospital's performance since the implementation of the All-Payer Model Agreement with the federal government, which took place in February 2014.

.05 Application for Temporary Change in Rates.

A.—E. (text unchanged)

F. **[**A temporary change in rates may not, absent extraordinary circumstances, result in a hospital's screening position being higher than 2 percent below the Statewide average on the regression-adjusted inpatient screen. Outpatient rates resulting from a temporary rate increase may not exceed the median, adjusted for mark-up and labor market.**]** *In conducting an expedited review to establish a temporary rate for both inpatient and outpatient services, the Commission shall consider the hospital's financial condition in addition to its relative efficiency and effectiveness in its performance under the Total Cost of Care Model. A temporary rate approved by the Commission may not result in regulated revenue exceeding regulated expenses in the most recently completed fiscal year.* G. (text unchanged)

Adam Kane, Chair

Health Services Cost Review Commission

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UM Midtown Temporary Rate Application

Staff Recommendation

September 14, 2022

UM Midtown Temporary Rate Change Request

- 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.

Criteria for Temporary Rate Change

- 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).

Staff Evaluation of Temporary Rate Change Request based on Hospital Revenue and Expenses

- 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 –** With the exception of 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.
- Staff recommends that the Commission deny the temporary rate change.

IN RE: APPLICATION FOR	* BEFORE THE MARYLAND HEALTH SERVICES
TEMPORARY CHANGES IN RATES	* COST REVIEW COMMISSION
UNIVERSITY OF MARYLAND	* DOCKET: 2022
MEDICAL CENTER	* FOLIO: 2412
MIDTOWN CAMPUS	* PROCEEDING: 2602T
BALTIMORE MARYLAND	

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STAFF RECOMMENDATION

September 14, 2022

Table of Contents

List of Abbreviations

CON	Certificate of Need
ECMAD	Equivalent Case Mix Adjusted Discharge
GBR	Global Budget Revenue
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commissions
ICC	Interhospital Cost Comparison
PAU	Potentially Avoidable Utilization PPC
PQI	Prevention Quality Indicator
QBR	Quality-Based Reimbursement
TCOC	Total Cost of Care
UMMS	University of Maryland Medical System
UMSOM	University of Maryland School of Medicine

Key Methodology Concepts and Definitions

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

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

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

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

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

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

Overview

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.

September 14, 2022 Update

This report represents a summary of the Hospital's temporary rate request as well as updated information that affects the Hospital's financial condition and temporary rate request.

Based on the analysis contained within this report, Staff does not find that the Hospital has demonstrated revenue loss beyond their control, expense growth beyond their control, or that the regulated expenses exceed regulated revenue at the Hospital, the thresholds required by COMAR 10.37.10.05 governing a temporary change in rates.

While the Hospital did experience a negative regulated margin in RY 22, i.e., regulated expenses exceeded regulated revenues at the Hospital, subsequent adjustments made by Staff to correct for CY 2021 market shift ($5,068,896) and GBR revenue transfer for inpatient psych services ($366,830) alter the Hospital's position from a negative regulated margin to a positive regulated margin. For the reasons stated above, Staff does not find that the Hospital has met any of the criteria required by COMAR.

In response to the Temporary Rate Change request filed by the Hospital on July 20, 2022, and based on the enclosed report, 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.

Summary of Temporary Rate Application

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.

Temporary Rate Change Procedures and Guidelines

The procedures for a temporary rate application are outlined in Maryland COMAR 10.37.10.05 and specify that a hospital may apply at any time for a temporary change in rates provided that one of the following conditions is satisfied:

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).

Within 12 working days from the filing of the application, the Commission shall issue its order either denying the temporary change in rates and stating the grounds therefor or granting a temporary change in rates, stating the amount, the necessity of the change, and that a regular rate review will be conducted as soon as practicable. A temporary change in rates is subject to the Commission's final rate order in the regular rate review proceeding, which may be effective as of the date of the temporary rate order.

Background

University of Maryland Medical Center Midtown

University of Maryland Medical Center Midtown (UMMC Midtown), part of the University of Maryland Medical System, 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, UMMC Midtown helps more than 15,000 people a year manage health issues like diabetes and high blood pressure. UMMC 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.

Negotiated Spenddown

A description of the negotiated spenddown agreement between the Hospital and the Commission in November of 2018 is described fully in a separate staff recommendation document pending before the Commission. Action taken by the Commission on the spenddown recommendation will have a direct bearing on the Hospital's financial condition. Staff Analyses

Staff Analysis

Due to the requirement for the temporary rate application to result in a Commission order within 12 working days, HSCRC Staff evaluated the Hospital's request as it relates to meeting the threshold outlined in COMAR 10.37.10.05. That is, the Staff will evaluate whether the Hospital has demonstrated that it has met at least one of the three conditions of the regulation described above. Additionally, Staff explored the secondary request that the Hospital be afforded additional ICC cost credit due to the patient population that is served by the Emergency Department, Inpatient Centers, and Regulated Outpatient Centers compared to other Maryland hospitals.

Financial Condition

In determining whether the Hospital meets the criteria in the temporary rate application, Staff reviewed the financial condition of the Hospital, including the Hospital's overall regulated and unregulated revenues and expenses, as well as other factors that might explain or otherwise shed light on the operating margins and financial condition of the Hospital such as FTE staff changes and physician losses as they compare to peers. Importantly, in order to qualify for the temporary rate adjustment, the Hospital must demonstrate that the reduction in revenue or increase in expenditures is beyond the Hospital's control.

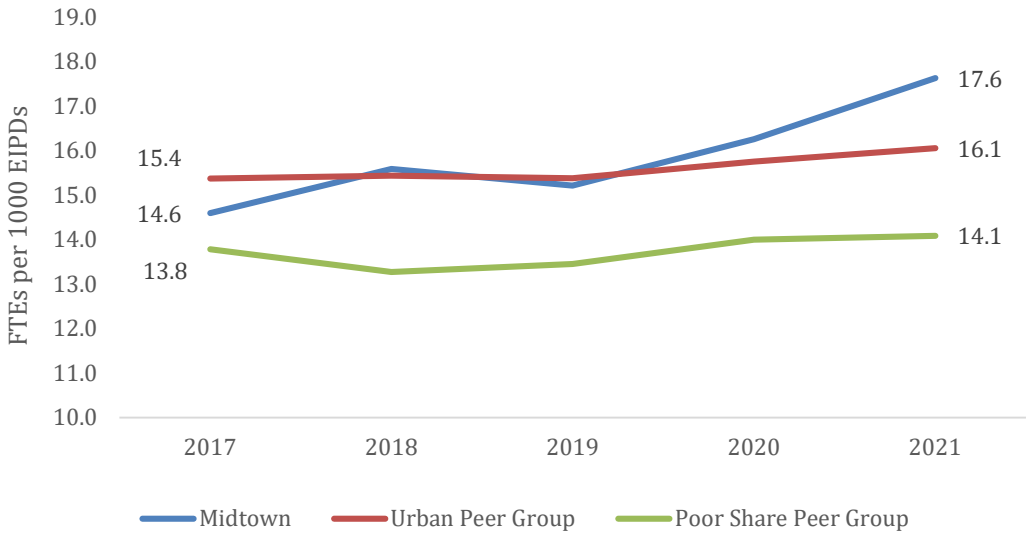
Operating Expenses and Revenue - Total Operating Margin Experience

Figure 2
UM Midtown Operating Margin
RY 2017-2021

	RY 2017	**RY 2018**	**RY 2019**	**RY 2020**	**RY 2021**
Regulated	15.6%	15.1%	9.4%	9.0%	3.5%
Unregulated	-151.8%	-101.4%	-93.6%	-89.0%	-107.9%
Total	**5.2%**	**2.6%**	**-2.3%**	**-2.8%**	**-10.3%**
Pro forma Regulated without Spenddown	15.6%	15.1%	12.0%	13.9%	8.7%
Pro forma Total without Spenddown	**5.2%**	**2.6%**	**0.4%**	**2.3%**	**-5.3%**

While it is true that total operating margins at the Hospital have eroded since the start of the Spenddown in RY 2019, Staff remains concerned that the Hospital increased both regulated and unregulated costs in the midst of a planned reduction in revenues. In RY 2017, regulated operating costs were $170.3 million and rose to $179.4 million in RY 2019, an increase of 5.3%. Unregulated operating expenses were $33.9 million in RY 2017 and rose to $48.8 million in RY 2019, an increase of 44%. As an example of how the Hospital's cost structure has continued to increase, Figure 3 below depicts FTE regulated staff per 1,000 EIPDs (Equivalent Inpatient Days) for Midtown compared to its urban peers and a grouping of hospitals with high poor share percentage. EIPD is a measure of total hospital volume. Despite the spenddown Midtown has continued to invest in regulated staff at a greater rate than their peers.

Figure 3
FTEs per 1,000 EIPD
UM Midtown compared to Peer Hospital Groups
2017-2021



From 2017 to 2019, Midtown's FTEs per 1000 EIPDs grew by 4% while their peers were relatively flat or down. The trend has accelerated since 2019. From 2017 to 2019, Midtown increased from 980.7 to 1,094.4 regulated FTEs, an increase of 11.6%.

Unregulated Physician Losses

The Hospital noted that it changed its physician strategy away from community physicians towards a greater reliance on University of Maryland School of Medicine (USOM) Faculty physicians. This decision came at an extraordinary cost. According to Physician's Practices Loss data in the Annual Filing Schedules (UR-6, UR-8), the physician investment loss per employed physician at Midtown Hospital was 5 times greater than the historical peer group of Prince George's, Mercy, Sinai, Union Memorial, Bayview, and Harbor hospitals and 6 times greater than comparable poor share peer group hospitals (defined as having a poor share payer mix greater than 35 percent). In RY 2019, UM Midtown lost $852,127 per employed physician FTE compared to the urban peer group average of $166,958 per FTE and a poor share peer group average of $141,763 per FTE.

Staff is concerned that a portion of this excess loss per FTE may be due to the Hospital's reporting of physician FTEs in its annual filings, as Midtown shifted from employed physicians to contracted members from the UMSOM and as a result reported 65.5 FTEs in RY 2018 and

only 29 in RY 2019 despite a relatively flat unregulated operating loss. In subsequent analyses of physician contracts since the release of the staff recommendation in August, staff have determined, in consultation with UMMS, that Midtown had at least 90.7 FTE in RY 2018 and 89.1 FTE in 2019, the latter of which would still yield losses of $277,348 per employed physician FTE compared to the urban peer group average of $166,958 per FTE. Staff remain concerned that analyses of physician losses are still incomplete because not all physician specialties have a corresponding FTE and generally there is a lack of uniformity in physician reporting in HSCRC Annual Filing Schedules. Nevertheless, prior to the spenddown (RY 2017 & RY 2018), Midtown maintained a loss per FTE roughly 2.5 times higher than the urban peer group and poor share peer group, and since the spenddown the unregulated physician losses have increased 30 percent from RY 2018 to RY 2021, suggesting that physician losses are potentially excessive.

Volume Changes

Additional volume growth was a purposeful strategy by the Hospital, as noted in the Spenddown agreement with the Commission implemented in 2018 and the subject temporary rate application; however, a corresponding revenue transfer was not requested. The GBR Agreement requires annual updates from each hospital or system relating to the initiation of ventures outside the hospital and shifts to other regulated or unregulated settings. Section IV.B.3a and Section VI.3 of the GBR Agreement outline the language relating to the required annual updates for Appendix F: Annual Disclosure and Certification Regarding Changes in Services Provided and Appendix G: Hospital Financial Interest, Ownership, or Control of other Hospital or Non-Hospital Services Provided Within the Service Area. According to page 8 of the Temporary Rate Application, "Midtown and UMMC undertook a conscious alignment of programs that includes the strategic transfer to Midtown of acute inpatient, post-acute, and certain outpatient surgical and clinic services from UMMC." This volume transfer should be accompanied by a corresponding transfer of revenue from UMMC to Midtown to account for volume growth in bedded care, surgical services, psychiatric services, and medical/surgical supplies and drugs. Hospitals are required to disclose the movement of services so that a hospital's GBR appropriately reflects intended volume shifts. These revenue adjustments will have bearing on the hospital's regulated operating margin. **Update: HSCRC Staff and the Hospital worked together to identify revenue transfers that should occur from UMMC to Midtown for inpatient psychiatric services. The resulting GBR transfer amounts to $366,830 that will be included in the permanent rates of Midtown beginning in RY 23.**

Midtown reports that the strategy deployed post-spenddown has resulted in a 23.1% overall growth in bedded care, an 18.7% growth in surgical services, and a 7.7% growth in supplies and drugs since RY 2018. **Update: Staff concluded the analysis of the final twelve month market shift report for CY 2021 and released the results on August 23, 2022. Midtown Hospital is**

entitled to an adjustment of $5,068,896 that will be included on a one-time basis in RY 23 and then made permanent in future years.

Revenue Changes

Per testimony from the November 2018 Commission public meeting, Dr. Mohan Suntha, then President of the University of Maryland Medical Center, and Mr. Robert Chrencik, then President of the University of Maryland Medical System agreed to the negotiated spenddown as presented to the Commission, which imposed a maximum revenue reduction of $28.5 million. Based on improved efficiency positions and unstable volume measurements due to COVID, only the first two years of the revenue spenddown were implemented for a reduction of $14.3 million in permanent revenue over RY 2019 and 2020. The total reduction that Midtown experienced was only half of what Dr. Suntha and Mr. Chrencik agreed to at the meeting in November 2018.

Since RY 2020, UM Midtown has seen an increase in GBR. Importantly, the revenue increase could have been far more significant if a direct revenue adjustment were made for the movement of entire service lines, most notably inpatient psychiatric services from UMMC to UM Midtown. Starting in RY 2019, UMMS appears to have shifted over 2,500 patients to UM Midtown (an increase of 36.6 percent); through RY 2022 UMMS appears to have shifted over 3,600 patient days from UMMC to UM Midtown (an increase of 51.3 percent at UM Midtown). Relying on market shift alone to capture this movement reduces the potential revenue impact to the Hospital. This is very consequential to the emergency rate application determination because in RY 2022 the Hospital is projected to have a regulated operating loss. Staff recognizes that some of this movement was picked up in market shifts. However, there are outstanding questions as to whether the market shift adjustment was sufficient or whether additional revenue transfers should occur. In addition to inpatient psych, the Hospital's Temporary Rate Application cites other strategic movement of services to Midtown including acute inpatient, post-acute, and certain outpatient surgical and clinic services from UMMC. Importantly, it is the Hospital's requirement to disclose such movement so that it can be more precisely captured. The Hospital plays a vital role in clarifying volume movement so that revenue can be appropriately allocated.

It is also important to note that revenue for special funding programs was granted to UMMC and Midtown to address population health and challenges specific to the patient population in West Baltimore. Special Funding for community-based programs since RY 2019 totaled approximately $15.2 million for improved care and infection reduction for patients at long-term care facilities, community vaccination efforts for COVID-19, catalyst grant programs directed at diabetes control and behavioral health crisis services, job training for individuals from disadvantaged areas, and mobile integrated health to reduce emergency department utilization and address high needs patients. Although this funding is a one-time adjustment and does not add to operating margin, it is important revenue that was allocated to UMMC and Midtown to improve health outcomes in its service area of West Baltimore.

Disproportionate Share Percentage

The Hospital argues in the Temporary Rate Application that UM Midtown, relative to its state peers, shoulders an outsized burden of poor share patients, which is a measure of Medicaid, dual eligibles, and self-pay/charity care as a percentage of total patient population. In the initial spenddown analysis conducted in 2018, Staff acknowledged the additional costs associated with serving the DSH population and included an additional 7% efficiency credit to account for the population directly served by Midtown. This ICC cost credit was in addition to the DSH recognition in the urban peer group, which was in place at the time and evaluated urban hospitals with higher cost bases against each other. Taking both the urban peer group's underlying cost adjustments and the additional efficiency credit for Midtown, the Hospital's ICC position improved by 11.4%.

In 2019, Staff and stakeholders reviewed the peer group adjustments and determined that a direct risk adjustment based on cost increases attributable to serving a higher than average share of Medicaid, dual eligible, and self-pay/charity care patients (DSH Adjustment) was preferable to an urban peer grouping because variation in population populations do exist within peer groups, especially over time. Using this newer direct risk adjustment methodology, Midtown's ICC standing would have improved by 10.8% (relative to an ICC with peer groups and no DSH Adjustment). The congruence of these "credits" essentially confirmed the assumption used during the spenddown. The latest version of the ICC also determined that there was no statistically significant relationship between ICC performance and percent of charges attributable to Medicaid, dual eligibles, and charity care or any measure of Area Deprivation Index (average score, percentage of charges, etc.), which suggests that the efficiency evaluation of regulated services adequately accounts for the incremental costs associated with serving a more disadvantaged population.

Since 2019, the payer mix at Midtown has changed as their casemix adjusted volumes have slightly grown. The Hospital still serves a majority of DSH patients in the Emergency Department, clinics, and certain service lines. However, in total, the payer mix of the Hospital has changed owing in part due to services transitioned from UMMC. Across all service lines, the Hospital experienced a 43% decline in charges stemming from DSH patients, a 20% increase in charges for commercially insured individuals, and a 56% increase in charges for Medicare Advantage beneficiaries.

Figure 4
Change in Charges and ECMADS, by Payer - CY 2019-2021

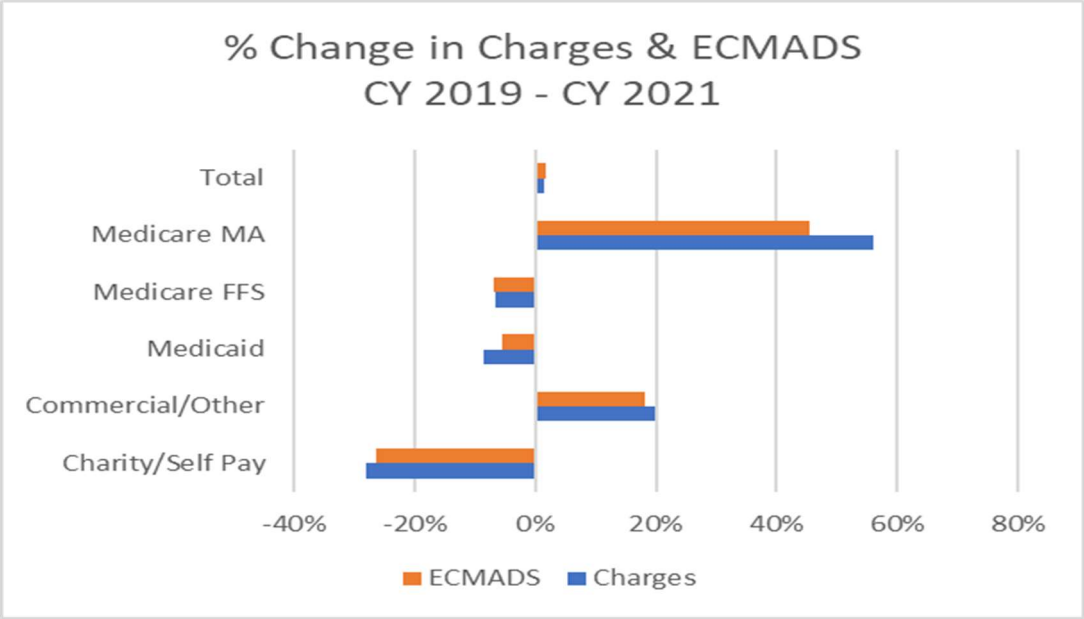
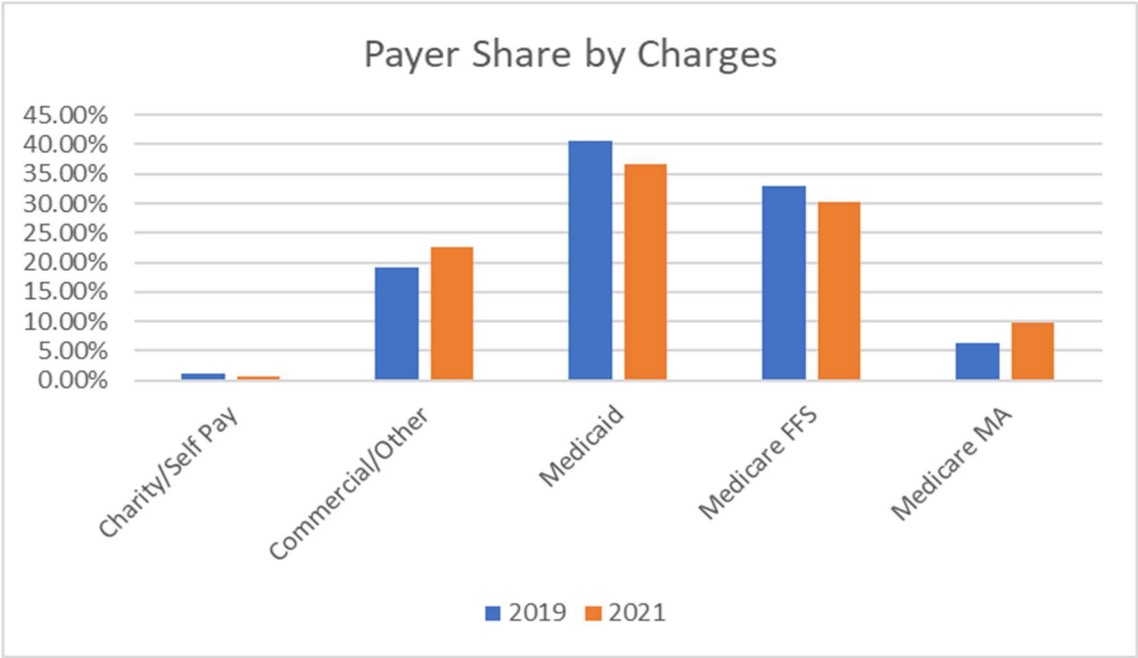


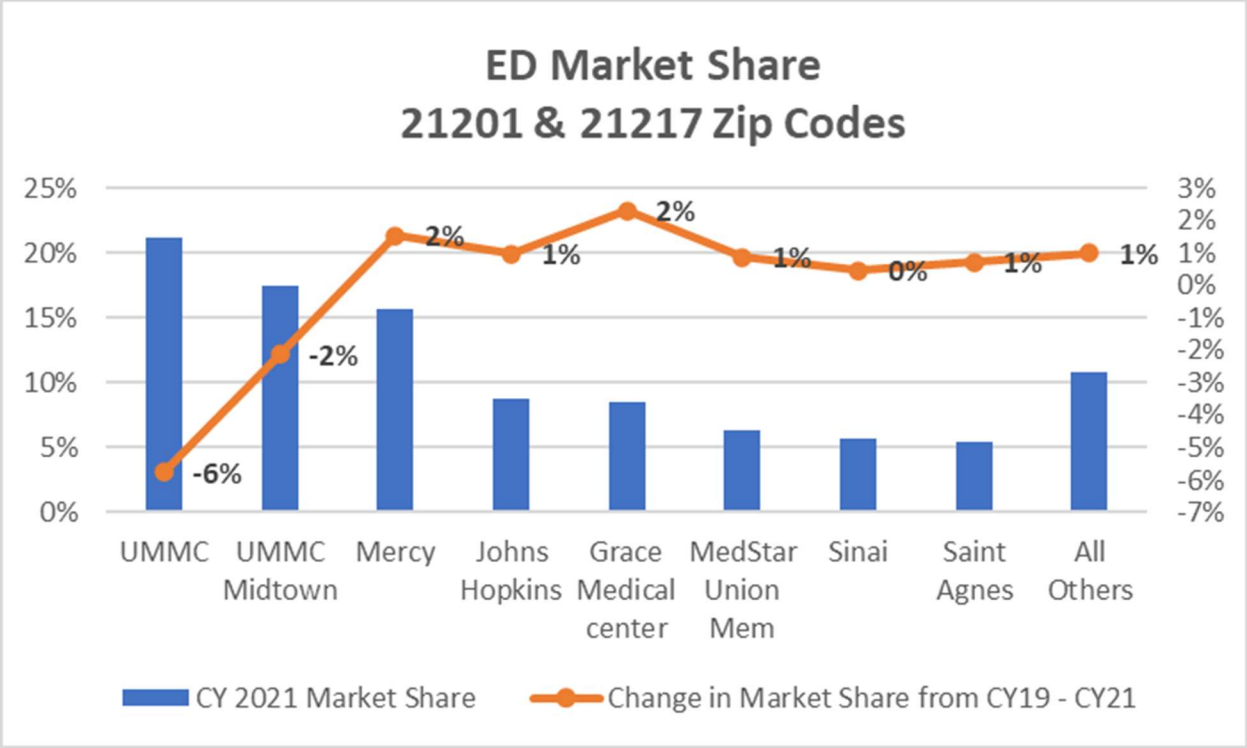
Figure 5
Payer Share at Midtown, by Charges - CY 2019 and 2021



Interestingly, the distribution of hospital ED visits from patients within two of the zip codes cited in the Temporary Rate Application, 21201 and 21217, appears to have changed between 2019 and 2021, with the share of patients being treated at Midtown and UMMC decreasing and instead

moving toward other ED options, including Grace Medical Center, Mercy Medical Center, and others.

Figure 6
Emergency Department Market Share for Zip Codes 21201 and 21217



These analyses indicate that the proportion of charges/patients that Midtown serves stemming from DSH patients has decreased since 2019 and there is greater diversity in patients served by the Hospital. The surrounding zip codes of 21201 and 21217, which are disproportionately represented by Medicaid enrollees (~65% of all ED visits were Medicaid in 2021), are accessing services at other facilities other than UM Midtown and UMMC.

Summary of Staff Analysis

Based on the analysis contained within this report, Staff does not find that the Hospital has demonstrated revenue loss beyond their control, expense growth beyond their control, or that the regulated expenses exceed regulated revenue at the Hospital, the threshold required by COMAR 10.37.10.05 governing a temporary change in rates.

The revenue loss associated with the negotiated spenddown was specific to Midtown Hospital. However, subsequent policy development that identifies high-cost outliers was applied statewide through the Integrated Efficiency policy. The Commission Staff hopes that future iterations of the Integrated Efficiency policy will be codified by the Commission which will exempt a

hospital from a revenue reduction if the revenue in question is being used to support community health needs (i.e., Revenue for Reform). As of this writing, no such formal policy exists to allow a hospital to keep excess revenue from being cut or redistributed.

Additionally, the revenue loss associated with the spenddown in FY 2019 and FY2020 was agreed to and known by the Hospital before the start of FY 2019. The Hospital was also excused from the final three years of the negotiated spenddown due to improved efficiency position and limitations presented by COVID volume anomalies.

Staff notes, however, that a subsequent statewide Integrated Efficiency policy was approved by the Commission that evaluates relative efficiency of Maryland hospitals. Given the fact that the evaluation of efficiency has evolved since the negotiated spenddown of Midtown Hospital, the Commission directed Staff to conduct a separate analysis of the negotiated spenddown. A separate recommendation concerning the negotiated spenddown is pending before the Commission.

The expense increase experienced by Midtown since 2019 also was a conscious and deliberate choice to rely on more UMSOM Faculty physicians, driving up the underlying cost structure of the Hospital. This expense increase was a strategic decision made by the Hospital.

The third litmus test for the Temporary Rate Application is that a hospital's expenses from regulated services exceed its revenues from regulated services. Staff does not find the Hospital to have met this criterion. Looking only at regulated services, the Hospital has had positive operating margins from RY 2019 through RY 2021. The losses from the unregulated services push the Hospital's total margin into negative territory. Furthermore, the Commission does not regulate expenses or revenues associated with unregulated services. It also does not have access to contracts and data from the unregulated side, nor does it have the expertise to confidently evaluate the reasonableness of those unregulated expenses. Until a change in statute occurs, Commission analysis for regulated rate increases must focus on the regulated side. Furthermore, the operating margin for the Hospital may improve once the revenue adjustment mentioned above for purposeful movement of services from UMMC to Midtown is complete.

While the Hospital did experience a negative regulated margin in RY 22, subsequent adjustments made by Staff to correct for CY 2021 market shift ($5,068,896) and GBR revenue transfer for inpatient psych services ($366,830) push the Hospital from a negative regulated margin to a positive regulated margin. For the reasons stated above, Staff does not find that the Hospital has met the third criterion.

Finally, the Temporary Rate Application requests an additional cost credit in the ICC for a DSH adjustment beyond the standard adjustment. The Commission recently revised its peer grouping

with input from the industry and determined that a direct risk adjustment based on cost increases attributable to serving a higher than average share of Medicaid, dual eligible, and self-pay charity care patients (DSH Adjustment) was preferable to an urban peer grouping. Using this newer direct risk adjustment methodology, Midtown's actual DSH share is accounted for, and risk adjusted in its ICC calculation. However, it should be noted that volume changes and transfers implemented by Midtown from UMMC may decrease its overall share of DSH patients and charges.

Staff Recommendation

In response to the Temporary Rate Change request filed by the Hospital on July 20, 2022, 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 request.

Review and Recommendation of UM-Midtown Negotiated Spenddown

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Evolution of Efficiency Policy

Spenddown Background

- HSCRC Commissioners, as part of its strategic sessions, directed staff to review high cost and low cost outlier hospitals based on a number of factors:
  - Interhospital Cost Comparison (ICC) result
  - Total Cost of Care (TCOC) per capita growth rate
  - Potentially Avoidable Utilization (PAU) growth rate and PAU attainment
  - Quality Program Performance - MHAC, RRIP, and QBR performance
- Evaluation of University of Maryland Medical Center Midtown Campus in 2018
  - Worst RY 2018 ICC Performance among Maryland hospitals (32.7% over the standard vs Statewide Avg of 13.17%)
    - **15.6% Regulated Margin vs Statewide ICC Avg of 7.8% (RY17 Statistics)**
    - **29.2% over Statewide Cost Per Case Avg (23% over Urban Peer Group Avg)**
  - Top quintile for TCOC growth rate per capita
  - Favorable PAU growth rate, but significantly high PAU attainment
  - Mixed quality outcomes
- Commission voted in November 2018 to implement a structured spenddown for Midtown between RY 19-23

Spenddown Results

Rate Year	Proposed Revenue Reduction (based on 2018 GBR)	$ Impact (2018 denominator locked)	Potential $ Cumulative Impact	Actual $ Cumulative Impact
2019	3%	-$7,134,794	-$7,134,794	-$7,134,794
2020	3%	-$7,134,794	-$14,269,588	-$14,269,588
2021	2%	-$4,756,529	-$19,026,117	-$14,269,588
2022	2%	-$4,756,529	-$23,782,647	-$14,269,588
2023	2%	-$4,756,529	-$28,539,176	-$14,269,588

Integrated Efficiency Policy

Purpose

- To formulaically **penalize and reward hospital efficiency** while:
  - Maintaining the TCOC Model's incentive to **reduce avoidable utilization**
  - Keeping fidelity to the HSCRC's statutory mandate to ensure **that total costs are reasonable** and that aggregate **charges are reasonably related to aggregate costs**
- Will be used to **scale annual inflation for poor performing outliers**; staff can also use the ranking to **evaluate GBR rate enhancement requests**

How it Works

Ranks hospitals on an efficiency matrix according to all-payer cost per case efficiency using a volume adjusted Inter-hospital Cost Comparison (ICC) as well as on Medicare and Commercial TCOC performance

Methodology

- The most efficient hospital receives a rank of 1 under both the ICC and TCOC ranking
- Total rank is the sum of a hospital's ICC and TCOC rank
- Both measures are weighted equally and hospitals are arrayed into quartiles to determine overall efficiency

Staff Recommendation

Analysis: Commission policy on efficiency has evolved under the All-Payer and Total Cost of Care Models. Integrated Efficiency policy provides a tool to evaluate all hospitals simultaneously and formulaically. Policy that applies uniformly to all hospitals is preferable to a policy that was only applied to one hospital.

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

- Provide a permanent rate adjustment of $13.6 million to reverse out the permanent rate reductions associated with the negotiated spenddown and implement the rate reduction associated with the statewide RY 2022 Integrated Efficiency Policy.

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University of Maryland – Midtown Spenddown Evaluation

Staff Recommendation

September 2022

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

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Overview

During the public Commission meeting on August 1, 2022, Commissioners expressed a desire to better understand the differences between the negotiated spenddown agreement with University of Maryland - Midtown approved by the Commission in November 2018 (implemented in July 2019) and the evolved Integrated Efficiency Policy (formally adopted for implementation July 2021). This report includes a history of efficiency policies, including the negotiated spenddown and development of Integrated Efficiency policy, as well as an analysis that reconciles the differences between the two approaches.

Staff Recommendation

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

- Provide a permanent rate adjustment of $13.6 million 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.

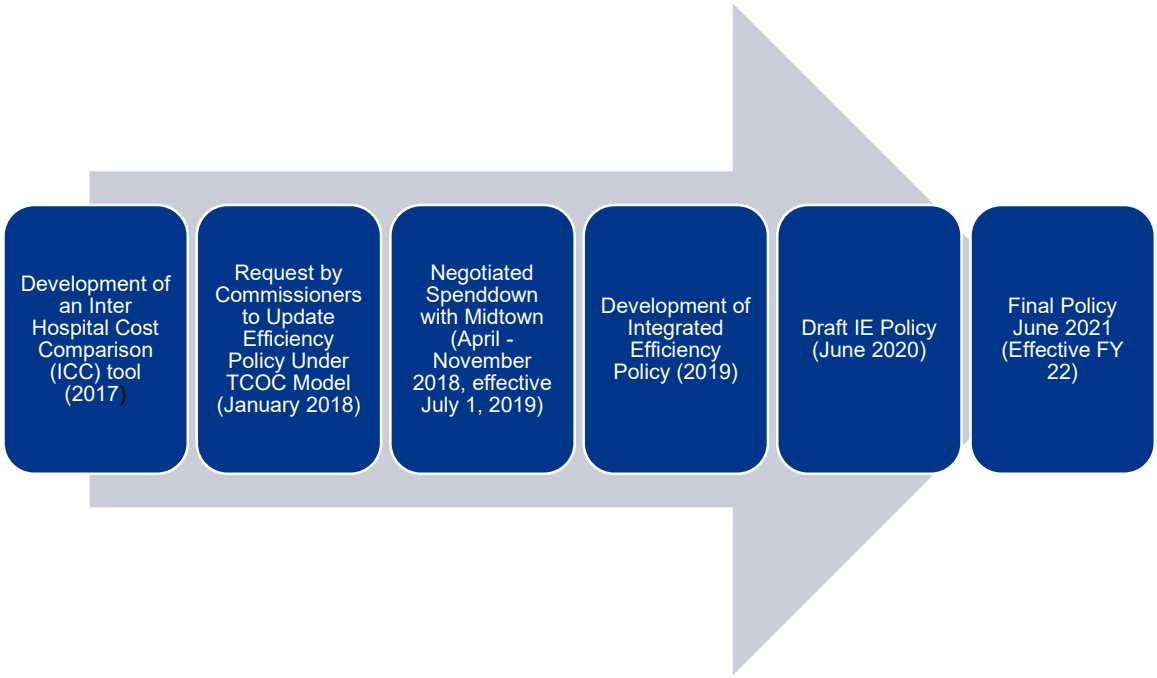
Background

As the State transitioned to the All-Payer Model and global budget reimbursement system, the Commission expressed a desire to update the measure of efficiency that the Commission traditionally used to measure hospital cost efficiency. In prior applications of the HSCRC efficiency methodologies, hospitals' revenues were reduced under spenddown agreements if they were deemed to have cost-per-case beyond a set level. In another application of efficiency measures, hospitals with favorable hospital cost-per-case positions were given higher annual updates than those hospitals with poor relative cost-per-case. However, all of these prior iterations of efficiency analyses were based on fee-for-service mechanisms and did not have to account for relative cost efficiency in a per capita system. In a per capita system, a hospital aligned with the Total Cost of Care (TCOC) Model will reduce utilization by improving the health of the population, retain a portion of the revenue associated with the reduced utilization, and potentially appear to be less cost efficient in a cost-per-case analysis. Moreover, hospitals can confound this analysis in the global revenue era by reducing utilization through shifting services to non-hospital providers (referred to as deregulation), eliminating services outright, or by simply continuing to pursue additional volume growth beyond population and demographic driven changes. Despite these complexities, the HSCRC must still establish charges that are reasonably related to costs, which in turn should be reasonable themselves, while also properly incentivizing hospitals to reduce unnecessary utilization, promote high quality care, and reduce total cost of care.

For these reasons, Staff set out to develop a way to evaluate both hospital cost-per-case and total cost of care performance, while also considering quality scores to ensure high quality of care at Maryland hospitals

at costs reasonably related to the services provided. This process took a number of years to complete, and the approach has evolved over time. As this report demonstrates, in the global budget era of the Maryland Model, the approach to address cost inefficiency has evolved from a single hospital evaluation to a statewide evaluation of cost and quality efficiency.

Figure 1. Timeline of Efficiency Policy Development



History of Spenddown Decision

Below is a brief description of the negotiated spenddown that was agreed upon by the University of Maryland Midtown ("Midtown," or "Hospital") and Staff and subsequently approved by the Commission in November 2018. The summary is based on the public report included at the November 2018 Commission meeting during which Dr. Mohan Suntha, then President of the University of Maryland Medical Center "UMMC"), and Mr. Robert Chrencik, then President of the University of Maryland Medical System, testified on behalf of the Hospital and accepted the terms of the negotiated spenddown, while emphasizing the unique challenges of the patient population in the Hospital's service area.

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, taking into account 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 Hospital 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 casemix adjusted readmissions rates, as measured through the Readmissions Reductions Incentive program.

Between April 2018 and November 2018, the HSCRC Staff and representatives of the Hospital met to discuss the reasons that the Hospital's adjusted charge per case was relatively high and what considerations should be made when determining an appropriate rate structure. Finally, Staff and the Hospital had a series of meetings to determine the acceptable terms of a negotiated revenue reduction over time, known as a "spenddown" agreement, which was ultimately brought before the Commission and approved by a vote of 4-3.

The Staff's proposal for the negotiated spenddown included considerations made for profits, a 100 percent passthrough of revenue not included in the ICC calculation, acknowledgement of RY 2018 revenue reductions already in place, growth and current levels of PAU relative to the State and peers, Medicare TCOC growth per capita compared to the State and peers, and an allowance for health disparities in the patient population that is treated at the Hospital. Additional detail on the considerations is included below:

In the past, when the Commission initiated spenddowns, it did not remove profits from the revenue target levels. The ICC removes peer group profits to get to a cost level comparison. The Staff restored profits to adjust the ICC calculation, which reduced the excess charge per case from 32.65% to 26.12%.

Certain revenues were excluded from the ICC and these were likewise excluded from spenddown consideration, i.e., these revenues received no adjustment. This reduced the excess charge per case from 26.12% to 20.25%.

Preexisting reductions to revenues in RY 2018 were accounted for. This reduced the excess charge per case from 20.25% to 19.03%.

Midtown was in the top decile of the State in terms of various measures of poverty such as Medicaid percentages, income per capita, Area Deprivation Index, among others. Staff incorporated a reduction allowance in the required spenddown to allow the Hospital to continue to invest in interventions that improve population health and reduce health disparities. This reduced the excess charge per case from 19.03% to 12.03%.

If a hospital's cost per case was high as a result of higher reductions in avoidable utilization, the HSCRC should avoid revenue reductions that would undermine the incentives of the global revenue system. If charge per case increased but cost per capita remained the same or decreased after accounting for inflation, revenue reductions should be mitigated for achieving the desired improvement. HSCRC staff reviewed the Medicare total cost of care growth for Midtown from 2013 to 2017 and found that the Hospital was in the least favorable quintile of state performance, with growth in excess of two times the statewide average. PAU reductions were greater than the state and peer group averages. After reviewing these results, Staff determined that the Hospital was not due relief for its performance in PAU reductions or total cost of care, as the favorable PAU reductions were offset by the unfavorable Medicare total cost of care growth.

In order to meet the challenge of a significant rate revenue reduction plan, a five-year time period was agreed to as appropriate. The Hospital believed that part of its unfavorable charge per case performance resulted from the reduction of inpatient services at the Hospital, some of which related to patients being treated in other hospitals or in deregulated settings. The Hospital introduced important new outpatient services focused on the reduction of health disparities, including diabetes clinics, infectious disease clinics, cardiology and pulmonary clinics, and behavioral health clinics, among others. The expanded clinic operations are part of a concerted effort to deal with the many chronic health conditions that challenge the residents of West Baltimore.

In addition to the investments to expand clinical capacity and expertise, the population health strategy also includes aspects such as transportation, transitional care, patient education, and social support. Significant investments are required to care for the social determinants of health in West Baltimore. Staff proposed spenddown targets that recognize the importance of this effort and the need to continue these investments. The Hospital also expected to work with the University of Maryland Medical Center to relocate additional low intensity services to the Midtown campus. This was expected to free up capacity at UMMC for more intense cases as well as to lower the charge-per-case at Midtown. The interim review process allowed for an assessment of the Hospital's progress in execution of its plans.

After discussions about the reasonable level of efficiency improvement that should be expected, the Hospital and HSCRC staff agreed to a 12% reduction to the Hospital's RY 2018 GBR, with an opportunity to assess the Hospital's efficiency level at two points during the five-year period as follows:

- RY 19: 3% reduction (Guaranteed Reduction)

- RY 20: 3% reduction (Guaranteed Reduction)
- RY 21: 2% reduction (Performance Evaluation)
- RY 22: 2% reduction
- RY 23: 2% reduction (Performance Evaluation)

Figure 2. Negotiated Spenddown for UM Midtown, RY 2019 - 2023

RY	Revenue Reduction based on FY 2018 GBR	$ Impact	Potential Cumulative $ Impact	Actual Cumulative $ Impact
RY 2019	3%	-$7,134,794	-$7,134,794	-$7,134,794
RY 2020	3%	-$7,134,794	-$14,269,588	-$14,269,588
RY 2021	2%	-$4,756,529	-$19,026,117	-$14,269,588
RY 2022	2%	-$4,756,529	-$23,782,647	-$14,269,588
RY 2023	2%	-$4,756,529	-$28,539,176	-$14,269,588

Figure 2 shows the value of the reduction to be included in rates that the spenddown agreement specified over the 5-year period. As shown in the Figure above, the impact of the rate reduction was mitigated in RY 21, due to improved cost efficiency. In RY 22, Staff decided not to assess the Hospital further because of the confounding effects of COVID on volume measurement.

Staff considered the spenddown to be complete, and the Hospital will now be subject to other statewide efficiency policy adjustments (i.e., Integrated Efficiency Policy), alongside all other hospitals.

Integrated Efficiency Policy

Following the successful development of the ICC tool and shortly after the conclusion of the negotiated spenddown of Midtown, Commissioners further directed Staff to establish a way to more formulaically evaluate the relative efficiency of the broader hospital system through the Integrated Efficiency Policy. The Integrated Efficiency Policy, established by the HSCRC aims to simultaneously evaluate whether hospitals are "technically efficient" on a *cost per case* basis AND are effective in controlling *total cost per capita.* Those hospitals identified as particularly high in both these categories are considered presumptively inefficient, while those that are low in both these categories are presumptively efficient. Presumptively inefficient hospitals are not granted access to a portion of inflation as part of the annual update factor. They are free to file a rate application if they so desire. Presumptively efficient and effective hospitals are granted the opportunity to request slightly higher revenue through an expedited adjustment to their GBR agreement.

The simultaneous nature of this comparison is important. Clearly, controlling TCOC is essential in order for the Maryland Model to succeed. At the same time, controlling hospital cost per case is central to the mission of the Commission. Finding the right balance between these two elements that tend to move in opposite directions is critical.

This policy is the first broad scale, incremental step towards creating a formulaic use of efficiency methodologies in the per capita and global revenue era. Over time, this policy will bring hospitals more in line with average cost-per-case and total cost of care performance.

Timeline and Process for Finalizing the IE Policy

Beginning in 2018, Staff worked with Commissioners and stakeholders to develop a formulaic and transparent methodology that identifies and addresses relative efficiency performance in order to bring hospitals closer to peer average standards over time. The purpose of this exercise was to update the HSCRC's efficiency measures to be in line with the incentives of Maryland's Total Cost of Care (TCOC) Model, so that objective standards are in place when the Commission adjusts hospitals' permanent rate structures and addresses and corrects maldistribution of global revenues.

In July 2019, a Staff draft recommendation was brought before the Commission. During the course of review following the publication of the July draft recommendation, a number of concerns were identified by Staff, Commissioners, and stakeholders regarding: a) the casemix adjustment for rehabilitation cases; b) use of a growth calculation in lieu of a benchmark attainment analysis for total cost of care performance; c) the appropriateness of current peer groups in the hospital cost per case efficiency assessment and d) general concerns that the policy should identify larger amounts of inappropriately retained revenue.

Commissioners at the October and November 2020 Commission meetings also expressed concern that the designation of hospitals as outliers based on a one standard deviation hospital pricing rule created an undesirable cliff effect, especially when the penalty was not scaled to reflect gradations in hospital performance. Commissioners also noted a desire to expedite the use of Staff's proposed Revenue for Reform concept that allows hospitals to have safe harbors for hospital revenue, i.e., revenue that is used for specific care transformation efforts at the hospital that could be excluded from efficiency analyses. Finally, Staff also noted that an additional risk adjustment for hospitals deemed similar to critical access hospitals would be included in future iterations of the Integrated Efficiency Policy. A final Integrated Efficiency Policy was adopted and implemented in RY 22. An adjustment for RY 23 has not taken effect yet due to COVID volume instability. Staff expects to be able to implement RY 23 Integrated Efficiency adjustments in January 2023.

Staff Analysis

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.

At this time, Staff is recommending a permanent rate increase, pending Commission approval, of $13,579,452. Staff is not recommending any one-time adjustments associated with this reversal, as the underlying temporary rate application was filed in RY 23. It is fundamental law that the courts do not favor retroactivity. Generally, rules and regulations, including Commission policies of general application as so defined by the Maryland Administrative Procedure Act, are not retroactively applied but are limited to the time following their becoming effective. All administrative rules typically have only prospective effect unless the language of the parent statute provides for a retroactive effect. The HSCRC statute does not provide for such a retroactive effect in this matter. In addition to the legal concerns, there are also practical concerns as well – i.e., the double-edged sword effect. Applying Commission policy retroactively may result in revenue increases as requested here; however, such application may also result in revenue decreases in other situations. To permit retroactivity to policies selectively – that is, only when the result is an increase -- is bad precedent and contrary to the Commission's mandate of establishing rates equitably among all purchasers of hospital services.

For these reasons, the resolution of this matter should be handled in RY 23 as a permanent adjustment.

Staff Recommendation

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 $13.6 million 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.

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FY 2021 Population Health Care Transformation Expenses Report

September 14, 2022

REPORTING GOALS

- 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
- “30,000 foot” view, to get a sense of the size and nature of investments as defined by hospitals
  - Include all physicians and categorize rather than trying to differentiate non-population health and population health physicians.
  - Complexities in broad definition of population health

Changes from FY 2020 to FY 2021 reporting

- Eliminate Indirect Non-Physician section and apply a 25% load assumption
- Provide Population Health categories for Non-Physician
  - No change in overall definition of Non-Physician expenses just provide buckets for guidance
  - Categories are consistent with Community Benefit categories and FY20 reporting
- Other smaller changes
- FY20 was a prototype, so would not expect year over year changes to be meaningful, therefore this analysis does not focus on these changes.

Direct Non-Physician Costs: Regulated Hospital by Annual Filing Cost Center

($ In millions)	2021	2020
Hospital Management	59.5	51.9
Social Services	35.5	30.0
Med Surg	8.1	8.5
Medical Care Review	11.4	5.8
Nursing Administration	7.4	5.5
Clinic	14.7	4.9
Community Health Education	7.5	4.0
All Other	33.5	30.8
Total	177.6	141.4

- Hospitals were asked to categorize regulated population health costs (which total $177 M) by the annual filing cost centers.
- Annual filing cost centers don't capture population cost well resulting in most costs being categorized as general management.
- The costs reported under general management cost account for significant share of management cost increases since 2013.

Direct Non-Physician Costs: Total by FY21 Pop. Health Categories

- When adding indirect allocation and including investments outside the regulated space total investments increase to ~$300 M.
- The costs that are more likely to qualify for Revenue for Reform, e.g., Community Outreach are concentrated in the unregulated and non-regulated space and are therefore considered margin in the ICC model.

($ In millions)	Regulated	% of Total	Unregulated + Non-Regulated	% of Total	Total	% of Total
Care Management	70.0	39.4%	10.6	16.3%	80.6	33.3%
Community Outreach	34.2	19.3%	18.1	27.9%	52.3	21.6%
Population Health Administration	33.3	18.7%	6.3	9.7%	39.6	16.3%
Population Health Clinics	9.6	5.4%	16.3	25.2%	25.9	10.7%
Workforce Development	9.9	5.6%	1.2	1.8%	11.1	4.6%
All Other	20.6	11.6%	12.3	19.0%	32.9	13.6%
Total Non-Physician Direct	177.6	100.0%	64.6	100.0%	242.3	100.0%
Assumed Load (25%)	44.4		16.2		60.6	
Total Non-Physician (% or Regulated Revenue)	222.1 (1.2%)		80.8 (0.4%)		302.9 (1.6%)	

FY21 Gains (Losses) On Physicians per Population Health Report

($ In millions)	Regulated	Unregulated*	Non-Regulated	Total
Hospital Coverage	-$193	-$375	-$14	-$583
Population Health focused clinics	$1	-$3	-$2	-$4
Community Physicians in specialties identified in CHNA*	-$33	-$131	-$39	-$204
Community Physicians - Primary Care, not in CHNA*	$0	-$32	-$16	-$48
Community Physicians - All Other, not in CHNA*	-$16	-$167	-$50	-$233
Total	-$242	-$708	-$122	-$1,072

% of Total	Regulated	Unregulated	Non-Regulated	Total
Hospital Coverage	18.0%	35.0%	1.3%	54.4%
Population Health focused clinics	-0.1%	0.3%	0.2%	0.4%
Community Physicians in specialties identified in CHNA*	3.1%	12.3%	3.7%	19.0%
Community Physicians - Primary Care, not in CHNA*	0.0%	3.0%	1.5%	4.4%
Community Physicians - All Other, not in CHNA*	1.5%	15.6%	4.7%	21.8%
Total	22.6%	66.1%	11.4%	100.0%

- Approximately half of reported losses relate to hospital coverage ($583 M)
- About 90% of losses are in the regulated entity (23% regulated + 66% unregulated)
- About 25% of losses relate to neither hospital coverage or needs assessed in the Community Health Needs Assessment (CHNA) (4.4% + 21.8%)
- There is considerable inconsistency across systems in where losses are reported.

*All physician revenue and costs are intended to be reported on the population health report, however, the losses reported in the annual filing are somewhat higher for unregulated business, so amounts on this page may be understated.

Next Steps

- Report will not be collected for FY2022 to reduce hospital reporting burden
  - No need to update annually given high-level nature of the report
  - Staff pursuing other initiatives
    - More focused reporting that would be required under a revenue for reform policy
    - Potential revisions to the annual filing
- May re-instate in FY 2023 if merited
- Potential relevant Annual Filing revisions
  - Improve Cost Report data collection around Physician costs
  - Refine Annual Filing Cost Centers to better align with current hospital operations

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Update on Medicare FFS Data & Analysis

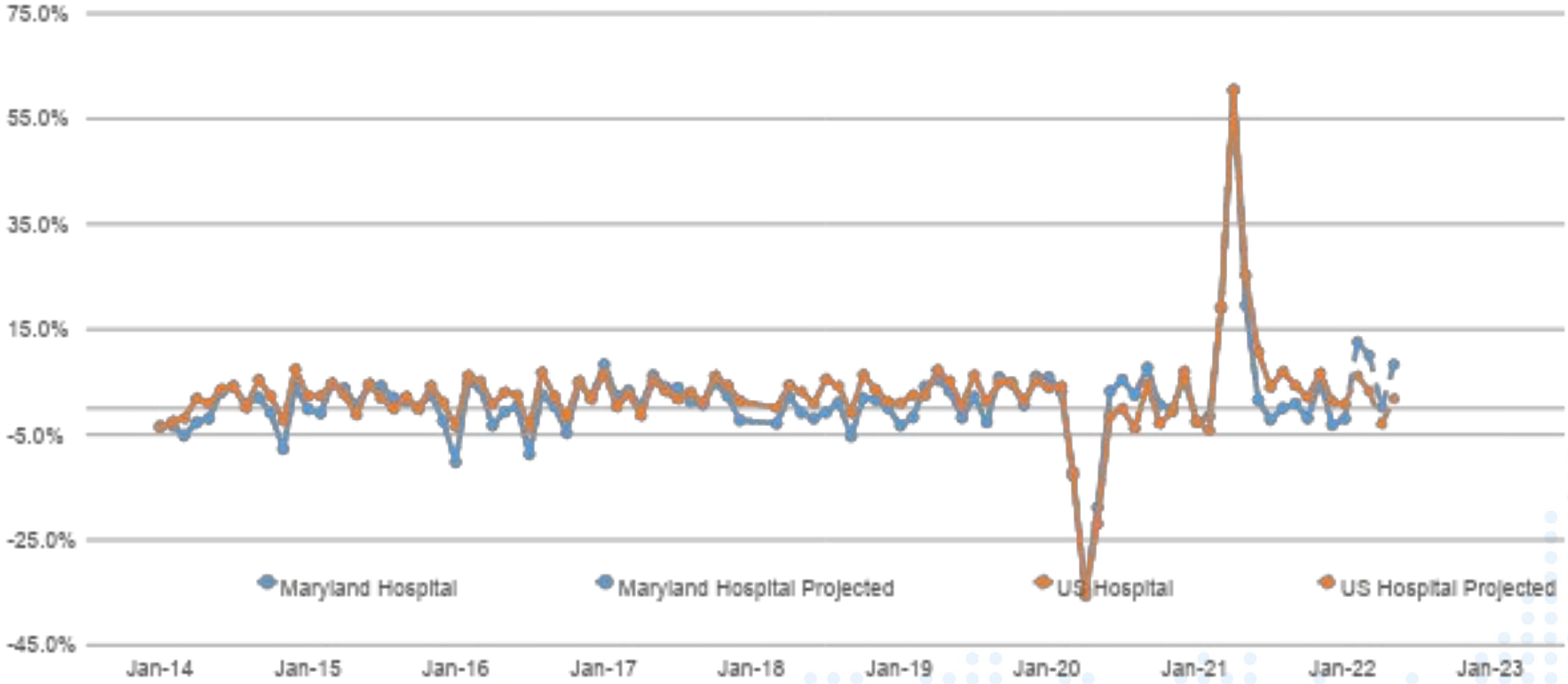
September 2022 Update

Data through May 2022, Claims paid through July 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

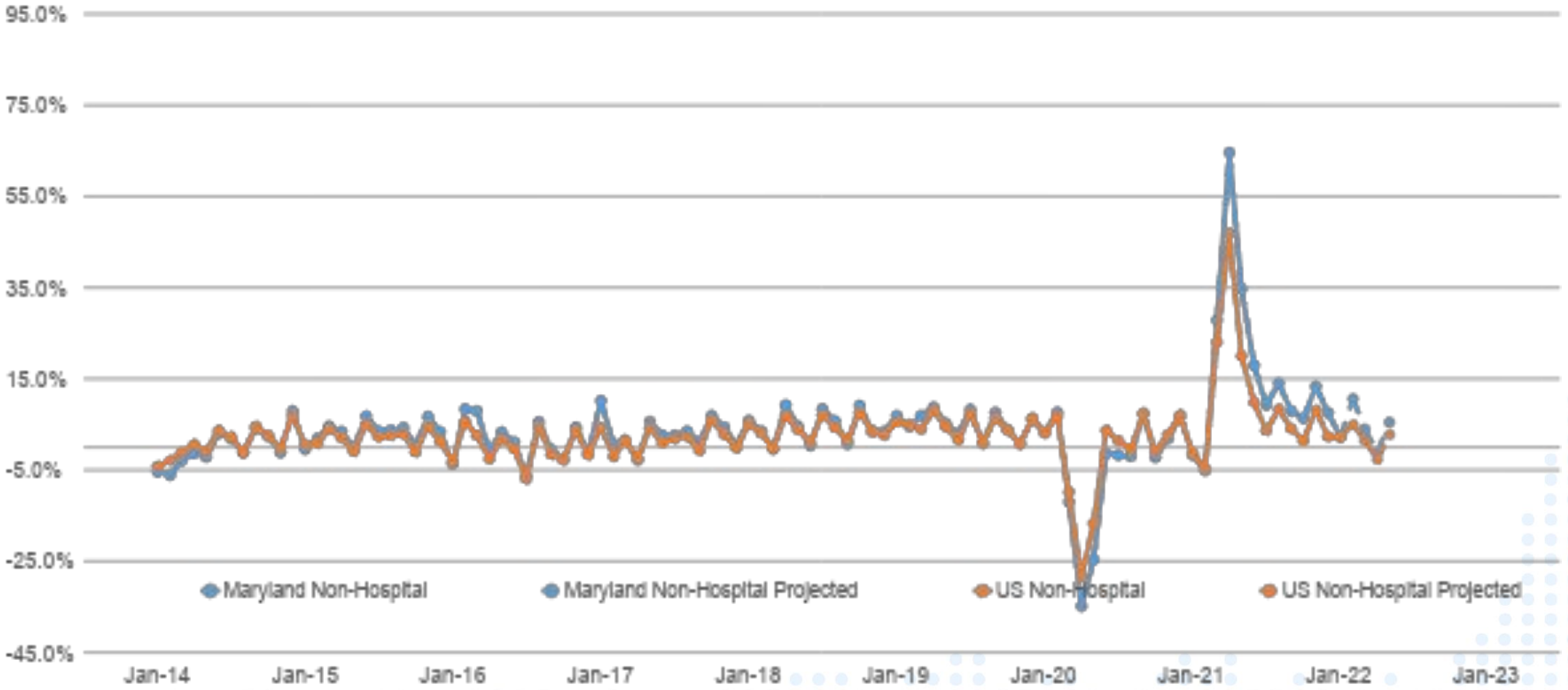
Actual Growth Trend (CY month vs. Prior CY month)



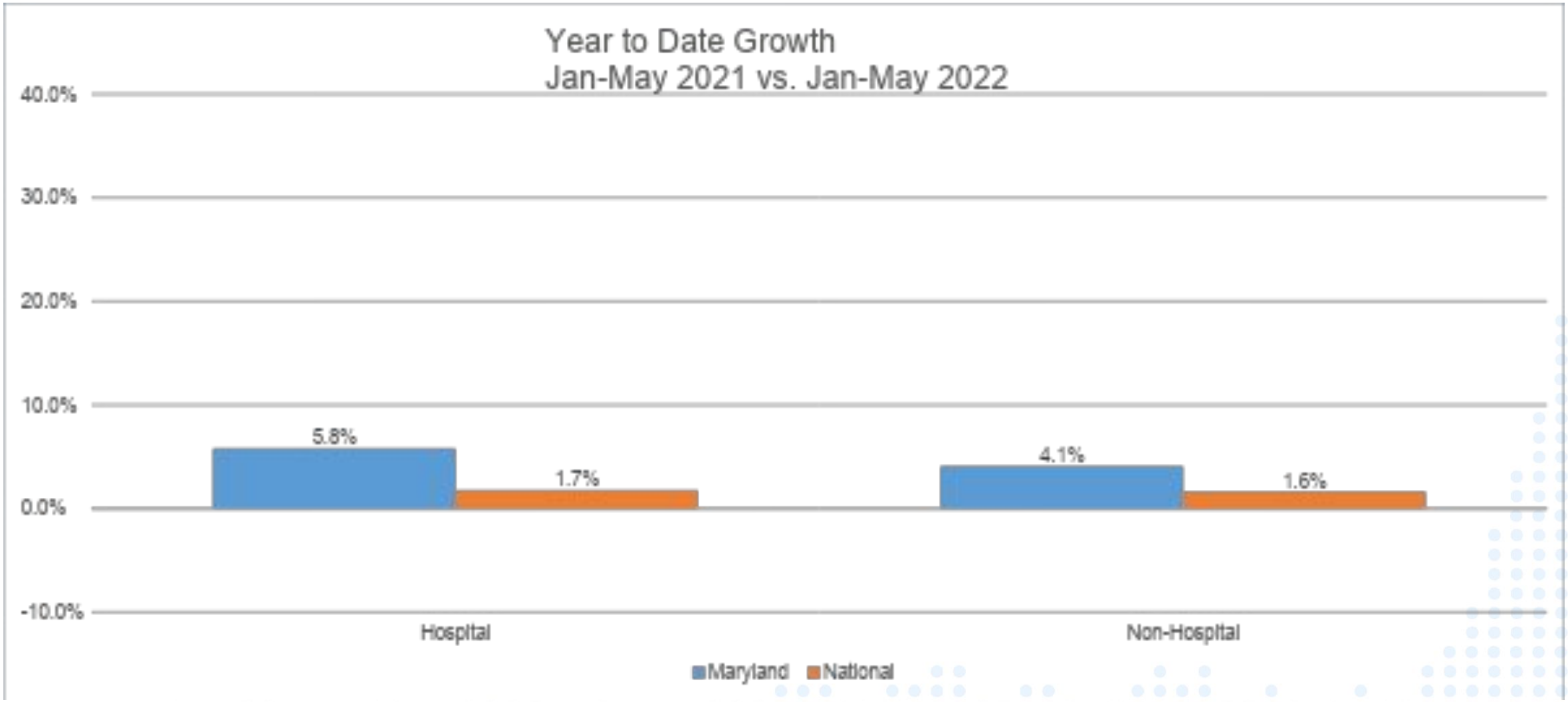
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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

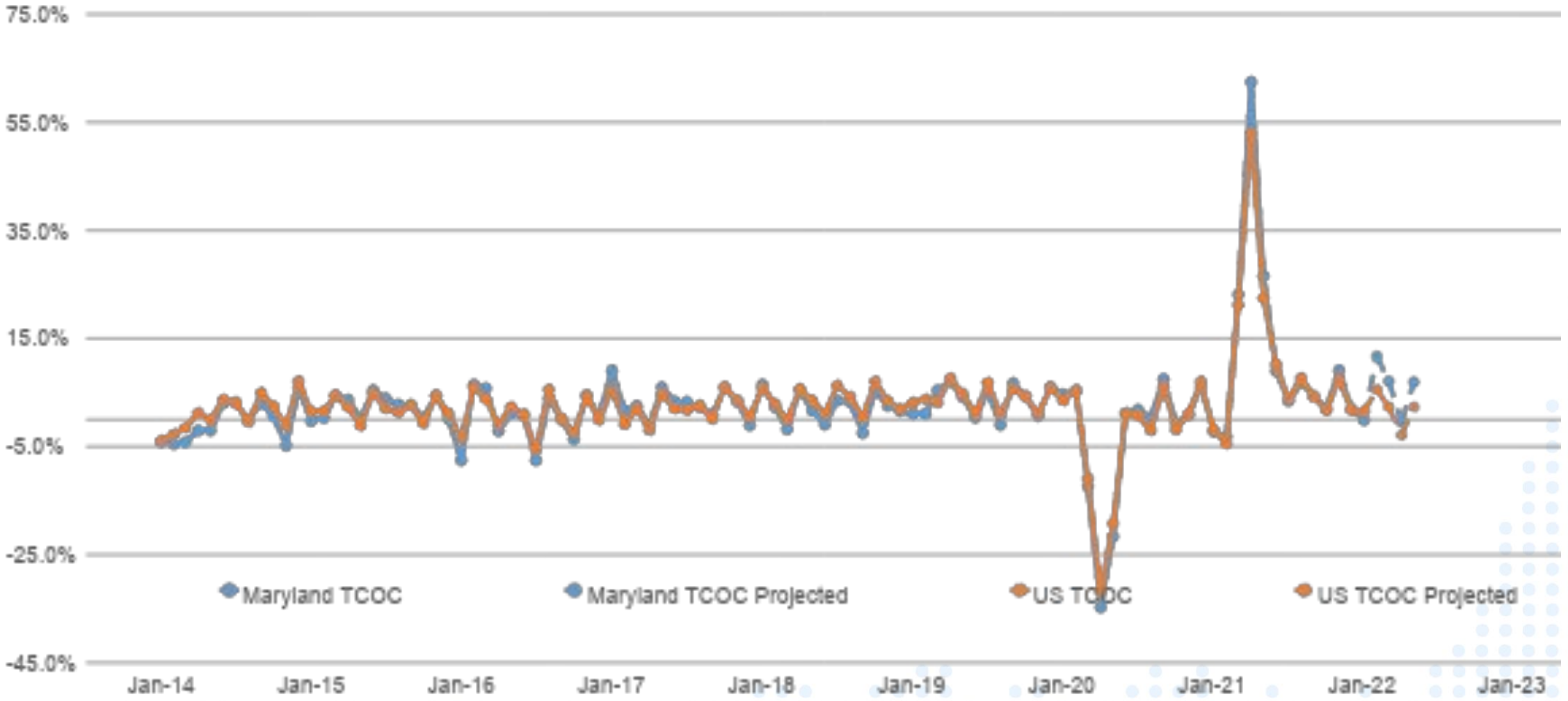


Medicare Hospital and Non-Hospital Payments per Capita



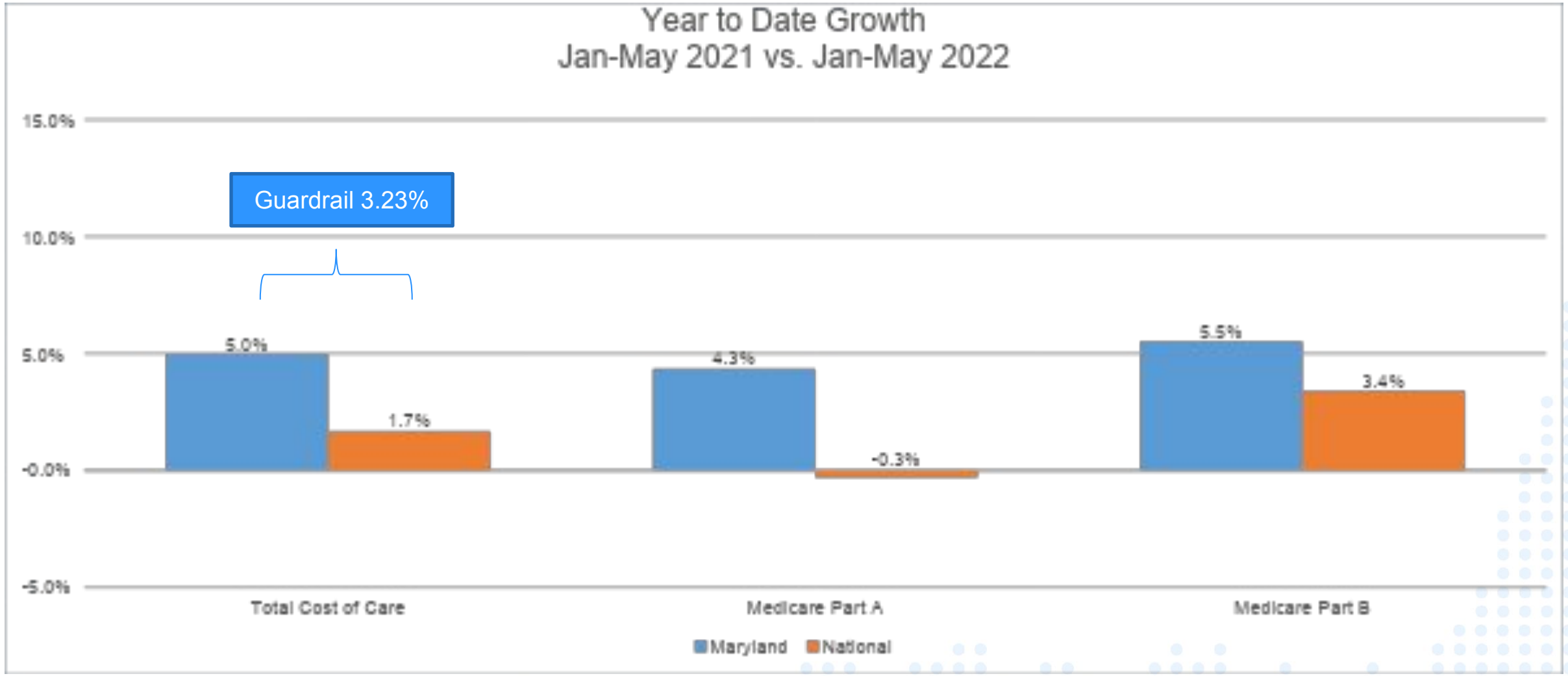
Medicare Total Cost of Care Spending per Capita

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



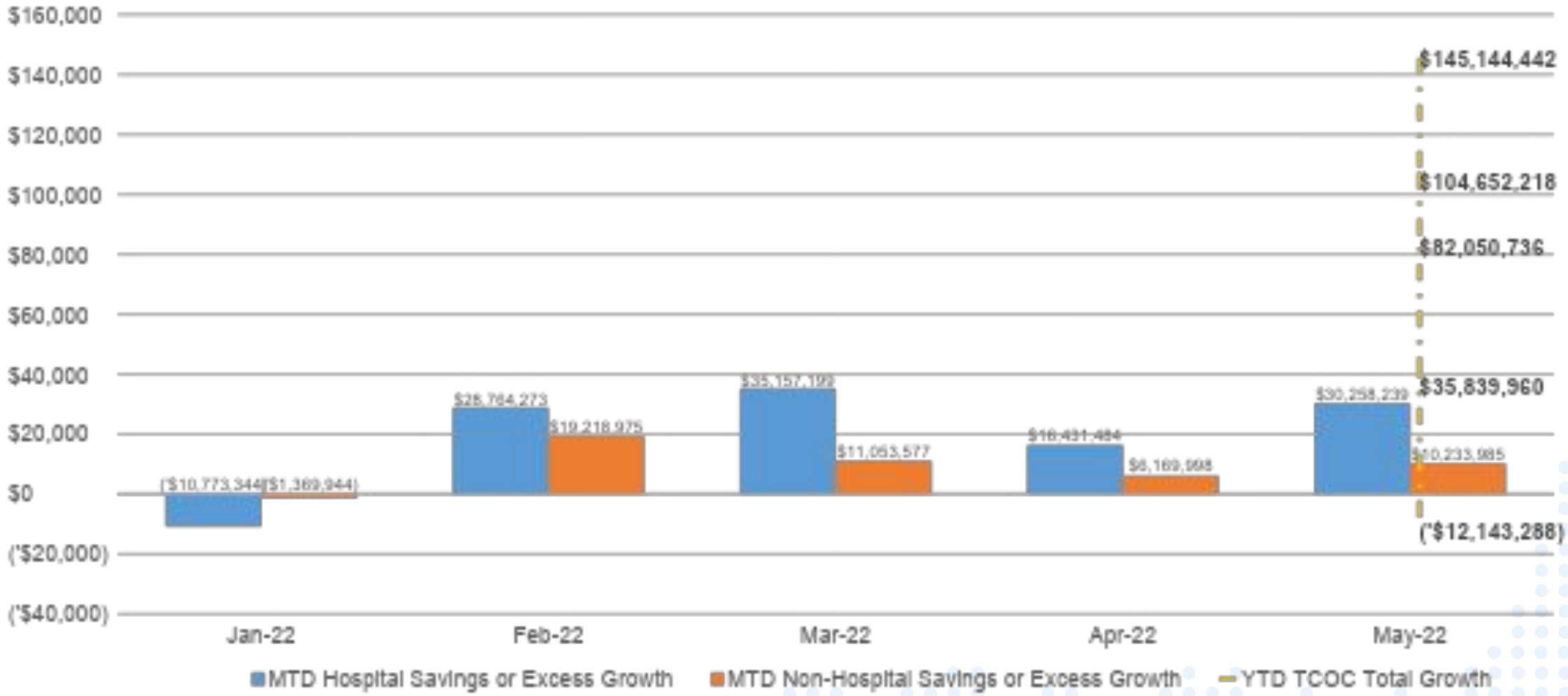
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through May 2022



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TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: September 14, 2022

RE: Hearing and Meeting Schedule

October 12, 2022 To be determined – In-person/Hybrid or GoTo Webinar

November 9, 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.