NOTICE OF WRITTEN COMMENT PERIOD

Notice is hereby given that the public and interested parties are invited to submit written comments to the Commission on the staff draft recommendations and updates that will be presented at the March 10, 2020 Public Meeting:

1. Draft Recommendation on the Payer Differential for Medicare Advantage

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATIONS ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE MARCH 24, 2020, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.

582nd Meeting of the Health Services Cost Review Commission
March 10, 2020

(The Commission will begin 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 February 10, 2020

2. Docket Status – Cases Closed

   2549A – University of Maryland Medical Center

3. Docket Status – Cases Open

   2550A – Johns Hopkins Health System 25510A – Johns Hopkins Health System

   2552A – Johns Hopkins Health System

4. Presentation on Regional Partnership Catalyst Grant Program Activities
   a. Greater Baltimore Regional Integrated Crisis System (GBRICS)
   b. Nexus Montgomery

5. Draft Recommendation on Medicare Advantage Payer Differential

6. Workgroup Updates
   a. Efficiency Workgroup
   b. Payment Models Workgroup
   c. Performance Measurement Workgroup

7. Policy Update and Discussion
    a. COVID-19 Surge Policy
    b. Model Monitoring
    c. Legislative Update

8. Legal Report
9. Hearing and Meeting Schedule

Closed Session Minutes
of the
Health Services Cost Review Commission

February 10, 2021

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. 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 11:35 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

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

In attendance via conference call representing Staff were Katie Wunderlich, Allan Pack, William Henderson, Jerry Schmith, Tequila Terry, Geoff Daugherty, Will Daniel, Alyson Schuster, Claudine Williams, Megan Renfrew, Xavier Colo, Amanda Vaughn, Bob Gallion, and Dennis Phelps.

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

Item One

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

Item Two

William Henderson, Director-Medical Economics & Data Analytics, updated the Commission on hospital volumes and profits. Mr. Henderson also summarized proposed approaches to settling hospital GBRs for FY 2020 and the first six months of FY 2021 to be discussed in Public Session.

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Item Three

Katie Wunderlich, Executive Director, summarized the February 3, 2021meeting with Hospital CEOs concerning future strategies and initiatives to improve the quality and delivery of health care in Maryland.

The Closed Session was adjourned at 1:10 p.m.

581st MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
February 10, 2021

Chairman Adam Kane called the public meeting to order at 11:30 am. Commissioners Joseph Antos, PhD, Victoria Bayless, Stacia Cohen, John Colmers, James Elliott, M.D., and Sam Malhotra were also in attendance. Upon motion made by Commissioner Antos and seconded by Commissioner Colmers, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:21 p.m.

REPORT OF FEBRUARY 10, 2021 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the February 10, 2021 Closed Session.

ITEM 1
REVIEW OF THE MINUTES FROM THE JANUARY 13. 2021 CLOSED SESSION AND PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the January 13, 2021 Closed Meeting and Public Session.

ITEM II
CASES CLOSED

2541N - Sheppard Pratt Hospital
2546N - Garrett Regional Medical Center
2547A – Johns Hopkins Health System
2548A - Johns Hopkins Health System

ITEM III
OPEN CASES

ITEM IV
STAFF RECOMMENDATION ON ARM EXTENSION APPROVAL

Mr. Phelps presented Staff's recommendation to grant a three-month extension to approve the University of Maryland Medical Center (UMMC) and OptumHealth Care Solutions, Inc. alternative rate arrangement. (see Recommendation to Grant an Extension of Approval of

Alternative Method of Rate Determination Arrangement between the University of Maryland Medical Center and OptumHealth Care Solutions, Inc. available on the HSCRC website).

Effective November 1, 2019, a one-year approval was granted for the renewal of an alternative rate arrangement (ARM) between the UMMC and OptumHealth Care Solutions, Inc. for the provision of solid organ and blood and bone marrow services.

In October of 2020, UMMC requested and was granted a three-month extension of the approval for the ARM arrangement with OptumHealth Care Solutions, Inc. to provide time to complete renegotiation of the arrangement.

On January 20, 2021, UMMC requested a second three-month extension, to April 30, 2021, to finalize negotiations on the ARM arrangement with OptumHealth Care Solutions, Inc.

Since the authority granted to staff to extend Commission approval on ARM arrangements is limited to three months, staff recommends that the Commission approve UMMC's request for an additional three-month extension, to April 30, 2021, of Commission approval for the ARM arrangement between the UMMC and OptumHealth Care Solutions, Inc.

Commissioners voted unanimously to approve Staff's recommendation.

ITEM V
CARES FUNDING AND COVID-19 RESPONSE

Mr. William Henderson, Director of Medical Economics and Data Analytics, presented of an update on CARES Funding Policy (see CARES Funding Policy Update" available on the HSCRC website).

Mr. Henderson stated that Staff continues to review and assess the impacts of COVID-19 on hospital financial performance to inform policy decisions. Staff has determined that hospital regulated profit margins experienced a decline from 8.0 percent in FY 2019 to 4.8 percent in FY 2020, before increasing slightly to 6.2 percent through the first six months of FY 2021. Staff also assessed the impact of COVID-19 on total operating profit margin (both regulated and unregulated). They concluded that total margins declined from 4.9 percent in FY 2019 to 2.0 in FY 2020 before partially recovering to 2.5 percent through the first six months of FY 2021. Staff also determined that Maryland hospital systems achieved an average operating margin of 1.0 percent in FY 2020. Since FY 2014, hospital system average operating margin has ranged from a high of 3.9 percent in FY 2015 to a low of 1.9 percent in FY 2019.

Staff has also continued to assess the impact of COVID-19 on hospital volumes. Staff has determined that CY 2020 outpatient volumes have stabilized since June, at a level slightly below that of the prior year. Inpatient volumes have also stabilized slightly below CY 2019 levels.

Staff proposed the following procedures for the settlement of FY 2020 and the first six months of FY 2021 GBR at the hospital level:

1. Calculate the hospital's total approved revenue as the sum of the hospital:
    - Total FY 2020 and first six months of FY 2021 approved charges, including approved expanded corridors
    - FY 2020 undercharge and first six months of FY 2021 undercharge
    - Impact of COVID-19 on FY 2020 expenses, aggregated through analysis of Annual Filings
    - Impact of COVID-19 on FY 2021 expenses, aggregated through analysis of Annual Filings) FY 2021 funding under current COVID Surge Funding Policy, if any

2. Calculate the hospital's total actual revenue as the sum of the hospital's:
    - Total FY 2020 and first six months of FY 2021 actual charges
    - Regulated portion of CARES funding, calculated using the proportion of regulated revenue versus unregulated revenue per the FY 2019 Annual Filing

3. Determine the hospitals over - /- underfunding by subtracting the hospital's total actual revenue from total approved revenue. If the result is positive, the Staff considers the hospital underfunded by that amount. If the result is negative, then the hospital would be regarded as being overfunded by that amount.

If the above analysis shows a hospital in a net underfunded position, then the hospital would be eligible to bill for that underfunding in subsequent periods. However, suppose a hospital is determined to be in an overfunded position. In that case, the hospital must reduce future charges to eliminate the overfunding. The earliest effective date for this would be July 1, 2021. Under this proposed methodology, if material CARES Act monies are subsequently recaptured by HHS, the Commission will work with the hospital to recover these funds through additional charges in subsequent rate years.

Staff also presented alternative procedures for the settlement of FY 2020 and FY 2021 GBR. Stakeholders proposed the alternative methodology. The alternative approach would follow the steps outlined above in the Staff approach. However, the alternative approach would cap the hospital's final amount over/underfunding at the amount of additional revenue that the hospital received through corridor expansion.

Under the Staff approach, and without factoring in the impacts of COVID-19 on expenses, Maryland hospitals would be in a net overfunded $284M position. Under the stakeholder approach, this statewide net overfunded position would be reduced to $31M. Staff argued that if HHS recovers unjustified CARES Act funding (as current guidance suggests), the two approaches will ultimately yield the same result.

Both proposed methodologies for the settlement of FY 2020 and the first six months of FY 2021 GBR include consideration of increased costs. Staff will assess changes in total operating costs between the FY 2019 and FY 2020 Annual Filings to quantify the impact of COVID-19 on hospital costs. Staff believes that it is appropriate to evaluate COVID-related expenses in the context of other changes in the cost to assess the full effect of COVID-19 on costs. Staff will continue to analyze changes in total costs and costs per unit at both a summary level and at the rate center level.

Staff completed an initial review of FY 2020 Annual Filings for hospitals with a June fiscal year end. From this initial review, Staff found that total operating expenses increased by 2.3 percent, from $15.4B in the FY 2019 Annual Filings to $15.8B in the FY 2020 Annual Filings. Simultaneously, net patient revenues decreased by 2.4 percent, from $14.8B in FY 2019 to $14.4B in FY 2020. This decrease offsets approximately $700M in CARES funding. Total operating profits also declined from $344M in FY 2019 to $328M in FY 2020 or 4.4 percent.

At the rate center level, most direct rate centers experienced declines in costs, primarily due to volume reductions. Across all direct patient care rate centers (Annual Filing Schedule D), hospital costs declined by 8.5 percent in FY 2020, with outpatient services driving the bulk of this reduction. Conversely, costs in indirect rate centers (Annual Filing Schedule C) increased slightly in FY 2020.

Staff will focus mainly on hospitals that experienced higher expense growth than revenue growth per their FY 2020 Annual Filing.

Commissioner Colmers inquired as to whether Staff had discussed the proposed approaches for GBR settlement with CMS.

Mr. Henderson responded that Staff had not yet involved CMS in these discussions.

Chairman Kane asked how CARES Act funding would be allocated between regulated and unregulated services.

Mr. Henderson replied that Staff will allocate the amount of CARES Act funding based on the split of regulated and unregulated revenue from the FY 2019 Annual Filings. Mr. Henderson noted that, statewide, CARES Act funding would be allocated 88 percent to regulated service, with the remaining 12 percent allocated to unregulated services.

Commissioner Colmers said CARES Act funds should be treated equitably across hospital systems. Commissioner Colmers raised several potential unintended consequences of accounting for CARES funding at hospital systems, rather than at the individual hospital level.

Commissioner Bayless asked how HSCRC Staff would collect information on COVID expenses.

Mr. Henderson stated that Staff would examine aggregate, year-over-year expenses to determine if a hospital's expense base had increased. Additional data may be requested to determine if COVID caused net expense increases.

Commissioner Bayless questioned why Staff was comparing hospital margins to that of other economic sectors when hospitals must continuously operate to care for patients during the pandemic.

Commissioner Elliot asked if physician losses would be included in HSCRC's calculation of hospital COVID expenses.

Mr. Henderson stated that incremental physician losses from COVID are not captured in hospital regulated expenses.

Mr. Brett McCone Senior Vice President Health Care Payment, of the Maryland Hospital Association thanked Staff for supporting hospitals during the pandemic. Mr. McCone asserted that Staff rate reductions should be limited to the amount of rate support provided by the HSCRC. Mr. McCone noted that CARES funding is contingent on hospitals justifying the support through expenses or lost revenues, otherwise the funding must be returned and that HHS guidelines allow hospitals to allocate CARES funding within their health system.

Arin Foreman, Senior Director, Regulatory Affairs, CareFirst supported HSCRC Staff's approach.

ITEM VI
POLICY UPDATE AND DISCUSSION

Model Monitoring

Ms. Caitlin Cooksey, Chief, Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 10 months ending October 2020. Maryland's Medicare Hospital spending per capita growth was unfavorable when compared to the nation. Ms. Cooksey noted that Medicare TCOC spending per capita was trending unfavorably for the past 3 months. Nonhospital spending per capita in Maryland is trending close to the nation thru October. Maryland's Medicare Part A nonhospital spending is favorable. Medicare Part B nonhospital spending is mixed when compared to the nation thru October.

Benchmarking Presentation

Mr. Henderson presented Staff's Benchmarking overview (see "Benchmarking Overview" available on the HSCRC website).

Mr. Henderson stated that the goal of the Benchmarking is to create a methodology to allow the incorporation of TCOC benchmarks into appropriate methodologies at a granular level and guide the State on areas of strength and weakness in terms of cost and quality. The policies that will include the TCOC benchmarks are the Full Rate Application Policy and the MPA Policy. The Staff also expects to use benchmarking in the Integrated Efficiency Policy currently under development.

The methodology bases the Medicare benchmarks on Medicare fee-for-service beneficiaries. The Commercial standards are limited to members under the age of 65. The method establishes peer geographies at the county level for the Medicare benchmarks and the Metropolitan Statistical Area (MSA) for the Commercial benchmarks.

The Medicare data is obtained from the Chronic Conditions Warehouse (CCW) and includes claims for Medicare A + B beneficiaries. Staff utilizes 100 percent of CCW claims from Maryland counties and a 5 percent sample for peer counties. The Staff obtained the commercial data for Maryland MSAs from the Maryland All-Payer Claims Database (MD-APCD), which includes approximately 40 percent of Maryland Commercial beneficiaries. For the peer MSAs, the Staff obtained the commercial data from Milliman's Consolidated Health Cost Guidelines Sources Database, reflecting about 98M commercially insured individuals in the United States.

The Staff methodology for developing benchmarks is as follows:

- Select and validate source data.
- Narrow the data to relevant comparable peer MSAs / counties based on population and density.
- Match peer MSAs / counties based on demographic characteristics.
    a) Characteristics used for Medicare include: Median Income, Deep Poverty

Percentage, Regional Price Parity, Hierarchical Conditioning Categories (HCC)
b) Characteristics used for Commercial include all Medicare Characteristics, as well as: Government Payer Share, Platinum Risk Scores

- Calculate benchmark value using the simple average of peers at the MSA / county level.
- Remove estimated medical education costs and adjust for risk and benefits (Commercial only)
- Normalize for demographics and translate to the hospital Primary Service Area Plus (PSAP)

The results show Maryland commercial performance 24.3 percent below the nation and Medicare performance 8.6 percent above the nation.

Mr. Henderson noted that at the hospital level, favorable performance versus Medicare and Commercial benchmarks are correlated. Hospitals that perform well versus Medicare benchmarks tend to perform well versus Commercial standards, and vice versa.

Mr. Henderson stated that the future areas of focus are as follows:

- Updating the data to include CY 2019 data. Mr. Henderson anticipates that the data release will continue to remain on year behind the current calendar year.
- Staff will continue to review the appropriateness of risk/demographic adjustment and assess the impacts of border-crossings.

Commissioner Colmers asked how Staff will handle the issue of hospital primary service areas that extend beyond Maryland's borders.

Mr. Henderson replied that any non-Maryland zip codes are excluded from the benchmarking calculation, as the benchmarking goal is to evaluate performance in Maryland.

Commissioner Cohen reminded Commissioners and stakeholders that the benchmarking calculations do not include drug costs on either the Medicare or Commercial side.

Commissioner Colmers questioned whether there is value in assessing benchmark performance in the aggregate by combining the Medicare and Commercial benchmarking results.

Mr. Henderson replied that a large subset of the population would be excluded without Medicaid data, impacting the validity of any findings.

Ms. Katie Wunderlich, Executive Director stated that the HSCRC uses the individual Commercial and Medicare benchmarks for various purposes. As an example, Ms. Wunderlich cited the use of the Medicare benchmarks in negotiations with CMMI.

Chairman Kane inquired about the availability of Medicaid data.

Ms. Wunderlich noted that differences in definitions and benefits across states would make it very difficult to use Medicaid data.

Mr. Henderson added that there are additional data security requirements for Medicaid data.

Chairman Kane asked whether Staff had assessed infrastructure as a cost driver. Chairman Kane suggested that Staff may want to analyze hospital beds per capita and hospital revenue per capita data.

Legislative Update

Ms. Megan Renfrew, Associate Director of External Affairs presented the Legislative Update (see "Legislative
Update" available on the HSCRC website).

Ms. Renfrew stated that due to the COVID-19 the following changes have been made to the legislative sessions:

- Members are strongly encouraged to limit the number of bills introduced;
- Virtual committee briefing and hearings;
- Access to legislative buildings is restricted to Members, some staff, and limited members of press;
- Floor sessions are limited to 2 hours;
- Weekly schedules will be condensed to limit days Members are on campus.

Ms. Renfrew noted that telehealth and health equity are priority health issues for legislators this year. Ms. Renfrew stated that Staff have been in contact with stakeholders on the issues of telehealth, medical debt, and financial assistance.

Ms. Renfrew noted that Staff is monitoring the following bills:

- HB 588- Budget Bill for FY 2022 (The Governor's Budget)
- HB 589/SB 493- Budget Reconciliation and Financing Act of 2021
- HB 123/SB 3- Preserve Telehealth Access Act of 2021
- HB 731/SB 567- Telehealth Services- Expansion
- HB 551/SB 393- Maryland Assistance Program and Health Insurance- Coverage and Reimbursement of Telehealth Services

- HB 565/SB 514- Hospitals- Medical Debt Protection
- HB 1021/SB 758- Health Insurance- Two-Sided Incentive Arrangements and Capitated Payments- Authorization
- HB 1022/SB 748- Public Health- State Designated Exchange- Clinical Information Sharing.

ITEM VII
HEARING AND MEETING SCHEDULE

- March 10, 2021

- April 14, 2021

There being no further business, the meeting was adjourned at 3:38 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 March 2, 2021

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2550A	Johns Hopkins Health System	2/22/2021	N/A	N/A	ARM	DNP	OPEN
2551A	Johns Hopkins Health System	2/24/2021	N/A	N/A	ARM	DNP	OPEN
2552A	Johns Hopkins Health System	2/26/2021	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE APPLICATION FOR	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2021
SYSTEM	*	FOLIO:	2360
BALTIMORE, MARYLAND	*	PROCEEDING:	2550A

Staff Recommendation

March 10, 2021I

INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on February 22, 2021 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to add outpatient joint replacement services to the global rate arrangement approved for bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, thyroid surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services, eating disorder, gender affirming surgery, and gall bladder surgery with Assured Partners. The Hospitals request that the approval be for the period from March 1, 2021 to September 30, 2021.

II. OVERVIEW OF APPLICATION

The contract will be continue to be held and administered by 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 procedures at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

The experience under the current arrangement for the last year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination to add outpatient joint replacement services to bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, thyroid surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services, eating disorder, gender affirming surgery, and gall bladder surgery approved effective October 1, 2020, for the period from March 1, 2021 to September 30, 2021. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2021**
SYSTEM	*	**FOLIO:**	**2361**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2551A**

Staff Recommendation

March 10, 2021

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on February 24, 2021 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 April 1, 2021.

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 believes that this arrangement is similar to several other successful arrangements approved by the Commission.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for 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 April 1, 2021. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2021
SYSTEM	*	FOLIO:	2362
BALTIMORE, MARYLAND	*	PROCEEDING:	2552A

Staff Recommendation

March 10, 2021

I. INTRODUCTION

Johns Hopkins Health System (the “System”) filed an application with the HSCRC on February 26, 2021 on behalf of its member Hospitals (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for joint replacement and joint replacement consult services with Carrum Health, Inc. Carrum also seeks approval to add Cardiovascular, and Spine surgery to the arrangement. The System requests that the approval be for a period of one year beginning April 1, 2021.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement, joint replacement consult services, bariatric, cardiovascular and spine surgery services for a one year period commencing April 1, 2021. 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.

GREATER BALTIMORE REGION INTEGRATED CRISIS SYSTEM (GBRICS) PARTNERSHIP

Health Services Cost Review Commission

March 10, 2021

GBRICS PARTNERSHIP

- $45 million over five years in behavioral health crisis response infrastructure and services
- Developed with the collaboration of:
  - 17 hospitals,
  - Four local behavioral health authorities,
  - Leaders in Baltimore City, Baltimore County, Carroll County, and Howard County
  - Peers, consumers of behavioral health services

OVERALL GOAL: Reduce unnecessary Emergency Department (ED) use and police interaction for people in behavioral health crisis

PARTNERSHIP ELEMENTS

Care Traffic Control System: Create a regional hotline that is supported with infrastructure for real-time capacity and referrals tracking, coordinated dispatching of mobile crisis response plus dashboard reporting

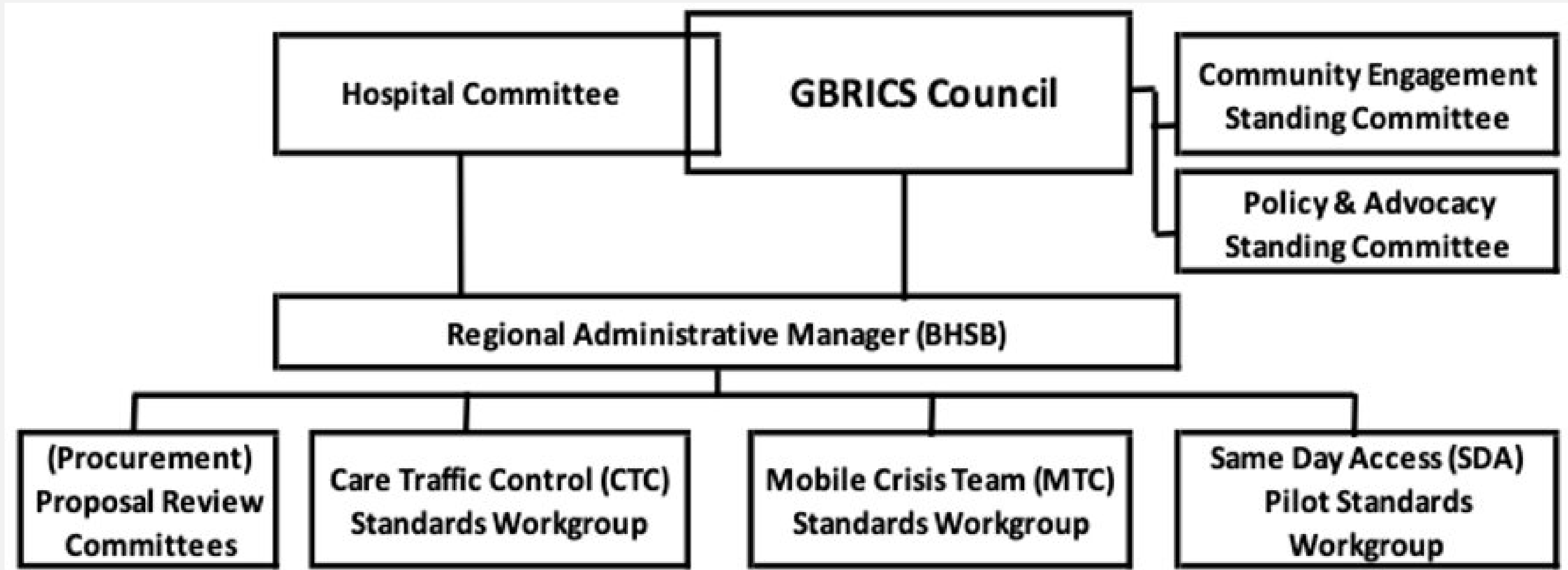
Mobile Crisis Teams: Expand capacity, set regional standards following national best practices

Walk-in/Virtual Crisis Services: Support behavioral health providers to offer immediate access to services for people in crisis

Community Engagement & Outreach: Support culture change to increase awareness and use of the hotline as an alternative to calling 911 or using the ED

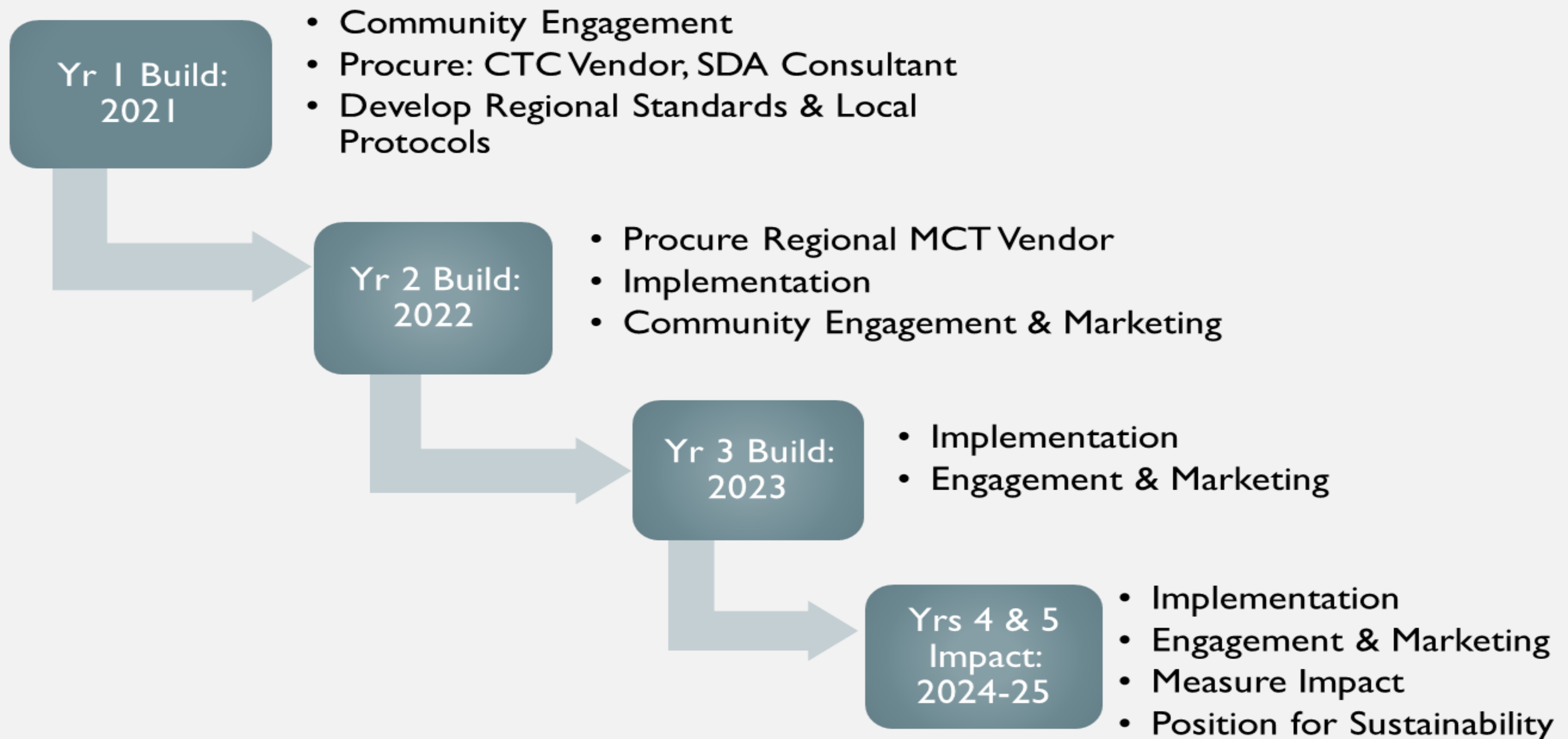
Non-profit Multi-Stakeholder Oversight: Drive regional activity and shared accountability

SHARED DECISION-MAKING ACCOUNTABILITY STRUCTURE



- **Strategy** decisions, such as: developing this proposal, overall guidance on GBRICS implementation to ensure success and sustainability
- **Management** decisions, such as annual planning, managing procurement and contracts, ensuring multi-stakeholder engagement, impact analysis and reporting
- **Implementation** decisions, such as: identifying regional standards and local protocols, developing messaging for coordinated outreach and engagement

IMPLEMENTATION TIMELINE



SCALABILITY AND SUSTAINABILITY

1. Revisions to "How Things are Done"
   - Regional Standards and Local Protocols
   - Changes in contracts and communications
   - Awareness and use of BH Crisis System (culture change)
2. Advocacy by GBRICS Partners
   - Track impact and communicate value proposition to public and private sector partners
   - Changes in policy
   - Seek coverage & reimbursement ("consistency & value")
3. Additional Funding Sources

RESOURCES & NEWS

GBRICS Partnership: https://www.bhsbaltimore.org/learn/gbrics-partnership/

The Headlines

- Baltimore metro region receives $45 million in funding to improve crisis response services (Baltimore Sun)
- County Leaders Hail $45 Million Behavioral Health Grant as 'a Game-Changer' (Maryland Matters)
- The Health Philanthropy That Set About to Change Behavioral Health Crisis Care in Maryland (Crisis Talk)

THANK YOU

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Behavioral Health System
Baltimore

Greater Baltimore Regional Integrated Crisis System (GBRICS) Regional Partnership

HSCRC Regional Partnership Program

The Health Cost Services Review Commission (HSCRC) Regional Partnership Catalyst Grant Program released an RFP to fund behavioral health crisis services in January 2020. The RFP makes a multi-million-dollar investment in system infrastructure that must be sustainable after the 5-year grant term. Key RFP requirements:

- Hospitals must engage in meaningful community partnership and collaboration
- Partnerships should focus on the nationally recognized, Crisis Now model
- Plan for sustainability

GBRICS Regional Partnership

The Greater Baltimore Regional Integrated Crisis System (GBRICS) Regional Partnership invests $45 million over five years in behavioral health crisis response infrastructure and services. GBRICS was developed with the collaboration of 17 hospitals, four local behavioral health authorities, and leaders in Baltimore City, Baltimore County, Carroll County, and Howard County.

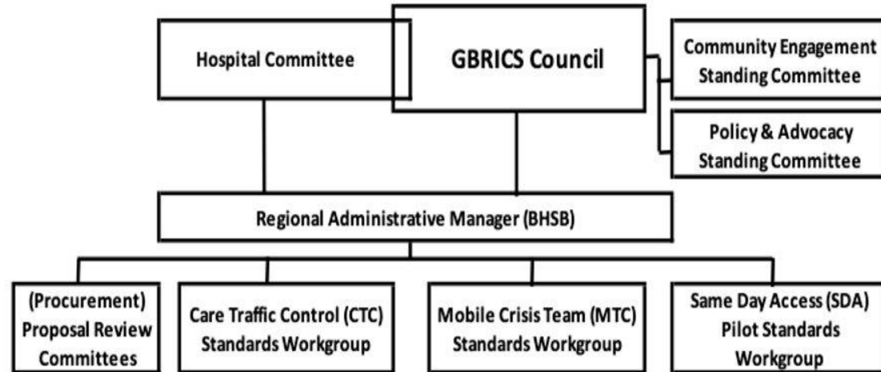
OVERALL GOAL: Reduce unnecessary Emergency Department (ED) use and police interaction for people in behavioral health crisis

PARTNERSHIP ELEMENTS

1. **Care Traffic Control System:** Create a regional hotline that is supported with infrastructure for real-time capacity and referrals tracking, coordinated dispatching of mobile crisis response plus dashboard reporting
2. **Mobile Crisis Teams**: Expand capacity, set regional standards following national best practices
3. **Walk-in/Virtual Crisis Services**: Support behavioral health providers to offer immediate access to services for people in crisis
4. **Community Engagement & Outreach:** Support culture change to increase awareness and use of the hotline as an alternative to calling 911 or using the ED
5. **Non-profit Multi-Stakeholder Oversight**: Drive regional activity and shared accountability

Accountability Structure

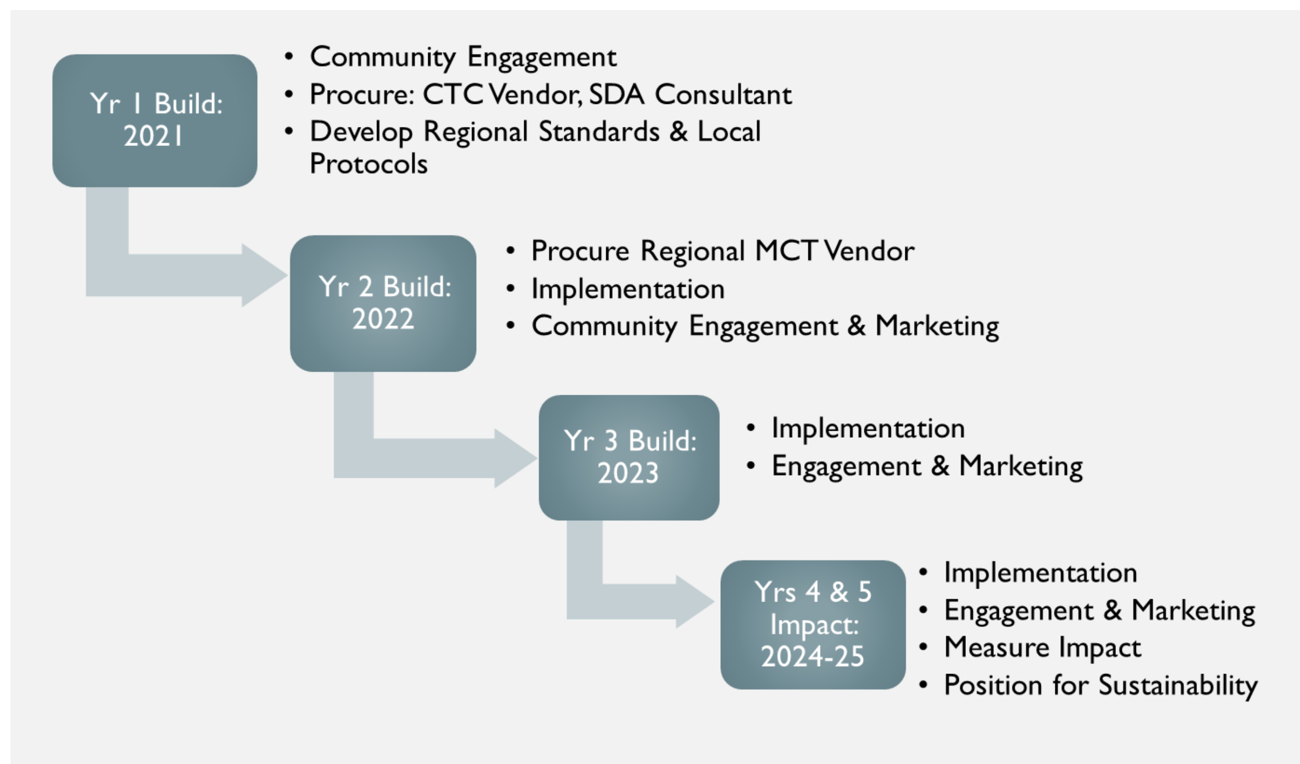
A multi-stakeholder GBRICS Council provides strategic guidance, support, and advocacy for the implementation and sustainability of the GBRICS project. The Council is comprised of 21 seats and includes representatives from hospitals, consumer/advocacy groups, county and city administration, first responders, payers, and groups that represent behavioral health providers.



Behavioral Health System Baltimore (BHSB) provides overall project management for the GBRICS Regional Partnership. BHSB is fiscally accountable for the funding received during the grant period, issues competitive procurements for the project components, manages day-to-day activities, and supports collaboration among stakeholders.

Implementation Plan: Build Infrastructure, Measure Impact

By the end of the 5-year grant period (Jan 2021-Dec. 2025), hospitals expect to see a decrease in the number of repeat ED cases for behavioral health (three or more ED visits in a calendar year), with the target goal of a 10% reduction. Another goal is to minimize encounters with law enforcement or police for people experiencing a behavioral health crisis.

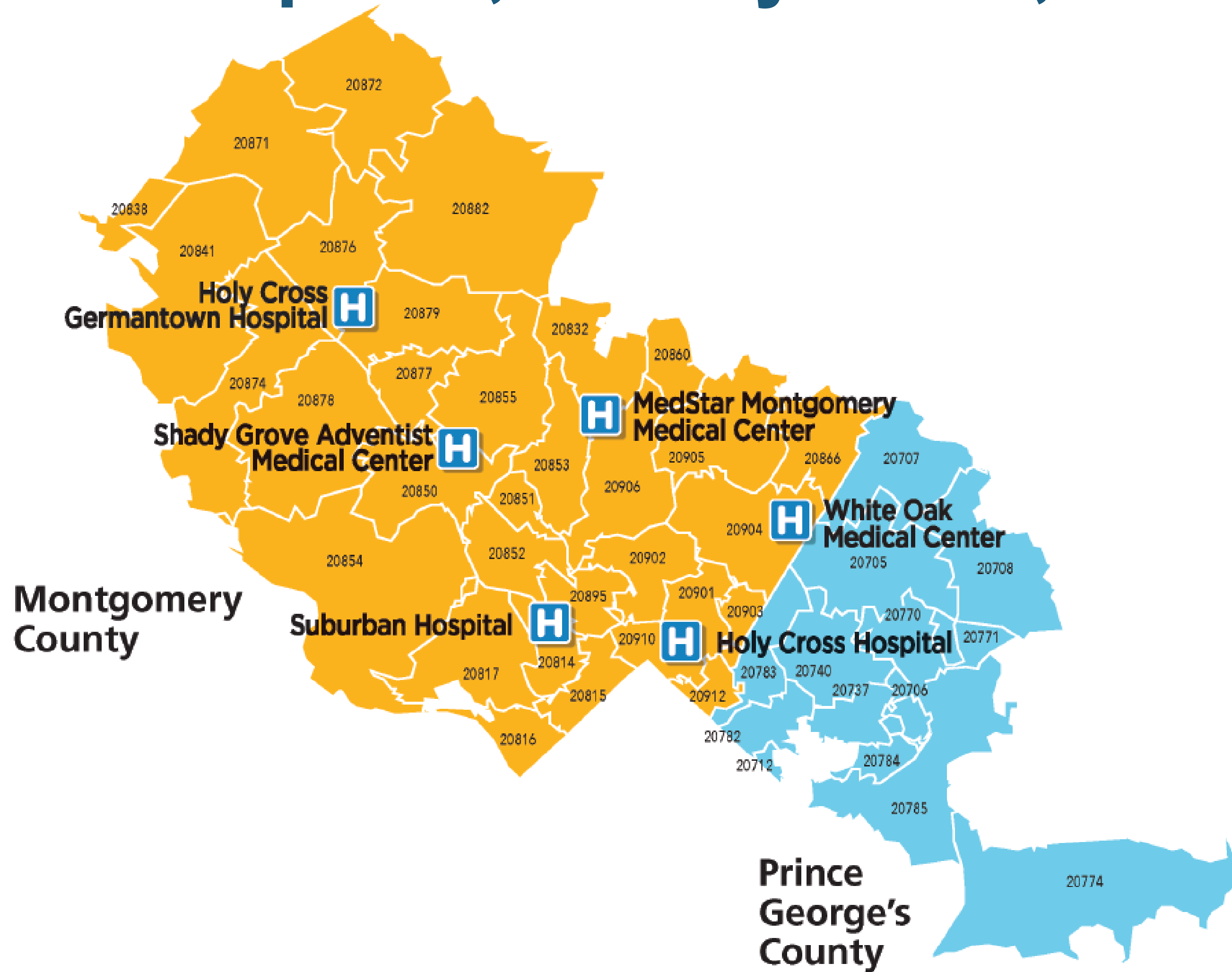


Nexus Montgomery Regional Partnership

Diabetes Education

MARCH 10, 2021

Nexus Montgomery Regional Partnership: six hospitals, four systems, one community



Our Mission

Nexus Montgomery, a collaboration among Montgomery County's hospitals, works with community partners to promote health, reduce hospital utilization & manage total cost of care for our shared community **in ways that no single hospital could achieve on its own**

NEXUS MONTGOMERY

Nexus Montgomery Impact: 2016 - 2020

> 165,000

Community Members Impacted

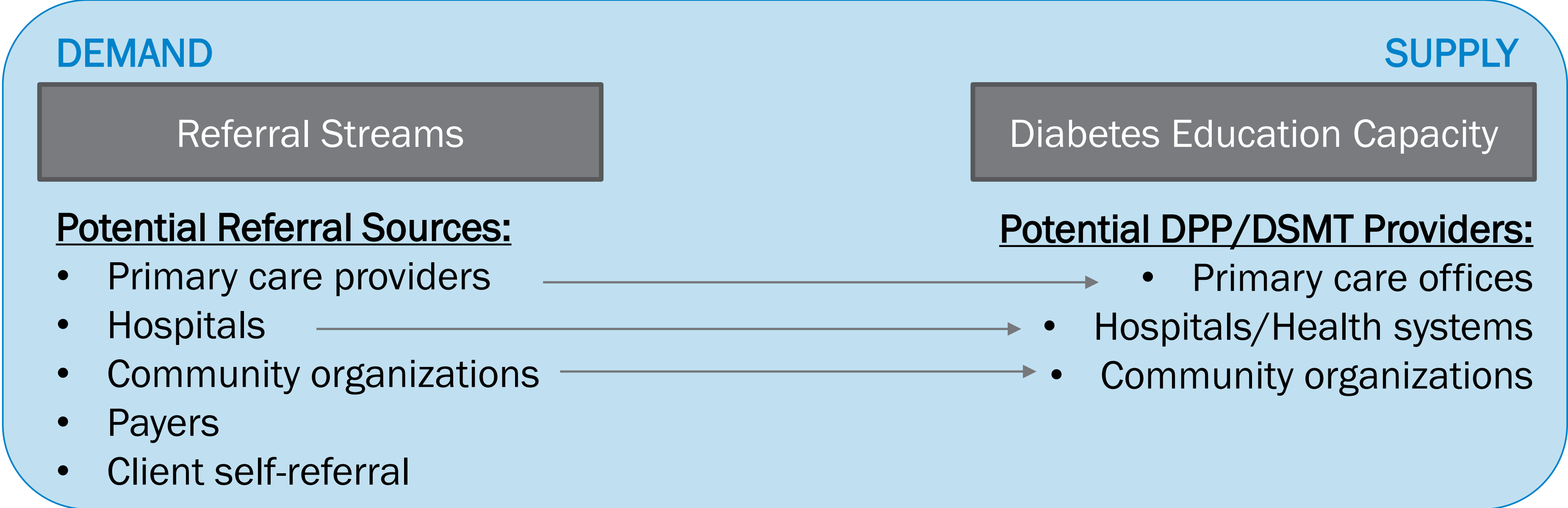
$38 Million

Cumulative Saved Medical Costs

NEXUS MONTGOMERY

Prior to Catalyst award: a trickle of referrals into a small number of diabetes education programs…

CURRENT STATE



NEXUS MONTGOMERY

…caused by web of interrelated supply & demand problems limiting greater utilization of diabetes education

CURRENT STATE

Referral Streams:

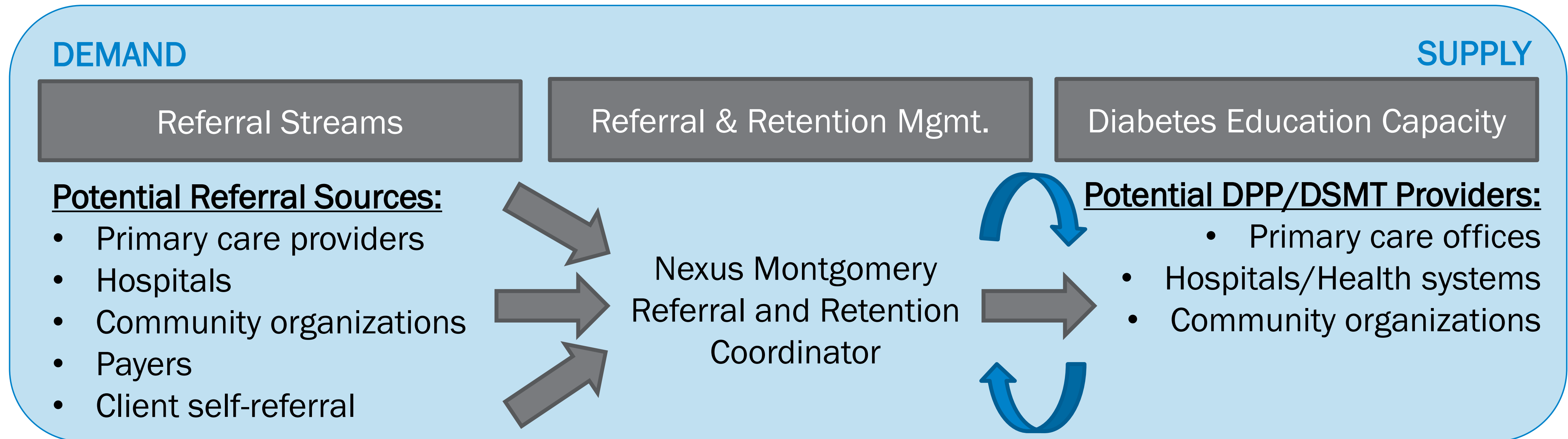
- Scattershot recruitment through individual entities across the community
- Trickle of referrals from single source or "in-reach" to an existing, engaged population
- No meaningful self-referral or payer-based recruitment strategy

Diabetes Education Providers:

- Significant Barriers to entry
- Lengthy and administratively complex accreditation process
- Reimbursement rates do not cover program expenses, especially during start-up
- Intensive processes to ensure retention in year long programs

Nexus Diabetes Program: A system of centralized support for decentralized education provided by community partners

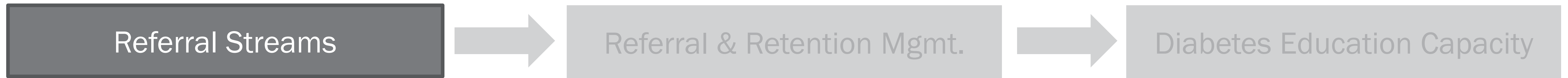
FUTURE STATE



RESULT: Population-level engagement; over 50% of target population across the community referred to DPP or initiated in diabetes education

NEXUS MONTGOMERY

Nexus Montgomery Diabetes Program Integrated Referral Pipeline



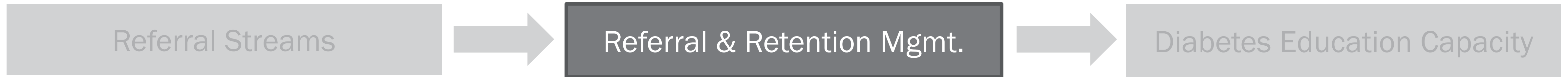
“All-hands-on-deck” outreach & recruitment

- Develop clinician referral relationships
- Traditional community engagement and public health outreach
- Direct recruitment from social service, community organizations
- Self-referral using online tool & risk assessment

CRISP eReferral tool

- Clinical partners will refer to DPP and DSMT through CRISP
- Feedback to clinical partners on client’s progress and outcomes

Nexus Montgomery Diabetes Program Integrated Referral Pipeline

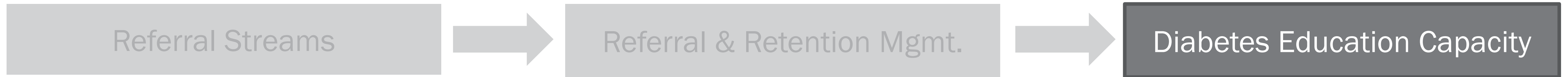


Centralized Referral Management

- All referrals to a single central hub
- Match clients to the appropriate program considering location, transportation, and language needs
- Minimize burden on referral sources, establish process for risk assessment & communication with diabetes educators
- Trained in Motivational Interviewing to assess readiness and activate client

NEXUS MONTGOMERY

Nexus Montgomery Diabetes Program
Support to Diabetes Educators



Technical Assistance to Diabetes Education providers

- Training, certification, data collection, reporting, & billing
- Support for startup period & uninsured/self-pay patients

Building stronger models of client retention

- Assessment & support from centralized case management team
- Learning Collaborative to identify best practices & shared challenges
- Lessons from the pandemic: remote education & engagement

Community-based coordination

- Identify new partners to host activities, recruit participants, or become diabetes educators
- Integrate complementary/reinforcing activities

NEXUS MONTGOMERY

Nexus Montgomery Diabetes Program Progress in CY2021

Staffing & Infrastructure

- Nexus Montgomery Diabetes team fully recruited
- Onboarded in CRISP eReferral tool
- RFAs for centralized case management and community outreach
- Engagement with community diabetes education partners and clinical referral partners

Diabetes Education

- DPP and DSMT cohorts (online) beginning in April
- Two CDC-accredited DPP providers in process to enroll with Maryland Medicare

Governance & Oversight

- Diabetes Planning Workgroup meeting monthly since proposal development
- Oversight from standing Nexus Programs Committee and Board of Managers

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Draft Recommendation to Change Payer Differential for Medicare Advantage

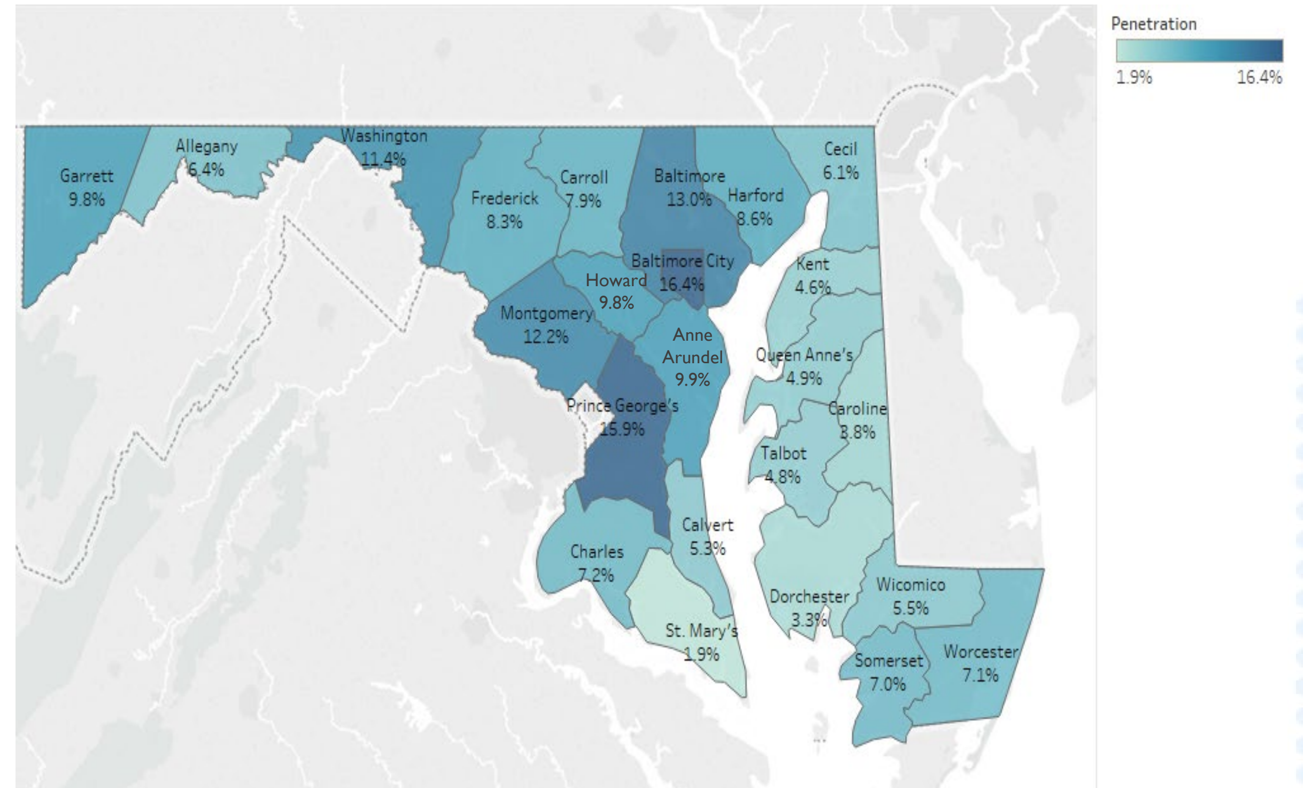
March 10, 2021

Maryland Health System Goals: Aligning MA with the TCOC Model

- In addition to financial savings and cost containment for all payers, Maryland is also committed to care transformation
  - Hospital savings and cost containment have exceeded targets since 2014
  - The focus for the remainder of the TCOC Model will be to improve care delivery, quality, and population health
  - Improved alignment between hospital global budget and non-hospital fee-for-service marketplace is necessary
- Further coordination of hospital and non-hospital cost and quality is desirable to achieve the aims of the Model
  - Particularly, a focus on non-hospital care coordination and access can improve health and reduce the burden of chronic conditions
- Availability of Medicare Advantage (MA) plans are one tool in the overall plan to:
  - Achieve greater care coordination
  - Increase opportunities for duals and near-duals
  - Drive value for consumers

Maryland's MA Penetration Lags Behind the Nation

- Maryland's MA penetration rate is approximately 13 percent, while the national average is 41 percent of eligible beneficiaries
- Rural areas have the lowest MA penetration
- No county in MD has a rate near the national average (34%)
- Several MA plans in Maryland have exited the market or reduced product offerings in the past several years
  - MedStar Medicare Advantage plan exited the market in 2019 (approx., 12,000 lives)
  - Cigna reduced its service area (reduction of approx. 12,000 lives)
  - UM Health Plan eliminated its MA-PD plan (reduction of approx., 11,000 lives)
- Six counties have no MA-PD options and many counties have no competition between plans



Source: CMS Medicare Advantage/Part D Contract and Enrollment Data. Accessed October 10, 2019. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration.html

Potential Solutions to Enhance Access and Options for MA in Maryland

- Maryland wants to work with CMS and stakeholders to identify potential solutions to increase MA participation in Maryland
  - Solution should recognize and honor the financial savings target that Maryland has guaranteed to the federal government under the TCOC Model
  - Strategy should contain and support shared goals for care transformation in Maryland
  - Approach should enable improved access to MA plans for Maryland beneficiaries and enhance the supplemental benefits offered by MA plans
- Potential Solutions
  - Short term grants for hospitals partnering with MA plans
  - Increase payer differential for MA plans
  - Advocate for a change in the benchmark calculation
  - Include provisions in a future Maryland Model Demonstration Agreement with CMMI

Draft Recommendation to Change Payer Differential

- Adjust the public payer differential for MA plans, while maintaining or exceeding savings targets in accordance with the TCOC Agreement
  - The differential change only impacts hospital payments
  - Changing the differential changes the allocation of costs between payers; the change is revenue neutral to hospitals
  - MA differential would change from 7.7% to 16.88%, resulting in approximately $75 million in hospital savings to MA
  - The Maryland Model has generated significant hospital savings for Medicare FFS since 2013; although this recommendation increases costs to Medicare FFS (approximately $30 million), as well as other payers, there has been significant savings to reinvest in enhancements to other parts of the delivery system
- Payer differential would be in place for three years from January 1, 2022 until December 31, 2024
- Staff would conduct an analysis and evaluation of changes in the MA marketplace to determine:
  - Changes in access and options to MA plans across all counties in Maryland
  - Net increase or decrease in eligible Medicare beneficiaries, particularly duals and near-duals, enrolled in MA plans
  - Changes in plan design and supplemental benefits offered to MA enrollees
  - Financial position of MA plans
- Proposal must be approved by CMS to take effect

Next Steps

- Continue conversations with CMS and CMMI on viable ways to enhance MA options in Maryland
- Gather feedback from stakeholders through comment letters, accepted through March 25th
    - Staff is requesting specific feedback on criteria of evaluation to determine the effectiveness of the short-term differential adjustment
    - Feedback also requested on other ways to continue to enhance access and options to MA plans in Maryland

Draft Recommendation on Payer Differential for Medicare Advantage

March 10, 2020

This document contains the draft recommendation to change the Medicare Advantage payer differential, pending federal approval. Comments may be submitted by email to latonya.hamilton@maryland.gov and are due by March 25, 2021.

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Table of Contents

Overview 1

Past Funding 2

Proposal to Change Payer Differential for Medicare Advantage 4

Recommendation 5

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
This draft recommendation seeks ways to increase access and options for seniors and dual eligible individuals through Medicare Advantage. The State is committed to finding ways to improve access to care, enhance quality and care transformation, improve health outcomes and ultimately lower the cost of care for all Marylanders.	A payer differential specific to Medicare Advantage has the potential to better align the State's all-payer hospital rate setting system with the Medicare Advantage rate setting methodology. This change to the payer differential is subject to CMS approval.	This recommendation is revenue neutral to hospitals.	This recommendation would change the allocation of charges across payers and would result in lower charges for Medicare Advantage patients and higher charges for other payers (Medicaid, Medicare FFS, Commercial, self-pay).	By strengthening the Medicare Advantage market and increasing options for seniors and dual eligible individuals, this recommendation has the opportunity to increase access to care and support services for Marylanders.

Overview

Since 2014, Maryland has worked with the Center for Medicare and Medicaid Innovation (CMMI) to reduce cost of care in Maryland and improve quality and health outcomes. The partnership has been successful thus far in implementing payment and system delivery reforms, resulting in over $1.4 billion dollars of hospital savings and improved hospital quality. The initiatives benefit not only Medicare fee-for-service (FFS) beneficiaries living in Maryland, but also all other patients under our all-payer rate setting system. While the Total Cost of Care (TCOC) Model agreement focuses primarily on Medicare FFS targets, the HSCRC must also maintain its historic hospital all-payer rate setting system that seeks to provide access, equity, and contain costs across all payers. Under this unique system, Maryland is able to fulfill its obligations of the TCOC Agreement while at the same time continue its equally important obligation to regulate the remaining 60 percent of the market that includes consumers enrolled in payers other than Medicare FFS.

As an all-payer system, we work to align our State programs across all payers, including commercial insurers, Medicaid, Medicare FFS and Medicare Advantage, to improve access to care, enhance quality and care transformation, improve health outcomes and ultimately lower the cost of care for all Marylanders. The following draft recommendation seeks to align the goals and infrastructure of the Medicare Advantage market under the terms of the all-payer hospital rate setting authority consistent with the Maryland Total

Cost of Care Model. Specifically, the Maryland Health Services Cost Review Commission (HSCRC), proposes to temporarily adjust the public payer differential for Medicare Advantage (MA) plans under the TCOC Model in order to improve access to MA for seniors and dual eligibles in Maryland. The MA market is significantly underperforming due in part to interactions between the Maryland rate setting model and the MA rate setting methodology. The lack of performance leaves consumers with few or no options for MA plans, including plans for dual eligibles, in a significant portion of the State.

This recommendation would align MA with the TCOC Model by adjusting the public payer differential, pending approval by the Centers for Medicare & Medicaid Services (CMS). The proposal would effectively adjust MA rates to what they would be but for the impact of the hospital rate setting component of the TCOC Model, while ensuring the State would still meet all required savings targets under the terms of the agreement with CMS. The recommendation does not undermine any of the goals or expectations of the TCOC Contract, harm hospitals, other providers, or beneficiaries.

Since early in Maryland's All-Payer system, government payers have been afforded a differential from rates paid by private payers. Currently, government payers (Medicare and Medicaid) pay 92.3 percent of HSCRC-approved hospital charges. The differential is designed to reflect differences in the practices of classes of payers, which result in cost-of-care differences. Under the TCOC Model Agreement, the HSCRC has the ability to adjust the public payer differential with CMS approval. CMS most recently approved a public payer differential change that took effect in July 2019[1], which resulted in a 1.17 percent rate increase for commercial payers and a savings of $46 million to Medicare.

The enclosed draft recommendation proposes to increase the public payer differential for MA plans, which will result in a 0.5 percent rate increase for other payers and annual savings of $75 million to MA plans. The resulting differential for MA would be approximately 16.88 percent and would be in effect from January 1, 2022 to December 31, 2024. This proposal will only take effect with CMS approval, in accordance with our TCOC Model Agreement.

The aim of this proposal is to adjust MA hospital costs to where the rates would be absent the State's all-payer rate setting. We believe that this adjustment will attract more MA investment in the State and accomplish significant complementary goals, including strengthening infrastructure to coordinate care for Medicare beneficiaries, assuring Maryland beneficiaries the same choice of coverage and benefits as beneficiaries in other states, creating a competitive MA marketplace, and supporting Federal and State policy goals under the TCOC Model. In CY2024, HSCRC would evaluate the proposal's effects and determine a path forward to potentially include MA-enrolled beneficiaries in the TCOC Model and examine

[1] Differential Increase effective July 1, 2019. Memorandum to Hospital CFOs. Available at: https://hscrc.maryland.gov/Documents/pdr/PolicyClarification/2019/DifferentialMemo061019.pdf

other ways to expand the MA-like benefits to other Maryland beneficiaries. While this differential will increase charges for Medicare FFS, the TCOC Model sets stringent annual savings goals that the State will continue to meet. The State is committed to lowering costs for Medicare total cost of care and to transforming the care delivery system. This proposal will better align the Maryland TCOC Model and the Medicare Advantage market to provide expanded services and lower total costs while not diminishing the hospitals or any other component of the TCOC demonstration.

Past Funding

In February 2020, the Commission approved a grant program to support MA through Maryland hospitals. This was intended to be an interim step to increase support for Medicare Advantage access throughout the State. The Medicare Advantage Partnership Grant Program was designed to achieve the following:

- Encourage partnerships and strategies that result in long term health improvement of Medicare Advantage Partnership beneficiaries
- Improve Medicare Advantage penetration and/or improved services to high cost and high risk populations
- Preserve and/or expand access to the number of 4+ Star Rating Medicare Advantage plans in the State to promote competition and access for seniors
- Develop strategies that improve care coordination and quality of services offered in Medicare Advantage Plans
- Extend healthcare transformation efforts to the Medicare Advantage market.

The Medicare Advantage Partnership Grant was authorized as a temporary funding mechanism for Fiscal Years 2020 and 2021. Hospitals were able to apply to participate in the grant program by partnering with an MA organization to submit a proposed list of activities that would result in increased quality and expanded access.

Grant Program Impact Areas

The Medicare Advantage Partnership Grants were narrowly focused to foster increased stability for Medicare Advantage organizations, expand access and create more robust plan designs for beneficiaries, and/or improved quality ratings. Hospitals agreed to spend grant funds on activities to focus on driving impact in one or more of the following areas:

Star Rating Measure Improvement

Medicare Advantage contracts are rated on up to 45 unique quality and performance measures. Grant funds should be used to design and implement strategies that will result in improvement in the Part C/Part D measures established by CMS for the Medicare Advantage Program. The MAP Grant Program was

designed to leverage hospital expertise on quality in an effort to improve star rating measures of Medicare Advantage plans. By doing this, the Medicare Advantage Plans will be eligible for higher reimbursement from CMS. This additional funding can then be returned to enrollees in the form of enhanced benefits and reduced cost-sharing.

Increase in Annual Wellness Visits

The Annual Wellness Visit provides an annual opportunity for Medicare Advantage beneficiaries to work with their providers to create or update their personalized prevention plan. This visit can be particularly important for beneficiaries who are high cost or who have high healthcare needs. The Annual Wellness Visit creates an opportunity to proactively assess changes in beneficiary health by performing a health risk assessment at 12 month intervals. Grant funds are being used to design and implement strategies that result in an increase in the number of annual wellness visits per year.

Expansion of Coverage

Maryland's current Medicare Advantage Plan penetration and distribution of services do not provide adequate coverage and choice for all eligible Marylanders. Plans are concentrated in urban counties while rural counties have far fewer choices without the extra benefits Medicare Advantage plans can provide, such as vision or dental services. Grant funds are being used to design and implement strategies that result in the expansion of coverage and access to these services.

High Cost Beneficiary Penetration

It has been well documented that a small portion of Medicare patients account for more than half the program's spending in any given year. This is true of Medicare Advantage Plans as well. According to a 2019 study by the Commonwealth Fund, "37 percent of Medicare Advantage enrollees have chronic conditions and functional limitations requiring a range of medical and social services; many also contend with low income, low education, and isolation." Because of this, the grant program was designed to encourage hospitals to collaborate with Medicare Advantage Plans to identify and address the high cost/high need beneficiaries. Grant funds are being used to design and implement outreach, education, enrollment, prevention, and management strategies that identify and target these beneficiaries with appropriate coverage and services.

Across these four impact measurement areas, hospitals and their Medicare Advantage Plan partners were required to define areas they intend to address and then start working to make progress in these areas. While this grant program was intended to be an interim step to increase quality among MA plans, it is not a sustainable long-term solution. To address and mitigate payment inconsistencies, HSCRC believes that a

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change to the underlying MA payment is necessary. Thus, this draft recommendation represents an additional adjustment that could be made to mitigate the disadvantage that MA plans face in Maryland.

Proposal to Change Payer Differential for Medicare Advantage

The HSCRC believes that care transformation and delivery system reform can be best achieved when all stakeholders, including hospitals, providers, post-acute providers, and payers are engaged.   While the TCOC Model is a hospital-based model targeting Medicare FFS cost and quality improvements, staff believe that the proposed change to the differential for MA can benefit Marylanders by providing an additional support for care coordination, wrap around services, and non-hospital care alignment for high and rising risk Marylanders. All Marylanders should have access to choice, enhanced benefit offerings, and competition that could be offered through a robust MA market. **The draft recommendation would temporarily increase the public payer differential from 7.7 percent to 16.88 percent for MA from January 1, 2022 until December 31, 2024.** While this recommendation is revenue neutral to hospitals, it does change the allocation of charges across payers as the table below depicts.

			Payer Differential			Estimated Net Revenue			
	FY2019 Revenue (in 000s)	Payer Mix	Current	Proposed	Projected Rate Increase	Current (in 000s)	Proposed (in 000s)	Change (in 000s)	% Change
Medicare Revenue	$6,516,300	37.20%	7.70%	7.70%	0.50%	$6,014,545	$6,044,469	$29,924	0.50%
Medicaid Revenue	788,244	4.50%	7.70%	7.70%	0.50%	727,549	731,169	3,620	0.50%
Blue Cross Revenue IP	1,087,915	6.21%	2.25%	2.25%	0.50%	1,063,437	1,068,728	5,291	0.50%
Blue Cross Revenue OP	1,195,576	6.83%	2.00%	2.00%	0.50%	1,171,664	1,177,494	5,829	0.50%
Medicare MCO	852,318	4.87%	7.70%	16.88%	0.50%	786,690	711,990	(74,700)	-9.50%
Medicaid MCO	2,715,718	15.50%	7.70%	7.70%	0.50%	2,506,607	2,519,078	12,471	0.50%
Medicare Deductibles paid by Medicaid	114,617	0.65%	2.00%	2.00%	0.50%	112,325	112,884	559	0.50%
Uncompensated Care	758,319	4.33%	100.00%	100.00%	0.50%	-	-	-	
Other Payors	3,488,009	19.91%	2.00%	2.00%	0.50%	3,418,249	3,435,255	17,007	0.50%
Total	$ 17,517,016	100.00%				$15,801,066	$15,801,066	($0)	0.00%

The HSCRC projects that, absent the effects of the TCOC waiver, the average MA benchmark in Maryland would be 100.8 percent of fee-for-service spending (4.9 percent above the current level).   The proposed increase in the payer differential reflects the additional discount necessary to reduce MA costs by the amount of revenue lost due to the 4.9 percent gap.

The 100.8 percent benchmark was calculated by looking at the average benchmark among the national peer counties identified for each Maryland county and blending to a Maryland average based on MA enrollment.   Given a national average of 103.6 percent, the HSCRC believes using the lower benchmark of 100.8 percent appropriately reflects that, even in the absence of the TCOC model, Maryland would be unlikely to fall into the quartiles for the lowest cost counties (107.5 or 115 percent of FFS).

At current enrollment levels the differential change would reduce hospital expenditures for MA plans by $75 million. This increased differential for MA would not apply to other public payers (Medicare FFS and Medicaid). To maintain revenue neutrality for hospitals, hospital rates would need to increase by 0.5 percent

for other payers resulting in cost increases of $30 million for Medicare FFS, $16 million for Medicaid and $29 million for other payers. The amount of rate increase required varies depending on the Medicare Advantage enrollment; therefore, should the State be successful in increasing enrollment, the rate offset would also increase proportionally. For example, doubling the enrollment would double the increase to 1.0 percent. The initial analysis in this draft recommendation was performed on FY 2019 revenue and enrollment. Should this recommendation be accepted by the Commission and CMS, a revised analysis would be performed with the most recent revenue and enrollment data.

This proposal is budget neutral and would not change the savings target for the TCOC Model and would not require any other Model changes. The current demonstration requires $300 million in savings by CY 2023 compared to the CY 2013. The HSCRC projects that the Model would still achieve annual savings that reach or exceed $300 million in CY 2023 under this proposal.

In CY 2024, Maryland is scheduled to begin working on the next iteration of the TCOC Model. Before that time, staff should complete an analysis of the Medicare Advantage market to determine the best path forward, including potentially incorporating MA enrolled beneficiaries into the TCOC Model.

Including MA in the TCOC Model has the potential to strengthen infrastructure to coordinate care for Medicare beneficiaries, assure Maryland beneficiaries the same choice of coverage and benefits as beneficiaries in other states, create a competitive MA marketplace, and support Federal and State policy goals under the TCOC Model.

Recommendation

Pending federal approval of the differential change, the draft recommendation would do the following:

1. Temporarily increase the public payer differential from 7.7 percent to 16.88 percent for MA from January 1, 2022 until December 31, 2024.
2. Prepare a report to be submitted to the Commission in July 2024 that compares penetration levels across the State, by county, to assess the effectiveness of the differential change on access and options to MA plans in Maryland.
3. Nothing in this recommendation shall change the State’s commitment to achieve TCOC savings under the terms of the contract with CMS.

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Workgroup Updates

Efficiency Workgroup Update

Purpose of Peer Groups

- Peer Groups in the ICC are intended to adjust for cost variations that:
  - Hospitals should not be held responsible for, e.g. labor market or casemix, and
  - Staff has not directly risk adjusted for

- Historically, the three cost variations the HSCRC have identified that require additional risk adjustment through peer grouping are
  - Medical education costs
  - Indigent Care (known as the DSH Adjustment)
  - Small hospitals (previously discontinued)

- Counterintuitively, the peer group for medical education was created more so to remove teaching hospitals from non-teaching hospital's efficiency assessment, due to perceived unfairness for the latter
  - Concerns the indirect medical education adjustment was biased upwards due to AMC bearing on IME calculation
  - Staff work to create a differential IME adjustment for AMC's and non-AMC's reduces this concern

- Staff have purposefully maintained urban peer group and discontinued collinear (or duplicative) DSH adjustment because there is still a relationship between indigent care and ICC performance when indigent care is not addressed

Assessment on Current Peer Groups in ICC

- Peer group cost per case variation is often higher within the peer group than across peer groups, which is undesirable
  - Different peer group combinations based on cluster analyses do not improve this result
- There is no relationship between resident count and ICC performance once direct medical education and indirect medical education are accounted for with new community and AMC IME adjustments
- The current peer groups address the additional costs of providing care to disadvantaged or indigent population but not adequately
  - Indigent care is still statistically significant (R2 is .160 using poor share variable, .235 using dual eligible variable)
- Being a hospital in the metropolitan area explains additional ICC variation that staff believes is undesirable to adjust for after directly risk adjusting for indigent care.
- Volume of inpatient services, being a sole community hospital, charge variance, and size of hospital do not explain meaningful variation in ICC performance
  - There is a slight relationship between reductions in PAU and ICC performance, but this is eliminated when PAU volume credit is provided in Integrated Efficiency Policy

Alternative Approach

- Proposed alternative approach is a direct adjustment of indigent care for residual cost variation in lieu of peer grouping
  - Staff were concerned that indigent care, as the last remaining adjustment in the ICC, was capturing other cost variation, likely due to actual inefficiency
    - Example: Excess Capacity
  - As such, staff explored including a metropolitan indicator in addition to a variable for indigent care to ensure any risk adjustment used in the ICC was not reflective of inefficiencies we would not want to pass through at 100% in an efficiency assessment
  - Approach will maintain peer group for AMCs since staff plans to develop IP only efficiency analysis relative to national AMC peers given unique cost structure; AMCs will have not bearing on regression

- Using a 3-year regression on cost per case variation that controls for Baltimore city and excludes AMC's yields a direct risk adjustment of $6,935 per ECMAD (statistically significant and R2 of .525)
  - Staff is advancing a 3-year approach to smooth out any volatility in indigent care coefficient
  - Coefficient when multiplied by statewide average poor share percentage (30.5%) is equal to $2,115 per ECMAD, which means approximately 14% of the statewide average charge per case for a hospital with average poor share is passed through at 100% in the efficiency analysis

- When indigent care is directly adjusted for through regression and PAU volume credit is applied, there is no statistically significant relationship between indigent care statistics and ICC performance.
  - Using a direct risk adjustment in lieu of peer groups does change efficiency results but not substantially so

Summary Statistics

	Reduction	ICC Correlation	ICC Rank Order Correlation	Efficiency Matrix Correlation	Efficiency Matrix Rank Order Correlation
Integrated Efficiency with Current Peer Groups	$21,338,214	0.7007	0.6916	0.8286	0.8211
Integrated Efficiency with Revision to Peer Groups	$24,080,496				

Payment Models Workgroup Update

Consideration of COVID-related GBR Adjustments, Accounting of CARES Funding, and RY 22 Update Factor Work

Potential Revisions to Staff Approach On COVID Funding

- Based on industry feedback staff is considering two modifications to the COVID settlement approach discussed in the February Commission meeting
  1. Revise to settle on a fiscal year basis rather than as of December 31, 2020 but make a preliminary adjustment in July 1, 2021 Rate Orders
  2. Use State Averages in determining the amount of CARES funds to be allocated to unregulated

Revised Adjustment Timing

- Revise to settle on a fiscal year basis rather than as of December 31, 2020 but make a preliminary adjustment in July 1, 2021 Rate Orders
  - Extends undercharge guarantee to 6/30/21
  - Avoids creating artificial December 31st settlement point and allows hospitals to offset over/undercharge in the second half of FY21
  - Allows savings to be achieved in Calendar 2021 which is likely needed under Medicare guardrails. Staff would propose to adjust the full amount in the first 6 months of FY22
  - Utilize preliminary FY21 charge data (e.g. through April 2021) in making the July 1, 2021 adjustment.

Settlement Approach Remains Largely the Same

Approved Revenue	
Total FY20 and ~~First Six Months of~~ FY21 Charges inclusive of Approved Expanded Corridors	A
FY 20 Undercharge + FY 21 Undercharge ~~for First Six Months~~	B
Impact of COVID on FY20 Expenses (1)	C
Impact of COVID on FY21 Expenses (1,2)	D
FY21 Funding Under Current COVID Surge Policy - if any (3)	E
Total Approved Revenue	F = A + B + C + D + E
Actual Revenue	
Actual Charges for FY20 and ~~First Six Months of~~ FY21	G
Regulated Portion of CARES funding (4)	H
Total Actual Revenue	I = G + H
Net Under (Over) Funding	J = F - I

- If analysis shows a net under funding hospital will be allowed to bill revenue in subsequent periods. If a net over funding hospitals will be required to reduce future charges to eliminate the over funding - earliest effective date is July 1, 2021.
- Some adjustments were made for hospitals that were undercharged in FY20 in the 1/1/21 rate orders. Any such adjustments will be offset against the July 1, 2021 rate order.
- If material CARES Act monies are subsequently recaptured by the Federal Government, the Commission will work with hospital to recover these funds through additional charges in subsequent rate years.

(1) Expenses will be assessed through aggregated annual filing analysis; will not calculate individual COVID related cost increases
(2) As these amounts will not be known until early FY22, final adjustment will likely be in the FY23 rate order.
(3) Calculated based on monthly assessments
(4) HSCRC will use amounts reported in Federal Reporting on the HHS Provider Relief Fund multiplied by the % of regulated revenue reported by the hospital entity in FY19. Hospital should submit separate reporting if that amount is not appropriate. HSCRC will also compare this amount to revenue reported in the annual filing (see potential change #2 in this presenatoin).

Current Estimated July 1, 2022 Adjustment

	Initial FY20 Adjustment			FY21 Estimate Plus Other Estimates and Revisions						Impact on Rates July 1, 2022	
	(1)	(2)	(3) = (1) + (2)	(4)	(5)	(6)	(7)	(8)	(9) = sum (3,4,5) - sum (6,7,8)	(10)	(11) = (9) - (10)
$ in Milions	FY 20 (Under) Over Charge	Plus: CARES Funding, net of unregulated portion as of 1/6/21	FY20 Net (Under) Over Charge to be adjusted in July 1 Rates	Plus: Additional CARES Funding to date	Plus: Estimated FY21 (Under) Over Charge (a)	Less: FY20 Expenses (b)	Less: Preliminary FY21 Expenses (c)	Less: COVID Surge Funding	Total Net (Under) Over Charge	Less: (Under) Charges in Jan 1, 2021 Rate Order	Net (Under) Over Charge to be adjusted in July 1, 2021 Rates (d)
Luminis	(54)	71	17	0	?	?	?	?	17	0	17
Adventist	(32)	88	56	0	?	?	?	?	56	0	56
Holy Cross	(23)	70	47	0	?	?	?	?	47	0	47
Johns Hopkins	(268)	243	(26)	0	?	?	?	?	(26)	(26)	0
LifeBridge	(67)	75	9	5	?	?	?	?	14	0	14
MedStar	(25)	151	126	0	?	?	?	?	126	0	126
Tidal	(22)	26	4	0	?	?	?	?	4	0	4
UMMS	(264)	293	29	13	?	?	?	?	42	0	42
All Other	(185)	134	(51)	12	?	?	?	?	(39)	(71)	32
Total	(941)	1,152	211	30	?	?	?	?	241	(97)	338

a. Actual implementation will use most complete possible FY21 data (April/May?)
b. Amounts will be calculated based on cost reporting and other data submitted by hospitals but will be captured net of estimated offsetting cost savings.
c. Commission will utilize FY20 experience and other hospital submitted reporting to include a preliminary estimate.
d. Amount will be set in rates to complete the adjustment in the first 6 months of FY22.

Revise Method to Allocate CARES funds to Unregulated

- Staff had proposed to allocate CARES funds to unregulated based on a hospital's FY19 revenue split.
- Instead, staff could use State averages in determining the amount of CARES funds to be allocated to unregulated
  - Recognizes the varying way in which unregulated business is organized and expenses are reported
    - Some systems report more or less business within their regulated entity
    - Commission has limited reporting on non-regulated business
  - Allows Commission to acknowledge these differences without complex or subjective new reporting requirements on non-regulated business.

Potential Implementation Approaches

- Current Approach: Use hospital-specific % regulated as reported in FY19 Annual Filing to determine the split of CARES funding
  - Staff could allow hospitals to submit information specific to their institution to request an adjustment but these could be hard to evaluate in absence of any broader reporting/auditing on the topic.
- Alternative 1: Use simple state average to determine % attributed to unregulated for all hospitals
  - Uses simple rather than weighted average to reflect smaller hospitals equally in the amount
  - Helps larger hospitals with low %'s where non-regulated business is outside the entity. Hurts smaller hospitals with simpler corporate structures
  - Net $20 M (~10%) reduction in recoveries due from hospitals
- Alternative 2: Use greater of simple state average or actual % attributed to unregulated hospital
  - Reduces impact of alternative 1 on smaller hospitals by allowing them to use their own higher than average value
  - Increase net impact to $45 M (~20%)

RY 22 Update Factor: Upcoming Work

Spring Dates for Payment Model & Update Factor Season

- **January 22 Workgroup Meeting**
  - Update Factor General Discussion
- **March 5 Workgroup Meeting**
  - Review of preliminary update model
  - Discussion of projected 2020 spending and preliminary review of savings tests
- **March 30 Workgroup Meeting**
  - Continued review of update model
  - Financial savings goals and 2021 spending projections
- **April 27 Workgroup Meeting**
  - Review of Draft Recommendation
- **May 12 Commission Meeting**
  - Draft Recommendation Presentation to the Commission
- **May 25 Workgroup Meeting**
  - Final Review of Proposed Update inclusive of comment letters
- **June 9 Commission Meeting**
  - Final Recommendation Presentation to the Commission

Balanced Update Adjustments

- Inflation
  - Total Gross Inflation & Inflation for Drugs
- Care Coordination
  - Grant Funding
- Volume (Department of Planning Population Growth)
  - Demographic Adjustment
  - Transfers
  - Drug Population/Utilization
- Quality
  - PAU Savings
  - QBR,
  - MHAC
  - Readmissions
- Other Adjustments
  - Set Aside for Unknown Adjustments
  - Complexity and Innovation
- Adjustments that don't impact Hospital Financial Statements
  - UCC
  - Medicaid Deficit Assessment

Balanced Update Model for RY 2022			
Components of Revenue Change Link to Hosptial Cost Drivers /Performance			
			Weighted Allowance
Adjustment for Inflation			0.00%
- Rising Cost of Outpatient Oncology Drugs			0.00%
Gross Inflation Allowance	**A**		**0.00%**
Care Coordination/Population Health			
- Regional Partnership Grant			
Total Care Coordination/Population Health	**B**		**0.00%**
Adjustment for Volume			
-Demographic /Population			
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**0.00%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		
- Low Efficiency Outliers	E		0.00%
- Capital Funding	F		0.00%
- Complexity & Innovation	G		0.00%
-Reversal of one-time adjustments for drugs	H		0.00%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.00%**
Quality and PAU Savings			
-PAU Savings	J		0.00%
-Reversal of prior year quality incentives	K		0.00%
-QBR, MHAC, Readmissions			
-Current Year Quality Incentives	L		0.00%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**0.00%**
Total Update First Half of Rate Year 22			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**0.00%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1+VOL%)	**0.00%**
Adjustments in Second Half of Rate Year 22			
-Oncology Drug Adjustment	P		0.00%
-QBR	Q		0.00%
Total Adjustments in Second Half of Rate Year 22	**R =**	P + Q	**0.00%**
Total Update Full Fiscal Year 22			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**0.00%**
Per Capita Fiscal Year	**T =**	(1+S)/(1+VOL%)	**0.00%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		0.00%
-Deficit Assessment	V		0.00%
Net decreases	**W =**	U + V	**0.00%**
Total Update First Half of Rate Year 22			
Revenue growth, net of offsets	**X =**	N + W	**0.00%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1+VOL%)	**0.00%**
Total Update Full Rate Year 22			
Revenue growth, net of offsets	**Z =**	S + W	**0.00%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1+VOL%)	**0.00%**

Balanced Update Compliance with the Waiver

- Increase in Hospital Spending per Capita (All-Payer)
  - 3.58%
- Medicare Savings Test
  - Achieve $300 million in annual Total Cost of Care Savings by end of 2023
- Total Cost of Care Guardrail
  - Can’t be above 1% in any given year
  - Can’t be above the nation two consecutive years

Performance Measurement Workgroup Update

RY 2022 Quality Programs:
How to handle COVID for CY 2020 performance period

RY 2022 Quality Programs: Next Steps

- Concerns over using CY 2020 performance for RY 2022 are numerous:

	RRIP	MHAC
Data Reliability	Strong data reliability for 6 and 12 months but readmissions from CY 2018 to CY 2020 YTD improving by approximately ⅔ of what was achieved in 5 years of the RRIP program under the All-Payer Model strains credulity.	Data is demonstrably less reliable using 6 months of data and CY 2020 YTD performance has limited relationship to CY 2019 despite program maturity.
Face Validity of Scores	RY 2022 YTD Net Revenue Adjustment is materially greater than RY 2021 revenue adjustment, which maintained less aggressive performance standards.	RY2022 MHAC scores uncorrelated with previous performance; concerns on case-mix adjustment using historical data.
Construct Validity	Significant readmissions improvement and inverse relationship between COVID volume and readmissions suggests CY 2020 performance is not indicative of quality of care.	Utilizing CY 2019 data, as a necessity to improve reliability, that results in all but 4 hospitals with diminished performance, due to lack of relationship between CY 2019 and CY 2020, is not indicative of actual quality of care in CY 2020.

- QBR: Consulting with CMMI on how to obtain data
- PAU Savings: Following RRIP for readmissions and still assessing per capita PQIs

Current Status and Next Steps

- To date the most reasonable approach to assessing RY 2022 performance is using RY 2021 revenue adjustments, but staff will continue to work through assessments to rule out any potential use CY 2020 performance.
- For the time being, staff advise the industry to use RY 2021 revenue adjustments for internal budgeting.
- HSCRC staff have met and are awaiting decision from CMMI on use of RY2021 revenue adjustments.
- If alternative solutions are required, HSCRC will vet with PMWG in a COVID specific meeting in March/April to finalize decisions for RY 2022.

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Update on Medicare FFS Data & Analysis

March 2021 Update

Data through November 2020, Claims paid through January 2021

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.

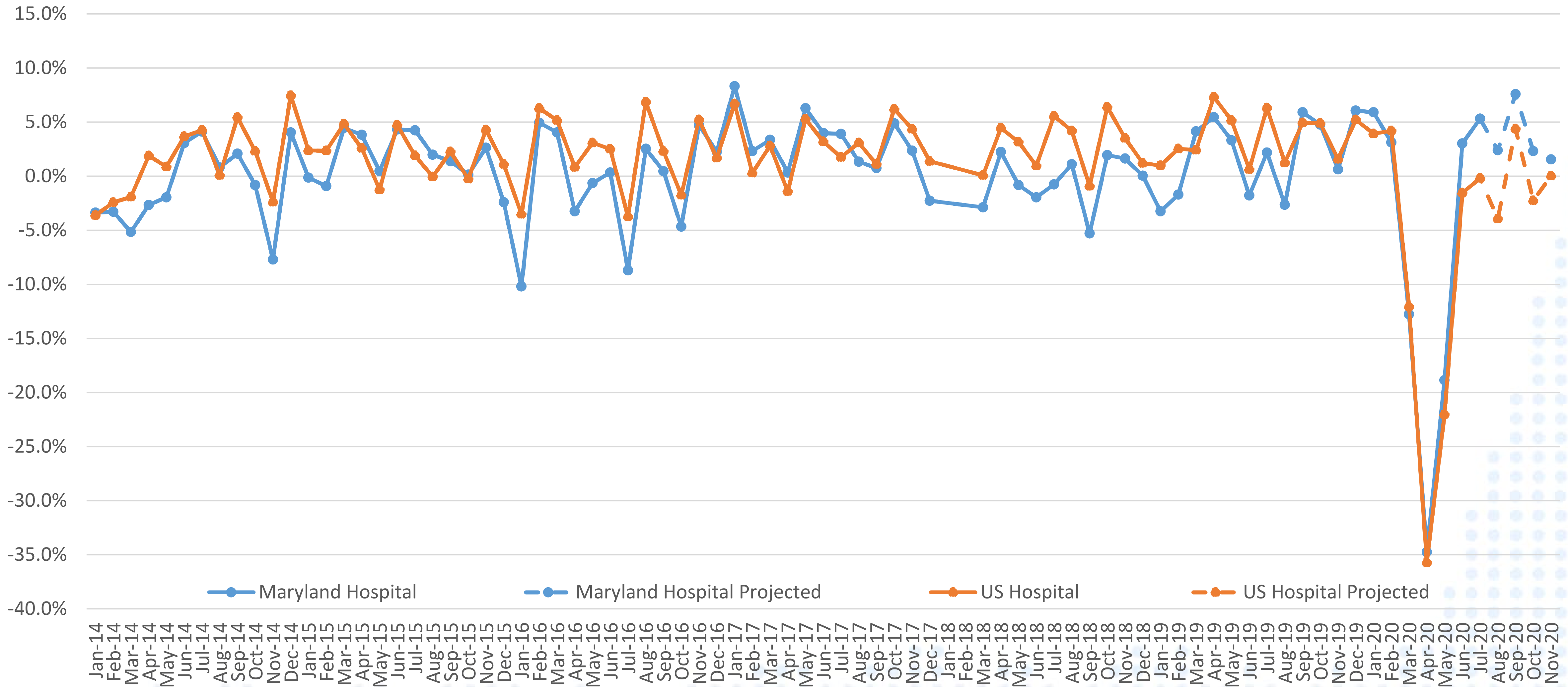
Note for CY 2016:

During the last six months of CY 2016 (July – December of 2016), Hospitals undercharged their Global Budget Revenue mid-year targets by approximately 1% ($25M dollars). The following slides have been adjusted to 'add back' the undercharge to the period of July – December 2016 to offset the decline in savings for January – June 2017.

Staff has noted which slides in the following presentation include the adjustment for the undercharge.

Medicare Hospital Spending per Capita

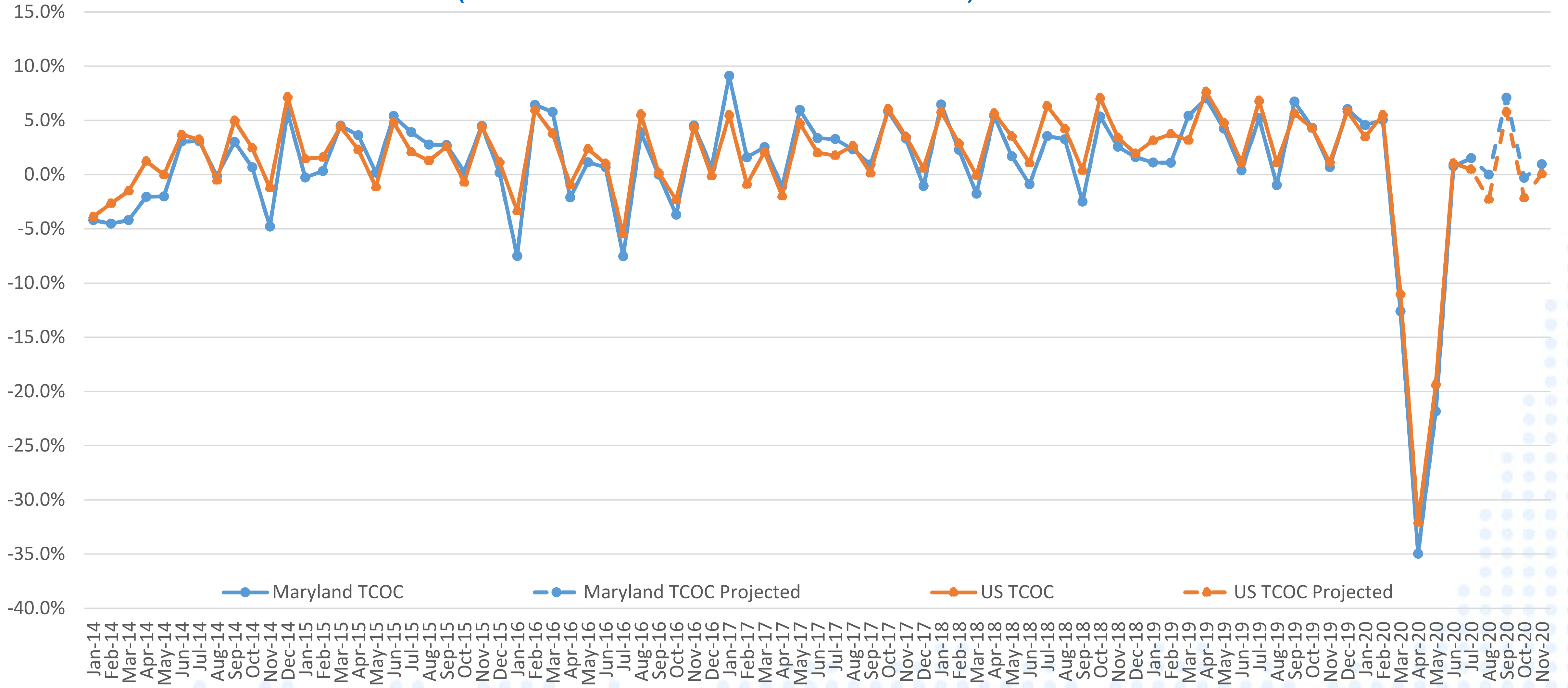
Actual Growth Trend (CY month vs. Prior CY month)



CY16 has been adjusted for the undercharge.

Medicare Total Cost of Care Spending per Capita

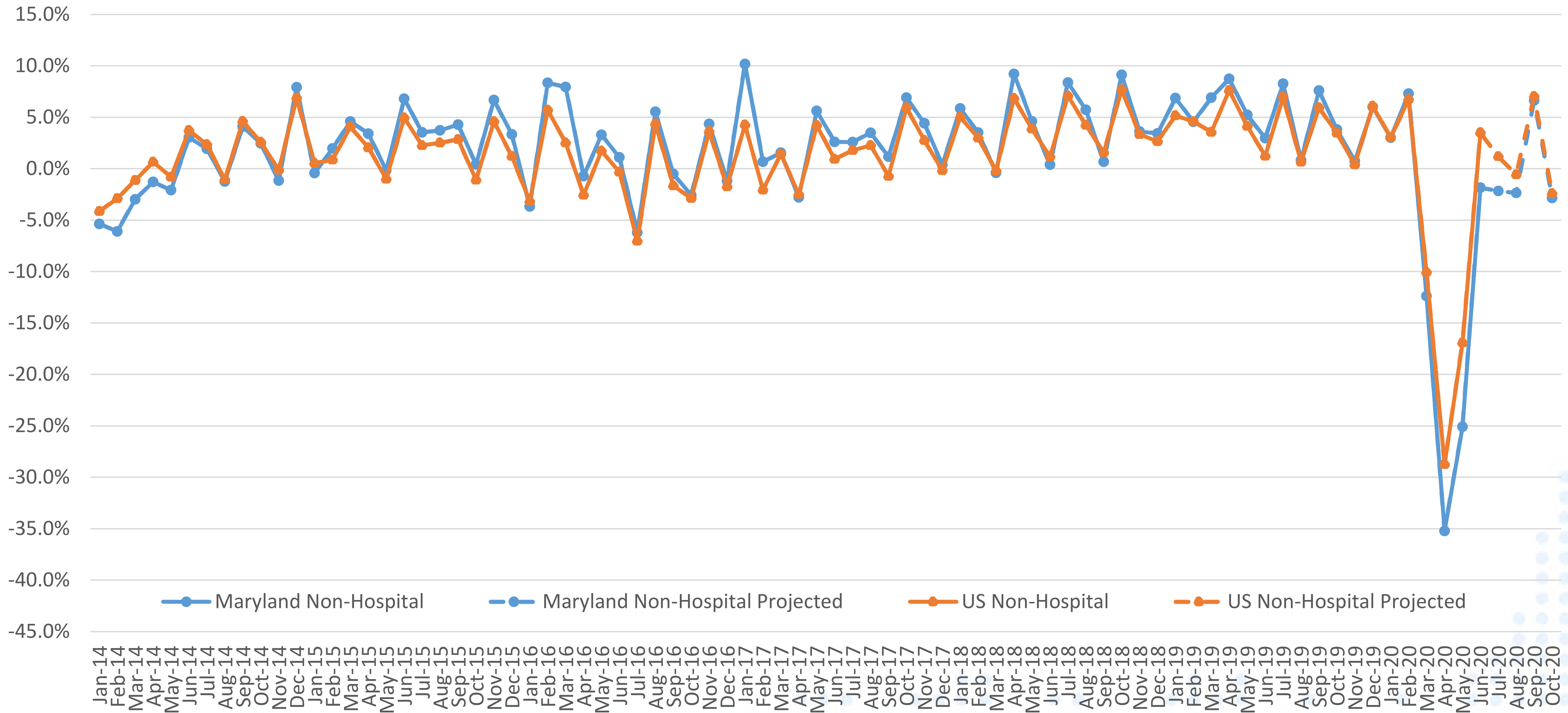
Actual Growth Trend (CY month vs. Prior CY month)



CY16 has been adjusted for the undercharge

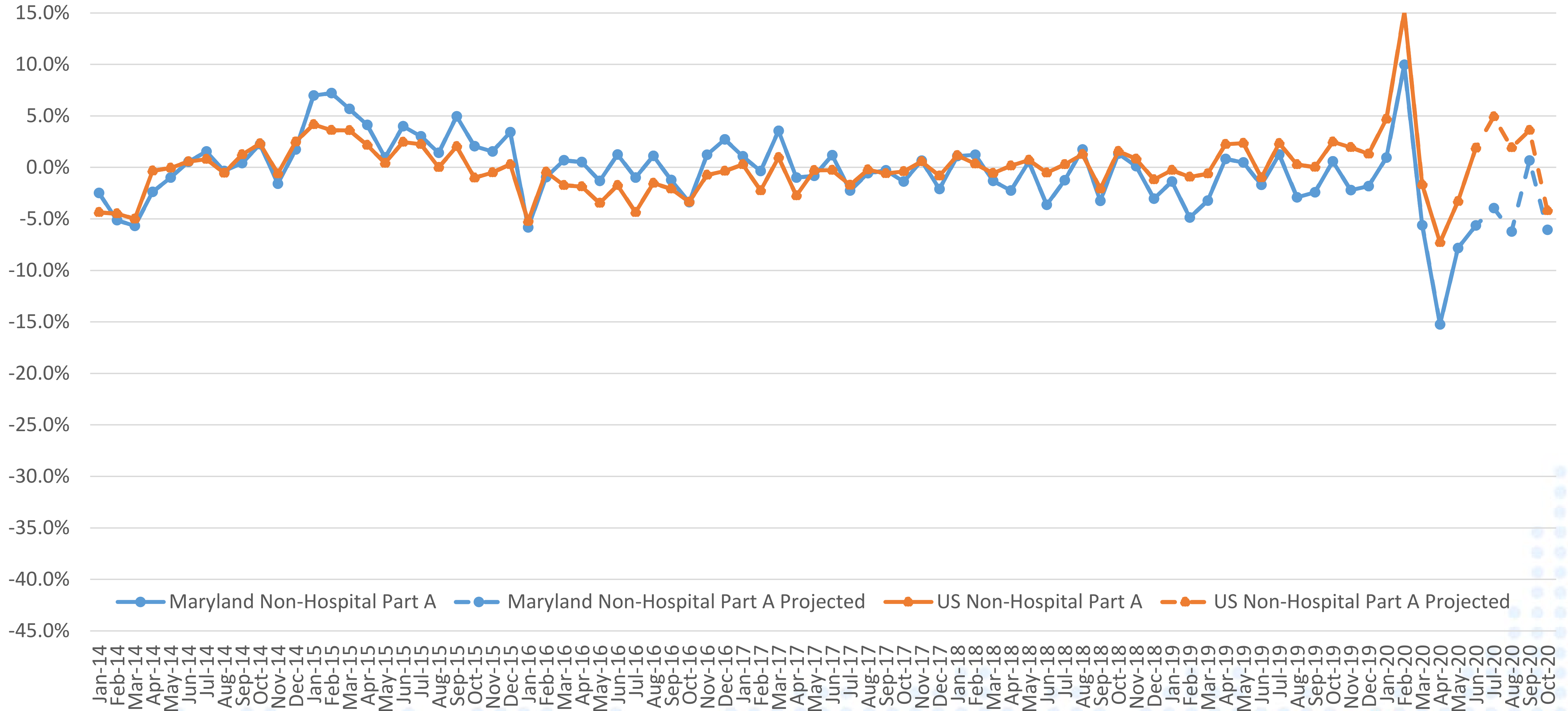
Non-Hospital Spending per Capita

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



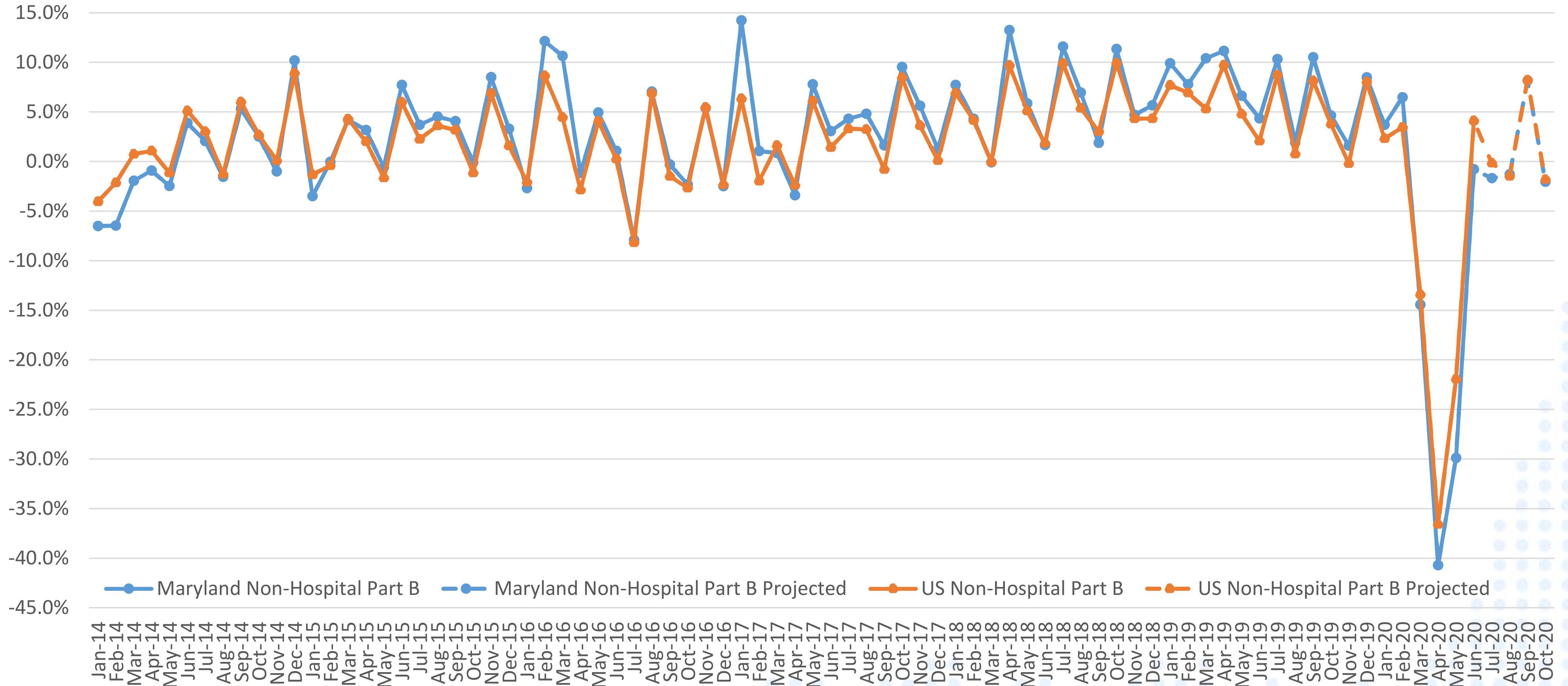
Non-Hospital Part A Spending per Capita

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

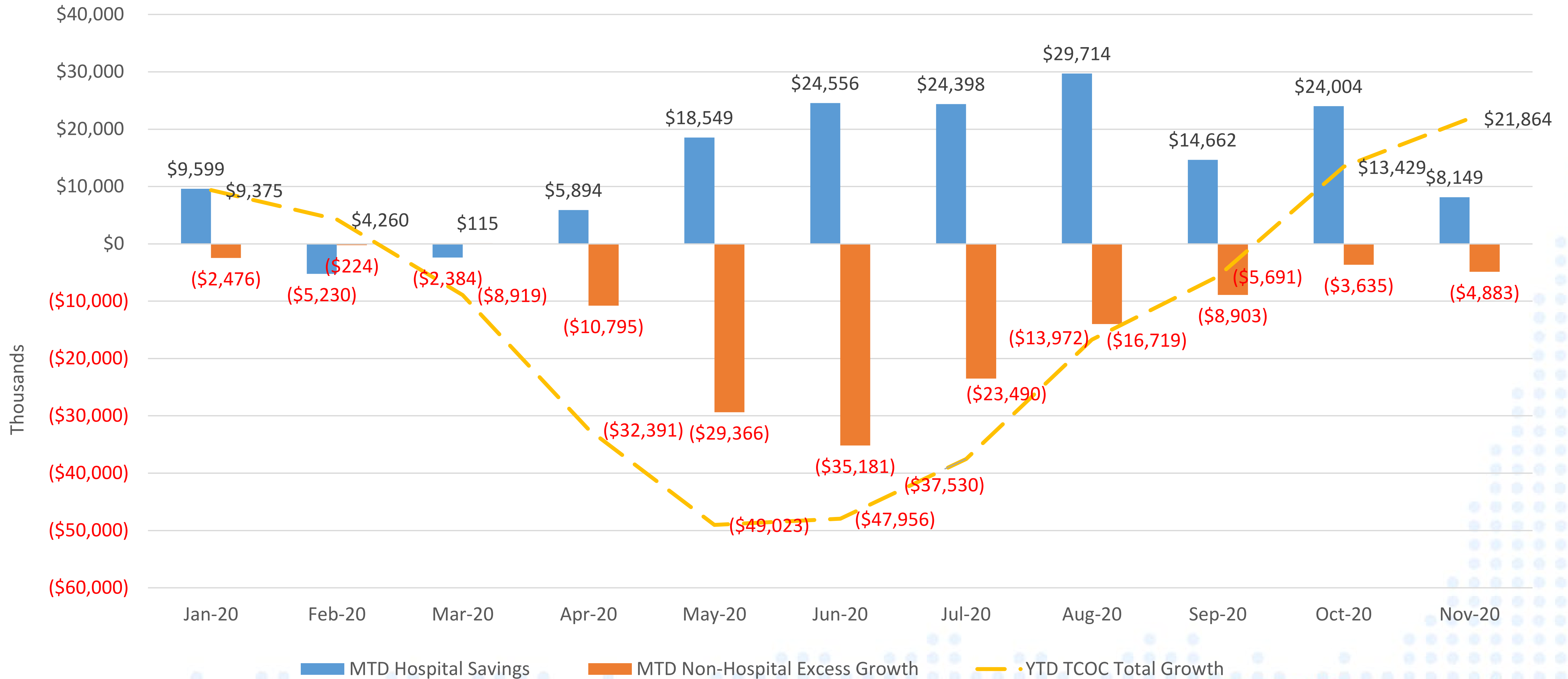


Non-Hospital Part B Spending per Capita

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



Maryland Medicare Hospital & Non-Hospital Growth
CYTD through November 2020



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Legislative Update

HSCRC March 2021 Commission Meeting

March 10, 2021

2021 Remaining Dates of Interest

- **March 16 –** Committee Courtesy Reporting Date
- **March 22 -** Opposite Chamber Cross-over Date
- **April 5 -** Budget bill to be passed by both chambers
- **April 12 -** Sine Die

Staff Activity with General Assembly

- Budget hearing
- Advocacy for amendments to telehealth bills and medical debt bills.
- Report, "*Analysis of the Impact of Hospital Financial Assistance Policy Options on Uncompensated Care and Costs to Payers*", mandated by House Bill 1420 (Ch. 470, 2020 Md. Laws), submitted 2/19/21.

Budget

Bill #	Description
HB 588	**Budget Bill for FY 2022 (The Governor's Budget)**
HB 589 SB 493	**Budget Reconciliation and Financing Act of 2021 (BRFA)**

- HSCRC budget hearing on February 15, 2021
  - DLS analysis focused on:
    - Hospital profits and federal pandemic-related funding
    - TCOC and MDPCP (study in 2021 interim)
    - Uncompensated care
  - Also note: No decrease to Medicaid Deficit Assessment compared to FY 21; $329,825,000 for FY 22 and beyond
- BRFA bill hearings on March 3, 2021

Telehealth Bills

Bill #	Description	HSCRC Actions
HB 123 SB 3	**Preserve Telehealth Access Act of 2021** • Requires Medicaid to provide medically necessary somatic, dental, or behavioral health services via telehealth. • Defines telehealth for Medicaid to include asynchronous and synchronous technology, audio-only, and remote patient monitoring. • Removes pre-PHE Medicaid telehealth limitations on where patients and providers are located. • Both Medicaid and private insurers must reimburse for telehealth at the same rate as in-person care.	HSCRC wrote a letter of information with amendments to protect flexibility in telehealth rate setting and policies related to clinic fees.
HB 731 SB 567	**Telehealth Services – Expansion** Lieutenant Governor’s bill; same provisions as HB 123/SB 3.	
HB 551 SB 393	**Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services** Similar to HB 123/SB 3, with a focus on mental health and SUD services and practitioners. Elements of this bill have been added to HB 123.	

Medical Debt Bill

Bill #	Description	HSCRC Actions
HB 565 SB 514	**Health Facilities - Hospitals - Medical Debt Protection** • Prohibits hospitals from filing an action for a patient who owes less than $1000, is uninsured, or has not been screened for financial assistance, and from handing collection activity for amounts less than $1000 over to a collection agency. • For purposes of payment plans, requires HSCRC to develop regulations containing standards for hospitals to determine the income of individuals who do not provide tax documents. • Establishes new reporting requirements on debt collection for hospitals. • Requires the HSCRC to submit an annual report to the legislature.	HSCRC wrote a letter of information requesting amendments. The letter: • Encouraged legislators to consider the impact of the bill on the sustainability of the UCC fund and hospital rates. • Asked for an amendment to strike the requirement for HSCRC to determine alternative tax documentation for payment plans. • Requested flexibility in the data sources that the Commission uses for reporting. • Requested an amendment to change references to hospital “costs” to hospital “charges”, to reflect Maryland’s all-payer rate setting model.

CRISP EHN and Nursing Home Data

Bill #	Description	HSCRC Actions
HB 1022 SB 748	**Public Health – State Designated Exchange – Clinical Information Sharing** Electronic Health Networks (EHN) • Requires EHNs to provide data on administrative transactions to the State-designated health information exchange (HIE) • The data must be used for public health and clinical purposes, such as informing ambulatory practices, urgent care centers, and hospitals about recent patient encounters. • EHNs may not charge providers or the HIE for the data. • The bill includes patient consent and communication requirements. Nursing Homes • MDH may require nursing homes to submit electronic clinical information to the State HIE. • The HIE can share the information with certain healthcare providers, government entities, and other HIEs. • The information can be used for state health improvement programs, mitigation of a public health emergency, or improvement of patient safety.	HSCRC submitted a letter of support

Questions?

Megan Renfrew

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Policy Update Report and Discussion

Staff will present materials at the Commission Meeting.

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Population-Based Methodologies

Tequila Terry
Director
Payment Reform & Provider Alignment

Gerard J. Schmith
Director
Revenue & Regulation Compliance

William Henderson
Director
Medical Economics & Data Analytics

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: March 10, 2020

RE: Hearing and Meeting Schedule

April 14, 2021 To be determined - GoTo Webinar

May 12, 2021 To be determined - GoTo Webinar

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

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

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